Application for Health Coverage & Help Paying Costs

Apply faster online at https://tenncareconnect.tn.gov

Use this Application to see what coverage you qualify for

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

Who can use this Application?

- Use this Application to apply for anyone in your family.
- Other people in your household who want to apply for TennCare or CoverKids.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- **This application can't be used for Katie Beckett coverage.** You must apply online for Katie Beckett. Go to https://tenncareconnect.tn.gov. Log into your account or create an account to apply.

Things you may need to complete this Application

- Social Security Numbers (or document numbers for any legal immigrants who need insurance).
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, bank statements or wage and tax statements). Policy numbers for any health insurance you have now (other than TennCare or CoverKids).
- Information about any job-related health insurance available to your family.

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.** To view the Privacy Act Statement, go to https://www.tn.gov/web-policies/privacy-statement.html.

What happens next?

Send your complete, **signed** Application to:
TennCare Connect
P.O. Box 305240
Nashville, TN 37230-5240

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

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

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

Do you want to know other ways you can apply?

Online: https://tenncareconnect.tn.gov

Phone: Call TennCare Connect to apply or get help at **1-855-259-0701.**
En español: Llame a nuestro centro de ayuda gratis al **1-855-259-0701.**

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

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

Help with completing this Application

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

What if you need help in person with your Application? You can get help from TennCare Connect 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://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 Disability and Aging (DDA) 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		
8. Signature		

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 C.F.R. 431(f), 42 C.F.R. 155.260(f) and 45 C.F.R. 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)

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

Before you get started:

Use this Application to apply for TennCare, CoverKids, or a Medicare Savings Program, like QMB/SLMB.

STEP 1: Person 1 Tell us about yourself.

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

1. First name Middle name Last name			Suffix (Jr., Sr., III)
2. Home address (Leave blank if you don't have one)			3. Apartment or suite number
4. City	5. State	6. ZIP code	7. County
8. Mailing address (if different from home address)			9. Apartment or suite number
10. City	11. State	12. ZIP code	13. County
14. Phone number Type: ☐ Mobile ☐ Home ☐ Work (__ __ __) __ __ __ - __ __ __ __ Ext:	15. Other phone number Type: ☐ Mobile ☐ Home ☐ Work (__ __ __) __ __ __ - __ __ __ __ Ext:		
16. What's your preferred spoken language? What's your preferred written language?			
17. Email address			

Are you and your household homeless or living in a shelter? ☐ Yes ☐ No

If you are homeless or if you want us to send any letters about your coverage, enter the mailing address where we can send your mail. What if you don't have a mailing address? Use a family member, friend, shelter or agency address where you can get your mail. We cannot make a decision on your application if you do not give us an address.

Are you and your household a part of the Safe at Home Program? ☐ Yes ☐ No

If yes, what is your ID number? _____

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 21 who you take care of and lives with you

You DON'T have to include:

- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

Children Under 21 also include:

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

Complete Step 2 for each person in your family.

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

You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure, as required by law. We'll use personal information only to check if you're eligible for health coverage.

STEP 2: PERSON 1 Start with yourself. Remember, Person 1 is the Head of Household.

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

1. First name	Middle name	Last name	Suffix (Jr., Sr., III)

2. Date of birth (mm/dd/yyyy)	3. Sex	4. Relationship to Person 1
	☐ Male ☐ Female	**SELF**

5. **Social Security Number (SSN)** _ _ _ - _ _ - _ _ _ _ If not, what date did you apply for one? _____

We need a Social Security number (SSN) if you want health coverage and have an SSN or can get one. We use 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 1-855-259-0701.

6. Are you 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. 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: ☐ Wellpoint ☐ BlueCare Tennessee ☐ 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 16-17
15. Are you a naturalized or derived citizen? ☐ Yes ☐ No **If yes,** provide a. and b.
a. Alien Number: _____
b. Certificate Number: _____
16. You don't have to answer this immigration question. But if you don't, it may limit the kind of coverage you may qualify for. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
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.

STEP 2: PERSON 1 Continue with yourself.

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: _____
Does this person live outside the household? ☐ Yes ☐ No
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. Do you live with at least one child under age 18 (or is the child age 18 and a full time student)? And, are you the main person taking care of this child? ☐ Yes ☐ No
If yes, to who? _____ What is your relationship to them? _____

24. Are you pregnant or were 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 under age 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. Are you enrolled in, or entitled to enroll in, Medicare Part A or B? ☐ Yes ☐ No

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

28. Were you in foster care at age 18 or older and getting Medicaid? ☐ Yes ☐ No

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

30. 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
(Optional) If yes, when did you go into the medical facility? _____ (mm/dd/yyyy)
(Optional) Please tell us the name of the medical facility you are in: _____
(Optional) Please tell us your doctor's name and phone number: _____

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

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

33. Do you qualify for care in a nursing home, but want care at home instead? ☐ Yes ☐ No
(Optional) 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 1-866-836-6678. You still need to finish this application but they can help you.

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

35. Do you have intellectual and/or other developmental disabilities and want to receive Home and Community Based Services (HCBS) and participate in Employment and Community First CHOICES? ☐ Yes ☐ No
What if you think you need care at home to keep from going into a nursing facility? Then you must also complete an online referral at: https://perlss.tenncare.tn.gov/externalreferral.
Remember, you can't use this paper application to apply for Katie Beckett. You must apply online at https://tenncareconnect.tn.gov.

36. 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.

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

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

39. Are you younger than 22 years old and do you work full time? ☐ Yes ☐ No

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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 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 (__ __ __) __ __ __ - __ __ __ __		
42. Wages/tips per pay period (before taxes) **$**	43. How often do you get paid? ☐ Hourly ☐ Daily ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ Quarterly ☐ Irregularly ☐ 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 you have additional jobs and need more space, attach another sheet of paper.)

45. Employer name		
a. Employer address		
b. City	**c.** State	**d.** Zip code
46. Employer phone number (__ __ __) __ __ __ - __ __ __ __		
47. Wages/tips per pay period (before taxes) **$**	48. How often do you get paid? ☐ Hourly ☐ Daily ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ Quarterly ☐ Irregularly ☐ 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 you get this month:** Check all that apply and give the amount and how often you get it.
Note: You don't need to tell us about Supplemental Security Income (SSI).

☐ 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) have you 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 you get? **$** _____

b. When did you get this lump sum? _____

c. Where did it come from? _____

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

a. What do you do? _____

b. What type of self-employment do you have? _____

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

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STEP 2: PERSON 1 Continue to tell us about yourself.

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

53. 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? _____

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

d. How much do you pay? **$** _____

e. How much do they pay? **$** _____

f. Number of people in the home? _____

g. Does everyone living with you 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. Do you have before tax deductions? ☐ Yes ☐ No

If yes, check all that apply. Give the amount you pay each month. **If no,** skip to question 55.

☐ Medical Insurance	**$** _____ Per Month	☐ Deferred Compensation	**$** _____ 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. Do you have expenses that can be deducted on an income tax return? ☐ Yes ☐ No

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

☐ Alimony Paid 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 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 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 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 1-855-259-0701.

6. Is PERSON 2 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 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: ☐ Wellpoint ☐ BlueCare Tennessee ☐ 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)
14. Is PERSON 2 a **U.S. citizen or U.S. national?** ☐ Yes ☐ No **If yes,** skip 16-17.
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. PERSON 2 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 PERSON 2's immigration status or chances of becoming a permanent resident or citizen.
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? _____
Fill in their 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 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.

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: _____
Does this person live outside the household? ☐ Yes ☐ No
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 dependent(s): _____
d. Will PERSON 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: How is PERSON 2 related to the tax filer?
_____ _____

23. Does PERSON 2 live with at least one child under the age of 18 (or is the child age 18 and a full time student)? And, is PERSON 2 the main person taking care of this child? ☐ 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 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 PERSON 2 enrolled in, or entitled to enroll in Medicare Part A or B? ☐ Yes ☐ No

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

28. Was PERSON 2 in foster care at age 18 or older and getting Medicaid? ☐ Yes ☐ No

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

30. 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
(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 PERSON 2 live in a medical facility or nursing home? ☐ Yes ☐ No
If yes, what is the name of the facility or nursing home? _____

32. Does PERSON 2 need hospice care? ☐ Yes ☐ No

33. Does PERSON 2 qualify for care in a nursing home, but wants care at home instead? ☐ Yes ☐ No
(Optional) 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.

34. 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

35. 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://perlss.tenncare.tn.gov/externalreferral
Remember, you can't use this paper application to apply for Katie Beckett. You must apply online at https://tenncareconnect.tn.gov.

36. 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.

37. 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? _____

38. Does PERSON 2 have expenses for things to help you work because you are blind or disabled? ☐ Yes ☐ No

39. Is PERSON 2 younger than 22 years old and work full time? ☐ Yes ☐ No

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

STEP 2: PERSON 2 Current Job & Income Information

Current job & income information

☐ **Employed:** If PERSON 2 is currently employed, tell us about your 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 (__ __ __) __ __ __ - __ __ __ __		
42. Wages/tips per pay period (before taxes) **$**	43. 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	44. Average hours worked each pay period (answer only if you checked the box for Hourly in question 43.)

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

45. Employer name		
a. Employer address		
b. City	**c.** State	**d.** Zip code
46. Employer phone number (__ __ __) __ __ __ - __ __ __ __		
47. Wages/tips per pay period (before taxes) **$**	48. 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	49. Average hours worked each pay period (answer only if you checked the box for Hourly in question 48.)

50. **Other income PERSON 2 gets this month:** Check all that apply and give the amount and how often PERSON 2 gets it.
Note: You don't need to tell us about Supplemental Security Income (SSI) for PERSON 2.

☐ 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 PERSON 2 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 PERSON 2 get? **$** _____
b. When did PERSON 2 get this lump sum? _____
c. Where did it come from? _____

52. 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? **$** _____

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STEP 2: PERSON 2 Continue to tell us about PERSON 2

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

53. 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.) ☐ Yes ☐ No

54. 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 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 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: _____	**$** _____ Per Month	☐ Health Savings Account Deduction	**$** _____ 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 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.

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 - j. **If no,** skip to question 2.

a. Name of Health Insurance Company		
b. Type of coverage: ☐ Medicare ☐ Peace Corps ☐ Retiree health plan ☐ VA Health Care Programs ☐ TRICARE ☐ COBRA ☐ Employer Insurance Name: _____		
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
j. Did anyone on your Application lose Medicare because they went back to work and were making more money than their social security limit?
If yes, who: _____

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? ☐ Yes ☐ No
If yes, check all that apply. **If no,** skip to question 6.

☐ Annuity
☐ Bonds
☐ Certificate of Deposit
☐ Dividends
☐ Individual Development Account
☐ Keogh Account
☐ Patient/Resident Trust Account
☐ Promissory Note
☐ Retirement Account
☐ Stocks, Mutual funds
☐ ABLE Account
☐ Cash
☐ Checking Account
☐ Health Reimbursement Account
☐ Individual Retirement Account
☐ Loan
☐ Pension fund
☐ Child Support
☐ Qualified tuition Savings Plan (529 Plans)
☐ Savings Account
☐ Trust Fund
☐ Veterans Benefits: Type: _____
☐ 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 **$**		
b. List everyone who owns this resource			
3. Tell us about the bank or company where you have this financial resource. Name of Bank or Company.			
a. Address			
b. City	**c.** State	**d.** Zip code	4. Bank or company phone number (__ __ __) __ __ __ - __ __ __ __
5. If anyone owns a Trust, tell us about the trust that they own.			
a. Trust type:	**b.** Trustee:	**c.** Value: **$**	

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Family Resources cont'd

6. Does anyone own any property? ☐ Yes ☐ No
If yes, check all that apply. **If no,** skip to question 9.

☐ 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? _____
If no, did they intend to return to this home? ☐ Yes ☐ No
d. Does a spouse or child (under age 21 or is blind or permanently disabled) live in this home? ☐ Yes ☐ No
e. Does anyone get rent money from this property? ☐ Yes ☐ No
If yes, tell us who: _____
If yes, what is the monthly income from this property? **$** _____ Per month
f. How much is owed on this property? **$** _____
g. What is the value of this property? **$** _____

8. Tell us the address of the property that you own, answer questions a-f.

a. Property address (Leave blank if you don't have one.)			**b.** Apartment or suite number
c. City	**d.** State	**e.** ZIP code	**f.** County

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

10. Tell us about the insurance company that issued the Life Insurance policy.

Name of Company			
a. Address			
b. City	**c.** State	**d.** Zip code	**e.** Company phone number (__ __ __) __ __ __ - __ __ __ __

11. Does anyone own burial resources (like contracts or lots)? ☐ Yes ☐ No **If no,** skip to question 14.
If yes, list anyone who owns burial resources: _____

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?

12. Does anyone in your household have shelter or utility expenses, dependent care expenses, or child support expenses? ☐ Yes ☐ No

13. Does anyone in your household have medical or dental bills for care 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 do you send payments to? _____

Family's Resources Cont'd

14. Does anyone own a vehicle? ☐ Yes ☐ No
If yes, check all that apply. **If no,** skip to question 18.

☐ ATV/Golf Carts	☐ Snowmobile	☐ Aircraft
☐ Cars/Trucks	☐ Boats/Personal Watercraft	☐ Other: _____
☐ Motorcycle	☐ Farm Equipment	
☐ Trailer	☐ RV	

15. Tell us more about the vehicle in question 14. 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?
$	**$**

16. Does the owner receive income from use of this vehicle? ☐ Yes ☐ No

17. How does the owner use this vehicle?

☐ Household Transportation	☐ Self-Employment	☐ Homestead
☐ Income Producing	☐ Recreational	☐ Tools of the Trade

18. 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? **$** _____
c. How much is owed on each resource? **$** _____

19. Who owns these resources: _____

20. Has anyone sold, traded, or given away resources in the last five years (60 months)? ☐ 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 <u>sign</u> 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 https://tenncareconnect.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 other 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.**

Change How You Get Your Letters

We mail your letters to you unless you say you want your letters electronically. Use your online account at https://tenncareconnect.tn.gov to change your communication preference and see your letters online. Haven't created an online account? Go to https://tenncareconnect.tn.gov and click on the Get Started button. After you create an account and have logged in, select Link My Case. You'll need your Social Security Number, your Application ID or your Individual ID along with your date of birth. Or call TennCare Connect for help 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 is 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 https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html 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 your tax data. 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 using tax data 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.

We will try to verify your household's resources using a credit reporting agency to make it easier for you. Do you give us your OK to check your household's resources with a credit reporting agency?

☐ Yes ☐ No

You have the right to the information the credit reporting agency has about your resources if you ask them for it within 60 days. If you have questions, call the credit reporting agency at 1-888-288-1345 or go online to www.accuity.com.

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.

Signature	Date signed (mm/dd/yyyy)
	☐☐ ☐☐ ☐☐☐☐

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 1-800-848-0298.

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.