Application for Health Coverage & Help Paying Costs

THINGS TO KNOW

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:
  Central Medicaid Unit, 129 Pleasant Street, Concord, NH 03301.
- **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 **1-844-275-3447 (1-844-ASK-DHHS)**. Filling out this application doesn't mean you have to buy health coverage

Get help with this application.

- **Online: HealthCare.gov**
- **Phone:** Call the DHHS Customer Service Center at **1-844-275-3447 (1-844-ASK-DHHS)**
- **In person:** There may be counselors in your area who can help. Call **1-844-275-3447 (1-844-ASK-DHHS)** for more information
- **En Espanol:** Llame a nuestro centro de ayuda gratis al **1-844-275-3447 (1-844-ASK-DHHS)**

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

You can apply for these additional programs by filling out BFA 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:

- Supplemental Nutrition Assistance Program (SNAP): SNAP (formerly known as Food Stamps)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 1-844-275-3447 (1-844-ASK-DHHS).

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 1-844-275-3447 **OR** ask the person helping you with this application.

? **NEED HELP WITH YOUR APPLICATION?** Visit **HealthCare.gov** or call us at **1-844-275-3447 (1-844-ASK-DHHS)**. Para obtener una copia de este formulario en Español, llame **1-844-275-3447**. If you need help in a language other than English, call **1-844-275-3447** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY/TDD users should call **1-800-735-2964** or **711**.

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:	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.

? **NEED HELP WITH YOUR APPLICATION?** Visit **HealthCare.gov** or call us at **1-844-275-3447 (1-844-ASK-DHHS)**. Para obtener una copia de este formulario en Español, llame **1-844-275-3447**. If you need help in a language other than English, call **1-844-275-3447** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY/TDD users should call **1-800-735-2964** or **711**.

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: ☐Male ☐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.)**

☐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 _____

? **NEED HELP WITH YOUR APPLICATION?** Visit **HealthCare.gov** or call us at **1-844-275-3447 (1-844-ASK-DHHS)**. Para obtener una copia de este formulario en Español, llame **1-844-275-3447**. If you need help in a language other than English, call **1-844-275-3447** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY/TDD users should call **1-800-735-2964** or **711**.

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
( ) --

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)
$	**$**

THANKS! This is all we need to know about you.

? **NEED HELP WITH YOUR APPLICATION?** Visit **HealthCare.gov** or call us at **1-844-275-3447 (1-844-ASK-DHHS)**. Para obtener una copia de este formulario en Español, llame **1-844-275-3447**. If you need help in a language other than English, call **1-844-275-3447** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY/TDD users should call **1-800-735-2964** or **711**.

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. ⇨

? **NEED HELP WITH YOUR APPLICATION?** Visit **HealthCare.gov** or call us at **1-844-275-3447 (1-844-ASK-DHHS)**. Para obtener una copia de este formulario en Español, llame **1-844-275-3447**. If you need help in a language other than English, call **1-844-275-3447** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY/TDD users should call **1-800-735-2964** or **711**.

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 **1-844-275-3447 (1-844-ASK-DHHS)**. Para obtener una copia de este formulario en Español, llame **1-844-275-3447**. If you need help in a language other than English, call **1-844-275-3447** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY/TDD users should call **1-800-735-2964** or **711**.

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. ⇨

? **NEED HELP WITH YOUR APPLICATION?** Visit **HealthCare.gov** or call us at **1-844-275-3447 (1-844-ASK-DHHS)**. Para obtener una copia de este formulario en Español, llame **1-844-275-3447**. If you need help in a language other than English, call **1-844-275-3447** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY/TDD users should call **1-800-735-2964** or **711**.

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 **$** _____ How Often? _____
☐Pensions **$** _____ 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: _____

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 **$** _____ How Often? _____
☐Student loan interest **$** _____ How Often? _____
☐Other deductions **$** _____ 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.

? **NEED HELP WITH YOUR APPLICATION?** Visit **HealthCare.gov** or call us at **1-844-275-3447 (1-844-ASK-DHHS)**. Para obtener una copia de este formulario en Español, llame **1-844-275-3447**. If you need help in a language other than English, call **1-844-275-3447** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY/TDD users should call **1-800-735-2964** or **711**.

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 _____

☐ CHIP _____

☐ Medicare _____

☐ TRICARE (don't check if you have direct care of Line of Duty)

_____

☐ VA health care programs _____

☐ Peace Corps

☐ Employer insurance _____

Name of the health insurance: _____

Policy number: _____

Is this COBRA coverage? ☐ Yes ☐ No

Is this a retiree health plan? ☐ Yes ☐ No

☐ Other

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.

? **NEED HELP WITH YOUR APPLICATION?** Visit **HealthCare.gov** or call us at **1-844-275-3447 (1-844-ASK-DHHS)**. Para obtener una copia de este formulario en Español, llame **1-844-275-3447**. If you need help in a language other than English, call **1-844-275-3447** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY/TDD users should call **1-800-735-2964** or **711**.

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:

Central Medicaid Unit (CMU)
129 Pleasant Street
Concord NH 03301

Fax your signed application to CMU:

(603) 271-8604

Call in your application to Client Services:

(603) 271-9700 or toll free
1-844-275-3447 (1-844-ASK-DHHS)

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 BFA 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)

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)

? **NEED HELP WITH YOUR APPLICATION?** Visit **HealthCare.gov** or call us at **1-844-275-3447 (1-844-ASK-DHHS)**. Para obtener una copia de este formulario en Español, llame **1-844-275-3447**. If you need help in a language other than English, call **1-844-275-3447** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY/TDD users should call **1-800-735-2964** or **711**.

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 Last	First Middle Last
2. Member of a federally recognized tribe?	☐Yes **If yes,** tribe name _____ ☐No	☐Yes **If yes,** tribe name _____ ☐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?	☐Yes ☐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? ☐Yes ☐No	☐Yes ☐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? ☐Yes ☐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: • 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? _____

? **NEED HELP WITH YOUR APPLICATION?** Visit **HealthCare.gov** or or call us at **1-844-275-3447 (1-844-ASK-DHHS)**. Para obtener una copia de este formulario en Español, llame **1-844-275-3447**. If you need help in a language other than English, call **1-844-275-3447** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY/TDD users should call 1-800-735-2964 or **711**.

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.
- ☐ Ask for an Administrative Appeal for me.
- ☐ Go to my eligibility interviews for me.
- ☐ Represent me at an Appeal if I decide I want one.
- ☐ Talk to my Managed Care Organization (MCO) or Qualified Health Plan (QHP) 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 Department.
- **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 until I or my Authorized Representative tells the Department of a change.

_____ _____
Client's Signature Date

_____
Client's **Printed** Name

? **NEED HELP WITH YOUR APPLICATION?** Visit **HealthCare.gov** or call us at **1-844-275-3447 (1-844-ASK-DHHS)**. Para obtener una copia de este formulario en Español, llame **1-844-275-3447**. If you need help in a language other than English, call **1-844-275-3447** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY/TDD users should call **1-800-735-2964** or **711**.

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 agree** to act as an Authorized Representative for the client noted on this form until I or the client tells DHHS of a change.

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)

Additional Requested Information to Determine Eligibility for Other Medical Assistance or Services

If you have completed BFA Form 800MA, *Application for Health Coverage and Help Paying Costs,* and are blind, disabled, over the age of 65, in a Nursing Facility, in need of home care services, or in need of help paying a Medicare premium, you must complete the questions below and return this form, along with your completed and signed BFA Form 800MA, to DHHS. You must complete the questions on this form if any person listed on BFA Form 800MA would like to apply for any of the following programs or services:

- 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)
- Home and Community-Based Care (HCBC) Services
- Nursing Facility (NF) Services
- Medicaid for Employed Adults with Disabilities (MEAD)
- Medicare Savings Programs (MSP) (help with Medicare premiums)

You must fill out this form **and** BFA Form 800MA, have an interview, and give us proof of your household circumstances to complete the process to apply for the above programs or services. Please read all of the questions below, and answer them as best as you can. ***Do not answer anything that you do not understand***. If you need help in filling out this form, tell us. If you have more than two people listed on BFA Form 800MA who are in need of the above programs or services, you must make a copy of this sheet and complete these questions for those individuals as well. You must return that document, along with this form and the signed BFA Form 800MA to DHHS.

Emergency Medicaid may be available to certain non-citizens, regardless of their immigration status, for temporary coverage of emergency medical services, including labor and delivery. SSNs are not needed to apply for Emergency Medicaid. However, you must provide an SSN to apply for any of the other programs or services listed above.

DHHS determines if a non-citizen meets the eligibility requirements of one of the Medicaid categories of eligibility and the Office of Medicaid Business and Policy (OMBP) determines if the non-citizen has a condition which meets the definition of an emergency condition.

Tell us about all the people listed on BFA Form 800MA who are in need of the above programs or services:

Person 1 This person does not need to be the same person as "Person 1" listed on BFA Form 800MA

1. First name, Middle name, Last name:

2. What is this person's current residence? ☐ Own home ☐ Nursing Facility ☐ Hospital ☐ Adult Family Home ☐ Residential Care Facility ☐ Assisted Living ☐ Hotel/Motel ☐ Congregate Housing ☐ Homeless ☐ Other

3. What type of assistance does this person want to apply for? ☐ Medical Assistance ☐ NF ☐ HCBC ☐ MSP

4. Is this person currently receiving Medicaid from another State? ☐Yes ☐No If so, which State? _____

5. If this person is in a Nursing Facility, what is the name of the facility? _____

6. Is this person blind? ☐Yes ☐No

7. Does this person have a physical or mental disability? ☐Yes ☐No

8. Is this person over the age of 65? ☐Yes ☐No

9. Does this person have Medicare A or B? ☐Yes ☐No

10. Check off each resource this person owns and list the value

☐ Checking	How much is in the account?	$	☐ Trusts	What is the total value?	$
☐ Savings	How much is in the account?	$	☐ Stocks/bonds	What is the total value?	$
☐ Certificates of Deposit	How much is the CD worth?	$	☐ Life Insurance	What is the total value?	$
☐ Other bank account	How much is in the account?	$	☐ Annuities	What is the total value?	$
☐ IRA/401K accounts	How much is in the account?	$	☐ Any other asset	What is the total value?	$

11. Does this person expect any resource amount changes in the near future? ☐Yes ☐No

12. Have you sold or transferred property in the last 5 years? ☐Yes ☐No

13. Does this person incur any medical expenses? ☐Yes ☐No If yes, how much? $ _____ How often? _____

14. Is this person obligated to pay child support/alimony? ☐Yes ☐No If yes, how much? $ _____ How often? _____

Person 2 This person does not need to be the same person as "Person 2" listed on BFA Form 800MA

1. First name, Middle name, Last name:

2. What is this person's current residence? ☐ Own home ☐ Nursing Facility ☐ Hospital ☐ Adult Family Home ☐ Residential Care Facility ☐ Assisted Living ☐ Hotel/Motel ☐ Congregate Housing ☐ Homeless ☐ Other

3. What type of assistance does this person want to apply for? ☐ Medical Assistance ☐ NF ☐ HCBC ☐ MSP

4. Is this person currently receiving Medicaid from another State? ☐Yes ☐No If so, which State? _____

5. If this person is in a Nursing Facility, what is the name of the facility? _____

6. Is this person blind? ☐Yes ☐No

7. Does this person have a physical or mental disability? ☐Yes ☐No

8. Is this person over the age of 65? ☐Yes ☐No

9. Does this person have Medicare A or B? ☐Yes ☐No

10. Check off each resource this person owns and list the value

☐ Checking	How much is in the account?	$	☐ Trusts	What is the total value?	$
☐ Savings	How much is in the account?	$	☐ Stocks/bonds	What is the total value?	$
☐ Certificates of Deposit	How much is the CD worth?	$	☐ Life Insurance	What is the total value?	$
☐ Other bank account	How much is in the account?	$	☐ Annuities	What is the total value?	$
☐ IRA/401K accounts	How much is in the account?	$	☐ Any other asset	What is the total value?	$

11. Does this person expect any resource amount changes in the near future? ☐Yes ☐No

12. Have you sold or transferred property in the last 5 years? ☐Yes ☐No

13. Does this person incur any medical expenses? ☐Yes ☐No If yes, how much? $ _____ How often? _____

14. Is this person obligated to pay child support/alimony? ☐Yes ☐No If yes, how much? $ _____ How often? _____

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.

Quality Control Reviews

Your case may be chosen for a quality control or other governmental review. Such a review means that there will be an in-depth study of your household's financial or medical situation, living arrangements and other circumstances. We will contact banks, employers, companies, merchants, and other appropriate sources, about your household and statements you made or information you gave to DHHS. If you do not help us in these reviews, your benefits could stop.

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.

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.

You must return this completed form, along with BFA Form 800MA, to your local District Office

Berlin	650 Main Street Suite 200 Berlin, NH 03570-2463	**Claremont**	17 Water Street, Ste. 301 Claremont, NH 03743-2280	**Concord**	40 Terrill Park Drive Concord, NH 03301-9955
Conway	73 Hobbs Street Conway, NH 03818-6188	**Seacoast**	19 Rye Street Portsmouth, NH 03801-6805	**Laconia**	65 Beacon Street West Laconia, NH 03246-9988
Littleton	80 North Littleton Road Littleton, NH 03561-3841	**Manchester**	1050 Perimeter Road, Ste. 501 Manchester, NH 03103-3303	**Rochester**	150 Wakefield Street, Suite 22 Rochester, NH 03867-1309
Keene	111 Key Road Keene, NH 03431	**Southern**	26 Whipple St. Nashua, NH 03060-9311		