

TN

Application for Health Coverage & Help Paying Costs – Extra Pages for Additional Family Members

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

Use these pages if you have more than 2 people in your family applying for TennCare, CoverKids, or a Medicare Savings Program, like QMB/SLMB. **Before getting started, make copies of these pages for each additional person in your family.**

STEP 1: Person 1 This is the person you listed as PERSON 1 on your Application.

PERSON 1 is the Head of Household on your Application.

1. First name _____ Middle name _____ Last name _____ Suffix (Jr., Sr., III) _____
2. Social Security Number: _ _ _ - _ _ - _ _ _ _

STEP 2: Tell us about other people who live with you.

Complete Step 2 for each additional person in your family.

If you have more 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.

When you send us your Application and these pages, be sure to send us proof of your income. This could be things like pay stubs or bank statements. Having this proof may help us decide faster if you get coverage with us.




STEP 2: Additional Family Member**Tell us about your additional family member(s).**

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.

1. First name	Middle name	Last name	Suffix
2. Date of birth (mm/dd/yyyy)		3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	4. Relationship to Person 1

5. **Social Security Number (SSN)** ___ - ___ - ____ If not, what date did this person apply for one? _____

 **We need a Social Security number (SSN) if this person wants health coverage and has a 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 this person needs help getting an SSN, visit socialsecurity.gov, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. Or call TennCare Connect for free at 1-855-259-0710.

6. Is this person applying for health coverage with us? Yes No If no, please answer questions 13, 23, 39-50, and 53-55.

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

9. Has this person ever been known by any other name? **If yes:**

First name	Middle initial	Last name	Suffix
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10. If this person is approved for TennCare Medicaid, there are three health plans to choose from. We'll try to enroll them in the health plan they choose. If they don't pick now, we can pick one for them. Usually, family members are enrolled in the same health plan. Please choose the same health plan for each person on this application. **I want their health plan to be:** AMERIGROUP BlueCare UnitedHealth Care Community Plan

If they are approved for CoverKids, their health plan will be Blue Care.

11. Is this person a Tennessee resident? Yes No

12. Is this person temporarily living out of state? Yes No

If Yes, does this person plan to return to Tennessee? Yes No Date this person plans to return to Tennessee: _____

13. If this person is younger than 22 years old, what is their school enrollment status? Skip this question if this person 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 this person is younger than 22 years old, does this person work full time? Yes No Skip this question if this person is age 22 or older.

15. Is this person a **U.S. citizen** or **U.S. national**? Yes No If yes, skip 16-22.

16. Is this person a naturalized or derived citizen? Yes No If yes, provide answers to a. and b.

a. Alien Number: _____ b. Certificate Number: _____

17. **If this person 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 this person'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 this person, or this person's spouse or parent, a veteran or an active-duty member of the U.S. military? Yes No

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

20. Is this person a member of a federally recognized tribe? Yes No **If Yes,** what is the name of the tribe? _____

21. Has this person 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 this person 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



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STEP 2: Additional Family Member**Continue with your additional family member.**

23. Will this person file a federal income tax return the next time taxes are due? *This person 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 this person file jointly with a spouse? Yes No

If yes, write name of spouse: _____

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

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

c. Do any of this person's dependents live outside of their household? Yes No

If yes, list the names of dependent(s): _____

d. Will this person be claimed as a dependent on someone's tax return? Yes No

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

How is this person related to the tax filer? _____

24. Is this person a primary caregiver to a child under age 19? Yes No

If yes, to who? _____ What is their relationship to this person? _____

25. Is this person pregnant or was she pregnant in the last 60 days? 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.

26. Is this person enrolled in, or entitled to enroll in Medicare Part A or B? Yes No

27. Has this person experienced an emergency health problem and needs help paying for those emergency services? Yes No

28. Is this person younger than 26 and was in foster care at age 18 or older and lived in Tennessee at that time? Yes No

29. Is this person under age 65 and getting treatment now or do they need treatment for breast or cervical cancer? Yes No

30. Is this person in the hospital and have been there for at least 30 days? OR, are they in the hospital and will be there for at least 30 days?
 Yes No

If yes, When did they go into the hospital? _____ (mm/dd/yyyy)

Please tell us the name of the hospital they are in: _____

Please tell us their doctor's name and phone number: _____

31. Does this person live in a nursing home? Yes No

If yes, what is the name of the facility? _____

32. Does this person need hospice care? Yes No

33. Is this person over age 65 or are you an adult with physical disabilities and wants to receive Home and Community Based Services (HCBS)?
 Yes No

What if this person things they need care at home to keep from going into a nursing facility? Call their Area Agency on Aging and Disability at 866-836-6678. This person still needs to finish this application but they can help you.

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

35. Does this person 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 this person thinks they need care at home to keep from going into a nursing facility? Then they must also complete an online referral at: <https://tcreq.tn.gov/tmtrack/ect/index.htm>.

36. Does this person have Medicare and want to get or keep help paying Medicare cost sharing like QMB or SLMB? Yes No

37. Did this person receive Supplemental Security Income, or SSI benefits, in the past but don't now? Yes No
If yes, when did it end? _____

38. Does this person have expenses for things to help them work because they are blind or disabled? Yes No



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STEP 2: Additional Family Member**Current Job & Income Information****Current job & income information**

Employed: If this person is currently employed, tell us about their 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 does this person 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 this person 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

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

\$

47. How often does this person 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)

49. **Other income this person gets this month:** Check all that apply and give the amount and how often this person gets it.

- | | | | |
|--|---------------------------|--|---------------------------|
| <input type="checkbox"/> None | | <input type="checkbox"/> Census worker | \$ _____ How often? _____ |
| <input type="checkbox"/> Unemployment | \$ _____ How often? _____ | <input type="checkbox"/> Alimony received | \$ _____ How often? _____ |
| <input type="checkbox"/> Pensions | \$ _____ How often? _____ | <input type="checkbox"/> Alimony Order Date | _____ |
| <input type="checkbox"/> Retirement | \$ _____ How often? _____ | <input type="checkbox"/> Net farming/fishing | \$ _____ How often? _____ |
| <input type="checkbox"/> Child Support | \$ _____ How often? _____ | <input type="checkbox"/> Net rental/royalty | \$ _____ How often? _____ |
| <input type="checkbox"/> Social Security | \$ _____ How often? _____ | <input type="checkbox"/> Veteran Benefits | \$ _____ How often? _____ |
| If you checked the Social Security box, you must answer question 51 below. | | <input type="checkbox"/> Lottery income | \$ _____ How often? _____ |
| | | <input type="checkbox"/> Other income | \$ _____ How often? _____ |
| | | Type | _____ |

50. If this person is self-employed answer questions a-c.

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



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STEP 2: Additional Family Member

Continue to tell us about your additional family member

(Answer question 51 only if you checked the Social Security box in question 49 above.)

51. Does someone other than a parent (if this person is under 18) or spouse help pay for this person's food OR housing each month? (Housing includes expenses such as rent, mortgage, property insurance, gas, electric, heating fuel, water, sewer, garbage collection service or property taxes.)

Yes No **If yes** answer questions a-g.

a. Does that someone who helps pay for this live with this person? Yes No

b. What do they help this person pay for? _____

c. How much is this expense or bill? \$ _____

d. How much does this person pay? \$ _____

e. How much does that someone pay? \$ _____

f. Number of people in the home? _____

g. Does everyone living with this person get any kind of public assistance? (Public assistance includes Families First, SSI, Disaster Relief and Emergency Assistance, VA Pension, VA Aid and Attendance, the Refugee Act of 1980. It also includes help this person gets from state or local governments to pay for things like housing, utility bills, or phones.)

Yes No

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

a. How much is this expense or bill? \$ _____

b. What was the date of service? \$ _____

c. Who does this person send payments to? \$ _____

53. Does this person have shelter or utility expenses, dependent care expenses, or child support expenses? Yes No

54. Does this person 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 this person have expenses that can be deducted on an income tax return? Yes No **If yes**, check all at apply. Give the amount that this person pays each month. If no, skip this question.

Alimony Paid Alimony Order Date \$ _____ 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

Military Moving Expense \$ _____ Total

Other Deduction Type \$ _____ Per Month

Thanks! This is all we need to know about this Additional Family Member!

After you finish telling us about each person in your family, send in these pages with the rest of your Application.



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