### Use this Application to see what coverage you qualify for

- Free or low-cost insurance from TennCare or CoverKids
- Help with paying for Medicare costs.

### Who can use this Application?

- Use this Application to apply for anyone in your family.
- Other people in your household who want to apply for TennCare or CoverKids.
- 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 this out, you may need to complete the Help with completing this Application section on the next page of this Application.

### Things you may need to complete this Application.

- 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, bank statements or wage and tax statements). Policy numbers for any health insurance you have now (other than TennCare or CoverKids).
- 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.** To view the Privacy Act Statement, go to https://tn.gov/tenncare/topic/hipaa-policies.

### What happens next?

Send your complete, **signed** Application to:
TennCare Connect
P.O. Box 305240
Nashville, TN 37202-5240

You may also **fax** your Application to TennCare Connect at 1-855-315-0669.

**What if you don’t have all the information we ask for when it’s time to send us your Application?** Sign and send us your Application anyway. After we get your Application, we’ll look to see what facts we still need from you. Then we’ll send you a letter that asks you to send us the facts we still need. That letter will include a cover page that you’ll send back with your facts. The cover page helps us easily link the facts you send to your Application.

After we get your Application and facts, we’ll review your information. We’ll send you a letter that tells you our decision. If you have questions, call us for free at 1-855-259-0701.

### Do you want to know other ways you can apply?

**Online:** [www.tenncareconnect.tn.gov](http://www.tenncareconnect.tn.gov)

**Phone:** Call TennCare Connect to apply or get help at 1-855-259-0701.

**En español:** Llame a nuestro centro de ayuda gratis al 1-855-259-0701.

In person: You can apply in person at your local Department of Human Services (DHS) office. To find your local office, go to: [www.tn.gov/humanservices](http://www.tn.gov/humanservices) and click “Office Locations” at the bottom of the page.

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**Need help with your Application?** Call us at 1-855-259-0701. Do you need help in a language other than English? When you call, tell us the language you need. We’ll get you help at no cost to you. Do you have a hearing or speech problem and use a TTY? Call 1-800-848-0298, then dial 1-855-259-0701.
Help with completing this Application

Do you need help with your Application?
You can call TennCare Connect at 1-855-259-0701.

What if you need help in person with your Application?
You can get help from TennCare Connect. Call: 1-855-259-0701.

Your local Department of Human Services (DHS) office can help you. To find your local office, go to: https://www.tn.gov/humanservices and click “Office Locations” at the bottom of the page or call 1-866-311-4287. If you are calling from Nashville, call 615-313-4700.

If you’re getting care at a local community mental health center, they can also help you. Their offices are listed at: www.tamho.org/#services.

Do you have an intellectual and/or other developmental disability and need help with your Application?
You can get help from the Department of Developmental and Intellectual Disabilities in the area where you live.

West TN: 1-866-372-5709
Middle TN: 1-800-654-4839
East TN: 1-888-531-9876

Do you want to apply for Home and Community Based Services (HCBS) or nursing home care and need help with your Application?
You can get help from the Area Agency on Aging and Disability. Call: 1-866-836-6678.

Is someone helping you fill out this application? If yes, tell us who. Name: __________________________________________________________

Do you have an Assisting Person who can talk to us about your Application on your behalf? This person can be the same or different than the person you named above. An Assisting Person is a trusted person who, with your consent (your OK), can:

- Sign an Application on your behalf
- Complete and submit a renewal form,
- Receive copies of your letters and other communications from us
- Act on your behalf in all other matters with us.

Your Assisting Person can be an individual or an organization. Information shared by and with your Assisting Person may be shared with others. Not everyone has to follow the same privacy rules.

Your Assisting Person will continue to have these rights until you tell us you want to change. If you ever need to change your Assisting Person, or end their rights as your representative, call TennCare Connect at 1-855-259-0701. This will not change facts we have already shared with your Assisting Person, but we won’t share any more facts.

If you or someone in this Application already has a legally Assisting Person (a guardian, custodian or power of attorney), send us proof with the Application. It’s helpful to send it even if you’ve already given us this proof before.

Tell us about your Assisting Person by filling out their information below.

1. Name of Assisting Person (First name, Middle name, Last name, Suffix)
2. Address
3. Apartment or suite number
4. City
5. State
6. ZIP code
7. Phone number

Please tell us the responsibilities and permission granted to this Assisting Person:

☐ Sign an Application on my (the applicant’s) behalf
☐ Complete and submit a renewal form on my (the applicant’s) behalf
☐ Receive copies of my (the applicant’s) letters and other communications from us.
☐ Act on my (the applicant’s) behalf in all other matters with us.

If your Assisting Person is part of an organization helping you apply, such as a hospital, a doctor, or a nursing home, the employee representative must complete the information and sign below. They must also agree that:

As an employee, staff member or volunteer with the named organization or provider below, they affirm that they will adhere to 42 CFR 431(f), 42 CFR 155.260(f) and 45 CFR 447.10, as well as other relevant State and Federal laws concerning conflicts of interest and confidentiality of information. The organization or provider shall notify the Agency of any change in name or contact information for the representative within ten (10) days of the change.

1. Organization name (if applicable)
2. ID number (if applicable)

3. Signature of authorized representative (if applicable)
4. Date (if applicable)

Need help with your Application? Call us at 1-855-259-0701. Do you need help in a language other than English? When you call, tell us the language you need. We’ll get you help at no cost to you. Do you have a hearing or speech problem and use a TTY? Call 1-800-848-0298, then dial 1-855-259-0701.

Rev: 15Apr19
Please print in capital letters using black or dark blue ink only. Check the boxes ( ☑ ) like this. ☑

Before you get started:
Use this Application to apply for TennCare, CoverKids, or a Medicare Savings Program, like QMB/SLMB.

### STEP 1: Person 1 Tell us about yourself

You'll be Person 1 starting on the next page. Person 1 is the Head of Household.

1. First name  Middle name  Last name  Suffix (Jr., Sr., III)
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
   Type: ☐ Mobile  ☐ Home  ☐ Work
   (   )   -   Ext:
15. Other phone number
   Type: ☐ Mobile  ☐ Home  ☐ Work
   (   )   -   Ext:

16. What’s your preferred spoken language?
17. What’s your preferred written language?

### STEP 2: Tell us about your family.

We’ll use your facts to see if you qualify for health care coverage with us. We’ll check first to see if you qualify for TennCare. If your income is too high but you’re under the age of 19 or pregnant and meet other rules, we’ll see if you qualify for CoverKids. The kind of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure you can get coverage with us.

Do Include:
- Yourself
- Your spouse
- Your children (or stepchildren) under 21 who live with you
- Anyone you include on your 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 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

Children Under 21 also include:
- Parent (or stepparent) who live with you
- Sibling (or stepsibling) who live with you
- Your children (or stepchildren) under 21 who live with you
- Anyone you include on your tax return, even if they don’t live with you

Complete Step 2 for each person in your family.

Start with yourself, then add other people who live with you. If you have more than 2 people in your family, you’ll need to make a copy of the pages and attach them. Or, you can print them from our website at www.tn.gov/tenncare.

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.
## STEP 2: PERSON 1

Start with yourself. Remember, Person 1 is the Head of Household.

Complete Step 2 for yourself and other family members who live with you. This includes anyone on your same federal tax return (if you file one). 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. Date of birth (mm/dd/yyyy)

### 3. Sex

- [ ] Male
- [ ] Female

### 4. Relationship to Person 1

- [ ] SELF

### 5. Social Security Number (SSN) ___-___-____ If not, what date did you apply for one? __________

We need a Social Security number (SSN) if you want health coverage and have an SSN or can get one. We use SSNs to check income and other information to see who’s eligible for help paying for health coverage. If you need help getting an SSN, visit socialsecurity.gov, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

### 6. Are you applying for health coverage with us?  [ ] Yes  [ ] No  If no, you can skip to questions 23, 39-50, and 54-55.

### 7. If Hispanic/Latino, ethnicity (Optional – Check all that apply.)

- [ ] Mexican
- [ ] Mexican American
- [ ] Chicano/a
- [ ] Puerto Rican
- [ ] Cuban
- [ ] Other ________________

### 8. Race (OPTIONAL – Check all that apply.)

- [ ] White
- [ ] Black or African American
- [ ] American Indian or Alaska Native
- [ ] Asian
- [ ] Native Hawaiian
- [ ] Guamanian or Chamorro
- [ ] Samoan
- [ ] Other ________________

### 9. Have you ever been known by any other name?  [ ] If yes:

- [ ] First name  Middle name  Last name  Suffix

### 10. Are you a U.S. citizen or U.S. national?  [ ] Yes  [ ] No  If yes, skip 16-22

### 11. Is Person 1 a naturalized or derived citizen?  [ ] Yes  [ ] No  If yes, provide a. and b.

- a. Alien Number: ______________________
- b. Certificate Number: ______________________

### 12. If you aren’t a U.S. citizen or U.S. national, do you have eligible immigration status?  [ ] YES.

- a. What is your immigration status? ______________________
- b. What date did you gain that status? ______________________

### 13. Are you or your spouse or parent, a veteran or an active-duty member of the U.S. military?  [ ] Yes  [ ] No

### 14. If PERSON 1 is American Indian or Alaska Native answer 20-22. If not, skip 20-22.

- a. Are you a member of a federally recognized tribe?  [ ] Yes  [ ] No
- b. If yes, what is the name of the tribe? ______________________

### 15. Have you ever received a service from the Indian Health Service, a tribal health program or urban Indian health program, or through referral of one of these?  [ ] Yes  [ ] No

### 16. Are you eligible to get services from the Indian Health Service, a tribal health program or urban Indian health program, or through referral of one of these?  [ ] Yes  [ ] No

**Need help with your Application?** Call us at 1-855-259-0701. Do you need help in a language other than English? When you call, tell us the language you need. We'll get you help at no cost to you. Do you have a hearing or speech problem and use a TTY? Call 1-800-848-0298, then dial 1-855-259-0701.
### STEP 2: PERSON 1

Continue with yourself

23. Will you file a federal income tax return the next time taxes are due? Yes if yes, please answer questions a–d. No. If no, skip to question d.
   - [ ] Yes
   - [ ] No
   - a. Will you file jointly with a spouse? Yes
   - a. Will you file jointly with a spouse? No
   - b. Will you claim any dependents on your tax return? Yes
   - b. Will you claim any dependents on your tax return? No
   - c. Do any of your dependents live outside of your household? Yes
   - c. Do any of your dependents live outside of your household? No
   - d. Will you be claimed as a dependent on someone’s tax return? Yes
   - d. Will you be claimed as a dependent on someone’s tax return? No
   - If yes, please list the name of the tax filer: __________________________
   - How are you related to the tax filer? __________________________

24. Are you a primary caregiver to a child under age 19? Yes
   - if yes, to who? __________________________
   - What is your relationship to them? __________________________

25. Do you have Medicaid in another state? Yes
   - if yes, what state? __________________________
   - When will your Medicaid in this state end? __________________________ (mm/dd/yyyy)

26. Are you pregnant? Yes
   - if yes, how many babies are expected during this pregnancy? ______
   - What is your due date? __________________________ (mm/dd/yyyy)
   - It’s ok to tell us an approximate date if you’re not sure.

27. Are you enrolled in, or entitled to enroll in, Medicare Part A or B? Yes
   - if yes, are you enrolled in Medicare Part A? No

28. Have you experienced an emergency health problem and need help paying for those emergency services? Yes
   - if yes, what is the name of the facility? __________________________

29. Are you under age 65 and getting treatment now or do you need treatment for breast or cervical cancer? Yes
   - If yes, are you getting treatment now? No

30. Are you under age 65 and getting treatment now or do you need treatment for breast or cervical cancer? No
   - If yes, when did it end? __________________________

31. Do you live in a nursing home? Yes
   - if yes, what is the name of the facility? __________________________

32. Do you need hospice care? Yes
   - if yes, to who? __________________________

33. Are you over age 65 or are you an adult with physical disabilities and do you want to receive Home and Community Based Services (HCBS)? Yes
   - if yes, do you need help paying Medicare cost sharing like QMB or SLMB? No
   - What if you think you need care at home to keep from going into a nursing facility? Call your Area Agency on Aging and Disability at 866-836-6678. You still need to finish this application but they can help you.

34. Do you have intellectual or development disabilities and want care at an intermediate care facility for individuals with Intellectual Disabilities (ICF/IID)? Yes
   - if no, list the name of the tax filer: __________________________

35. Do you have intellectual and/or other developmental disabilities and want to receive Home and Community Based Services (HCBS) and participate in Employment and Community First CHOICES? Yes
   - if yes, will you be claiming the tax filer? No
   - What if you think you need care at home to keep from going into a nursing facility? Then you must also complete an online referral at: https://tcreq.tn.gov/tmtrack/ect/index.htm.

36. Do you have Medicare and want to get or keep help paying Medicare cost sharing like QMB or SLMB? Yes
   - if yes, are you enrolled in Medicare Part A? No

37. Did you receive Supplemenatal Security Income, or SSI benefits, in the past but don’t now? Yes
   - if yes, when did it end? __________________________

38. Do you have expenses for things to help you work because you are blind or disabled? Yes
   - if yes, list the name of the tax filer: __________________________

Need help with your Application? Call us at 1-855-259-0701. Do you need help in a language other than English? When you call, tell us the language you need. We’ll get you help at no cost to you. Do you have a hearing or speech problem and use a TTY? Call 1-800-848-0298, then dial 1-855-259-0701.

Rev: 15Apr19
**STEP 2: PERSON 1**

### Current Job & Income Information

- **Employed**: If you are currently employed, tell us about your income. Start with question 39.
- **Not employed**: Skip to question 49.
- **Self-employed**: Skip to question 50.

#### Current job 1:

39. **Employer name**

- **a. Employer address**
  - **b. City**
  - **c. State**
  - **d. ZIP code**
  - **40. Employer phone number**

41. **Wages/tips per pay period (before taxes)** $  

42. **How often do you get paid?**  
   - **Hourly**
   - **Daily**
   - **Weekly**
   - **Every 2 weeks**
   - **Twice a month**
   - **Monthly**
   - **Yearly**
   - **Quarterly**
   - **Irregularly**
   - **Semi-annually**
   - **One Time only**

43. **Average hours worked each pay period** (Answer only if you checked the box for Hourly in question 42.)

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

44. **Employer name**

- **a. Employer address**
  - **b. City**
  - **c. State**
  - **d. ZIP code**
  - **45. Employer phone number**

46. **Wages/tips per pay period (before taxes)** $  

47. **How often do you get paid?**  
   - **Hourly**
   - **Daily**
   - **Weekly**
   - **Every 2 weeks**
   - **Twice a month**
   - **Monthly**
   - **Yearly**
   - **Quarterly**
   - **Irregularly**
   - **Semi-annually**
   - **One Time only**

48. **Average hours worked each pay period** (Answer only if you checked the box for Hourly in question 47.)

#### Other income you get this month: Check all that apply, and give the amount and how often you get it.

- **None**
- **Unemployment** $ _____ How often? ________
- **Pensions** $ _____ How often? ________
- **Social Security** $ _____ How often? ________
- **Child Support** $ _____ How often? ________
- **Retirement Accounts** $ _____ How often? ________
- **Alimony received** $ _____ How often? ________
- **Net farming/fishing** $ _____ How often? ________
- **Net rental/royalty** $ _____ How often? ________
- **Veteran Benefits Type** $ _____ How often? ________
- **Other income Type** $ _____ How often? ________

50. If you are self-employed answer questions a-c.

  - **a. What do you do?** ____________________________
  - **b. What type of self-employment do you have?** ____________________________
  - **c. How much net income (profits once business expenses are paid) will you get from this self-employment this month?** $ ________________
**STEP 2: PERSON 1**

Continue to tell us about yourself.

51. Does someone other than a parent (if you are under 18) or spouse help pay for your food OR housing each month? □ Yes □ No  
   If **yes** answer questions a-f.  
   a. Does the person who helps you pay for this live with you? □ Yes □ No  
   b. What do they help you pay for? __________________________  
   c. How much is this expense or bill? $_____________________  
   d. How much do you pay? $______________________  
   e. How much does the other person pay? $_____________________  
   f. Number of people in the home? ______

52. Do you have medical or dental bills for care you’ve received or paid in the last 90 days? □ Yes □ No

53. Do you have shelter or utility expenses, dependent care expenses, or child support expenses? □ Yes □ No

54. Do you have before tax deductions? □ Yes □ No  If **yes**, check all that apply. Give the amount you pay each month. If no, skip to question 55.

<table>
<thead>
<tr>
<th>Type of Deduction</th>
<th>Amount Per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Insurance</td>
<td>$________</td>
</tr>
<tr>
<td>Dental Insurance</td>
<td>$________</td>
</tr>
<tr>
<td>Vision Care Insurance</td>
<td>$________</td>
</tr>
<tr>
<td>Flexible Spending Account (Health and dependent plans)</td>
<td>$________</td>
</tr>
<tr>
<td>Deferred Compensation</td>
<td>$________</td>
</tr>
<tr>
<td>Pre-Tax life insurance premiums</td>
<td>$________</td>
</tr>
<tr>
<td>Pre-Tax life insurance premiums</td>
<td>$________</td>
</tr>
<tr>
<td>Other Deduction Type</td>
<td>$________</td>
</tr>
</tbody>
</table>

55. Do you have expenses that can be deducted on an income tax return? □ Yes □ No  If **yes**, check all at apply. Give the amount that you pay each month. If no, skip this question.

<table>
<thead>
<tr>
<th>Type of Deduction</th>
<th>Amount Per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alimony Paid</td>
<td>$________</td>
</tr>
<tr>
<td>Student Loan Interest Paid</td>
<td>$________</td>
</tr>
<tr>
<td>Tuition and Fees</td>
<td>$________</td>
</tr>
<tr>
<td>Educator Expenses</td>
<td>$________</td>
</tr>
<tr>
<td>Business Expenses</td>
<td>$________</td>
</tr>
<tr>
<td>Deductible part of self-employment</td>
<td>$________</td>
</tr>
<tr>
<td>Health Savings Account Deduction</td>
<td>$________</td>
</tr>
<tr>
<td>Moving Expense</td>
<td>$________</td>
</tr>
<tr>
<td>Other Deduction Type</td>
<td>$________</td>
</tr>
</tbody>
</table>

Thanks! This is all we need to know about you!
**STEP 2: PERSON 2**

Tell us about another family member.

Complete Step 2 for other family members who live with you. This includes anyone on your same federal tax return (if you file one). If you don’t file a tax return, remember to still add family members who live with you.

<table>
<thead>
<tr>
<th>First name</th>
<th>Middle name</th>
<th>Last name</th>
<th>Suffix</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of birth (mm/dd/yyyy)</th>
<th>Sex</th>
<th>Relationship to Person 1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td></td>
</tr>
</tbody>
</table>

### 5. Social Security Number (SSN) __________-________-________

If not, what date did you apply for one? __________

**We need a Social Security number (SSN) if you want health coverage and have an SSN or can get one. We use SSNs to check income and other information to see who’s eligible for help paying for health coverage. If you need help getting an SSN, visit socialsecurity.gov, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.**

---

6. Is PERSON 2 applying for health coverage with us? ☐ Yes ☐ No If no, you can skip to questions 23, 39-50, and 54-55.

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7. If Hispanic/Latino, ethnicity (Optional – Check all that apply.)

☐ Mexican  ☐ Mexican American  ☐ Chicano/a  ☐ Puerto Rican  ☐ Cuban  ☐ Other ________

8. Race (OPTIONAL – Check all that apply.)

☐ White  ☐ Filipino  ☐ Vietnamese  ☐ Other Pacific Islander

☐ Black or African  ☐ Japanese  ☐ Other Asian  ☐ Other ________

☐ American  ☐ Korean  ☐ Native Hawaiian  ☐ ☐

☐ American Indian or  ☐ Asian Indian  ☐ Guamanian or Chamorro  ☐ Other ________

☐ Alaska Native  ☐ Chinese  ☐ Samoan  ☐ ☐

9. Has PERSON 2 ever been known by any other name? If yes:

<table>
<thead>
<tr>
<th>First name</th>
<th>Middle initial</th>
<th>Last name</th>
<th>Suffix</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. If you are approved for TennCare Medicaid, there are three health plans to choose from. We’ll try to enroll you in the health plan you choose. If you don’t pick now, we can pick one for you. Usually, family members are enrolled in the same health plan. Please choose the same health plan for each person on this application. **I want my health plan to be:** ☐ AMERIGROUP  ☐ BlueCare  ☐ UnitedHealth Care Community Plan

If you are approved for CoverKids, your health plan will be Blue Care.

11. Is PERSON 2 a Tennessee resident? ☐ Yes ☐ No

12. Is PERSON 2 temporarily living out of state?

If Yes, does PERSON 2 plan to return to Tennessee? ☐ Yes ☐ No Date PERSON 2 plans to return to Tennessee: __________ (mm/dd/yyyy)

13. If PERSON 2 is younger than 22 years old, what is their school enrollment status? Skip this question if PERSON 2 is age 22 or older.

☐ None ☐ Less than 6 hours a week ☐ 6 or 7 hours a week ☐ 8 to 11 hours a week ☐ 12 or more hours a week (full time)

14. If PERSON 2 is younger than 22 years old, does PERSON 2 work full time? ☐ Yes ☐ No Skip this question if PERSON 2 is age 22 or older.

15. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No If yes, skip 16-22.

16. Is PERSON 2 a naturalized or derived citizen? ☐ Yes ☐ No If yes, provide answers to a. and b.

a. Alien Number: ____________________

b. Certificate Number: ____________________

17. IF PERSON 2 isn’t a U.S. citizen or U.S. national, do they have eligible immigration status? ☐ YES.

a. What is their immigration status? ____________________

What date did they gain that status? ____________________

Fill in Person 2’s document type and ID number below. Document Type:

☐ Alien Number  ☐ I-94 Number  ☐ Card Number  ☐ Passport Number

☐ SEVIS ID  ☐ Certificate of Citizenship Number  ☐ Naturalization Certificate Number  ☐ Visa Number

ID Number: ____________________ Expiration date: __________ (mm/dd/yyyy)

b. Did they have a different immigration status before? ☐ Yes ☐ No

c. Have they lived in the U.S. since 1996? ☐ Yes ☐ No

18. Is PERSON 2, or PERSON 2’s spouse or parent, a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

19. If PERSON 2 is American Indian or Alaska Native answer 20-22. If not, skip 20-22.

20. Is PERSON 2 a member of a federally recognized tribe? ☐ Yes ☐ No If Yes, what is the name of the tribe? ____________________

21. Has PERSON 2 ever gotten a service from the Indian Health Service, a tribal health program or urban Indian health program, or through referral of one of these? ☐ Yes ☐ No

22. Is PERSON 2 eligible to get services from the Indian Health Service, a tribal health program or urban Indian health program, or through referral of one of these? ☐ Yes ☐ No

---

**Need help with your Application?** Call us at 1-855-259-0701. Do you need help in a language other than English? When you call, tell us the language you need. We’ll get you help at no cost to you. Do you have a hearing or speech problem and use a TTY? Call 1-800-848-0298, then dial 1-855-259-0701.

Rev: 15Apr19
23. Will PERSON 2 file a federal income tax return the next time taxes are due? Person 2 can still apply for coverage even if he/she doesn’t file a federal income tax return.
   □ YES. If yes, please answer questions a–d. □ NO. If no, skip to question d.
   a. Will PERSON 2 file jointly with a spouse? □ Yes □ No
      If yes, write 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 your dependents live outside of your household? □ Yes □ No
      If yes, list the names of dependent(s):
   d. 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?

24. Is PERSON 2 a primary caregiver to a child under age 19? □ Yes □ No
    If yes, to who? ___________________________________________ What is their relationship to PERSON 2?

25. Does PERSON 2 have Medicaid in another state? □ Yes □ No
    If yes, what state? __________ When will PERSON 2’s Medicaid in this state end? ______________ (mm/dd/yyyy)

26. Is PERSON 2 pregnant? □ Yes □ No
    If yes, how many babies are expected during this pregnancy? _______ What is their due date? ______________ (mm/dd/yyyy)
    It’s ok to tell us an approximate date if you’re not sure.

27. Is PERSON 2 enrolled in, or entitled to enroll in Medicare Part A or B? □ Yes □ No

28. Has PERSON 2 experienced an emergency health problem and needs help paying for those emergency services? □ Yes □ No

29. Is PERSON 2 younger than 26 and was in foster care at age 18 or older and lived in Tennessee at that time? □ Yes □ No

30. Is PERSON 2 under age 65 and getting treatment now or do they need treatment for breast of cervical cancer? □ Yes □ No

31. Do you live in a nursing home? □ Yes □ No
    If yes, what is the name of the facility?

32. Do you need hospice care? □ Yes □ No

33. Are you over age 65 or are you an adult with physical disabilities and do you want to receive Home and Community Based Services (HCBS)? □ Yes □ No
    What if you think you need care at home to keep from going into a nursing facility? Call your Area Agency on Aging and Disability at 866-836-6678.
    You still need to finish this application but they can help you.

34. Do you have intellectual or development disabilities and want care at an intermediate care facility for individuals with Intellectual Disabilities (ICF/IID)? □ Yes □ No

35. Do you have intellectual and/or other developmental disabilities and want to receive Home and Community Based Services (HCBS) and participate in Employment and Community First CHOICES? □ Yes □ No
    What if you think you need care at home to keep from going into a nursing facility? Then you must also complete an online referral at:

36. Do you have Medicare and want to get or keep help paying Medicare cost sharing like QMB or SLMB? □ Yes □ No

37. Did you receive Supplemental Security Income, or SSI benefits, in the past but don’t now? □ Yes □ No
    If yes, when did it end? __________________________

38. Do you have expenses for things to help you work because you are blind or disabled? □ Yes □ No

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**STEP 2: PERSON 2**  
Current Job & Income Information

<table>
<thead>
<tr>
<th>Current job &amp; income information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Employed: If PERSON 2 is currently employed, tell us about their income. Start with question 39.</td>
<td>□ Not employed: Skip to question 49.</td>
</tr>
</tbody>
</table>

### Current job 1:

39. Employer name

- a. Employer address
- b. City
- c. State
- d. ZIP code
- 40. Employer phone number

<table>
<thead>
<tr>
<th>41. Wages/tips per pay period (before taxes)</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td>42. How often do you get paid?</td>
<td></td>
</tr>
<tr>
<td>□ Hourly</td>
<td>□ Daily</td>
</tr>
<tr>
<td>□ Every 2 weeks</td>
<td>□ Twice a month</td>
</tr>
<tr>
<td>□ Yearly</td>
<td>□ Quarterly</td>
</tr>
<tr>
<td>□ Semi-annually</td>
<td>□ One Time only</td>
</tr>
<tr>
<td>43. Average hours worked each pay period. (Answer only if you checked the box for Hourly in question 42.)</td>
<td></td>
</tr>
</tbody>
</table>

### Current job 2: (If PERSON 2 has additional jobs and need more space, attach another sheet of paper.)

44. Employer name

- a. Employer address
- b. City
- c. State
- d. ZIP code
- 45. Employer phone number

<table>
<thead>
<tr>
<th>46. Wages/tips (before taxes)</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td>47. How often do you get paid?</td>
<td></td>
</tr>
<tr>
<td>□ Hourly</td>
<td>□ Daily</td>
</tr>
<tr>
<td>□ Every 2 weeks</td>
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<td>□ Quarterly</td>
</tr>
<tr>
<td>□ Semi-annually</td>
<td>□ One Time only</td>
</tr>
<tr>
<td>48. Average hours worked each pay period. (Answer only if you checked the box for Hourly in question 47.)</td>
<td></td>
</tr>
</tbody>
</table>

### 49. Other income you get this month: Check all that apply, and give the amount and how often PERSON 2 gets it.

- □ None
- □ Unemployment $ _______ How often? ____________
- □ Pensions $ _______ How often? ____________
- □ Social Security $ _______ How often? ____________
- □ Child Support $ _______ How often? ____________
- □ Retirement Accounts $ _______ How often? ____________
- □ Alimony received $ _______ How often? ____________
- □ Net farming/fishing $ _______ How often? ____________
- □ Net rental/royalty $ _______ How often? ____________
- □ Veteran Benefits Type $ _______ How often? ____________
- □ Other income Type $ _______ How often? ____________

### 50. If PERSON 2 is self-employed answer questions a-c.

- a. What does PERSON 2 do? __________________________
- b. What type of self-employment does PERSON 2 have? __________________________
- c. How much net income (profits once business expenses are paid) will PERSON 2 get from this self-employment this month? $ __________________________
STEP 2: PERSON 2

Continue to tell us about PERSON 2

51. Does someone other than a parent (if under 18) or spouse help pay for PERSON 2’s food OR housing each month? ☐ Yes ☐ No
   If yes answer questions a-e.
   a. Does the person who helps PERSON 2 pay for this live with PERSON 2? ☐ Yes ☐ No
   b. What do they help PERSON 2 pay for? ______________________
   c. How much is this expense or bill? $ ______________________
   d. How much does PERSON 2 pay? $ ______________________
   e. How much does the other person pay? $ ______________________
   f. How many people are in the home? ____________

52. Does PERSON 2 have medical or dental bills for care you've received or paid in the last 90 days? Yes ☐ No ☐

53. Does PERSON 2 have shelter or utility expenses, dependent care expenses, or child support expenses? Yes ☐ No ☐

54. Do you have before tax deductions? ☐ Yes ☐ No ☐ If yes, check all that apply. Give the amount you pay each month. If no, skip to question 55.
   ☐ Medical Insurance $ ________ Per Month
   ☐ Dental Insurance $ ________ Per Month
   ☐ Vision Care Insurance $ ________ Per Month
   ☐ Flexible Spending Account (Health and dependent plans) $ ________ Per Month
   ☐ Deferred Compensation $ ________ Per Month
   ☐ Pre-Tax life insurance premiums $ ________ Per Month
   ☐ Other Deduction Type $ ________ Per Month

55. Does PERSON 2 have expenses that can be deducted on an income tax return? ☐ Yes ☐ No ☐ If yes, check all at apply. Give the amount that PERSON 2 pays each month. If no, skip this question.
   ☐ Alimony Paid $ ________ Per Month
   ☐ Student Loan Interest Paid $ ________ Per Month
   ☐ Tuition and Fees $ ________ Per Month
   ☐ Educator Expenses $ ________ Per Month
   ☐ Business Expenses $ ________ Per Month
   ☐ Deductible part of self-employment $ ________ Per Month
   ☐ Health Savings Account Deduction $ ________ Per Month
   ☐ Moving Expense $ ________ Per Month
   ☐ Other Deduction Type $ ________ Per Month

Thanks! This is all we need to know about PERSON 2!

What if you have more than 2 people living with you that need to apply?
Make a copy of Step 2 Person 2 for each additional person who wants to apply.
Or, print them from our website at www.tn.gov/tenncare.

Need help with your Application? Call us at 1-855-259-0701. Do you need help in a language other than English? When you call, tell us the language you need. We’ll get you help at no cost to you. Do you have a hearing or speech problem and use a TTY? Call 1-800-848-0298, then dial 1-855-259-0701.

Rev: 15Apr19
STEP 3  
Tell us about your family’s health coverage

1. Is anyone on your Application enrolled in health coverage now?  
   □ Yes □ No
   If yes, tell us more about that health coverage. Answer a-i.  
   If no, skip to question 2.
   a. Name of Health Insurance Company
   b. What type of Health Insurance coverage is this?
   c. Who all is covered on this policy?
   d. Policy Number:
   e. Group Number:
   f. Date coverage started (mm/dd/yyyy)
   g. Is this a state employee benefit plan?  □ Yes □ No
   h. Is this a limited benefit plan (like a school accident policy)?  □ Yes □ No
   i. Does this plan cover maternity benefits?  □ Yes □ No

2. Does anyone on your Application have access to other health insurance coverage but is not enrolled?  □ Yes □ No
   If yes, who:

STOP and READ: The next set of questions below ask about your family’s resources. You do not have to answer them if you think you might qualify as a pregnant woman, a child, or a caretaker of a minor child. If you choose not to answer, go to Step 4 to finish this application. But answering these questions now will help us review your application for more eligibility categories where resources count. If you skip these questions, go to Step 4 to finish.

1. Does anyone have any financial resources? This includes things like checking accounts, savings accounts, stocks or mutual funds, pension funds, bonds, trust funds, annuities, and qualified tuition savings plans.  □ Yes □ No
   If yes, check all that apply.  If no, skip to question 6.
   □ Annuity
   □ Bonds
   □ Certificate of Deposit
   □ Dividends
   □ Individual Development Account
   □ Keogh Account
   □ Patient/ Resident Trust Account
   □ Promissory Note
   □ Retirement Account
   □ Stocks, Mutual funds
   □ ABLE Account
   □ Checking Account
   □ Health Reimbursement Account
   □ Individual Retirement Account
   □ Loan
   □ Pension fund
   □ Qualified tuition Savings Plan (529 Plans)
   □ Savings Account
   □ Trust Fund
   □ Other ______

Tell us more about the financial resources that your family owns. If you’ve checked more than one kind of resource above, tell us about the other resource(s) on a separate sheet of paper.

2. Resource Type:  
   Resource Value: $

List everyone who owns this resource:

3. Tell us about the bank or company where you have this financial resource
   Name of Bank or Company
   a. Address
   b. City
   c. State
   d. ZIP code
   4. Bank or Company phone number

5. If anyone owns a Trust, tell us about the trust that they own.
   a. Trust type:
   b. Trustee:
   c. Value: $

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Family Resources cont’d

6. Does anyone own any property? ☐ Yes ☐ No
   If yes, check all that apply.  If no, skip to question 9.
   ![Property Types]

7. Tell us more about the property that your family owns.
   a. List anyone who owns this property: ____________________________
   b. Property Use: _______________
   c. Does anyone live here? ☐ Yes ☐ No  If yes, tell us who? ___________
   If no, Did they intend to return to this home? ☐ Yes ☐ No
   d. Does a spouse or child (under age 21 or is blind or permanently disabled) live in this home? ☐ Yes ☐ No
   e. Does anyone get rent money from this property? ☐ Yes ☐ No  If yes, tell us who: _________________________
   If yes, what is the monthly income from this property? $ ________________ Per month
   f. How much is owed on this property? $ ________________
   g. What is the value of this property? $ ________________

8. Tell us the address of the property that you own, answer questions a-f.
   a. Property address (Leave blank if you don’t have one.)
   b. Apartment or suite number
   c. City
   d. State
   e. ZIP code
   f. County

9. Does anyone own a life insurance policy? ☐ Yes ☐ No  If no, skip to question 11.
   a. List anyone who owns a life insurance policy: ____________________________
   b. What type of life insurance do you have? ☐ Term/Group ☐ Whole/Universal
   c. What is the face value of this Life Insurance Policy? $ ________________
   d. What is the cash surrender of this Life Insurance policy? $ ________________
   e. Policy Number: ____________________

10. Tell us about the insurance company that issued the Life Insurance policy.
    Name of Company
    a. Address
    b. City
    c. State
    d. ZIP code
    e. Company phone number

11. Does anyone own burial resources (like contracts or lots)? ☐ Yes ☐ No  If no, skip to question 12.
    If yes, list anyone who owns burial resources: ____________________________
    a. Value of Burial Resource: $ ________________
    b. How much do you owe on this burial resource? $ ________________
    c. Burial resource type: ____________________
    d. Who is the burial resource designated for?
Family’s Resources Cont’d

12. Does anyone own a vehicle? □ Yes □ No  If yes, check all that apply. If no, skip to question 16.
   - ATV/Golf Carts
   - Cars/Trucks
   - Motorcycle
   - Trailer
   - Snowmobile
   - Boats/Personal Watercraft
   - Farm Equipment
   - RV
   - Aircraft
   - Other

13. Tell us more about the vehicle in question 12. If you’ve checked more than one vehicle above, tell us about other the vehicle(s) on a separate sheet of paper.
   a. Who owns this vehicle? ______________________________________________________________
   b. Year:  
   c. Make:  
   d. Model:  
   e. How much is owed on the vehicle?  
   f. How much is the vehicle worth? $

14. Does the owner receive income from use of this vehicle? □ Yes □ No

15. How does the owner use this vehicle?
   - Household Transportation
   - Self-Employment
   - Homestead
   - Income Producing
   - Recreational
   - Tools of the Trade

16. Does anyone have any other resources? □ Yes □ No  If yes, list all of them below.
   a. Type of resource(s): ______________________________________________________________
   b. How much is each resource worth? $  
   c. How much is owed on each resource? $

17. Who owns these resources: _________________________________________________________

18. Has anyone sold, traded, or given away resources in the last five years? □ Yes □ No  If no, skip this question.
   a. Resource type: ________________________________
   b. Who owned this resource: ________________________________
   c. Who did you sell, trade, or give away this resource too? ________________________________
   d. Why did you sell, trade, or give away this resource? ________________________________
   e. What date did you sell, trade, or give away this resource? ________________________________
   f. What was the value of the resource? $  
   g. How much money was received when the resource was sold, traded, or given away? $

Thanks! This is all we need to know about what your family owns.

You are not finished with this Application. Read the next pages and then sign this Application!
If you are not registered to vote where you live now.

**To register to vote:**
- You must be a U.S. Citizen
- You must be a Tennessee Resident
- You must be at least 18 years old on or before the next election and
- You must not have been convicted of a felony or if you have, your voting rights have been restored.

If you are not registered to vote where you live now, you can complete a voter registration form at [www.tn.gov/sos/election/registration](http://www.tn.gov/sos/election/registration).

Or you can choose for us to mail you a voter registration application.
Would you like us to mail you a voter registration application?

☐ Yes ☐ No

If you do not make a choice, we will consider your answer to be “No.” If you would want help registering to vote, we will help you.

If you think someone has interfered with your right, you can file complaint. You can mail your complaint to:

Division of Elections
312 Rosa L. Parks Avenue
7th Floor, Snodgrass Tower
Nashville, TN 37243-1102

Or call: 877-850-4959
(615)741-7956

Individuals with hearing or speech impairments can use Tennessee Relay Center: 800-848-0299

STEP 4: Read & Sign this Application

Renewal for Coverage in Future Years

Usually, we must renew your eligibility each year to see if you still qualify. To make it easier to renew your coverage, we can use federal sources, like information from your tax returns. We need your OK to check this information automatically. If you don’t give us permission, that’s ok. We’ll reach out to you when it’s time to renew each year. Please choose an option below.

Yes, you have permission to try to renew my eligibility automatically for the next:

☐ 5 Years (the maximum number of years allowed)
☐ 4 Years
☐ 3 Years
☐ 2 Years
☐ 1 Year
☐ Don’t use information from tax returns to renew my coverage.

Sign this Application in the space below. The person who filled out Step 1 should sign below. If you’re an Assisting Person you may sign below, as long as you have provided the information required on page 2.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date signed (mm/dd/yyyy)</th>
</tr>
</thead>
</table>

STEP 5: Mail completed Application

Mail your signed Application to the address below.

TennCare Connect
P.O. Box 305240
Nashville, TN 37202-5240

You may also fax your Application to 1-855-315-0669. Remember to send in the proof we need to decide if you can get health care coverage with us.