State of Hawaii, Department of Human Services

Federal Health Insurance Marketplace

# 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).

## Who can use this application?

- Use this application to apply for you or anyone in your family.
- Apply even if you or your child already have health coverage. You could be eligible for lower-cost or free coverage.
- Families that include immigrants can apply. You can apply for your child even if you are not eligible for coverage. Applying will not 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

- Apply faster online at mybenefits.hawaii.gov.
- If you want to purchase insurance without help, apply directly at www.healthcare.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 pay stubs, 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 will keep all the information you provide private and secure, as required by law.** To view the Privacy Act Statement, go to mybenefits.hawaii.gov.

## What happens next?

Send your complete, signed application to the address on page 7. **If you do not have all the information we ask for, sign and submit your application anyway.** We will follow-up with you within 1-2 weeks. You will get instructions on the next steps to complete your health coverage. If you do not hear from us, visit **mybenefits.hawaii.gov** or **call 1-877-628-5076 (TTY/TDD 1-855-585-8604 or 711)**. Filling out this application does not mean you have to buy health insurance.

## Get help with this application

- **Online**: **mybenefits.hawaii.gov**
- **Phone**: Call the Contact Center at **1-877-628-5076 (TTY/TDD 1-855-585-8604 or 711)** for assistance with completing and submitting an application or getting information on the status of your application.
- **In person**: There may be counselors in your area who can help. Visit our website or call **1-877-628-5076 (TTY/TDD 1-855-585-8604 or 711)** for more information.
- **Medicaid**: For specific questions on Medicaid/CHIP eligibility, call **1-800-316-8005 (TTY/TDD 1-800-603-1201)**.

**NEED HELP WITH YOUR APPLICATION? Visit mybenefits.hawaii.gov or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 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 1-855-585-8604 or 711.**

| | |
|---|---|
| Do you need help in another language? We will get you a free interpreter. Call **1-877-628-5076** to tell us which language you speak. (TTY: 1-855-585-8604 or 711). | **English**  |
| 您需要其它語言嗎？如有需要，請致電 **1-877-628-5076**，我們會提供免費翻譯服務 (TTY: 1-855-585-8604 或 711). | **Cantonese**  |
| En mi niit alilis lon pwal eu kapas? Sipwe angei emon chon chiaku ngonuk ese kamo. Kokori **1-877-628-5076** omw kopwe ureni kich meni kapas ka ani. (TTY: 1-855-585-8604 ika 711). | **Chuukese**  |
| Avez-vous besoin d'aide dans une autre langue? Nous pouvons vous fournir gratuitement des services d'un interprète. Appelez le **1-877-628-5076** pour nous indiquer quelle langue vous parlez. (TTY: 1-855-585-8604 ou 711). | **French**  |
| Brauchen Sie Hilfe in einer andereren Sprache? Wir koennen Ihnen gern einen kostenlosen Dolmetscher besorgen. Bitte rufen Sie uns an unter **1-877-628-5076** und sagen Sie uns Bescheid, welche Sprache Sie sprechen. (TTY: 1-855-585-8604 oder 711). | **German**  |
| Makemake `oe i kokua i pili kekahi `olelo o na `aina `e? Makemake la maua i ki`i `oe mea unuhi manuahi. E kelepona **1-877-628-5076** `oe ia la kaua a e ha`ina `oe ia la maua mea `olelo o na `aina `e. (TTY: 1-855-585-8604 a 711). | **Hawaiian**  |
| Masapulyo kadi ti tulong iti sabali a pagsasao? Ikkandakayo iti libre nga paraipatarus. Awaganyo ti **1-877-628-5076** tapno ibagayo kadakami no ania ti pagsasao nga ar-aramatenyo. (TTY: 1-855-585-8604 wenno 711). | **Ilokano**  |
| 貴方は、他の言語に、助けを必要としていますか？私たちは、貴方のために、無料で 通訳を用意できます。電話番号の、**1-877-628-5076**に、電話して、私たちに貴方の話されている言語を申し出てください。(TTY: 1-855-585-8604 または 711). | **Japanese**  |
| 다른언어로 도움이 필요하십니까? 저희가 무료로 통역을 제공합니다. **1-877-628-5076** 로 전화해서 사용하는 언어를 알려주십시요 (TTY: 1-855-585-8604 1 또는 711). | **Korean**  |
| 您需要其它语言吗？如有需要, 请致电 **1-877-628-5076**，我们会提供免费翻译服务 (TTY: 1-855-585-8604 或 711). | **Mandarin**  |
| Kwoj aikuij ke jiban kin juon bar kajin? Kim naj lewaj juon am dri ukok eo ejjelok wonen. Kirtok **1-877-628-5076** im kwalok non kim kajin ta eo kwo melele im kenono kake. (TTY: 1-855-585-8604 ak 711). | **Marshallese**  |
| E te mana'o mia se fesosoani i se isi gagana? Matou te fesosoani e ave atu fua se faaliliu upu mo oe. Vili mai i le numera lea **1-877-628-5076** pea e mana'o mia se fesosoani mo se faaliliu upu. (TTY: 1-855-585-8604 po o le 711). | **Samoan**   |
| ¿Necesita ayuda en otro idioma? Nosotros le ayudaremos a conseguir un intérprete gratuito. Llame al **1-877-628-5076** y diganos que idioma habla. (TTY: 1-855-585-8604 o 711). | **Spanish**  |
| Kailangan ba ninyo ng tulong sa ibang lengguwahe? Ikukuha namin kayo ng libreng tagasalin. Tumawag sa **1-877-628-5076** para sabihin kung anong lengguwahe ang nais ninyong gamitin. (TTY: 1-855-585-8604 o 711). | **Tagalog**  |
| 'Oku ke fiema'u tokoni 'iha lea makehe? Te mau malava 'o 'oatu ha fakatonulea ta'etotongi. Telefoni ki he **1-877-628-5076** 'o fakaha mai pe koe ha 'ae lea fakafonua 'oku ke ngaue'aki. (TTY: 1-855-585-8604 pe 711). | **Tongan**  |
| Bạn có cần giúp đỡ bằng ngôn ngữ khác không ? Chúng tôi se yêu cầu một người thông dịch viên miễn phí cho bạn. Gọi **1-877-628-5076** nói cho chúng tôi biết bạn dùng ngôn ngữ nào. (TTY: 1-855-585-8604 hoặc 711). | **Vietnamese** Việt Nam |
| Gakinahanglan ka ba ug tabang sa imong pinulongan? Amo kang mahatagan ug libre nga maghuhubad. Tawag sa **1-877-628-5076** aron magpahibalo kung unsa ang imong sinulti-han. (TTY: 1-855-585-8604 o 711). | **Visayan (Cebuano)**  |

# 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 want to get information about this application by email? ☐ **Yes** ☐ **No**

Email address: _____

| 17. What is your preferred spoken language (if not English)? | 18. What is your preferred written language (if not English)? |
|---|---|
| | |
| 19. How many family members live with you? | 20. Is any family member you usually live with incarcerated (detained or jailed) or residing in the Hawaii State Hospital? ☐ **Yes** ☐ **No** **If yes**, please list their name(s): |
| | |

# 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 19 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on our tax return, even if they don't live with you
- Anyone else under 19 who you take care of and lives with you

**You DON'T have to include:**

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 19)
- 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 get 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 two (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 mybenefits.hawaii.gov or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 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 1-855-585-8604 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. Gender ☐ 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–c. ☐ **No. If no,** skip to question c.

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. 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,** how many babies are expected during this pregnancy? _____ Expected 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 disability that will last more than twelve (12) months? ☐ **Yes** ☐ **No**
a. Do you currently receive long term care nursing services: ☐ **Yes**, in a nursing facility ☐ **Yes**, in my home in the community ☐ **No**
b. Have you received long term care nursing services in the last three (3) months? ☐ **Yes. If yes**, what date(s)? _____ ☐ **No**
c. Do you think you need long term care nursing services now? ☐ **Yes** ☐ **No**
d. Do you receive Supplemental Security Income (SSI)? ☐ **Yes** ☐ **No**

10. Did you receive any medical services in the past ten (10) calendar days immediately prior to the date of this application?
☐ **Yes.** If yes, what date(s)? _____ ☐ **No**

11. Are you a U.S. citizen or U.S. national? ☐ **Yes. If yes**, skip to Question 13. ☐ **No**

12. If you aren't a U.S. citizen or U.S. national, please provide the information below.
a. Immigration document type _____
b. Document ID number _____
c. When did you enter the U.S.? _____
d. Are you a citizen of the Federated State of Micronesia, the Republic of the Marshall Islands, and Palau. ☐ **Yes** ☐ **No**
e. Are you, or your spouse or parent, a veteran or an active-duty member of the U.S. military? ☐ **Yes** ☐ **No**

13. Are you the primary or one of the primary person(s) taking care of a child under age 19 years that lives with you? ☐ **Yes** ☐ **No**

14. Were you in foster care at age 18 or older in Hawaii? ☐ **Yes** ☐ **No**

15. Are you a full-time student? ☐ **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 | ☐ Black or African American | ☐ Filipino | ☐ Vietnamese | ☐ Guamanian or Chamorro |
| ☐ Asian Indian | ☐ American Indian or Alaska Native | ☐ Japanese | ☐ Other Asian | ☐ Other Pacific Islander |
| ☐ Chinese | ☐ Native Hawaiian | ☐ Korean | ☐ Samoan | ☐ Other _____ |

**NEED HELP WITH YOUR APPLICATION? Visit mybenefits.hawaii.gov or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 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 1-855-585-8604 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.

☐ **Self-employed**
Skip to question 27.

☐ **Not employed**
Skip to question 28.

**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

**$**_____

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

**$**_____

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 (profit 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 or veteran's payment.

☐ Unemployment **$**_____ How often? _____
☐ Pensions **$**_____ How often? _____
☐ Social Security **$**_____ How often? _____
☐ Retirement accounts **$**_____ How often? _____
☐ Alimony received **$**_____ How often? _____
☐ Net farming/fishing **$**_____ How often? _____
☐ Net rental/royalty **$**_____ How often? _____
☐ Other income **$**_____ 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. **NET YEARLY INCOME:** Complete if your net income changes a lot 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.

**If there is 2 or more people to include, please make a copy of STEP 2: PERSON 2 (Pages 4 and 5) and Complete**

.

**NEED HELP WITH YOUR APPLICATION? Visit mybenefits.hawaii.gov or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 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 1-855-585-8604 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 PERSON 1? |
|---|---|---|---|---|
| | | | | |

3. Date of birth (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐

4. Gender ☐ 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–c. ☐ **No. If no,** skip to question c.

a. Will PERSON 2 file jointly with a spouse? ☐ **Yes** ☐ **No**
**If yes**, name of spouse: _____

b. Will PERSON 2 claim any dependents on his/her tax return? ☐ **Yes** ☐ **No**
**If yes**, list name(s) of dependents: _____

c. 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,** how many babies are expected during this pregnancy? ____ Expected 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 disability that will last more than twelve (12) months? ☐ **Yes** ☐ **No**
a. Does PERSON 2 currently receive long term care nursing services: ☐ **Yes**, in a nursing facility ☐ **Yes**, in my home in the community ☐ **No**
b. Has PERSON 2 received long term care nursing services in the last three (3) months? ☐ **Yes. If yes**, what date(s)? _____ ☐ **No**
c. Does PERSON 2 need long term care nursing services now? ☐ **Yes** ☐ **No**
d. Does PERSON 2 receive Supplemental Security Income (SSI)? ☐ **Yes** ☐ **No**

11. Did PERSON 2 receive any medical services in the past ten (10) calendar days immediately prior to the date of this application?
☐ **Yes.** If yes, what date(s)? _____ ☐ **No**

12. Is PERSON 2 a U.S. citizen or U.S. national? ☐ **Yes. If yes**, skip to Question 14. ☐ **No**

13. If PERSON 2 isn't a U.S. citizen or U.S. national, please provide the information below.
a. Immigration document type _____
b. Document ID number _____
c. When did PERSON 2 enter the U.S.? _____
d. Is PERSON 2 a citizen of the Federated State of Micronesia, the Republic of the Marshall Islands or Palau? ☐ **Yes** ☐ **No**
e. Is PERSON 2, or their spouse or parent, a veteran or an active-duty member of the U.S. military? ☐ **Yes** ☐ **No**

14. Is PERSON 2 the primary or one of the primary person(s) taking care of a child under age 19 years that lives with you? ☐ **Yes** ☐ **No**

15. Was PERSON 2 in foster care at age 18 or older in Hawaii? ☐ **Yes** ☐ **No**

16. Is PERSON 2 a full-time student? ☐ **Yes** ☐ **No**

17. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other_____

18. Race (OPTIONAL – check all that apply.)

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

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

**NEED HELP WITH YOUR APPLICATION? Visit mybenefits.hawaii.gov or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 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 1-855-585-8604 or 711.**

# STEP 2: PERSON 2

## CURRENT Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 19.

☐ **Self-employed**
Skip to question 28.

☐ **Not employed**
Skip to question 29.

### CURRENT JOB 1:

19. Employer name and address

20. Employer phone number

21. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly
**$**_____

22. Average hours worked each WEEK

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

23. Employer name and address

24. Employer phone number

25. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly
**$**_____

26. Average hours worked each WEEK

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

28. **If self-employed, answer the following questions:**

a. Type of work
_____

b. How much net income (profit once business expenses are paid) will you get form this self-employment this month?
**$**_____

29. **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 or veteran's payment.

☐ Unemployment **$**_____ How often? _____
☐ Pensions **$**_____ How often? _____
☐ Social Security **$**_____ How often? _____
☐ Retirement accounts **$**_____ How often? _____
☐ Alimony received **$**_____ How often? _____
☐ Net farming/fishing **$**_____ How often? _____
☐ Net rental/royalty **$**_____ How often? _____
☐ Other income **$**_____ How often? _____
Type: _____

30. **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 health coverage a little lower.

**NOTE:** You shouldn't include a cost that you already considered in your answer to net self-employment (question 28b).

☐ Alimony paid **$**_____ How often? _____
☐ Student loan interest **$**_____ How often? _____
☐ Other deductions **$**_____ How often? _____
Type: _____

31. **NET YEARLY INCOME:** Complete if PERSON 2 net income changes a lot from month to month.
**If you don't except changes to PERSON 2 monthly income, skip to the next section.**

| 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.**

**If there are no more people to include, skip to next page.**

**NEED HELP WITH YOUR APPLICATION? Visit mybenefits.hawaii.gov or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 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 1-855-585-8604 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?**

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

# STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. Does anyone have health coverage or health insurance other than Medicaid?

☐ **Yes. If yes,** check the type of coverage and write the person(s) name(s) on the line provided and additional information as appropriate.

☐ Employer insurance_____
Name of health insurance:_____
Policy number:_____
Is this COBRA coverage? ☐ **Yes** ☐ **No**
Is this a retiree health plan? ☐ **Yes** ☐ **No**

☐ Medicare_____
☐ TRICARE_____
(Don't check if you have direct care or Line of Duty)
☐ VA health care programs_____
☐ Peace Corp_____
☐ Other_____
Name of health insurance:_____
Policy number:_____
Is this a limited-benefit plan (like a school accident policy)? ☐ **Yes** ☐ **No**

☐ **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 Paper work 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 0938-1191. 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 suggestion for improving this from, 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 mybenefits.hawaii.gov or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 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 1-855-585-8604 or 711.**

# !!!SIGNATURE REQUIRED BELOW!!!

## STEP 5 Read and 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 state or federal law if I provide false and/or untrue information.
- I understand I must tell the Department of Human Services or the Federal Health Insurance Marketplace if anything changes (and is different than) what I wrote on this application. I can visit **mybenefits.hawaii.gov** or call **1-800-316-8005** (TTY/TDD: 1-855-585-8604 or 711) or visit **www.healthcare.gov** or call 1-800-318-2596 (TTY: 1-855-889-4325) to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I understand 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 understand the Department of Human services and the Federal Health Insurance Marketplace will obtain information to verify eligibility with electronic databases, to include but not limited to, the Internal Revenue Services (IRS), Social Security Administration (SSA), Department of Homeland Security (DHS) or a consumer reporting agency. If the information doesn't match, we may ask to you 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 Federal Health Insurance Marketplace to use income data, including information from tax returns. The Federal Health Insurance 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 years ☐ Don't use information from tax returns to renew my coverage.

### If anyone on this application is eligible for Medicaid.

- I am assigning the Department of Human Services, my rights to payments for medical care from any third party, which may include but not limited to, other health insurance or legal settlement. I am also assigning the Department of Human Services, my rights to pursue and get medical support from a spouse or parent. I will cooperate in obtaining third party payments.
- Does any child on this application have a parent living outside of the home? ☐ **Yes** ☐ **No If yes**, I understand I will be asked to cooperate with the Department of Human Services and the agency that collects medical support form 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 agree to cooperate with the Department of Human Services, Federal Quality Control reviewers or auditors if my case is selected for a review.

### My right to appeal

If I think the Department of Human Services or the Federal Health Insurance Marketplace has made a mistake. I can appeal its decision. To appeal means to tell someone at the Department of Human Services or the Federal Health Insurance Marketplace that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting someone at **1-877-628-5076**. I know that I can be represented in the process by someone other than myself. My eligibility and other 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 with your name, as long as you have provided the information required in Appendix C.

| Signature | Date (mm/dd/yyyy) |
|---|---|
| | |

## STEP 6 Mail your signed application to:

**MQD/EB**
**Oahu Section**
**P.O. Box 3490**
**Honolulu, HI 96811-3490**

**MQD/EB**
**Kapolei Unit**
**P.O. Box 29920**
**Honolulu, HI 96820-2320**

**MQD/EB**
**East Hawaii Section**
**1404 Kilauea Avenue**
**Hilo, HI 96720-4670**

**MQD/EB**
**West Hawaii Section**
**Lanihau Professional Center**
**75-5591 Palani Road, Suite 3004**
**Kailua-Kona HI 96740-3633**

**MQD/EB**
**Lanai Unit**
**P.O. Box 1619**
**Kaunakakai, HI 96748-1619**

**MQD/EB**
**Maui Section**
**Millyard Plaza**
**210 Imi Kala Street, Suite 101**
**Wailuku, HI 96793-1274**

**MQD/EB**
**Molokai Unit**
**P.O. Box 1619**
**Kaunakakai, HI 96748-1619**

**MQD/EB**
**Kauai Section**
**4473 Pahee Street, Suite A**
**Lihue, HI 96766-2037**

If you want to register to vote you can complete the attached voter registration from or download a form from **hawaii.gov/elections**.

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# 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

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 section.

| 3. Employer name | | 4. Employer Identification Number (EIN) |
|---|---|---|
| 5. Employer address (notice will be sent to this address) | | 6. Employer phone number |
| 7. City | 8. State | 9. Zip Code |
| 10. Who can we contact about employee health 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 three (3) months?

☐ Yes (continue)

a. 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 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 ☐ Once a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new 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 ☐ Once 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 cost 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. Social Security Number ☐☐☐-☐☐-☐☐☐☐ |
|---|---|
| | |

## EMPLOYER Information

Ask the employer for this section.

| 3. Employer name | | 4. Employer Identification Number (EIN) |
|---|---|---|
| 5. Employer address (notice will be sent to this address) | | 6. Employer phone number |
| 7. City | 8. State | 9. Zip Code |
| 10. Who can we contact about employee health 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 be eligible in the next three (3) months?

☐ Yes (continue)

a. 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 (Continue)

☐ 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 ☐ Once a month ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know 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 ☐ Once 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 cost 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 program, 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<br><br>Last | First Middle<br><br>Last |
| 2. Member of a federally recognized tribe? | ☐ **Yes** If yes, tribe name is:<br><br>☐ **No** | ☐ **Yes** If yes, tribe name is:<br><br>☐ **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**<br><br>☐ **No. If no**, is this person eligible to get services from the Indian Health services, tribal health programs, or urban Indian health programs, or through a referral from one of these programs?<br>☐ **Yes** ☐ **No** | ☐ **Yes**<br><br>☐ **No**. **If no**, is this person eligible to get services from the Indian Health services, tribal health programs, or urban Indian health programs, or through a referral from one of these programs?<br>☐ **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:<br>• Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties.<br>• 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).<br>• Money from selling things that have cultural significance. | $_____<br><br>How often?_____ | $_____<br><br>How often?_____ |

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# APPENDIX C

## Assistance with Completing this Application

### You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, call 1-877-628-5076. If you're a legally appointed representative for someone on this application, submit proof with the application.

| 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. Organization name | | 9. ID number (if applicable) |

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

| 10. Your signature | 11. Date (mm/dd/yyyy) |
|---|---|

### Authorized Representative

As the designated Authorized Representative, I agree to maintain the confidentiality of any information provided to me by the Department or it's designee and I can be released as the Authorized Representative by signing below:

Signature of Authorized Representative _____ Telephone _____ Date _____

Street Address _____ City _____ State _____ Zip Code _____

As applicable, I _____ ,am a provider or staff member or volunteer
PRINT Name of Individual

of an organization: _____
PRINT Name of Provider/Organization

**I understand and agree, as a condition of serving as the Authorized Representative, will adhere to the regulations relating to confidentiality of information and the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf, as well other relevant State and Federal laws covering conflicts of interest and confidentiality of information.**

### 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 someone else.

| 1. Application start date (mm/dd/yyyy) | |
|---|---|
| 2. First name, Middle name, Last name, & Suffix | |
| 3. Organization name | 4. ID number (if applicable) |

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**STATE OF HAWAII**
**NATIONAL VOTER REGISTRATION ACT QUESTIONNAIRE**

## You may register to vote in Hawaii if:

1. You are a United States citizen.
2. You are a resident of the State of Hawaii.
3. You are at least 16 years of age and understand that you must be 18 years of age by election day to vote.
4. You are not an incarcerated felon.
5. You are not registered in any other state, unless you cancel that registration. (There is an area on the Hawaii registration application for you to cancel if needed.)

If you are not registered to vote where you live now, would you like to apply to register to vote here today? (Check one.)

☐ YES ☐ NO

**If you do not check either box, you will be considered to have decided not to register to vote at this time.**

## Important Notices

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help filling out the voter registration form, we will help you in person or you can call: Oahu: 524-3370; Neighbor Islands: 1-800-316-8005; or for an Interpreter: 1-888-764-7586. The decision to seek or accept help is yours. You may fill out the application form in private.

Applying to register or declining to register to vote will remain confidential and will be used only for your voter registration purposes.

If you need additional information about voting or if you believe that someone has interfered with your right to register or not to register to vote; or your right to privacy in deciding whether or not to register or applying to register to vote, you may contact:

Office of Elections
802 Lehua Avenue
Pearl City, Hawaii 96782
Phone: (808) 453-VOTE (8683)
Neighbor Islands Toll Free: 1-800-442-VOTE (8683)

_____
Name

_____ _____
Signature Date

State Agency I.D. # A 0 1 7

# Voter Registration & Permanent Absentee

Important: Print clearly in black ink.

## I hereby swear (or affirm) that the following information is true and correct:

| | | | |
|---|---|---|---|
| 1 | Social Security Number* _ _ _ - _ _ - _ _ _ _ | 2 Date of Birth _ _/ _ _/_ _ _ _ | 3 Telephone Number |
| 4 | Last Name | First Name | M.I. |
| 5 | Residence Address (Must be completed. P.O. Box, R.R., S.R. are not acceptable) | Apt. No. / City/Town | Zip |
| 6 | Mailing Address in Hawaii (Street address or P.O. Box) | City/Town | Zip |
| 7 | If no street address, describe location of residence (Leave blank if box #5 is completed) | City/Town | Zip |
| 8 | Gender ❑ F ❑ M | 9 Optional - Email Address | |
| 10 | Are you a registered voter in another state? If "yes" please provide your last registered address, county, state, and zip<br>I hereby authorize cancellation of my previous registration. | | |

**READ AND SIGN BELOW**

### VOTER REGISTRATION

I hereby swear (or affirm) that:

For Federal, State, and County Elections:

A. I am a citizen of the United States of America ❑ YES ❑ NO
(Non-U.S.citizens including U.S. nationals do not qualify).

B. I am at least 16 years of age and I understand that I must be 18 years old by election day to vote. ❑ YES ❑ NO

C. I am a resident of the State of Hawaii.
(The residence stated in this affidavit is not simply because of my presence in the State, but that the residence was acquired with the intent to make Hawaii my legal residence with all the accompanying obligations therein...) ❑ YES ❑ NO

If you checked 'no' in response to any of these affirmations, do not complete this form.

**Signature** _____

**Date** _____

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### PERMANENT ABSENTEE

*Complete only if you want to receive your ballots by mail*

I am requesting to receive absentee ballots permanently.

Please mail my ballots to:

❑ Residence Address (box #5) ❑ Mailing Address (box #6)

❑ Address_____

City State _____ Zip Code _____

I shall be responsible for informing the clerk of any changes to my personal information, including changes to the mailing address for my absentee ballots; I also understand that my permanent voter status will remain in effect unless and until one of the following conditions occur:

A. If I request termination of status in writing; or
B. If I die, lose my voting rights, or I am otherwise disqualified from voting; or
C. If I register to vote in another jurisdiction; or
D. If my absentee ballot, voter notification postcard, or any other election mail is returned as undeliverable for any reason; or
E. If I do not return a voter ballot by 6:00 p.m. election day in both the primary and general election of an election year; and

I understand that if my permanent absentee voter status is terminated I will be responsible for reapplying for permanent absentee status.

**Signature** _____

**Date** _____

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13 Witness Signature, Address, and Phone Number (required only if applicant makes a mark)

**FOR OFFICE USE ONLY**

| 14 | | |
|---|---|---|
| | I.D. No. A 0 1 7 | Location Code |

**Warning: Any person who knowingly furnishes false information may be guilty of a class C felony, punishable by up to 5 years of imprisonment and/or $10,000 fine.**

*Notice: Section 11-15 and 15-4 of the Hawaii Revised Statutes requires that a person provide, under oath, his or her social security number, if any. It is used to prevent fraudulent registration and voting. An application lacking this information will, therefore, be denied. Pursuant to Section 7 of the Federal Privacy Act (P.L. 93-579), be advised that his information may be released to government agencies for government purposes. The office at which a person registers to vote is confidential. A person's declination to register to vote is also confidential and is used for voter registration purposes only (National Voter Registration Act of 1993).

# Wikiwiki Voter Registration & Permanent Absentee Form - Instructions

## STEP 1
## Complete the Application

1. Print your Social Security Number.
2. Print your Date of Birth.
3. Enter your Telephone Number.
4. Print your Name - Last, First and Middle Initial(s).
5. Print your Residence Address in Hawaii (house number and street name).
   You must be registered to vote in the county and precinct where you live.
   *Note: A Post Office Box, Star Route, Rural Route, General Delivery, Business Address or Mailing Service Address is not an acceptable residence address.*
6. Print your Mailing Address in Hawaii.
7. If your residence does not have a street address, describe the location of your residence. Include details such as subdivision, village, tax map key no. and zip code.
8. Check the appropriate "Female" or "Male" box.
9. Print your email address.
10. If you are registered to vote in another state but now wish to register to vote in Hawaii, complete box #10. Your registration in that state will be canceled.
    *Note: You may register to vote in only one state.*
11. Read carefully, and remember to check "Yes" or "No" box for each affirmation. Sign and date. Your application will not be accepted if you fail to mark the appropriate boxes or withhold your signature. If your signature is a mark, a witness signature is required. (Box #13)
12. Read carefully, and check appropriate box for address. Sign and date. If your signature is a mark, a witness signature is required. (Box #13)

## Notice to First Time Voters Who Register to Vote by Mail:

If you are (1) registering to vote for the first time in the State of Hawaii; and (2) are mailing in this Application for Voter Registration, federal law (42 U.S.C. § 15483) requires you to provide proof of identification.
Proof of identification includes a copy of:

- A current and valid photo identification, or
- A current utility bill, bank statement, government check, paycheck, or other government document that shows your name and address.

If you do not provide the required proof of identification with this Application for Voter Registration, you will be required to do so at your polling place, or with your voted absentee mail-in ballot.

## STEP 2
## Mail the Application:

- no later than 30 days prior to the election if applying to register to vote
- no later than 7 days prior to the election if applying for permanent absentee status

### County of Hawaii
25 Aupuni St., Rm. 1502
Hilo, HI 96720-4245
Ph. (808) 961-8277

### City and County of Honolulu
530 S. King St., Rm. 100
Honolulu, HI 96813-3077
Ph. (808) 768-3800

### County of Maui
200 S. High St., Rm. 708
Wailuku, HI 96793-2155
Ph. (808) 270-7749

### County of Kauai
4386 Rice St., Rm. 101
Lihue, HI 96766-1819
Ph. (808) 241-4800