## Application for Health Coverage & Help Paying Costs

Apply faster online at www.tenncareconnect.tn.gov

<table>
<thead>
<tr>
<th>Use this Application to see what coverage you qualify for</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Free or low-cost insurance from TennCare or CoverKids.</td>
</tr>
<tr>
<td>• Help with paying for Medicare costs.</td>
</tr>
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<thead>
<tr>
<th>Who can use this Application?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Use this Application to apply for anyone in your family.</td>
</tr>
<tr>
<td>• Other people in your household who want to apply for TennCare or CoverKids.</td>
</tr>
<tr>
<td>• 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.</td>
</tr>
<tr>
<td>• <strong>This application can’t be used for Katie Beckett coverage.</strong> You must apply online for Katie Beckett. Go to tenncareconnect.tn.gov. Log into your account or create an account to apply.</td>
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<table>
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<tr>
<th>Things you may need to complete this Application</th>
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</thead>
<tbody>
<tr>
<td>• Social Security Numbers (or document numbers for any legal immigrants who need insurance).</td>
</tr>
<tr>
<td>• 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).</td>
</tr>
<tr>
<td>• Information about any job-related health insurance available to your family.</td>
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<table>
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<tr>
<th>Why do we ask for this information?</th>
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<tbody>
<tr>
<td>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. <strong>We’ll keep all the information you provide private and secure, as required by law.</strong> To view the Privacy Act Statement, go to <a href="https://www.tn.gov/web-policies/privacy-statement.html">https://www.tn.gov/web-policies/privacy-statement.html</a>.</td>
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<tr>
<th>What happens next?</th>
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<tr>
<td>Send your complete, signed Application to:</td>
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<tr>
<td>TennCare Connect</td>
</tr>
<tr>
<td>P.O. Box 305240</td>
</tr>
<tr>
<td>Nashville, TN 37230-5240</td>
</tr>
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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.

<table>
<thead>
<tr>
<th>Do you want to know other ways you can apply?</th>
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<tr>
<td>Online: <a href="http://www.tenncareconnect.tn.gov">www.tenncareconnect.tn.gov</a></td>
</tr>
<tr>
<td>Phone: Call TennCare Connect to apply or get help at 1-855-259-0701.</td>
</tr>
<tr>
<td><strong>En español:</strong> Llame a nuestro centro de ayuda gratis al 1-855-259-0701.</td>
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</table>

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 and click “Office Locations” at the bottom of the page.
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 by calling 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 1-615-313-4700.

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 act on behalf of you and all members in your household.

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 for all members in my household.
- ☐ Complete and submit a Renewal Packet for the members in my household.
- ☐ Receive all notices, insurance cards, and other communications about the application, appointments, renewals or eligibility for all members of my household.
- ☐ Act as the Authorized Representative for all members in my household. This means this person can help with all eligibility issues including:
  - Signing applications, complete and submitting Renewal Packets, and receiving notices as listed above;
  - Going to interviews, hearings or appeals;
  - The appeal process, including legal proceedings.

How long do you want your Assisting Person to help you? ☐ 3 Months ☐ 5 Months ☐ 1 Year ☐ Ongoing

If you ever need to change your Assisting Person, or end their rights as your representative, call TennCare Connect at 1-855-259-0701.

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)
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.

<table>
<thead>
<tr>
<th>1. First name</th>
<th>Middle name</th>
<th>Last name</th>
<th>Suffix (Jr., Sr., III)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>2. Home address (Leave blank if you don’t have one)</th>
<th>3. Apartment or suite number</th>
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</table>

|---------|---------|-------------|-----------|

<table>
<thead>
<tr>
<th>8. Mailing address (if different from home address)</th>
<th>9. Apartment or suite number</th>
</tr>
</thead>
</table>

|----------|-----------|-------------|------------|

<table>
<thead>
<tr>
<th>14. Phone number</th>
<th>Type: ☐ Mobile ☐ Home ☐ Work</th>
<th>15. Other phone number</th>
<th>Type: ☐ Mobile ☐ Home ☐ Work</th>
</tr>
</thead>
</table>

( __ __ __ ) __ __ __ - __ __ __ __ Ext:  
( __ __ __ ) __ __ __ - __ __ __ __ Ext:

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<thead>
<tr>
<th>16. What’s your preferred spoken language?</th>
<th>What’s your preferred written language?</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>17. Email address</th>
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</table>

**STEP 2: Person 1**  
**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: ___________________________ Last name: ___________________________
   Middle initial: ___________________________
   Suffix (Jr., Sr., III): ___________________________

2. Date of birth (mm/dd/yyyy): ___________________________

3. Sex
   ☐ Male ☐ Female

4. Relationship to Person 1
   SELF

5. Social Security Number (SSN)
   We need a Social Security number (SSN) if you want health coverage and have an SSN or can get one. We use SSN’s 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. Or call TennCare Connect for free at 1-855-259-0710.

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

6. Are you applying for health coverage with us? ☐ Yes ☐ No
   If no, please answer questions 13, 22, 38-49, and 52-54.

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 ☐ Asian American
   ☐ Native Hawaiian ☐ Other Pacific Islander
   ☐ American Indian or Alaska Native ☐ Other Native American
   ☐ Asian American ❌ Other Asian
   ☐ Korean ☐ Guamanian or Chamorro
   ☐ Filipino ☐ Hawaiian
   ☐ Chinese ☐ Other Asian
   ☐ Vietnamese ☐ Other Pacific Islander
   ☐ Japanese ☐ Samoan
   ☐ Other: ___________________________

9. Have you ever been known by any other name? If yes:
   First name: ___________________________ Middle initial: ___________________________
   Last name: ___________________________
   Suffix (Jr., Sr., III): ___________________________

10. If you are approved for TennCare Medicaid or CoverKids, 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 ☐ UnitedHealthcare Community Plan

   To learn more about these health plans and how to contact them, visit www.tn.gov/tenncare/members-applicants/managed-care-organizations.

11. Are you a Tennessee resident? ☐ Yes ☐ No
12. Are you temporarily living out of state? ☐ Yes ☐ No
   If yes, do you plan to return to Tennessee? ☐ Yes ☐ No
   Date you plan to return to Tennessee: __________________________ (mm/dd/yyyy)

13. If you are younger than 22 years old, what is your school enrollment status? Skip this question if you are 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. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No
   If yes, skip 15-17
15. Are you a naturalized or derived citizen? ☐ Yes ☐ No
   If yes, provide a. and b.
   a. Alien Number: ___________________________
   b. Certificate Number: ___________________________

16. If you aren’t a U.S. citizen or U.S. national, do you have eligible immigration status? ☐ YES ☐ NO
   a. What is your immigration status?
      What date did you gain that status? ___________________________
      Fill in your 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 you have a different immigration status before? ☐ Yes ☐ No
   c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No

17. Are you or your spouse or parent, a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No
18. If you are an American Indian or Alaska Native answer 19-21.
   ☐ Yes ☐ No
   If no, skip 19-21.
19. Are you a member of a federally recognized tribe? ☐ Yes ☐ No
   If yes, what is the name of the tribe?

20. Have you 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
21. 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.

Rev: 26Sept22
22. Will you file a federal income tax return the next time taxes are due? You can still apply for coverage even if you don’t file a federal income tax return.

☐ Yes. If yes, please answer questions a–d. ☐ No. If no, skip to question d.

a. Will you file jointly with a spouse? ☐ Yes ☐ No

If yes, write name of spouse: ________________________________

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No

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

c. Do any of your dependents live outside of your household? ☐ Yes ☐ No

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

d. 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? ____________________________

23. Are you a primary caregiver to a child under age 19? ☐ Yes ☐ No

If yes, to who? __________________________________________

What is your relationship to them? ___________________________

24. Are you pregnant or were you pregnant in the last 12 months? ☐ Yes ☐ No

If yes, how many babies are/were you expecting from this pregnancy? __________

Are you still pregnant? ☐ Yes ☐ No

If yes, what is your due date? (It’s ok to tell us an approximate date if you’re not sure.) __________ (mm/dd/yyyy)

If no, when did your pregnancy end? __________ (mm/dd/yyyy)

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

If yes, how many babies are/were you expecting from that pregnancy? __________

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

25. Are you enrolled in, or entitled to enroll in, Medicare Part A or B? ☐ Yes ☐ No

26. Have you experienced an emergency health problem and need help paying for those emergency services? ☐ Yes ☐ No

27. Are you younger than 26 and were in foster care at age 18 or older and lived in Tennessee at that time? ☐ Yes ☐ No

28. Are you under age 65 and getting treatment now or do you need treatment for breast or cervical cancer? ☐ Yes ☐ No

29. Are you in a medical facility (like a hospital) and have been there for at least 30 days? OR, are you a medical facility (like a hospital) and will be there for at least 30 days? ☐ Yes ☐ No

If yes, please list the name of the medical facility you are in: ________________________________

When did you go into the medical facility? __________ (mm/dd/yyyy)

30. Do you live in a nursing home? ☐ Yes ☐ No

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

31. Do you need hospice care? ☐ Yes ☐ No

32. 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 1-866-830-6678. You still need to finish this application but they can help you.

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

34. 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: https://perlss.tenncare.tn.gov/externalreferral.

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

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

You may know this as Medicare Savings Plan or MSP.

36. Did you receive Supplemental Security Income, or SSI benefits, in the past but don’t now? ☐ Yes ☐ No

If yes, when did it end? __________________________

37. Do you have expenses for things to help you work because you are blind or disabled? ☐ Yes ☐ No
# STEP 2: PERSON 1  
## Current Job & Income Information

### Current job & income information
- **Employed:** If you are currently employed, tell us about your income. Start with question 38.
- **Not employed:** Skip to question 48.
- **Self-employed:** Skip to question 49.

### Current job 1:

- **Employer name**
- **Employer address**
- **City**
- **State**
- **Zip code**

### Employer phone number

- **(_____) ____-_______**

### Wages/tips per pay period

- **(before taxes)**
- **$**

<table>
<thead>
<tr>
<th>How often do you get paid?</th>
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<tbody>
<tr>
<td>Hourly</td>
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<tr>
<td>Daily</td>
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<tr>
<td>Weekly</td>
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<tr>
<td>Every 2 weeks</td>
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<td>Twice a month</td>
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<tr>
<td>Monthly</td>
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<td>Yearly</td>
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<td>Quarterly</td>
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<tr>
<td>Irregularly</td>
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<td>Semi-annually</td>
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<tr>
<td>One Time Only</td>
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### Average hours worked each pay period

- (answer only if you checked the box for Hourly in question 41.)

### Current job 2:

- **Employer name**
- **Employer address**
- **City**
- **State**
- **Zip code**

### Employer phone number

- **(_____) ____-_______**

### Wages/tips per pay period

- **(before taxes)**
- **$**

### How often do you get paid?

<table>
<thead>
<tr>
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<tbody>
<tr>
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<td>Semi-annually</td>
<td></td>
</tr>
<tr>
<td>One Time Only</td>
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### Average hours worked each pay period

- (answer only if you checked the box for Hourly in question 46.)

### Other income you get this month:

- Check all that apply and give the amount and how often you get it.

  - **None**
  - **Social Security** $_________ How often? ___________
  - **Net farming/fishing** $_________ How often? ___________
  - **Unemployment** $_________ How often? ___________
  - **Net rental/royalties** $_________ How often? ___________
  - **Alimony received** $_________ How often? ___________
  - **Pension** $_________ How often? ___________
  - **Veteran benefits** $_________ How often? ___________
  - **Census worker** $_________ How often? ___________
  - **Type:** ___________
  - **Other income** $_________ How often? ___________
  - **Type:** ___________
  - **Tribal income**$_________ How often? ___________
  - **Type:** ___________

### Tribal income (Certain money received cannot be counted for Medicaid or CoverKids.)

List any Tribal income that includes money from these sources:

- Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties: $_________ How often? ___________
- 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): $_________ How often? ___________
- Money from selling things that have cultural significance: $_________ How often? ___________

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

- **What do you do?** _______________________
- **What type of self-employment do you have?** _______________________
- **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.

(Answer question 50 only if you checked the Social Security box in question 48 above.)

50. Does someone other than a parent (if you are under 18) or spouse help pay for your 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 the person who helps you pay for this live with you?
   - [ ] Yes
   - [ ] No

b. What do they help you pay for?

<table>
<thead>
<tr>
<th>Expense category</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>$__________ Per Month</td>
</tr>
<tr>
<td>Flexible Spending Account (Health and dependent plans)</td>
<td>$__________ Per Month</td>
</tr>
</tbody>
</table>

If yes, check all that apply. Give the amount you pay each month. If no, skip to question 54.

- [ ] Medical Insurance
- [ ] Dental Insurance
- [ ] Vision Care Insurance
- [ ] Flexible Spending Account (Health and dependent plans)

51. Do you have any medical or dental bills for care you've received or paid in the last 3 months?

- [ ] Yes
- [ ] No

If yes,

<table>
<thead>
<tr>
<th>Expense category</th>
<th>Amount per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical or dental bill</td>
<td>$__________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of service</td>
<td></td>
</tr>
<tr>
<td>Person sending payments to</td>
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</tbody>
</table>

<table>
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<tr>
<th>Description</th>
<th>Amount per month</th>
</tr>
</thead>
</table>
| Are you younger than 22 years old, do you work full time? | [ ] Yes
- [ ] No

52. Do you have shelter or utility expenses, dependent care expenses, or child support expenses?

- [ ] Yes
- [ ] No

53. Do you have any before tax deductions?

- [ ] Yes
- [ ] No

If yes, check all that apply. Give the amount you pay each month. If no, skip to question 54.

- [ ] Medical Insurance
- [ ] Deferred Compensation
- [ ] Pre-Tax life insurance premiums
- [ ] Other Deduction

<table>
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</tr>
<tr>
<td>Other Deduction</td>
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</tr>
</tbody>
</table>

54. Do you have expenses that can be deducted on an income tax return?

- [ ] Yes
- [ ] No

If yes, check all that apply. Give the amount you pay each month. If no, skip this question.

- [ ] Alimony Paid
- [ ] Health Savings Account Deduction
- [ ] Student Loan Interest Paid
- [ ] Military Moving Expense
- [ ] Tuition and Fees
- [ ] Other Deduction
- [ ] Educator Expenses
- [ ] Type: __________________________
- [ ] Business Expenses
- [ ] Business Expenses
- [ ] Deductible part of self-employment

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</tr>
<tr>
<td>Tuition and Fees</td>
<td>$__________ Per Month</td>
</tr>
<tr>
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</tr>
<tr>
<td>Business Expenses</td>
<td>$__________ Per Month</td>
</tr>
<tr>
<td>Deductible part of self-employment</td>
<td>$__________ Per Month</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.

1. First name ___________ Middle initial: ___________ 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 Person 2 apply for one? ___________

We need a Social Security number (SSN) if PERSON 2 wants health coverage and has an SSN or can get one. We use SSN’s to check income and other information to see who’s eligible for help paying for health coverage. If PERSON 2 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 PERSON 2 applying for health coverage with us? ☐ Yes ☐ No If no, please answer questions 13, 22, 38-49, and 52-54.

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 ☐ Asian Indian ☐ Native Hawaiian ☐ American Indian or Alaska Native ☐ Other Pacific Islander

☐ Native Hawaiian or Chamorro ☐ Samoan

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

First name: ___________ Middle initial: ___________ Last name: ___________ Suffix (Jr., Sr., III): ___________

10. If you are approved for TennCare Medicaid or CoverKids, 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 ☐ UnitedHealthcare Community Plan

To learn more about these health plans and how to contact them, visit www.tn.gov/tenncare/members-applicants/managed-care-organizations.

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

12. Is PERSON 2 temporarily living out of state? ☐ Yes ☐ No

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.

☐ 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)


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

a. Alien Number: ____________________________

b. Certificate Number: ____________________________

16. IF PERSON 2 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? ____________________________

☐ 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 they have a different immigration status before? ☐ Yes ☐ No

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

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

18. If PERSON 2 is American Indian or Alaska Native answer 19-21. ☐ Yes ☐ No If no, skip 19-21.

19. Is PERSON 2 a member of a federally recognized tribe? ☐ Yes ☐ No

If yes, what is the name of the tribe? ____________________________

20. 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

21. 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: 26Sept22
STEP 2: PERSON 2 Continue with PERSON 2.

22. 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 these dependents live outside of PERSON 2’s household? ☐ Yes ☐ No
      If yes, list the names of dependents(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? ________________________________

23. 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? ________________________________

24. Is PERSON 2 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 approximate due date? (It’s okay to tell us an approximate date if you’re 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 PERSON 2 enrolled in, or entitled to enroll in Medicare Part A or B? ☐ Yes ☐ No
26. Has PERSON 2 experienced an emergency health problem and needs help paying for those emergency services? ☐ Yes ☐ No
27. 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
28. Is PERSON 2 under age 65 and getting treatment now or do they need treatment for breast or cervical cancer? ☐ Yes ☐ No
29. Is PERSON 2 in a medical facility like a hospital and have 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
   If yes, when did they go into the medical facility? ________ (mm/dd/yyyy)
   Please tell us the name of the medical facility they are in: ________________________________
   Please tell us their doctor’s name and phone number: ________________________________

30. Does PERSON 2 live in a nursing home? ☐ Yes ☐ No
    If yes, what is the name of the facility? ________________________________

31. Does PERSON 2 need hospice care? ☐ Yes ☐ No
32. Is PERSON 2 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 PERSON 2 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. PERSON 2 still needs to finish this application but they can help you.
33. Does PERSON 2 have intellectual or development disabilities and want care at an intermediate care facility for individuals with Intellectual Disabilities (ICF/IID)? ☐ Yes ☐ No
34. Does PERSON 2 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 PERSON 2 thinks they need care at home to keep from going into a nursing facility? Then they must also complete an online referral at: https://perls.tenn-care.tn.gov/externalreferral
   Remember, you can’t use this paper application to apply for Katie Beckett. You must apply online at www.tenn-care-connect.tn.gov.
35. Does PERSON 2 have Medicare and want to get or keep help paying Medicare cost sharing like QMB or SLMB? ☐ Yes ☐ No
   You may know this as Medicare Savings Plan or MSP.
36. Did PERSON 2 receive Supplemental Security Income, or SSI benefits, in the past but don’t now? ☐ Yes ☐ No
   If yes, when did it end? ________________________________
37. Does PERSON 2 have expenses for things to help you work because you are blind or disabled? ☐ Yes ☐ No

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Rev: 26Sept22
## Step 2: Person 2

### Current job & income information

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employed:</strong></td>
<td>If Person 2 is currently employed, tell us about your income. Start with question 38.</td>
</tr>
<tr>
<td><strong>Not employed:</strong></td>
<td>Skip to question 48.</td>
</tr>
<tr>
<td><strong>Self-employed:</strong></td>
<td>Skip to question 49.</td>
</tr>
</tbody>
</table>

#### Current job 1:

1. **Employer name**
2. **Employer address**
3. **City**
4. **State**
5. **Zip code**

#### Current job phone number

(______ ) ____ __ - ____ __

#### Wages/tips per pay period

(before taxes)

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Hourly</strong></td>
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<tr>
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<tr>
<td><strong>Weekly</strong></td>
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<tr>
<td><strong>Every 2 weeks</strong></td>
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<tr>
<td><strong>Twice a month</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Monthly</strong></td>
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</table>

#### How often does Person 2 get paid?

- Hourly
- Daily
- Weekly
- Every 2 weeks
- Twice a month
- Monthly
- Yearly
- Quarterly
- Irregularly
- Semi-annually
- One Time Only

#### Average hours worked each pay period

(answer only if you checked the box for Hourly in question 41.)

### Current job 2:

- If Person 2 has additional jobs and needs more space, attach another sheet of paper.

#### Employer name

a. Employer address

#### Employer phone number

(______ ) ____ __ - ____ __

#### Wages/tips per pay period

(before taxes)

<table>
<thead>
<tr>
<th>Option</th>
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<tr>
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#### How often does Person 2 get paid?

- Hourly
- Daily
- Weekly
- Every 2 weeks
- Twice a month
- Monthly
- Yearly
- Quarterly
- Irregularly
- Semi-annually
- One Time Only

#### Average hours worked each pay period

(answer only if you checked the box for Hourly in question 46.)

### Other income Person 2 gets this month

Check all that apply and give the amount and how often Person 2 gets it.

- None
- Social Security $______ How often? ______
- Net farming/fishing $______ How often? ______
- Net rental/royalties $______ How often? ______
- Alimony received $______ How often? ______
- Alimony order date: ____________________________
- Unemployment $______ How often? ______
- Pension $______ How often? ______
- Veteran benefits $______ How often? ______
- Type: ____________________________
- Census worker $______ How often? ______
- Retirement accounts $______ How often? ______
- Other income $______ How often? ______
- Type: ____________________________
- Lottery income $______ How often? ______
- Type: ____________________________
- Tribal income (Certain money received may not be counted for Medicaid or CoverKids.)
  - List any Tribal income that included money from these sources:
    - Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties: $______ How often? ______
    - 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): $______ How often? ______
    - Money from selling things that have cultural significance: $______ How often? ______

### 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? $______

---

**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: 26Sept22
STEP 2: PERSON 2  
Continue to tell us about PERSON 2

(Answer question 50 only if you checked the Social Security box in question 48 above.)

50. Does someone other than a parent (if PERSON 2 is under 18) or spouse help pay for PERSON 2’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 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 that someone pay? $ ____________________________
   f. Number of people in the home? ______________
   g. Does everyone living with PERSON 2 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 PERSON 2 may get from state or local governments to pay for things like housing, utility bills, or phones.)  □ Yes  □ No

51. Does PERSON 2 have medical or dental bills for care they’ve received or paid in the last 3 months?  □ Yes  □ No
   a. How much is this expense or bill? $ ____________________________
   b. What was the date of service? ________________________________
   c. Who does PERSON 2 send payments to? _________________________
   d. Is PERSON 2 younger than 22 years old, and work full time?  □ Yes  □ No

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

53. Does PERSON 2 have before tax deductions?  □ Yes  □ No
   If yes, check all that apply. Give the amount PERSON 2 pays each month. If no, skip to question 54.
   □ 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: _______________________________

54. 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  Alimony Order Date: _____________________________
   □ 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  $______ Per Month
   Type: _______________________________

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: 26Sept22
**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. Do you think you might qualify as a pregnant woman, a child, or a caretaker of a minor child? Then you don’t have to answer these questions. 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 this application.

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.

   a. Annuity  
   b. Bonds  
   c. Certificate of Deposit  
   d. Dividends  
   e. Individual Development Account  
   f. Keogh Account  
   g. Patient/Resident Trust Account  
   h. Promissory Note  
   i. Retirement Account  
   j. Stocks, Mutual funds  
   k. ABLE Account  
   l. Checking Account  
   m. Health Reimbursement Account  
   n. Individual Retirement Account  
   o. Loan  
   p. Pension fund  
   q. Qualified tuition Savings Plan (529 Plans)  
   r. Savings Account  
   s. Trust Fund  
   t. 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  
   a. Resource value $  
   b. 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: $
Family Resources cont’d

6. Does anyone own any property?  □ Yes  □ No  
   If yes, check all that apply.  If no, skip to question 9.
   □ Apartment Building  □ Life Estate  □ Farm  □ Vacation home
   □ Duplex  □ Rental Property  □ Land  □ Other: ______________
   □ House  □ Condo  □ Mobile Home

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 there?  □ Yes  □ No
      If yes, tell us who? ______________
   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: ______________
   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.
    a. Name of Company
    b. Address
    c. City
    d. State
    e. ZIP code
    f. Company phone number
       (______) ____-____

11. Does anyone own burial resources (like contracts or lots)?  □ Yes  □ No  
    If no, skip to question 12.
    a. Value of Burial Resources: $ ______________
    b. How much do you own on this burial resources? $ ______________
    c. Burial resource type: __________________________
    d. Who is the burial resources 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  □ Snowmobile  □ Aircraft
   □ Cars/Trucks   □ Boats/Personal Watercraft  □ Other: ____________________________
   □ Motorcycle   □ Farm Equipment  
   □ Trailer  □ RV

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 to? ____________________________
   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!
STEP 4: Read & Sign this Application

- I’m signing this page under penalty of perjury which means I’ve provided true answers to all the questions to apply for or renew health coverage or report changes for the persons named in this application and its supplements to the best of my knowledge.

- I know that I must tell TennCare if anything changes (and is different than) what I answered on the Application or Renewal Packet within 10 days of that change. I can report changes online at www.tennicareconnect.tn.gov. I can call 1-855-259-0701 to report any changes. I can mail changes to TennCare Connect at P. O. Box 305240, Nashville, TN 37230-5240. I can fax changes to 1-855-315-0669. Someone at a county DHS office can help me report a change. I understand that a change in my information could affect the eligibility for a member(s) of my household.

- I know that under federal law, discrimination isn’t permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. If you think you have been treated unfairly, call 1-855-259-0701 to report it. It’s a free call.

- I know that if I am approved, I can’t keep any health insurance payments or medical payments I get from insurance or other companies. Those payments belong to the State. I understand that I must sign them over to the State.

- I know that TennCare may use the email address (or mobile phone number) that I provided to send emails or Short Message Service (SMS) messages related to my coverage, depending on my communication preference selections. TennCare and their partners may also use the phone number I provided to call me about my coverage.

- I know that if the Tennessee Bureau of Investigation, TennCare, Office of Inspector General, or another agency asks for my help catching health care fraud and abuse, I must help.

- I know that if the State pays for medical bills or for nursing home care for me, the State may get that money back. I know that after my death, the State may be paid back with money from my estate.

- I know no one else can use my health care card. I know if I let someone else use my card I may have to pay the State back for that person’s medical bills. And I could go to jail.

- If I have a Social Security Number (SSN) and I’m applying for coverage, I know I am required to provide a valid SSN. Federal and State law lets us ask for an SSN. [42 CFR 435.910; Tenn. Code Ann § 71-5-106]

- If anyone on the Application or Renewal Packet is eligible for health care coverage with TennCare, I am giving TennCare rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving TennCare rights to pursue and get medical support from a spouse or parent.

- Does any child on this Application or Renewal Packet have a parent living outside of the home? If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell TennCare and I may not have to cooperate.

- If I think TennCare or CoverKids (CHIP) has made a mistake, I can appeal its decision. To appeal means to tell someone that I think the action is wrong, and ask for a fair review of the action. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me. I know that I can find out how to appeal by contacting TennCare Connect at 1-855-259-0701.

- I understand if I’m eligible for other kinds of benefits like disability, unemployment income, or retirement income, I must apply for those programs if I want to keep coverage with TennCare.

- If I think TennCare is taking more than 45 days (or more than 90 days if I applied for long-term care), I can ask for a “delay hearing”. I know I can ask for a delay hearing by contacting TennCare Connect at 1-855-259-0701.

Your Right to Privacy
We know you value the privacy of your personal information. Federal law states we must follow privacy rules to keep your facts private. You can read all about the rules on our website. For more information about our privacy rules, go to our privacy page. If you want us to mail you a copy, call TennCare Connect for free at 1-855-259-0701.

Non-Discrimination
We do not allow unfair treatment in our program. No one is treated in a different way because of race, color, birthplace, religion, language, sex, age, or disability. Do you think you’ve been treated unfairly? Do you have more questions? Do you need more help? You can make a free call to TennCare Connect at 1-855-259-0701. Or go to http://www.tn.gov/tenncare/topic/non-discrimination-compliance to learn more.
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, if you have provided the information required on page 2.

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

STEP 5: Mail completed Application

Mail your signed Application to the address below.

TennCare Connect
P.O. Box 305240
Nashville, TN 37230-5240

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.

Voter Registration

TennCare is a voter registration agency. You can choose to apply today to register to vote.

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, would you like to apply to register to vote here today?
- [ ] Yes  [ ] No

IMPORTANT: IF YOU DO NOT CHECK EITHER YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

Did you check Yes to the Question above? Then TennCare will send you a voter registration form in the mail. You can also apply to register to vote online at https://sos.tn.gov/elections.

You do not have to be registered to vote to be enrolled in our program. 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 in filling out the voter registration application form, we will help you. Call TennCare Connect at 1-855-259-0701. The decision whether to seek or accept help is yours. You may fill out the application form in private.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Division of Election:

By MAIL: Division of Election
312 Rosa L. Parks Avenue
7th Floor, Snodgrass Tower
Nashville, TN 37243-1102

By PHONE: 1-877-850-4959
1-615-741-7956

Individuals with hearing or speech impairments can use Tennessee Relay Center by calling 1-800-848-0299.

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.