

OFFICIAL

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: **New Hampshire**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

NH-13-018

Proposed Effective Date

10/01/2013 (mm/dd/yyyy)

Federal Statute/Regulation Citation

42 CFR 435.10; 42 CFR 435, Subpart J and Subpart M

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	\$ 0.00
Second Year	2015	\$ 0.00

Subject of Amendment

This plan page is used to indicate the application forms and methods for individuals to apply for and renew Medicaid coverage. In addition, the page is used to indicate the frequency of Medicaid renewals and to document agreements for the coordination of eligibility and enrollment with other agencies administering insurance affordability programs.

Governor's Office Review

- Governor's office reported no comment
 Comments of Governor's office received

Describe:

- No reply received within 45 days of submittal
 Other, as specified

Describe:

Comments, if any, will follow.

Signature of State Agency Official

Submitted By: **Dawn Landry**
Last Revision Date: **Mar 6, 2014**
Submit Date: **Dec 31, 2013**

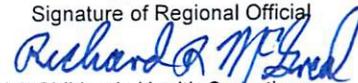
Date Received: 12/31/2013

Plan Approved - One Copy Attached

Effective Date of Approved Material: 10/01/2013

Typed Name: Richard R. McGreal

Date Approved: 03/11/2014
Signature of Regional Official



Division of Medicaid & Children's Health Operations
Boston, MA



Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

General Eligibility Requirements **S94**
Eligibility Process

42 CFR 435, Subpart J and Subpart M

Eligibility Process

- The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

- The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

- An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

- An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

- The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

- An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

- Yes No



Medicaid Eligibility

Indicate the other electronic means below:

	Name of Method	Description	
+	Fax	Applications can also be submitted through facsimile	X

The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Redetermination Processing

Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:

Once every 12 months

Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency

If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

Once every 12 months

Once every 6 months

Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Application for Health Coverage & Help Paying Costs

Use this application to see what coverage choices you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well.
- A new tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP)
- You may qualify for a free or low-cost program even if you earn as much as \$94,000 a year (for a family of 4).

Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- If you're single, you may be able to use a short form. Visit HealthCare.gov.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.

Apply faster online Go to HealthCare.gov or nheasy.nh.gov.

What you may need to apply

- Social Security numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family

Why do we ask for this information? We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. We'll keep all the information you provide private and secure, as required by law.

What happens next?

- Send your complete, signed application to the address on page 7.
- If you don't have all the information we ask for, sign and submit your application anyway. We'll follow-up with you within 1-2 weeks.
- You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, visit HealthCare.gov or call 1-800- 852-3345 ext. 9700. Filling out this application doesn't mean you have to buy health coverage.

Get help with this application.

- **Online:** HealthCare.gov
- **Phone:** Call Client Services at 1-800- 852-3345 ext. 9700.
- **In person:** There may be counselors in your area who can help. Call 1-800- 852-3345 ext. 9700 for more information.
- **En Espanol:** Llame a nuestro centro de ayuda gratis al 1-800- 852-3345 ext. 9700.

You can apply for additional programs by completing a few more questions

You can apply for these additional programs by filling out DFA Form 800MA Insert, included with this application. To apply for these programs, you must return all pages of this application, including the insert, to your local District Office.

- State Supplement Program (SSP) Medical Assistance: Aid to the Needy Blind (ANB), Aid to the Permanently and Totally Disabled (APTD), and Old Age Assistance (OAA).
- Long Term Care Services: If you are living in a Nursing Facility, or you require Home Care services, we may be able to help pay for some of those costs.
- Medicaid for Employed Adults with Disabilities, otherwise known as the MEAD program.
- Medicare Savings Programs (MSP) to help with your Medicare premiums.

Did you know that we offer other forms of assistance?

You may be able to get the following help from us:

- Food Stamps: The Food Stamp Program helps thousands of people buy healthy food.
- Cash: If you are having trouble paying your bills, we offer cash assistance for qualifying adults and families.
- Child Care: If you are having trouble paying for child care while you are working, looking for work, or going to school, we may be able to help pay for some of your child care costs.

YOU CANNOT USE THIS APPLICATION TO APPLY FOR THESE OTHER FORMS OF ASSISTANCE. If you want to apply for any of these other forms of assistance, go to www.nheasy.nh.gov to apply online, visit our website at www.dhhs.nh.gov/dfa/apply.htm to download an application, or call us at 1-800-852-3345 ext. 9700.

If you **ONLY** want to apply for Medicaid or federal payment assistance to help buy health coverage fill out all pages as best you can. Do not fill out any questions you do not understand. If you have questions, call Client Services at 1-800-852-3345 ext. 9700 OR ask the person helping you with this application.

NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov or call us at 1-800-345-3345 ext. 9700. Para obtener una copia de este formulario en Español, llame 1-800-852-3345 ext. 9700. If you need help in a language other than English, call 1-800-852-3345 ext. 9700 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-735-2964 or 711.



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STEP 1 Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

1. First name, Middle name, Last name, & Suffix:

2. Home address (Leave blank if you don't have one.):

3. Apartment or suite number:

4. City:

5. State:

6. ZIP code:

7. County:

8. Mailing address (if different from home address.):

9. Apartment or suite number:

10. City:

11. State:

12. ZIP code:

13. County:

14. Phone number:

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15. Other phone number:

() -

16. Do you have an email address? Yes No

If so, what is your Email address: _____

17. Would you like to get your notices online instead of getting them in the mail? Yes No

If you select "yes" above, a letter will be sent to you in the mail. This letter will contain the following:

- information about New Hampshire's online eligibility web portal, NH EASY;
- steps on how to establish a NH EASY account; and
- a time-sensitive PIN, which is needed to create a NH EASY account.

You must create a NH EASY account to receive your notices online. You can also check your application status and report changes through NH EASY!

18. Preferred spoken or written language (if not English).

STEP 2 Tell us about your family.

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage.)

DO Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner if you have children in common or if he or she needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:

- Your unmarried partner who doesn't need health coverage if you have no children in common
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than 2 people in your family, you'll need to make a copy of the pages and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

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STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & suffix: _____		2. Relationship to you? SELF	
3. Date of birth (mm/dd/yyyy) _____		4. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	

5. Social Security number (SSN): _____

We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

6. Do you plan to file a federal income tax return NEXT YEAR?
(You can still apply for health insurance even if you don't file a federal income tax return.)

YES. If yes, please answer questions a–e. NO. If no, skip to question d.

a. Will you file jointly with a spouse? Yes No

If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? Yes No

If yes, list name(s) of dependents: _____

c. Do any of these dependents live with someone else? Yes No

If yes, list name(s) of dependents: _____

d. Are you required to file a federal income tax return next year? Yes No

e. Will you be claimed as a dependent on someone's tax return? Yes No

If yes, please list the name of the tax filer: _____

How are you related to the tax filer? _____

7. Are you pregnant? Yes No If yes, a. how many babies are expected during this pregnancy? _____ b. due date: _____

8. Do you need health coverage? (Even if you have insurance, there might be a program with better coverage or lower costs.)

Yes. If yes, answer all the questions below No. If no, skip to the income questions on page 3.
Leave the rest of this page blank.

9. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? Yes No

10. Are you a U.S. citizen or U.S. national? Yes No

11. If you aren't a U.S. citizen or U.S. national, do you have eligible immigration status?

Yes. Fill in your document type and ID number below.

a. Immigration document type _____ b. Document ID number _____

c. Have you lived in the U.S. since 1996? Yes No d. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? Yes No

12. Do you want help paying for medical bills from the last 3 months? Yes No

13. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? Yes No

14. Are you a full-time student? Yes No 15. Were you in foster care at age 18 or older? Yes No

16. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)

Mexican Mexican American Chicano/a Puerto Rican Cuban Other _____

17. Race (OPTIONAL—check all that apply.)

<input type="checkbox"/> White	<input type="checkbox"/> Korean	<input type="checkbox"/> Japanese	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Filipino	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Other Pacific Islander
<input type="checkbox"/> Chinese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Samoan	<input type="checkbox"/> American Indian or Alaska native	<input type="checkbox"/> Other _____

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STEP 2: PERSON 1 (Continue with yourself)

Current Job & Income Information

Employed

If you're currently employed, tell us about your income. Start with question 18.

Not employed

Skip to question 28.

Self-employed

Skip to question 27.

CURRENT JOB 1:

18. Employer name and address

19. Employer phone number

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20. Wages/tips (before taxes) Hourly Weekly Every 2 weeks Twice a month Monthly Yearly

\$ _____

21. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

22. Employer name and address

23. Employer phone number

() --

24. Wages/tips (before taxes) Hourly Weekly Every 2 weeks Twice a month Monthly Yearly

\$ _____

25. Average hours worked each WEEK

26. In the past year, did you: Change jobs Stop working Start working fewer hours None of these

27. If self-employed, answer the following questions:

a. Type of work

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

\$ _____

28. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or supplemental security income (SSI).

- None
 - Unemployment \$ _____ How Often? _____
 - Pensions \$ _____ How Often? _____
 - Social security \$ _____ How Often? _____
 - Retirement \$ _____ How Often? _____
 - Alimony \$ _____ How Often? _____
 - Net farming/fishing \$ _____ How Often? _____
 - Rental/royalty \$ _____ How Often? _____
 - Annuity/trust \$ _____ How Often? _____
 - Other income \$ _____ How Often? _____
- Type: _____

29. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b).

- Alimony paid \$ _____ How Often? _____
 - Student loan interest \$ _____ How Often? _____
 - Other deductions \$ _____ How Often? _____
- Type: _____

30. **YEARLY Income:** Complete only if your income changes from month to month.

If you don't expect changes to your monthly income, skip to the next person. ➡

Your total income this year \$ _____	Your total income next year (if you think it will be different) \$ _____
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THANKS! This is all we need to know about you.

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STEP 2: PERSON 2

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & suffix: _____ 2. Relationship to you? _____

3. Date of birth (mm/dd/yyyy) _____ 4. Sex: Male Female

5. Social Security number (SSN): _____
We need this if you want health coverage and have an SSN.

6. Does PERSON 2 live at the same address as you? Yes No
If no, list address: _____

7. Does PERSON 2 plan to file a federal income tax return NEXT YEAR?
(You can still apply for health insurance even if you don't file a federal income tax return.)
 YES. If yes, please answer questions a-e. NO. If no, skip to question d.
a. Will PERSON 2 file jointly with a spouse? Yes No
If yes, name of spouse: _____
b. Will PERSON 2 claim any dependents on your tax return? Yes No
If yes, list name(s) of dependents: _____
c. Do any of these dependents live with someone else? Yes No
If yes, list name(s) of dependents: _____
d. Are you required to file a federal income tax return next year? Yes No
e. Will PERSON 2 be claimed as a dependent on someone's tax return? Yes No
If yes, please list the name of the tax filer: _____
How is PERSON 2 related to the tax filer? _____

8. Is PERSON 2 pregnant? Yes No If yes, a. how many babies are expected during this pregnancy? _____ b. due date: _____

9. Does PERSON 2 need health coverage? (Even if they have insurance, there might be a program with better coverage or lower costs.)
 Yes If yes, answer all the questions below ↓ No If no, skip to the income questions on page 5. ⇒
Leave the rest of this page blank.

10. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? Yes No

11. Is PERSON 2 a U.S. citizen or U.S. national? Yes No

12. If PERSON 2 isn't a U.S. citizen or U.S. national, do they have eligible immigration status?
 Yes. Fill in their document type and ID number below.
a. Document type _____ b. Document ID number _____
c. Has PERSON 2 lived in the U.S. since 1996? Yes No d. Is PERSON 2, or their spouse or parent a veteran or an active-duty member of the U.S. military? Yes No

13. Does PERSON 2 want help paying for medical bills from the last 3 months? Yes No
14. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child? Yes No
15. Were you in foster care at age 18 or older? Yes No

Please answer the following questions if PERSON 2 is 22 or younger:

16. Did PERSON 2 have insurance through a job and lose it within the past 3 months? Yes No
a. If yes, end date: _____ b. Reason the insurance ended: _____

17. Is PERSON 2 a full-time student? Yes No

18. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)
 Mexican Mexican American Chicano/a Puerto Rican Cuban Other _____

19. Race (OPTIONAL—check all that apply.)
 White Korean Japanese Native Hawaiian Guamanian or Chamorro
 Vietnamese Asian Indian Filipino Black or African American Other Pacific Islander
 Chinese Other Asian Samoan American Indian or Alaska native Other _____

Now, tell us about any income from PERSON 2 on the back. ⇒

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STEP 2: PERSON 2

Current Job & Income Information

Employed

If you're currently employed, tell us about your income. Start with question 20.

Not employed

Skip to question 30.

Self-employed

Skip to question 29.

CURRENT JOB 1:

20. Employer name and address

21. Employer phone number

() --

22. Wages/tips (before taxes) Hourly Weekly Every 2 weeks Twice a month Monthly Yearly

\$ _____

23. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

24. Employer name and address

25. Employer phone number

() --

26. Wages/tips (before taxes) Hourly Weekly Every 2 weeks Twice a month Monthly Yearly

\$ _____

27. Average hours worked each WEEK

28. In the past year, did PERSON 2: Change jobs Stop working Start working fewer hours None of these

29. If self-employed, answer the following questions:

a. Type of work

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

\$ _____

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or supplemental security income (SSI).

None

Unemployment \$ _____ How Often? _____ Net farming/fishing \$ _____ How Often? _____

Pensions \$ _____ How Often? _____ Rental/royalty \$ _____ How Often? _____

Social security \$ _____ How Often? _____ Annuity/Trust \$ _____ How Often? _____

Retirement \$ _____ How Often? _____ Other income \$ _____ How Often? _____

Alimony \$ _____ How Often? _____ Type: _____

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b).

Alimony paid \$ _____ How Often? _____ Other deductions \$ _____ How Often? _____

Student loan interest \$ _____ How Often? _____ Type: _____

32. **YEARLY Income:** Complete only if PERSON 2's income changes from month to month.

If you don't expect changes to PERSON 2's monthly income, skip to the next person.

PERSON 2's total income this year

PERSON 2's total income next year (if you think it will be different)

\$ _____

\$ _____

THANKS! This is all we need to know about PERSON 2.

? **NEED HELP WITH YOUR APPLICATION?** Visit HealthCare.gov or call us at 1-800-852-3345 ext. 9700 . Para obtener una copia de este formulario en Español, llame 1-800-852-3345 ext. 9700. If you need help in a language other than English, call 1-800-852-3345 ext. 9700 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-735-2964 or 711.

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STEP 2: PERSON 3

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & suffix: _____ 2. Relationship to you? _____

3. Date of birth (mm/dd/yyyy) _____ 4. Sex: Male Female

5. Social Security number (SSN): _____
We need this if you want health coverage and have an SSN.

6. Does PERSON 3 live at the same address as you? Yes No
If no, list address: _____

7. Does PERSON 3 plan to file a federal income tax return NEXT YEAR? (You can still apply for health insurance even if you don't file a federal income tax return.)

YES. If yes, please answer questions a–e. NO. If no, skip to question d.

a. Will PERSON 3 file jointly with a spouse? Yes No

If yes, name of spouse: _____

b. Will PERSON 3 claim any dependents on your tax return? Yes No

c. Do any of these dependents live with someone else? Yes No

If yes, list name(s) of dependents: _____

d. Are you required to file a federal income tax return next year? Yes No

If yes, list name(s) of dependents: _____

e. Will PERSON 3 be claimed as a dependent on someone's tax return? Yes No

If yes, please list the name of the tax filer: _____

How is PERSON 3 related to the tax filer? _____

8. Is PERSON 3 pregnant? Yes No If yes, a. how many babies are expected during this pregnancy? _____ b. due date: _____

9. Does PERSON 3 need health coverage? (Even if they have insurance, there might be a program with better coverage or lower costs.)

Yes If yes, answer all the questions below No If no, skip to the income questions on page 7. Leave the rest of this page blank.

10. Does PERSON 3 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? Yes No

11. Is PERSON 3 a U.S. citizen or U.S. national? Yes No

12. If PERSON 3 isn't a U.S. citizen or U.S. national, do they have eligible immigration status?

Yes. Fill in their document type and ID number below.

a. Document type _____ b. Document ID number _____

c. Has PERSON 3 lived in the U.S. since 1996? Yes No d. Is PERSON 3, or their spouse or parent a veteran or an active-duty member of the U.S. military? Yes No

13. Does PERSON 3 want help paying for medical bills from the last 3 months? Yes No

14. Does PERSON 3 live with at least one child under the age of 19, and are they the main person taking care of this child? Yes No

15. Was PERSON 3 in foster care at age 18 or older? Yes No

Please answer the following questions if PERSON 3 is 22 or younger:

16. Did PERSON 3 have insurance through a job and lose it within the past 3 months? Yes No

a. If yes, end date: _____ b. Reason the insurance ended: _____

17. Is PERSON 3 a full-time student? Yes No

18. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)

Mexican Mexican American Chicano/a Puerto Rican Cuban Other _____

19. Race (OPTIONAL—check all that apply.)

White Korean Japanese Native Hawaiian Guamanian or Chamorro
 Vietnamese Asian Indian Filipino Black or African American Other Pacific Islander
 Chinese Other Asian Samoan American Indian or Alaska native Other _____

Now, tell us about any income from PERSON 3 on the back. →

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STEP 2: PERSON 3

Current Job & Income Information

Employed

If you're currently employed, tell us about your income. Start with question 20.

Not employed

Skip to question 30.

Self-employed

Skip to question 29.

CURRENT JOB 1:

20. Employer name and address

21. Employer phone number

() --

22. Wages/tips (before taxes) Hourly Weekly Every 2 weeks Twice a month Monthly Yearly
\$ _____

23. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

24. Employer name and address

25. Employer phone number

() --

26. Wages/tips (before taxes) Hourly Weekly Every 2 weeks Twice a month Monthly Yearly
\$ _____

27. Average hours worked each WEEK

28. In the past year, did PERSON 3: Change jobs Stop working Start working fewer hours None of these

29. If self-employed, answer the following questions:

a. Type of work

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

\$ _____

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or supplemental security income (SSI).

None

Unemployment \$ _____ How Often? _____ Net farming/fishing \$ _____ How Often? _____

Pensions \$ _____ How Often? _____ Rental/royalty \$ _____ How Often? _____

Social security \$ _____ How Often? _____ Annuity/Trust \$ _____ How Often? _____

Retirement \$ _____ How Often? _____ Other income \$ _____ How Often? _____

Alimony \$ _____ How Often? _____ Type: _____

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If PERSON 3 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b).

Alimony paid \$ _____ How Often? _____ Other deductions \$ _____ How Often? _____

Student loan interest \$ _____ How Often? _____ Type: _____

32. **YEARLY Income:** Complete only if PERSON 3's income changes from month to month.

If you don't expect changes to PERSON 3's monthly income, move to step 3.

PERSON 3's total income this year \$ _____	PERSON 3's total income next year (if you think it will be different) \$ _____
-----------------------------------------------	-----------------------------------------------------------------------------------

THANKS! This is all we need to know about PERSON 3.

If you have more than three people to include, make a copy of Step 2: Person 3 (pages 6 and 7) and complete the questions for those people.

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STEP 3 American Indian or Alaska Native (AI/AN) family member(s)

1. Are you or is anyone in your family American Indian or Alaska Native?

- If No, skip to Step 4.
- Yes. If yes, go to Appendix B.

STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. Is anyone enrolled in health coverage now from the following?

- YES. If yes, check the type of coverage and write the person(s)' name(s) next to the coverage they have. NO.
- Medicaid _____ Employer insurance _____
- CHIP _____ Name of the health insurance: _____
- Medicare _____ Policy number: _____
- TRICARE (don't check if you have direct care of Line of Duty) Is this COBRA coverage? Yes No
Is this a retiree health plan? Yes No
- _____
- VA health care programs _____ Other
- Peace Corps Name of health insurance: _____
- Policy number: _____
- Is this a limited-benefit plan (like a school accident policy)?
 Yes No

2. Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone else's job, such as a parent or spouse.

- YES. If yes, you'll need to complete and include Appendix A. Is this a state employee benefit plan? Yes No
- NO. If no, continue to Step 5.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-XXXX. The time required to complete this information collection is estimated to average [insert time (hours or minutes)] per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail stop C4-26-05, Baltimore, Maryland 21244-1850.



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STEP 5 Read & sign this application.

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and or untrue information.
- I know that I must tell the Health Insurance Marketplace or the Medicaid agency if anything changes (and is different than) what I wrote on this application. I can visit HealthCare.gov or call 1-877-464-2447 to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If I have included an individual who is incarcerated, I understand this person will not be eligible for health benefits until they are released.

The following person is incarcerated _____ and will be released _____

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Marketplace to use income data, including information from tax returns. The Marketplace will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next

- 5 years (the maximum number of years allowed), or for a shorter number of years:
- 4 years 3 years 2 years 1 year Don't use information from tax returns to renew my coverage.

If anyone on this application is eligible for Medicaid

- I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home? Yes No
- If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.
- I understand that, if I am in a nursing home, DHHS must be able to exchange eligibility information with the nursing home to best administer the program. My signature below authorizes that exchange and remains in effect for as long as I receive DHHS assistance for my nursing home care.
- I understand that for long-term care services (Nursing Facility or Home and Community-Based Care), I am required to disclose to DHHS any interest that my spouse or I have in any annuity.
- I understand that if either my spouse or I are requesting long-term care services, any annuity purchased or modified by my spouse or me on or after February 8, 2006 will be considered a transfer of assets for less than fair market value unless the State is named the beneficiary for at least the amount of Medicaid paid for long-term care services.
- I understand that the information I have provided will be verified by collateral contacts and/or Federal, State, and local officials and that if any information is found to be incorrect or false, or if I have deliberately withheld information related to my receipt of assistance, now or in the future, I may lose my benefits and may be prosecuted for fraud.
- I understand that my signature below and/or on the application authorizes DHHS to obtain verification that I or anyone in my assistance group (AG) meet the eligibility requirements for assistance, and authorizes release of such information to DHHS. My authorization to release information to DHHS remains in effect for as long as I or anyone in my AG receives any kind of DHHS assistance.
- I understand that my signature below and/or on the application permits DHHS and any contracted third party entity to verify my income, identity, and assets, and the income, identity, and assets of any other person whose income, identity, and assets are required to determine eligibility for the assistance I am requesting. Failure to give permission to conduct these verifications or revoking permission to conduct these verifications will result in denial or termination of assistance.

My right to appeal

If I think the Health Insurance Marketplace or DHHS has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Marketplace or DHHS that I think the action is wrong, and ask for an administrative appeal of the action. I know that I can find out how to appeal by contacting the Marketplace at 1-800-318-2596 or DHHS at (603) 271-4292. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in Appendix C. Your signature below certifies, under penalty of perjury, that you have reviewed the information on this application, including any information indicated on the appendixes and insert, and it is true and complete to the best of my knowledge.

Signature _____

Date (mm/dd/yyyy) _____

STEP 6 Mail completed application.

Mail your signed application to CMU: Fax your signed application to CMU: Call in your application to Client Services:
Central Medicaid Unit (CMU) (603) 271-9700 or toll free
129 Pleasant Street (603) 271-8604 1-800-852-3345 ext. 9700
Concord NH 03301

If you would like to follow up on an application that has been mailed or faxed to CMU, you can call them at (603) 271-9729 or toll free at 1-877-464-2447.

If you are filling out DFA Form 800MA Insert, you must send all pages of this application, including the insert, to your local District Office.

APPENDIX A

Health Coverage from Jobs

You DON'T need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

EMPLOYEE Information

1. Employee name (First, Middle, Last) 2. Employee Social Security number

EMPLOYER Information

3. Employer name 4. Employer Identification Number (EIN)

5. Employer address 6. Employer phone number
() ---

7. City: 8. State: 9. ZIP code:

10. Who can we contact about employee health coverage at this job?

11. Phone number (if different from above) 12. Email address
() ---

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

Yes (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? (mm/dd/yyyy)
List the names of anyone else who is eligible for coverage from this job.

Name: Name: Name:

No (Stop here and go to Step 5 in the application)

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? Yes No

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$

b. How often? Weekly Every 2 weeks Twice a month Quarterly Yearly

16. What change will the employer make for the new plan year (if known)?
 Employer won't offer health coverage
 Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? \$

b. How often? Weekly Every 2 weeks Twice a month Quarterly Yearly

Date of change (mm/dd/yyyy):

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

EMPLOYEE Information

The employee needs to fill out this section.

1. Employee name (First, Middle, Last)	2. Employee Social Security number ____-____-____
----------------------------------------	------------------------------------------------------

EMPLOYER Information

Ask the employer for this information.

3. Employer name	4. Employer Identification Number (EIN) ____-____	
5. Employer address	6. Employer phone number () ---	
7. City:	8. State:	9. ZIP code:
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above) () ---	12. Email address	

13. Is the employee currently eligible for coverage offered by this employer, or will the employee become eligible in the next 3 months?

Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?

____/____/____
(mm/dd/yyyy)

No (Stop and return this form to employee)

Tell us about the health plan offered by this employer.

Does the employer offer a health plan that covers an employee's spouse or dependent?

Yes. Which people? Spouse Dependent(s)

No

(Go to question 14)

14. Does the employer offer a health plan that meets the minimum value standard*?

Yes (Go to question 15) No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans):

If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Quarterly Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Quarterly Yearly

Date of change (mm/dd/yyyy): _____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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APPENDIX B

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods.

Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1		AI/AN PERSON 2	
1. Name (First name, Middle name, Last name)	First	Middle	First	Middle
	Last		Last	
2. Member of a federally recognized tribe?	<input type="checkbox"/> Yes If yes, tribe name _____ <input type="checkbox"/> No		<input type="checkbox"/> Yes If yes, tribe name _____ <input type="checkbox"/> No	
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: <ul style="list-style-type: none"> Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) Money from selling things that have cultural significance 	\$ _____ How often? _____		\$ _____ How often? _____	

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APPENDIX C

Authorized Representative Declaration

You may choose an authorized representative to help you with some or all of the requirements of applying for or getting Medical Assistance. An authorized representative is a friend, relative or other person who has a concern for your well-being. An authorized representative is a person you choose. We will not choose one for you. The person you choose must agree to help you. An agency cannot act as an authorized representative, but an individual at an agency can. An authorized representative must be an individual person.

An authorized representative may fill out an application form and other paperwork for you. They may also report changes in your income, resources, and other changes for you. They may receive your medical assistance ID card, and other mail from us. You get to choose what you would like them to do for you or on your behalf by checking the boxes below.

AUTHORIZED REPRESENTATIVE DUTIES

Check off the things that you want the authorized representative to do for you:

- Get my application, forms and other Department paperwork, and fill these forms out for me.
- Provide the Department with proof of my income, resources, and other case information, and report and verify changes in my case circumstances to the Department for me.
- Receive my notices from the Department.
- Receive my medical assistance ID card for me.
- Go to my eligibility interviews for me.
- Other: _____

CLIENT'S SIGNATURE

Please read the following statements carefully. Your signature below means you have read and understand these statements.

- I **certify** that I have read and understand the information on this form.
- I **understand** that I am responsible for any errors, omissions, or inaccurate information that my authorized representative reports to the District Office.
- I **understand** that if my authorized representative uses my benefits without my permission, these benefits will not be replaced or reissued by the Department of Health and Human Services.
- I **understand** that the person I named as my authorized representative will continue to act for me unless I tell the Department in writing of a change.

Client's Signature

Date

Client's Printed Name



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AUTHORIZED REPRESENTATIVE INFORMATION

Tell us your authorized representative's name, address, and telephone number. Please print clearly.

1. Name of authorized representative (First name, Middle name, Last name)

2. Address		3. Apartment or suite number
4. City:	5. State:	6. ZIP code:
7. Phone number () ---		
8. Describe your relationship to the authorized representative.		9. Date of Birth (Optional)
10. Agency name (if applicable)		

AUTHORIZED REPRESENTATIVE'S SIGNATURE

I certify that I have read and understand the information on this form. I agree to accept the duties noted on this form and understand the following:

- **I understand** that I must give proof of my identity to act as an Authorized Representative.
- **I understand** that if I have been disqualified for a program violation, I cannot act as an Authorized Representative unless there is no one else suitable to represent this individual.
- **I understand** that the Department has the authority to discontinue my ability to act as an Authorized Representative if it is determined that I am not acting in the best interest of the household I am assisting.

Authorized Representative's Signature

Date

Authorized Representative's **Printed** Name

FOR CERTIFIED APPLICATION COUNSELORS, NAVIGATORS, AGENTS, AND BROKERS ONLY.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)

2. First name, Middle name, Last name, & Suffix

3. Organization name

4. ID number (if applicable)

APPLICATION FOR ASSISTANCE

Welcome to the Department of Health & Human Services (DHHS), Division of Family Assistance (DFA)

To apply for the programs and services we offer, you must fill out this *Application for Assistance*, have an interview, and give us proof of your household circumstances. Please read all of the information given to you, and answer all of the questions as best as you can. **Do not answer anything that you do not understand.** If you need help in filling out this *Application*, tell us. **We will accept your Application even if you only fill in your name, address, and signature.** However, we will be able to figure out if you can get benefits much quicker if you complete the entire *Application*. DFA assistance is based on your income. Some DFA programs may also look at the cash value of things that you own, your "assets," when figuring out if you qualify for a program DFA offers.

Food Stamp (FS) Benefits

The Food Stamp Program helps low-income people buy the food they need for good health. You will need to have an interview with a DHHS worker to see if you are eligible for this program. **Your FS benefits are based on the date of application.**

With identification, you may get emergency FS benefits within 7 calendar days if:

- you have less than \$150 in monthly gross income and no more than \$100 in liquid resources;
- you have shelter costs that are higher than your gross income and liquid resources; **or**
- you are a migrant or seasonal farm worker who is destitute as defined in 7 CFR 273.10(e)(3).

Social Security Numbers (SSN)

The Federal Privacy Act of 1974 as amended, requires that we tell you the laws that allow us to ask for the SSN of each person requesting assistance, whether you are required to give them to us, and what we will do with them. SSNs are required for the following programs. After each program is the law or regulation that requires us to ask for these SSNs, or why we need it:

- FANE: 42 USC 405(c)(2), 45 CFR 205.52, RSA 167:4-c, & RSA 167:79,iii(h).
- Food Stamps: RSA 167:4-c, Food Stamp Act of 1977, as amended, 7 USC 2011-2036, 7 CFR 273.2(b)(4), & 7 CFR 273.6.
- Medical Assistance and other financial assistance: RSA 167:4-c, Section 2651 of PL 98-369, 42 CFR 435.910, 42 CFR 435.920, & 42 USC 1320b-7.

Each person who wants assistance from the above programs must provide an SSN or apply for a number at the Social Security Administration (SSA).

If you are applying only for some members of your family, such as a parent applying for Medical Assistance just for a child, you only have to give us the child's number or apply for one for your child. Your child's eligibility for medical coverage will not be affected if you don't give us your SSN.

If an SSN is not provided for each person who is applying for the listed programs, your application may be denied or you may get less benefits. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

Applicants for NH Child Care Scholarship only do not have to provide an SSN but if SSNs are provided it may help shorten the eligibility verification process.

We ask for SSNs so we can verify identity, earned and unearned income, and resource information you give us. It will be shared with:

- federal, state, and local entities;
- various offices within DHHS as allowed by federal law;
- employment and unemployment databases;
- the Internal Revenue Service and SSA;
- financial entities; and
- other computer matching programs.

The information will be used:

- to figure out if your household is eligible or continues to be eligible for the assistance you requested;
- to figure out the amount of your benefits or errors in your eligibility or benefits; and
- in an investigation of suspected abuse of program law or rules.

This information may be disclosed to other Federal and State agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law. If a

Food Stamp claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action.

We do not give SSNs or any other information regarding non-applicants to the US Citizenship and Immigration Services (USCIS), formerly known as INS, or any other agency not directly connected with programs and/or services offered by DHHS.

Emergency Medicaid for Non-Citizens

Emergency Medicaid may be available to certain non-citizens, regardless of their immigration status, to cover some emergency services, including labor and delivery. **Social Security Numbers are not needed to apply for Emergency Medicaid.**

Citizenship & Identity

You must declare and prove the citizenship or non-citizenship status of each household member applying for assistance. Non-citizens applying for assistance, except Emergency Medicaid, must provide USCIS documentation of qualified alien status. USCIS documentation will be verified.

Third Party Insurance or Medical Payments

If you are applying for Medical Assistance, receipt of such assistance is an assignment to DHHS of your rights to all third party insurance or medical payments without anyone having to sign any other form. All available parties must be billed and all resulting payments must be applied to the cost of medical care before DHHS will pay. Also, if you receive a settlement or an award from a liable third party, you must pay DHHS back for related medical services we paid. RSA 167:14-a

Benefits Received in Error

You are required to pay back any benefits or services received in error, regardless of whether you made a mistake in the information you provided, or failed to provide, to us. If you get Food Stamps, you must also pay back any benefits you

received in error if we made a mistake in processing your case.

Financial or Medical Child Support

If you are applying for TANF cash payments, your receipt of such assistance is an assignment to DHHS of your rights to financial child support. Without signing any other form, you give DHHS the right to collect and keep financial child support payments made on behalf of your children who receive assistance. RSA 161-C:22

DHHS collects and keeps the support to partially offset the amount of cash assistance paid to you. If support payments are equal to or more than the amount we give you, your cash assistance case will be closed and the support payments sent to you.

Receipt of Children's Medicaid is an assignment of medical child support rights. This means that you must cooperate with DHHS to establish and enforce medical child support for your children. Medical child support usually means health insurance provided by the absent parent, but can also be an ongoing dollar amount paid by the other parent to allow you to buy health insurance for your children.

If you receive money to purchase medical insurance, this money will be kept by the State if you receive Medicaid for your child and will be used to pay back the state and federal governments. If paternity is not established for any of your children who are getting Medicaid, you must also cooperate with DHHS to legally establish paternity.

The assignment of support rights is a requirement. Your rights and responsibilities and the penalty for refusal without a good reason, will be explained to you when you meet with your District Office worker.

Begin Date for Medicaid Eligibility

Your Medicaid eligibility generally begins on the day that you meet all the requirements for the program you applied for, including the resource limit.

AGENCY USE ONLY

This is your record of application and will be filled out by a Department of Health and Human Services worker and returned to you. DFA has received a completed application for _____ from _____ on _____

District Office

Signature of Worker

Initials: _____

APPLICATION FOR ASSISTANCE

A. Please tell us about who you are and where you live.

Name: _____ Primary Language: _____

Current Place of Residence: Own home Nursing Facility Adult Family Home Assisted Living
 Congregate Housing Homeless Hospital Hotel/Motel Residential Care Facility Other

Street Address: _____ Mailing Address: _____
 (if different)

City/State/Zip: _____

Home Phone: _____ Work Phone: _____ Cell/Message: _____

E-Mail Address: _____ I do not have an E-Mail address.

Does anyone in your family have Medicare Part A or B? Y N

Why do you need our help? _____

Information Supplier: _____
 (if different from applicant) Name Address Phone #

OFFICIAL

B. Please tell us about the people you live with. Start with yourself and list ALL of the people living with you. You do not have to give the Social Security Number or citizenship status of any individual who is not applying for assistance.

Name	SSN	DOB	Relation to you	U.S. Citizen?	Student (Yes or No. If Yes, put grade too)	RID (DFA Use Only)
1.			SELF	<input type="checkbox"/> Y <input type="checkbox"/> N		
2.				<input type="checkbox"/> Y <input type="checkbox"/> N		
3.				<input type="checkbox"/> Y <input type="checkbox"/> N		
4.				<input type="checkbox"/> Y <input type="checkbox"/> N		
5.				<input type="checkbox"/> Y <input type="checkbox"/> N		
6.				<input type="checkbox"/> Y <input type="checkbox"/> N		

C. I want to apply for: (TYPES OF ASSISTANCE REQUESTED)

ALL PROGRAMS Cash Food Stamps Child Care

Home and Community-Based Care (HCBC) Medicare Savings Programs (MSP) [QMB/QWDI/SLMB/SLMB135]

Nursing Facility (NF) Services - Facility Name: _____

Medical Assistance – if you need Medical Assistance for a child, pregnant women, or parent/caretaker relative of a child, you must also complete the insert entitled *Medical Assistance for Children, Pregnant Women, and Parent/Caretaker Relatives Insert*

D. The following information is collected to be sure that everyone is served fairly. Your answers are voluntary. The information provided will not affect your eligibility or benefit amount.

Are you Hispanic or Latino? Yes No

Are you: White? Y N Asian? Y N Native Hawaiian or Other Pacific Islander? Y N
 Black or African American? Y N American Indian or Alaskan Native? Y N

AGENCY USE ONLY:						
RFA#	Case #				Forms Given:	
Cash	_____	OPEN	CLOSE	DENY	DATE: _____	DO: _____
Food Stamps	_____	OPEN	CLOSE	DENY	DATE: _____	DO: _____
MA	_____	OPEN	CLOSE	DENY	DATE: _____	DO: _____
CM/MCPW	_____	OPEN	CLOSE	DENY	DATE: _____	DO: _____
Child Care	_____	OPEN	CLOSE	DENY	DATE: _____	DO: _____

PLEASE SIGN YOUR APPLICATION ON THE BACK!

EBT Card Status: None Active Deactivated Cancelled

E. Please tell us about all income for everyone in your home.

Your Wages: \$ _____ Weekly Bi-Weekly Monthly
 Other Wages: \$ _____ Weekly Bi-Weekly Monthly
 Other Wages \$ _____ Weekly Bi-Weekly Monthly
 Has anyone recently lost a job? Yes No
 If yes, who? _____ When? ____ / ____ / ____
 SSA/SSDI: \$ _____ Spousal Support: \$ _____
 SSI: \$ _____ Unemployment: \$ _____
 VA: \$ _____ Child Support: \$ _____
 Pension: \$ _____ Other: \$ _____

G. Your Expenses:

Rent (monthly): \$ _____
 Mortgage (monthly): \$ _____
 Lot Rent/Condo Fee (monthly): \$ _____
 Taxes (yearly): \$ _____
 Dependent Care: \$ _____
 Medical Expenses: \$ _____

F. Please tell us about all assets for everyone in your home.

Checking/Savings: \$ _____ Other Chk/Save: \$ _____
 Stocks/Bonds/CD's: \$ _____ IRA: \$ _____
 Your or Your Spouse's Annuity: \$ _____ Other Assets: \$ _____
 Trusts: \$ _____ Life Insurance: \$ _____
 Vehicle (Yr/Mdl): _____ Vehicle (Yr/Mdl): _____

Do you pay for the following utilities separate from your rent or mortgage?

Heat: Yes No
 Phone: Yes No
 Electric: Yes No
 Other: Yes No

H. Potential Eligibility Questionnaire

1. Are you a migrant or seasonal farm worker? Yes No
2. **Have you or anyone in your household received Food Stamp assistance for this month?** Yes No
3. Are you currently living in a shelter for battered individuals? Yes No
4. **Is anyone in your household blind or disabled?** Yes No
5. Have you sold or transferred property in the last 5 years? Yes No
6. **Is anyone in your household currently receiving assistance from another State?** Yes No
 If yes, which State? _____ What kind of assistance? _____
7. Is anyone in your household pregnant or has anyone given birth in the last 3 months? Yes No
8. **Do you have any unpaid medical bills from the past 3 months that you would like help paying?** Yes No
9. If you are applying for Financial Assistance to Needy Families (FANF), is the father's name blank or "not stated" on the birth certificate for any of your children? Yes No
10. **If applying for FANF, how many absent parents?** _____
11. Do you or any other household member have health insurance other than Medicaid? Yes No
 If yes, name of Insurer? _____ Policy Number: _____

I. Signatures

I CERTIFY, UNDER PENALTY OF PERJURY, THAT I HAVE REVIEWED THIS INFORMATION ON THIS APPLICATION, INCLUDING ANY INFORMATION INDICATED ON THE INSERT; IT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE, INCLUDING THE INFORMATION CONCERNING CITIZENSHIP AND ALIEN STATUS. I UNDERSTAND A FULL FINANCIAL AND MEDICAL ELIGIBILITY INTERVIEW MAY NEED TO BE CONDUCTED BEFORE MY ELIGIBILITY CAN BE DETERMINED.

 Applicant Signature Date

 Signature of Person Helping the Applicant Date Relationship to Applicant

I withdraw my application for: Cash Medical Assistance Food Stamps Child Care HCBC/NF MSP

 Signature Date

I certify that I have given the above individual(s) the opportunity to review this application. I also certify that I have provided a copy of this form, if one was requested.

Printed Name & Signature

Title/Agency

Date

OFFICIAL

APPLICATION: YOUR RIGHTS AND RESPONSIBILITIES

Time Limits

You can only receive Financial Assistance to Needy Families for 60-months in your lifetime. Months you received this assistance while you were a child do not count towards the lifetime limit. Your time limit begins when you receive benefits as an adult. **There is no time limit on State Supplement Programs, Medical Assistance, Food Stamp benefits, or child care assistance.**

Nondiscrimination Notice

In accordance with Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is also prohibited on the basis of religion or political beliefs.

To file a complaint of discrimination, contact USDA or HHS. Write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (202) 720-5964 (voice & TDD). Write HHS, Director, Office of Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TTY). USDA and HHS are equal opportunity providers and employers. Or you may also write Ombudsman, NH DHHS, 129 Pleasant St., Concord, NH 03301-3857 or call (603) 271-6941 or 1-800-852-3345 ext 6941. TDD Access: Relay NH 1-800-735-2964 or 711.

Administrative Appeal

You or someone representing you may request an Administrative Appeal if you are not satisfied with any decision regarding eligibility made by DHHS. You may be represented by an attorney, yourself, or another person, such as a relative or friend, at an Administrative Appeal. DHHS will not pay for the cost of any legal services, but there are free and reduced cost legal services available in NH. An Administrative Appeal may be requested either verbally or in writing by contacting a District Office or DHHS, 105 Pleasant Street, Concord, NH 03301-6521. Telephone (603) 271-4292 or 1-800-852-3345 ext 4292; TDD Access: Relay NH 1-800-735-2964 or 711.

Quality Control

Your case may be selected for a quality control or other governmental review. Such a review entails an in-depth investigation into your household's financial or medical situation, living arrangements and other circumstances. We may be contacting banks, employers, companies, merchants, child care providers, and other appropriate sources, concerning your household and statements you made to DHHS. **Failure to cooperate in these reviews could result in the loss of your benefits.**

Reporting Changes

You will be required to periodically complete a review of your circumstances. Your cash, child care, and Food Stamp case could be closed, and/or your eligibility for Medical Assistance may be affected, if you do not completely fill out the form and return it by the due date and participate in a personal interview, if required.

If you only get Food Stamp benefits and you have a 4, 5, or 6-month eligibility period, you only need to report those changes in household circumstances that would place your household's income above 130% of the poverty level.

If you receive cash, child care, Medical Assistance, or if your Food Stamp eligibility period is not 4, 5, or 6 months, then you must notify the Department within 10 calendar days after the change happens for changes in factors that affect eligibility, such as:

- source of income;
- hours worked by a household member;
- amount of income of any member in your household;
- all household changes, such as marriage, divorce, new baby, child leaves, etc.;
- child care provider;
- resources (e.g., cash, stocks, bonds, or money in a bank or savings account);
- receipt of any lump sum payment or settlement;
- residence, or shelter costs; or
- dependent care costs, child support payments or medical deductions, or other changes that may affect the amount of your household's benefits.

Protection of Medical Assistance for Social Security Beneficiaries

If you are receiving cash assistance under the OAA, ANB, or APTD program, and a Social Security cost-of-living increase or this increase combined with an increase in other income makes you ineligible for financial assistance, you may still be entitled to Medical Assistance under the Pickle Amendment policy.

Once you begin receiving Medical Assistance under the Pickle Amendment, future Social Security cost-of-living increases will not affect your eligibility. However, other changes in your circumstances can still make you ineligible for Medical Assistance.

If you are eligible to receive money payments under one of the above programs, but choose not to receive a payment, you will **NOT** be entitled to this protection of your Medical Assistance under the Pickle Amendment.

ATTENTION!

Anything you tell or give to us will be verified:

- at the federal, state and local levels; and also
- through collateral contacts and/or computer matching with other electronic verification tools such as, but not limited to, USCIS, IEVS, Vital Records, SSA, financial institutions, & employment databases.

We do this to confirm your eligibility for our programs and determine your benefits. If any information we get from using these sources doesn't match the information you provided to us, you may be denied assistance, your benefits may change, and you may be subject to criminal prosecution for knowingly providing false information. Any member of your household who breaks any of these rules on purpose can be prohibited from participating in the cash assistance, child care assistance, and Food Stamp programs for periods ranging from one year to permanently. In the Food Stamp Program, you can also be fined up to \$250,000, imprisoned up to 20 years, or both, and will be subject to prosecution under the applicable state and federal laws for violations of the Food Stamp Act.

Notice to Immigrant Families

If you get help with health care or Food Stamps, it will not affect your immigration status. If you or members of your family used or received Medicaid or Food Stamps, it will not affect your or your family members' ability to become U.S. citizens. However, if you get cash assistance such as TANF or help with the cost of nursing home care, it might create problems with becoming a U.S. citizen, especially if the benefits are your family's only income. Before you apply, you may want to talk with an agency that helps immigrants with legal questions or contact the US Citizenship and Immigration Services (USCIS).

DO NOT

- Do not give false information or hide information to get or continue to get benefits.
- Do not trade or sell Food Stamp benefits to anyone who is not authorized to use them for your household.
- Do not use Food Stamp benefits to buy ineligible items, such as alcoholic drinks and tobacco.
- Do not use any benefits your household was not entitled to receive.
- Do not give your EBT Card PIN out to anyone.
- Do not use child care services paid for by DHHS, for employment-related activities not approved by DHHS.
- Do not use your EBT card or cash from your EBT card at liquor stores, gaming establishments, or businesses which provide adult-oriented entertainment.

Identity & Residence

Anyone convicted of making a fraudulent statement or representation with respect to identity or residence in order to receive benefits in two locations at the same time will be ineligible for financial assistance and Food Stamp benefits for 10 years.

Trafficking Food Stamp Benefits

Any person who is found guilty in a court of law for buying or selling illegal drugs or certain prescription drugs in exchange for Food Stamp benefits, will be prohibited from participating in the Food Stamp Program for 24 months for the first offense and permanently for the second offense. Any person who is found guilty in a court of law for buying or selling ammunition, firearms or explosives in exchange for Food Stamp benefits, or of any trafficking in Food Stamp benefits of more than \$500, will become permanently ineligible for Food Stamp benefits.

Medical Assistance Fraud

Section 1128B of the Social Security Act provides federal penalties for fraudulent acts and false reporting in connection with your application for or receipt of Medical Assistance benefits.

A person may be prosecuted in Federal Court for deliberate statements that are known to be false and which affect eligibility for any benefit or payment under the Medical Assistance program.

A person may also be prosecuted for concealing or failing to disclose any event that affects their right to any benefit or payment, or its conversion to a use other than intended. The law also provides a penalty for a kickback, bribe, or rebate in connection with the furnishing of Medical Assistance.

Conviction of an offense could result in loss of Medical Assistance benefits for a period not to exceed 1 year. Penalties are fines up to \$25,000 or imprisonment for not more than 5 years, or both.

Intentional False Statements

Any person who intentionally makes a false statement or misrepresents his or her circumstances or intentionally fails to disclose the receipt of property, wages, income or resources or any change in circumstances that would affect his or her initial or continued eligibility for assistance may be found guilty of violating state law. The penalties are: a class A felony where the value of the monetary award or goods or services exceeds \$1,000; a class B felony where the value exceeds \$100; and a misdemeanor where the value does not exceed \$100. RSA 167:17-b and 17-c.

APPLICATION: STATEMENTS OF UNDERSTANDING

INITIALS

All Programs

I **certify** that I have read "Your Rights and Responsibilities," and I understand them. _____

I **understand** that DHHS will keep my eligibility and case information confidential and only persons involved in administering DHHS' programs or as otherwise permitted by Federal regulations or State law will review it. _____

I **understand** that despite other rules of confidentiality, names of children in Food Stamp and/or FANF households are required to be released to schools so that they may be determined automatically eligible for Free School Meals. _____

I **understand** that I must provide proof of: my household situation, what I have written on the application, and what I have told DHHS. _____

I **understand** that the information I have provided will be verified by collateral contacts and/or Federal, State, and local officials and that if any information is found to be incorrect or false, or if I have deliberately withheld information related to my receipt of assistance, now or in the future, I may lose my benefits and may be prosecuted for fraud. _____

I **understand** that my signature below and/or on the application authorizes DHHS to obtain verification that I or anyone in my assistance group (AG) meet the eligibility requirements for assistance, and authorizes release of such information to DHHS. My authorization to release information to DHHS remains in effect for as long as I or anyone in my AG receives any kind of DHHS assistance. _____

I **understand** that my signature below **and/or** on the application permits DHHS and any contracted third party entity to verify my income, identity, and assets, and the income, identity, and assets of any other person whose income, identity, and assets are required to determine eligibility for the assistance I am requesting. Failure to give permission to conduct these verifications or revoking permission to conduct these verifications will result in denial or termination of assistance. _____

Cash & Food Stamp Programs

I **certify** that if I applied for FANF, the Domestic Violence Option has been explained to me, and I understand it. _____

I **certify** that if I applied for FANF, I got written information about the treatment of lump sum income. _____

I **understand** that my receipt of TANF cash assistance is an assignment to DHHS of each recipient's rights to child and spousal support. _____

I **understand** that if I get cash assistance from DHHS, the cash I get could cause my Food Stamp benefits to end or be reduced. I also understand that if this happens, I will not get advance notice of this change. _____

I **understand** that to get a cash payment from any DFA program, I must be eligible to get that cash every day of the entire payment period. If I am not eligible for cash at any time during that payment period, I understand that a cash payment will not be issued to me. _____

I **understand** that in NH, if anyone in my household is fleeing to avoid prosecution of a felony crime, or is violating conditions of probation or parole, that person will be ineligible to get cash or Food Stamp benefits until that individual has satisfied his/her legal obligations with respect to the felony crime or probation or parole violations. My signature below is my sworn statement that no one in my household at this time is fleeing felony prosecution or violating conditions of probation or parole. _____

I **understand** that the use of my Electronic Benefits Transfer (EBT) card for Food Stamp or cash benefits is controlled by my 4-digit Personal Identification Number (PIN), that I am responsible for the security of my EBT card and PIN, and that EBT benefits will not be replaced if someone else uses my card after I have activated it. _____

I **understand** that if I do not use my Food Stamp benefits on my EBT card for 365 days in a row, I will lose those benefits and not get them back. If I do not use my cash benefits for 90 days in a row, I will lose those benefits and not get them back. I understand that I will be disqualified from the Food Stamp Program and may be prosecuted if I use my EBT card for illegal purposes. These illegal activities include selling my card and my PIN for cash, drugs, or other items, or exchanging Food Stamp benefits for cash at a retailer. _____

PLEASE INITIAL AND SIGN THE BACK!

Cash & Food Stamp Programs Con't

INITIALS

I understand that for Food Stamp benefits, to get a deduction for child care expenses, rent or mortgage payments, utility or other shelter expenses, child support paid to a non-household member, or medical expenses (only for the elderly or disabled), I **must** tell DHHS about these expenses and then provide proof of them. Failure to report or verify any of the above listed expenses, or of receipt of fuel assistance, could mean that I will get less Food Stamp benefits each month, and will be seen as my statement that my household does not want to get a deduction for the unreported or unverified expense.

I understand that my EBT card or cash from my EBT card cannot be used at liquor stores, gaming establishments, or businesses which provide adult-oriented entertainment, and that if I use my EBT card or cash from my EBT card at one of these places, I will be sanctioned with a cash penalty, per RSA 167:7-b.

Medical Assistance

I understand that my receipt of medical assistance is an assignment to DHHS of my rights to all third party medical insurance or payments, including medical child support.

I understand that my receipt of medical assistance means DHHS must be able to obtain medical records from medical providers. My signature below and/or on the application authorizes my family's medical providers to release any records to DHHS.

I understand that, if I am in a nursing home, DHHS must be able to exchange eligibility information with the nursing home to best administer the program. My signature below and/or on the application authorizes that exchange and remains in effect for as long as I receive DHHS assistance for my nursing home care.

I understand that for long-term care services (Nursing Facility or Home and Community-Based Care), I am required to disclose to DHHS any interest that my spouse or I have in any annuity.

I understand that if either my spouse or I are requesting long-term care services, any annuity purchased or modified by my spouse or me on or after February 8, 2006 will be considered a transfer of assets for less than fair market value unless the State is named the beneficiary for at least the amount of Medicaid paid for long-term care services.

NH Child Care Scholarship

I understand that I must only use child care services paid for by DHHS for those employment-related activities approved by DHHS. I may have to reimburse DHHS for those payments made for times I was involved in other, non-approved activities.

Signatures

I certify, under penalty of perjury, that I have reviewed the above information and the information summarizing my interview, and it is true and complete to the best of my knowledge.

Applicant Signature

Date

Signature of Person Helping the Applicant

Date

Relationship to Applicant

I certify that I have given the above signed individual(s) the opportunity to review this document, and that I have completely explained and given them a copy of the Rights and Responsibilities Notice. I also certify that I have given them a copy of this page, if it was requested.

Printed Name & Signature

Title/Agency

Date

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OFFICIAL

1 Introduction

1.1 Background

As part of the Affordable Care Act (ACA) implementation for New Hampshire EASY, the Centers for Medicare and Medicaid Services (CMS) mandate all applicants have a specialized, streamlined application when applying for medical coverage. New Hampshire has an integrated eligibility system for government benefits, medical coverage included. Because of this, there are questions that are asked – even when an applicant only requests medical coverage – that may not be required for medical benefit eligibility determination. In order to comply with the CMS requirement for a streamlined medical coverage application, there are certain questions that need to be made optional, or removed altogether.

1.2 Scope

This document will outline the following:

- Streamlined application field changes to NH EASY

1.3 References

The following references were leveraged to guide decision making regarding requirements and design for all items in the Scope section of this document.

Document Title	Date	Publishing Organization	Ver
Guidance on State Alternative Applications for Health Coverage	June 2013	Centers for Medicare and Medicaid Services (Federal CMS)	-
Application for Health Coverage and Help Paying Costs (Short Form)	September 2013	Centers for Medicare and Medicaid Services (Federal CMS)	3.0
Application for Health Coverage and Help Paying Costs (Family Attachment)	September 2013	Centers for Medicare and Medicaid Services (Federal CMS)	3.0
Single Streamlined Application for the Health Insurance Marketplace (Online Application)	September 2013	Centers for Medicare and Medicaid Services (Federal CMS)	3.0

Table 1-1: List of References

2 NH EASY Streamlined Application Changes

The following details all field changes that will be implemented for NH EASY. Modifications that are made to show/hide individual fields when certain programs are requested at the case level will require looping through all individuals in the case if programs requested subsequently change.

2.1 Start Module – Getting Started

The screenshot shows the 'Getting Started' page of the NH EASY application. At the top, there is a navigation bar with icons for Start, Household, People, Income, Expense, Assets, Other, Tax Credit, and Finish. Below this, the 'Getting Started' section contains a list of assistance programs to select. The 'Medical Coverage for Children, Pregnant Women and Non-Disabled Adults Age 18-64' option is checked. There is also a section for 'Medical Coverage and Medicare Beneficiary Assistance for Past Months' with a dropdown menu set to 0 months. At the bottom, there is an 'Assisting Person Information' section with a dropdown menu for 'Are you completing this application on behalf of someone else?'.

Figure 2-1: Getting Started

The following field changes will be implemented:

- “Please select the reason why you are applying for assistance:”
 - This field will be removed from the front-end in all cases, regardless of what program is being requested.
- “Are you completing this application on behalf of someone else?”
 - This field will be changed from always required to always optional
 - It will continue to default as blank per existing functionality
 - All conditionally dependent fields will remain required/optional as per existing functionality

2.2 Household Module – Household Information

NH@easy SYSTEMS an official New Hampshire government website
Department of Health and Human Services

DHHS | Change text size: A A A Logout

Application #: 360273234 5% Complete Print Help

Start → **Household** → People → Income → Expense → Other → Finish

Household Information

Applicant ?

*First Name: MI: *Last Name: Suffix:

Primary Language

*What is the language most commonly spoken in the household?

Address Where You Live

Do you consider yourself to be homeless?

House Number: Direction: *Street Name: Street Type:

Unit: Apt: Additional Address Information:

*City: *State: *Zip:

Mailing Address Information

*Do you have a mailing address that is different from the address where you live?

Phone Contact Information

Home: - -

Cell: - -

Work: - - Ext:

⚠ If you provide a phone number (home or cell) we may be able to conduct your eligibility interview over the phone.

Email Contact Information

Do you have an email address?

Close Comments Back Next

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Figure 2-2: Household Information

The following field changes will be implemented:

- “Do you have an email address?”
 - This field will be changed from always required to always optional.
 - It will continue to default as blank per existing functionality.

2.3 People Module – People Details

The screenshot shows the 'People Details' section of the NH@easy application. At the top, the NH@easy logo and 'INTEGRATION' are on the left, and 'an official New Hampshire government website' and 'Department of Health and Human Services' are on the right. Below this, the user 'John Doe' is logged in. The application number is 800122787, and the progress is 15% complete. A navigation bar includes 'Start', 'Household', 'People' (active), 'Income', 'Expense', 'Other', and 'Finish'. The 'People Details' form contains the following fields:

- *First Name: Jane
- MI: []
- *Last Name: Doe
- Suffix: []
- Has Jane Doe ever applied for benefits in New Hampshire under any other name (e.g., maiden name, nickname, etc.): No
- Programs Requested:
 - *What is Jane Doe applying for: Medical Coverage for Children, Pregnant Women and Non-Disabled Adults Age 18-64, None
- Personal Details:
 - *Gender: Female
 - *Date of Birth: 01 / 05 / 1995
 - *Does this person have a Social Security Number? No. Note: If you give us an SSN right now, it will help us process your application quicker. Providing your SSN is protected by the Federal Privacy Act of 1974 as Amended.
 - *What is the reason for not having a Social Security Number? Applied
 - *What is Jane Doe's marital status? Never Married
 - *Which of these best describes where Jane Doe is living? In Apartment, House, etc.
 - Hispanic Origin: []
 - Race (select all that apply):
 - American Indian/Alaska Native
 - Black/African American
 - White
 - Asian
 - Native Hawaiian/Pacific Islander
 - Other

Figure 2-3: People Details (pictured: 19 year old applicant)

*Is Jane Doe a US Citizen? No ▾

Immigration Information

*Does Jane Doe have an eligible immigration status? 

*Has Jane Doe lived in the US since 1996? Yes ▾

Does Jane Doe have an Alien/USCIS Number? No ▾

Does Jane Doe have an I-94 Number? Yes ▾

*I-94 Number 24344353452

*Supporting Document: Other ▾

*Document Description: I-94 Machine Readable

Pregnancy

Is Jane Doe pregnant or has she been pregnant recently? ▾

Education

*What is Jane Doe's current enrollment status? Full-Time ▾

Disability

Is Jane Doe permanently disabled or blind? ▾

Tax Filer Information

*Is Jane Doe planning to file a federal income tax return next year? No ▾

*Is Jane Doe a tax dependent claimed by a parent not living in the household? No ▾

Household Relationships

*Jane Doe is the Daughter ▾ of John Doe.

*Is Jane Doe a tax dependent of John Doe No ▾

*Is John Doe a tax dependent of Jane Doe No ▾

Close 
Comments 
◀ Back
Next ▶

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Figure 2-4: People Details (pictured: 19 year old applicant)

The following field changes will be implemented:

- “Has <Name> ever applied for benefits in New Hampshire under any other name (e.g., maiden name, nickname, etc.)?”
 - This field will be changed from always required to always optional
 - It will continue to default as ‘No’ per existing functionality
- A new orange header, “Programs Requested”, will be added above the “Personal Details” orange header and will include the Programs Requested question.
- “What is <Name> applying for:”
 - The existing Programs Requested question will be moved below the “Programs Requested” orange header.
 - The following text will be added below this field that will dynamically appear if the individual in context selects “None” for Programs Requested:
 - “You have indicated you are not applying for benefits. You are only required to answer questions in this application that have an orange asterisk.”
- “Does <Name> have a Social Security Number?”
 - If at least one program is requested for the individual in context, this field will be required. This includes dynamically changing the label to include a leading asterisk.

- If the individual in context selects “None” for Programs Requested, this field will be optional and visible. This includes dynamically changing the label to omit a leading asterisk.
- It will continue to default as blank per existing functionality
- The current SSN text (“If you give us an SSN right now...”) below the SSN free form text box will be moved such that it will now only be displayed with the high level SSN question
- “Social Security Number:”
 - As per existing functionality this is only shown when a user enters ‘Yes’ to the high level SSN question.
 - If displayed, this field will never be required for all individuals.
- “What is the reason for not having a Social Security Number?”
 - As per existing functionality this is only shown when a user enters ‘No’ to the high level SSN question.
 - If displayed, this field will be required for individuals who have selected at least one program for Programs Requested. For non-applicants, it will be optional.
 - If displayed, it will continue to default as blank per existing functionality.
- “Is <Name> a US Citizen?”
 - It will always be mandatory for applicants (clients requesting a program).
 - This field will not be visible when the individual in context chooses “None” for the “What is <Name> applying for:” question.
 - It will continue to default as blank per existing functionality.

The following immigration information fields will show when the field “Is <Name a US Citizen?” is populated as “No”.

- “US Entry Date”
 - If MAGI Only is requested at the case level, this field will not be visible. Else, this field will be visible and will always be required per existing functionality.
- “Immigration Status”
 - This field will be removed entirely from the front-end for all programs requested at the case level.
- “Does <Name> have an eligible immigration status?”
 - This will be a new mandatory question that will be visible for all programs requested (when US Citizen is “No”). There will be a checkbox next to this field; if checked, the other immigration information fields will be revealed (see specific logic for each question below).
 - If the checkbox is not populated, no other alien fields will be visible.
 - A blue question mark icon will appear next to this field and will include the policies for declaring an eligible immigration status, when selected by the user.
- “Has <Name> lived in the US since 1996?”
 - This will be a new Yes/No field, only visible when MAGI Only has been requested at the case level and the “Does <Name> have an eligible immigration status” checkbox is checked.
 - If this field is visible, it will be required.
 - This field will default to blank.
- “Alien Status”
 - If anything other than MAGI Only is requested at the case level, this field will be visible and required when a user populates “Does <Name> have an eligible immigration status?” as “Yes”. Else, this field will not be visible.
- “Does <Name> have an Alien/USCIS Number?”
 - If the “Does <Name> have an eligible immigration status?” checkbox is checked, this field will be visible.
 - If MAGI Only is requested at the case level, this field will always be optional if visible. Else, this field will remain required per existing functionality.

- “Does <Name> have an I-94 Number?”
 - If the field “Does <Name> have an Alien/USCIS Number?” is populated as “No”, this field will be visible per existing functionality.
 - If MAGI Only is requested at the case level, this field will always be optional if visible. Else, this field will remain required per existing functionality.
- For all Alien fields: “US Entry Date”, “Does <Name> have an eligible immigration status”, “Has <Name> lived in the US since 1996?”, “Alien Status”, “Does <Name> have an Alien Registration Number”, “Alien Registration Number”, “Does <Name> have an I-94 Number?”, “I-94 Number”, “Supporting Document” and “Document Description”
 - For all application types, if the user does not fill out all possible Immigration Information questions and that individual is requesting at least one program, upon selecting the “Next” button for that individual a Yes/No popup will appear before validation errors occur as well as before calling the Hub, that will read: “We will be able to process your application more quickly if you provide your citizenship information. Would you like to input the information now?”
 - If “Yes” is selected, the user will stay on the People Details page. If “No” is selected, validation errors will appear if applicable, otherwise the user will be brought to the People Summary page per existing driver functionality.
 - This popup will only show once while the user is on the People Details page. If the user does not fill in the applicable information and navigates back to the People Details page from a future page, the user will see the same popup if the applicable information is not populated and the “Next” button is selected.
- “What is <Name>’s current enrollment status?”
 - This field will be moved up to be the first question in the “Education” section
 - If at least one program is requested for the individual in context, and the individual is 19 – 20 years of age, this field will be required. Else, this field will not be visible.
 - This change will be implemented for applications where MAGI-Only is requested at the case level.
- “What is <Name>’s highest level of education?”
 - This field will not be visible for MAGI-Only applications. For all other applications where MAGI is not requested at the case level, this field will be visible and optional per existing functionality.
- “Is <Name> on active duty in the armed forces?”
 - This field will not be visible for MAGI-Only applications. For all other applications where MAGI is not requested at the case level, this field will be visible and optional per existing functionality.
- “Is <Name> a veteran?”
 - This field will not be visible for MAGI-Only applications. For all other applications where MAGI is not requested at the case level, this field will be visible and optional per existing functionality.
- “Is <Name> required to file a federal tax return next year?”
 - This field will be removed entirely from the front-end.
- “Do <Name> and <Name> buy and prepare meals together?”
 - This field will not be visible for MAGI-Only applications. For all other applications where MAGI is not requested at the case level, this field will be visible and required, per existing functionality.

2.4 People Module – People Summary

an official New Hampshire government website
Department of Health and Human Services

DHHS | My Account | Change text size: A A A John Doe | Logout

Application #: 800122787 15% Complete Print Help

Start Household **People** Income Expense Other Finish

People Details

	Name/SSN	Date of Birth	Relationship to Applicant	Student Status	Pregnant	View/Edit	Remove
	John Doe ⚠ 000-00-0000	10/10/1980	Applicant			<input type="button" value="Edit"/>	
	Jane Doe ⚠ 000-00-0000	01/05/1995	Daughter	Full-Time		<input type="button" value="Edit"/>	<input type="button" value="Remove"/>

*Are there any other people in your household that are applying for assistance or are a parent of a child under 18 that is applying for assistance?

Note: If you are applying for medical coverage, also be sure to include any tax dependents living with you.

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Figure 2-5: People Summary

The following changes will be implemented:

- "Student Status"
 - For MAGI Only applications, the first line will be blank if the question "What is <Name>'s current enrollment status?" is not displayed for that particular individual during application entry.
 - For MAGI Only applications, the second line will always be left blank (i.e. the value for Highest Level Completed).

2.5 Income Module – Employment Details

The screenshot shows the NH@EASY SYSTEMS interface. At the top, it says "an official New Hampshire government website" and "Department of Health and Human Services". The user is logged in as "John Doe" with a "Logout" link. The application number is "360273234" and it is "20% Complete". There are navigation buttons for "Start", "Household", "People", "Income", "Expense", "Other", and "Family". The "Income" section is active, showing tabs for "Employment", "Self-Employment", "Other Income", and "Yearly Income". The "Employment" tab is selected, and the form contains the following fields:

- *Is anyone in your household currently working at a job or has anyone lost a job in the last 30 days? Yes (dropdown)
- *Who has or had the job? John Doe (dropdown)
- Employer Information
 - *Employer name: Bagel Store (text input)
 - Employer Telephone Number: [] - [] - [] (text input)
 - Employer Address Information
 - Would you like to add the Employer Address? No (dropdown)
- Employment Details
 - *Date the job started: 10 / 10 / 2000 (date input)
 - Job Title: [] (text input)
 - *Do you still have this job? Yes (dropdown)
- Wage/Salary Information
 - *How often is John Doe paid? Bi-Weekly (dropdown)
 - *Average pay before taxes, including tips? \$ 400 (text input)
 - *Average hours worked per pay period: 30 (text input)

At the bottom of the form, there are buttons for "Close", "Comments", "Back", and "Next".

Figure 2-6: Employment Details

The following field changes will be implemented:

- "Job Title"
 - This field will be changed from always required to always optional
 - It will continue to default as blank per existing functionality

2.6 Income Module – Self-Employment Details

The screenshot shows the NH@ASY SYSTEMS interface for the Department of Health and Human Services. The user is logged in as John Doe. The application number is 360273234 and the progress is 29% complete. The navigation bar includes Start, Household, People, Income (selected), Expense, Other, and Finish. The Self-Employment tab is active, showing the following fields:

- *Is anyone in your household self-employed? Yes
- *Who is self-employed? John Doe
- Self-Employment Information
- *What kind of self-employment is this? Child Care Provider
- *What is the average monthly profit/loss after deducting expenses (do not include monthly depreciation here)? \$132
- What is the monthly depreciation? \$

Buttons for Close, Comments, Back, and Next are visible at the bottom of the form.

Figure 2-7: Self-Employment Details

The following field changes will be implemented:

- “What is the monthly depreciation?”
 - This field will be changed from always required to always optional
 - It will continue to default as blank per existing functionality
- “What are the average monthly hours worked?”
 - This field will be removed from the page.

2.7 Income Module – Other Income Details

an official New Hampshire government website
 Department of Health and Human Services
 John Doe | Logout

DHHS | My Account | Change text size: A A A
 Application #: 360273234 36% Complete Print Help

Start Household People Income Expense Other Finish

Employment Self-Employment **Other Income** Yearly Income

*Does anyone in your household get any other money? Yes

*Who gets any other money? John Doe

Other Income Details

*Other income type: Soc. Security Disability

*How often is he/she paid? Bi-Weekly

*How much does John Doe receive, Bi-Weekly? \$903

SSI/SSA/VA/RR Information

What is the Claim Number?

What is the Entitlement Date? mm / dd / yyyy

Close Comments Back Next

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Figure 2-8: Other Income Details

The following field changes will be implemented:

- “Other income type”
 - If MAGI Only is requested at the case level, the reference table TAUI that populates this field will be restricted to display only MAGI countable income types.
 - If a user proceeds past the screen, and then changes the Programs Requested at the case level, this field will still show the initial filtered/unfiltered reference table. For example, if a user requests MAGI Only, proceeds past this screen, and subsequently changes the Programs Requested at the case level, the initial values populated in this “Other income type” change will not change if the user returns to this screen.
- “What is the Claim Number?”
 - If displayed, this field will be changed from always required to always optional
 - It will continue to default as blank per existing functionality

2.8 Income Module – Yearly Income Details

NH@ASY SYSTEMS *an official New Hampshire government website*
 Department of Health and Human Services
 DHHS | My Account | Change text size: A A A John Doe | Logout
 Application #: 360273234 43% Complete [Progress Bar] Print Help

Start Household People **Income** Expense Other First

Employment Self-Employment Other Income **Yearly Income**

*Does anyone in your household have income that changes from month to month? [Dropdown]

Close Comments Back Next

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Figure 2-9: Yearly Income Details (No)

NH@ASY SYSTEMS *an official New Hampshire government website*
 Department of Health and Human Services
 DHHS | My Account | Change text size: A A A John Doe | Logout
 Application #: 360273234 43% Complete [Progress Bar] Print Help

Start Household People **Income** Expense Other First

Employment Self-Employment Other Income **Yearly Income**

*Does anyone in your household have income that changes from month to month? Yes [Dropdown]

Yearly Income Information

*Who has income that changes from month to month? John Doe [Dropdown]

*What will be John Doe's total income this year? \$3458 [Text Box]

What will be John Doe's total income next year (if it is expected to be different)? \$ [Text Box]

Close Comments Back Next

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Figure 2-10: Yearly Income Details (Yes)

A new details page “Yearly Income” will be added in the Income Module and will always be displayed as the last tab in the Income Module. If MA or MAGI-Only is requested at the case level, this tab will be scheduled in the driver. Else, this tab will not be scheduled or visible to the client.

The following headers and fields will be added:

- Gateway Question
 - “Does anyone in your household have income that changes from month to month?”
 - This will be a mandatory, Yes/No question and will default to blank.
 - If Yes, the Yearly Income Information section will become visible.
 - If a record already exists and a user selects to add another record, this question will be hidden and all subsequent questions will be shown per NH EASY standard.
- Yearly Income Information
 - “Who has income that changes from month to month?”
 - This will be a mandatory dropdown that will include all household members on the application.
 - Household members will not show in the dropdown if he/she has already been associated with a record in this screen.
 - “What will be <Name>’s total income this year?”
 - This will be a mandatory freeform text field and will default to blank.
 - This will use the standard NH EASY money field and validation(s), and will require a value greater than 0 to be entered.
 - “What will be <Name>’s total income next year (if it is expected to be different)?”
 - This will be an optional freeform text field and will default to blank.
 - This will use the standard NH EASY money field and validation(s).

2.9 Income Module – Yearly Income Summary

an official New Hampshire government website

NH EASY SYSTEMS Department of Health and Human Services

DHHS | My Account | Change text size: A A A John Doe | Logout

Application #: 360273234 46% Complete Print Help

Start Household People **Income** Expense Other Finish

Employment Self-Employment Other Income **Yearly Income**

Name	Income This Year	Income Next Year	View/Edit	Remove
John Doe	\$3,458.00	\$0.00	Edit	Remove

* Does anyone else earn income that changes month to month?

Close Comments Next

Figure 2-11: Yearly Income Summary

A new summary page “Yearly Income” will be added in the Income Module.

The following columns will be added and populated with values from the Yearly Income Details page:

- Name
 - This field will be populated with the value of “Who has income that changes from month to month?”
- Income This Year
 - This field will be populated with the value of “What will be <Name>’s total income this year?”
- Income Next Year
 - This field will be populated with the value of “What will be <Name>’s total income next year (if it is expected to be different)?”
- The trailing question will be “Does anyone else earn income that changes month to month?”
 - If Yes, the user will be taken to the Details page upon selecting the Next button where he/she can add another person’s income.
 - If No, the user will be taken to the Expense Module if applicable or the Finish Module upon selecting the Next button.

2.10 Expense Module – Dependent Care Details

The screenshot shows the NH@ASY SYSTEMS interface for the Department of Health and Human Services. The user is logged in as Dan J Lilly Sr. The application progress is 81% complete. The navigation menu includes Start, Household, People, Income, Expense, Other, and Finish. The 'Expense' tab is active, and the 'Dependent Care' sub-tab is selected. The form contains the following fields:

- *Does anyone in your household pay for child care or adult day care to be employed? Yes
- *Who pays for the care? Dan J Lilly Sr
- Dependent Care Information
- *Who needs this care? Wife Q Lilly
- *Who is providing the care? Some Place
- Expense Payment Information
- *How often? Bi-Weekly
- *How much does Dan J Lilly Sr pay? \$213

Buttons for Close, Comments, Back, and Next are visible at the bottom of the form. The footer includes links for NH.gov, privacy policy, accessibility policy, non-discrimination policy, and contact us.

Figure 2-12: Dependent Care Details

The Dependent Care tab will be visible in the driver until December 31st, 2013 for all MAGI Only applications, in order to accommodate the Healthy Kids program and MAGI in the same switch. Starting January 1st, 2014, this tab will never show for MAGI Only applications.

2.11 Expense Module – Child/Spousal Support Details

The screenshot shows the NH@ASY SYSTEMS interface. At the top, it says "an official New Hampshire government website" and "Department of Health and Human Services". The user is logged in as "John Doe". The application is 58% complete. The navigation bar includes "Start", "Household", "People", "Income", "Expense" (selected), "Other", and "Finish". The "Support Payments" tab is active, showing the following fields:

- *Does anyone in your household make support payments? (Yes)
- *Who makes support payments? (John Doe)
- *What kind of support is being paid: (Spousal Support)
- Actual Payment Information:
 - *How often? (Bi-Weekly)
 - *How much does John Doe pay? (\$ 324)
 - *Are the support payments court ordered? (Yes)
 - How often? ()
 - How much is John Doe ordered to pay? (\$)

Buttons for "Close", "Comments", "Back", and "Next" are visible at the bottom of the form.

Figure 2-13: Child/Spousal Support Details

The following field changes will be implemented:

- The tab label will be changed to “Support Payments”.
- “What kind of support is being paid”
 - If MAGI Only is being requested at the case level, the only value that will be displayed/selectable in this field will be “Spousal Support”. Else, both values will be selectable.
- The field order will be changed to be as follows:
 - Who makes support payments?
 - What kind of support is being paid:
 - How often?
 - How much does <Name> pay?
 - Are the support payments court ordered?
 - How often?
 - How much is <Name> ordered to pay?
- “How often?” (Court ordered value)
 - If displayed, this field will be changed from always required to always optional
 - If displayed, It will continue to default as blank per existing functionality
- “How much is <Name> ordered to pay?” (Court ordered value)
 - If displayed, this field will be changed from always required to always optional
 - If displayed, It will continue to default as blank per existing functionality

- A new validation will be added such that if the court ordered amount is > 0, then the opposite field not populated will also be required.

2.12 Expense Module – Other Expenses Details

an official New Hampshire government website
Department of Health and Human Services
 NH@ASY SYSTEMS
 DHHS | My Account | Change text size: A A A Dan J Lilly Sr | Logout
 Application #: 960237496 81% Complete Print Help

Start Household People Income Expense Other Finish

Medicare Health Insurance Dependent Care Child/Spousal Support **Other Expenses**

Expense Information
 *Who has the expense? Dan J Lilly Sr
 *What kind of expense is it? Student Loan Interest

Payment Information
 *How Often? Monthly
 *How much does this person pay? \$ 123.00

Close Comments Back Next

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Figure 2-14: Other Expenses Details

The following field changes will be implemented:

- “What kind of expense is it?” – For the dropdown option, “Student Loan Interest Pd,” change this value in the reference table TDDT to “Student Loan Interest”.

2.13 Other Module – Other State Assistance Details

NH@ASY *an official New Hampshire government website*
Department of Health and Human Services

DHHS | My Account | Change text size: A A A John Doe | Logout

Application #: 800122787 60% Complete Print Help

Start Household People Income Expense **Other** Final

Other State Assistance Comments

*Has anyone in the household received benefits from another state?

*Who received benefits while living in another state?

*Which state?

Medicaid Benefit Details

*Did John Doe receive Medicaid in any other state?

*When did the assistance end? / /

Close Comments Back Next

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Figure 2-15: Other State Assistance Details

The following field changes will be implemented:

- “Did <Name> receive Cash benefits in any other state?”
 - If MAGI Only is requested at the case level, this field (as well as its child fields) will not be visible.
- “Did <Name> receive Food Stamps in any other state?”
 - If MAGI Only is requested at the case level, this field (as well as its child fields) will not be visible.
- “Did <Name> receive Child Care in any other state?”
 - If MAGI Only is requested at the case level, this field (as well as its child fields) will not be visible.
- For this screen, the existing validation to have at least one of the above questions populated as “Yes” when the gateway question “Has anyone in the household received benefits from another state?” is “Yes” will be removed for MAGI Only applications.

2.14 Other Module – Other State Assistance Summary

NH@ASY *an official New Hampshire government website*
Department of Health and Human Services

DHHS | My Account | Change text size: A A A John Doe | Logout

Application #: 800122787 62% Complete Print Help

Start Household People Income Expense Other Family

Name	State	Medicaid	View/Edit	Remove
John Doe	Massachusetts	Yes	<input type="button" value="Edit"/>	<input type="button" value="Remove"/>

*Has anyone else in your household received assistance from another state?

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Figure 2-16: Other State Assistance Summary

The following changes will be implemented:

- "Cash", "Food Stamps", "Child Care"
 - o For MAGI Only applications, these columns will never be displayed.