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 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 (Jr., Sr., III) |
|---|---|---|---|
| | | | |

| 2. Date of birth (mm/dd/yyyy) | 3. Sex ☐ Male ☐ 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 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 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 855-259-0701.

6. Is this person applying for health coverage with us? ☐ Yes ☐ No **If no,** please answer questions 13, 22, 40-52, and 54-55.

7. **If Hispanic/Latino, ethnicity (Check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban
☐ Other: _____ ☐ Prefer not to answer

8. **Race (Check all that apply.)**

| | | | |
|---|---|---|---|
| ☐ White | ☐ Japanese | ☐ Vietnamese | ☐ Samoan |
| ☐ Black or African American | ☐ Korean | ☐ Other Asian | ☐ Other Pacific Islander |
| ☐ American Indian or Alaska Native | ☐ Asian Indian | ☐ Native Hawaiian | ☐ Other: _____ |
| ☐ Filipino | ☐ Chinese | ☐ Guamanian or Chamorro | ☐ Prefer not to answer |

9. Has this person ever been known by any other name? **If yes:**
First name: _____ Middle initial: _____ Last name: _____ Suffix (Jr., Sr., III): _____

10. If this person is approved for TennCare Medicaid or CoverKids, 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:** ☐ Wellpoint ☐ BlueCare Tennessee ☐ UnitedHealthcare Community Plan
To learn more about these health plans and how to contact them, visit tn.gov/tenncare/members-applicants/managed-care-organizations.

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: _____ (mm/dd/yyyy)
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. Is this person a **U.S. citizen or a U.S. national?** ☐ Yes ☐ No **If yes,** skip 16-17.
15. Is this person a naturalized or derived citizen? ☐ Yes ☐ No **If yes,** provide a. and b.
**a.** Alien Number: _____
**b.** Certificate Number: _____
16. This person doesn't have to answer this immigration question. But if they don't, it may limit the kind of coverage they may qualify for. Applying won't affect their immigration status or chances of becoming a permanent resident or citizen.
**If this person isn't a U.S. citizen or U.S. national,** do they have eligible immigration status? ☐ Yes ☐No
**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
☐ Other: _____
ID Number: _____
**b.** Did this person have a different immigration status before? ☐ Yes ☐ No
**c.** Has this person lived in the U.S. since 1996? ☐ Yes ☐ No
17. Is this person, or this person's spouse or parent, a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

18. If this person is American Indian or Alaska Native answer 19-21. ☐ Yes ☐ No **If not,** skip 19-21.
19. Is this person a member of a federally recognized tribe? ☐ Yes ☐ No
**If yes,** what is the name of the tribe? _____
20. Has this person ever gotten a service from the Indian Health Service, a tribal health program, an urban Indian health program, or through referral of one of these? ☐ Yes ☐ No
21. Is this person eligible to get services from the Indian Health Service, a tribal health program, an urban Indian health program, or through referral of one of these? ☐ Yes ☐ No

**Need help with your Application?** Call us at **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 855-259-0701.

# STEP 2: Additional Family Member

**Continue with your additional family member.**

22. 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: _____

Does this person live outside of the household? ☐ Yes ☐ No

**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? _____

23. Does this person live with at least one child under age 18 (or is the child age 18 and a full-time student)? And is this person the main person taking care of this child? ☐ Yes ☐ No

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

24. Is this person pregnant or were they pregnant in the last 12 months? ☐ Yes ☐ No

**If yes,** how many babies are/were they expecting from this pregnancy? _____

Are they still pregnant? ☐ Yes ☐ No

**If yes,** what is their due date? (It's ok to tell us an approximate date if they are not sure.) _____ (mm/dd/yyyy)

**If no,** when did their pregnancy end? _____ (mm/dd/yyyy)

Do they have any other pregnancies in the last 12 months that they want to report? ☐ Yes ☐ No

**If yes,** how many babies are/were they expecting from that pregnancy? _____

When did that pregnancy end? _____ (mm/dd/yyyy)

25. Is this person under 19 or pregnant and received any medical services in the last 3 months? ☐ Yes ☐ No

**If yes,** what was the date of service?_____(mm/dd/yyyy)

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. Was this person in foster care at age 18 or older and getting Medicaid? ☐ Yes ☐ No

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

30. Is this person in a medical facility (like a hospital) and has been there for at least 30 days? OR, are they in a medical facility (like a hospital) and will be there for at least 30 days? ☐ Yes ☐ No

**(Optional) If yes,** when did they go into the medical facility? _____ (mm/dd/yyyy)

**(Optional)** Please tell us the name of the medical facility they are in: _____

**(Optional)** Please tell us their doctor's name and phone number: _____

31. Does this person live in a medical facility or nursing home? ☐ Yes ☐ No

**If yes,** what is the name of the facility or nursing home? _____

32. Does this person need hospice care? ☐ Yes ☐ No

33. Does this person qualify for care in a nursing home, but wants care at home instead? ☐ Yes ☐ No

**(Optional)** What if this person thinks they need care at home to keep from going into a nursing facility? Call their Area Agency on Aging and Disability at 1-866-836-6678. This person still needs to finish this application but they can help you.

34. Does this person have intellectual or developmental 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: perlss.tenncare.tn.gov/externalreferral.

**Remember, you can't use this paper application to apply for Katie Beckett. You must apply online at tenncareconnect.tn.gov.**

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

You may know this as a Medicare Savings Plan or MSP.

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

39. Is this person younger than 22 years old and do they work full time? ☐ 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 40.

☐ **Not employed:** Skip to question 50.

☐ **Self-employed:** Skip to question 52.

### Current job 1:

| | | | |
|---|---|---|---|
| 40. Employer name | | | |
| **a.** Employer address | | | |
| **b.** City | | **c.** State | **d.** Zip code |
| 41. Employer phone number<br>( __ __ __ ) __ __ __ - __ __ __ __ | | | |
| 42. Wages/tips per pay period (before taxes)<br>**$** | 43. How often does this person get paid?<br>☐ Hourly ☐ Daily ☐ Weekly<br>☐ Every 2 weeks ☐ Twice a month ☐ Monthly<br>☐ Yearly ☐ Quarterly ☐ Irregularly<br>☐ Semi-annually ☐ One Time Only | | 44. Average hours worked each pay period (answer only if you checked the box for Hourly in question 43.) |

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

| | | | |
|---|---|---|---|
| 45. Employer name | | | |
| **a.** Employer address | | | |
| **b.** City | | **c.** State | **d.** Zip code |
| 46. Employer phone number<br>( __ __ __ ) __ __ __ - __ __ __ __ | | | |
| 47. Wages/tips per pay period (before taxes)<br>**$** | 48. How often does this person get paid?<br>☐ Hourly ☐ Daily ☐ Weekly<br>☐ Every 2 weeks ☐ Twice a month ☐ Monthly<br>☐ Yearly ☐ Quarterly ☐ Irregularly<br>☐ Semi-annually ☐ One Time Only | | 49. Average hours worked each pay period (answer only if you checked the box for Hourly in question 48.) |

50. **Other income this person gets this month:** Check all that apply and give the amount and how often this person gets it.
Note: You don't need to tell us about Supplemental Security Income (SSI) for this person.

☐ None

☐ Social Security **$** _____ How often? _____

If you checked the Social Security box, you must answer question 53 below.

☐ Unemployment **$** _____ How often? _____

☐ Pension **$** _____ How often? _____

☐ Census worker **$** _____ How often? _____

☐ Retirement accounts **$** _____ How often? _____

☐ Net farming/fishing **$** _____ How often? _____

☐ Net rental/royalties **$** _____ How often? _____

☐ Lottery income **$** _____ How often? _____

☐ Alimony received **$** _____ How often? _____

Alimony order date: _____

☐ Other income **$** _____ How often? _____

Type: _____

☐ Tribal income (Certain money received cannot be counted for Medicaid or CoverKids.) List any Tribal income (amount and how often) that includes money from these sources:

- Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
- Money from selling things that have cultural significance

**$** _____ How often? _____ **$** _____ How often? _____

51. In the last 12 months (1 year) has this person gotten a lump sum of money such as back pay for Social Security or a lottery prize? ☐ Yes ☐ No

**a. If yes,** how much did this person get? **$** _____

**b.** When did this person get this lump sum? _____

**c.** Where did it come from? _____

52. 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 53 only if you checked the Social Security box in question 50 above.)

53. 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.) ☐ Yes ☐ No

54. Does this person have before-tax deductions? ☐ Yes ☐ No

**If yes,** check all that apply. Give the amount this person pays each month. **If no,** skip to question 55.

| | | | |
|---|---|---|---|
| ☐ Medical Insurance | **$** _____ Per Month | ☐ Deferred Compensation | **$** _____ Per Month |
| ☐ Dental Insurance | **$** _____ Per Month | ☐ Pre-tax life insurance premiums | **$** _____ Per Month |
| ☐ Vision Care Insurance | **$** _____ Per Month | ☐ Other Deduction | **$** _____ Per Month |
| ☐ Flexible Spending Account (Health and dependent plans) | **$** _____ Per Month | Type: _____ | |

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<br>Alimony Order Date: _____ | **$** _____ Per Month | ☐ Health Savings Account Deduction | **$** _____ Per Month |
| ☐ Student Loan Interest Paid | **$** _____ Per Month | ☐ Military Moving Expense | **$** _____ Total |
| ☐ Tuition and Fees | **$** _____ Per Month | ☐ Other Deduction | **$** _____ Per Month |
| ☐ Educator Expenses | **$** _____ Per Month | Type: _____ | |
| ☐ Business Expenses | **$** _____ Per Month | | |
| ☐ Deductible part of self-employment | **$** _____ 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.**