Citizens' Council for Health Freedom
Securing Health Freedom for All

OBAMACARE APPLICATION (Draft) CONDENSED

Questions & Basic Instructions

STEP 1 Tell us about yourself.	(We will need to contact an adult member of the family)		
First Name	Middle Name	Last Name	Suffix
Home Address	Apartment Number		
City	State	Zip Code	County
Mailing Address	Apartment Number		
City	State	Zip Code	County
Check here if you don't have a home address	Phone Number	Other Phone Number	Email (Yes/No) Text (Yes/No)
Email address	Text number	Preferred Language Spoken (if not English)	Preferred Language Read (if not English)
STEP 2 – Tell us about your family.	Your income and family size help us decide what programs you qualify for. With this information, we can make sure everyone gets the most coverage possible.		
PERSON 1			
First Name	Middle Name	Last Name	Suffix
Relationship to You	Social Security Number	Date of Birth (mo/day/yr)	Sex (Male/Female)
Pregnant (Yes/No)	If yes, how many babies are expected? ______		
Does PERSON 1 plan to file a federal income tax return next year? (Yes/No) (You can still apply for health insurance even if you don't file a federal income tax return)	If yes, answer questions 1 – 3. If no, skip to question 1.	(1) Will PERSON 1 file jointly with a spouse/partner? (2) (Yes/No)	If yes, name of spouse/partner. ___________________
(2) Does PERSON 1 have any dependents? (Yes/No)	If yes, list names(s) of dependents.	(3) Is PERSON 1 claimed as a dependent on someone else's tax return? (Yes/No)	If yes, please list the name of the tax filer.
How is PERSON 1 related to the tax filer? ___________			
Is PERSON 1 applying for health insurance? (Yes/No) (Even if you have insurance, there might be a program with better coverage of lower costs)	If yes, answer all the questions below. If no, SKIP to the income questions on page 4.	Social Security Number REQUIRED if you have one and if not listed above.	Have a disability? (Yes/No)
Needs help with activities of daily living through personal assistance services or a medical facility? (Yes/No)	U.S. citizen or national? (Yes/No)	If PERSON 1 isn't a U.S. citizen or national, do they have eligible immigration status? (Yes)	Go to page 20 for a list of eligible immigration statuses and add the information below.
Document Type	ID Number	Has PERSON 1 lived in the U.S. since 1996? (Yes/No)	Does PERSON 1 want help paying for medical bills from the last 3 months? (Yes/No)
Does PERSON 1 live with at least one child under the age of 19 and are they the main person taking care of this child? (Yes/No)	Please answer the following questions if PERSON 1 is 26 or younger.	Did PERSON 1 have insurance through a job and lose it within the past 3 months? (Yes/No)	End date______ Reason the insurance ended ______________

Is PERSON 1 a full time student? (Yes/No)	Was PERSON 1 ever in foster care? (Yes/No)	Does PERSON 1 have a parent living outside the home (Yes/No)	If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply): ___Mexican, ___Mexican American, ___Chicano/a, ___Puerto Rican, ___Cuban, ___Other
Race (OPTIONAL—check all that apply)	___White, ___Black or African American, ___American Indian or Alaska Native	___Asian Indian, ___Chinese, ___Filipino, ___Japanese, ___Korean, ___Vietnamese, ____Other Asian	___Native Hawaiian, ___Guamanian or Chamorro, ___Samoan, ___Other Pacific Islander, ___Other
Current Job and Income Information	*If check "Not employed",* skip to "other income" lower on this page.	Current Job 1 (employer name, wages/tip (before taxes) $_______; ____Hourly, ____Weekly, ____ Every 2 weeks, _____monthly _____yearly	Average hours worked each WEEK________
Current Job 2 (if you have more jobs and need more space, attach another sheet of paper)	Current Job 1 (employer name, wages/tip (before taxes) $_______; ____Hourly, ____Weekly, ____ Every 2 weeks, ____monthly ____yearly	Average hours worked each WEEK_________	In the past 6 months, did PERSON 1: ___change jobs, ___stop working; ___Start working fewer hours; __None of these.
If self-employed, please answer the following questions:	Type of work_______	How much net income (profits once expenses are paid) will PERSON 1 get from this self-employment this month? See instructions on page 20 to see what could be counted: $_______	**Other income:** Check all that apply, and give the amount and how often you get it. **NOTE**: You don't need to tell us about child support, veteran's payment or Supplemental Security Income (SSI)
Other income: ____None ____Unemployment $____ How often? _______	_____Pensions $____How often?_______ _____Social Security $____ How often? _______	____Retirement Accounts $___How often?______ ____Alimony $___How often? _______	____Capital Gain $___How often?______ ____Dividends/Interest $___How often? _______
____Net Farming/Fishing $___How often? _______ ____Net Rental/Royalty $___How often? _______	____Other Income $___How often? ______ Type__________	If PERSON 1 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health insurance a little lower.	NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment: __Alimony $___ How often?_______ __ Student loan interest $___How often?_____ ___Other deductions $___How often? ______
Yearly Income: If the income you listed on this page is not steady from month to month, please tell us what you expect the yearly income to be. For example, some people expect their income to change because they only work some months of the year.	If you don't expect changes to your monthly income, skip to Step 3.	PERSON 1's total income **this year**: $______________	PERSON 1's total income **next year**: $________________
Step 2: PERSON 2	*Similar questions to above*		
Step 2: PERSON 3	*Similar questions to above*		
Step 2: PERSON 4	*Similar questions to above*		
Step 2: PERSON 5	*Similar questions to above*		
Step 2: PERSON 6	*Similar questions to above*		

STEP 3 Your Family's Health Insurance	Answer these questions for everyone applying for help paying for health insurance.		
Insurance From Jobs	Is anyone offered health coverage from a job? (Yes/No) (This includes coverage from someone else's job, such as a parent or spouse, and includes private employer plans as well as TRICARE, federal or state employee plans, and Peace Corps plans.)	If yes, answer these questions. If there are plans offered by more than one employer and you need more space, attach another sheet of paper.	Is this a state health benefit plan? (Yes/No/Don't know)
If no, skip to "Other Health Insurance" on page 16)	Tell us about the job the job that offers coverage. We need to know about any health coverage you could get through a job. You can use the Employer Coverage Form on page 21 to get information from the employer about health coverage this job offers to help you complete this section. If there is more than one job, copy this page.	Employee Name______ Employee Social Security Number___ Employer Name _____ Employer Identification Number (EIN*) *You can ask your employer for this information. See page 21.	Employer Address _________________ Employer Phone Number ________________ City_________ Zip Code ________
Who can we contact about employee health coverage at this job?	Phone number	Email address	What's the name of the lowest cost self-only health plan the employee listed above could enroll in at this job (Only consider plans that meet the "minimum value standard" set by the Affordable Care Act.) Name: ________ ___No plans meet the "minimum value standard" ____Don't know.
How much would the employee have to pay in premiums for that plan? $______ How often? ___Weekly, ___Every 2 weeks, ___Twice a month, ___Monthly, ___Yearly, ___Other: ______	Do you think the employer's coverage is affordable? (Yes/No)	PERSON 1: ____Enrolled Now ____Plans to Enroll Start Date: _______ ____Not Enrolled	Changes you plan to make next year: ___Plans to drop coverage Date: ________ ___Will become eligible Start Date: _______
Check here if this job will no longer offer health coverage next year ___	Check here if you think this health insurance will not be affordable next year: ___	**Other Health Insurance:** Does anyone have another health insurance now, including Veterans, Medicaid or CHIP, Medicare, COBRA, Private/Other, Retiree Health Plan? ___Yes. ___No. If no, skip to step 4 on the next page.	Who has other health insurance? Name: ________ What type do they have: __________ Name of Plan: __________ Policy Number: __________

STEP 4 Is anyone in your family American Indian or Alaska Native?			
___No, nobody in my family is American Indian or Alaska Native. If no, skip to Step 5 on the next page.	___Yes. If yes, continue	American Indians and Alaska Natives who enroll in Medicaid, the Children's Health Insurance Program (CHIP), and the Market6place can also get services from the Indian Health Services, tribal health programs, or urban Indian health programs. …	…If you or your family members are American Indian or Alaska Native, you may not have to pay cost sharing and may get special monthly enrollment periods. We are asking you to answer the following questions to make sure you and your family get the most help possible. **NOTE:** If you need more space please attach another piece of paper.
First Name	Middle Name	Last Name	Member of federally recognized tribe? (Yes/No) If yes, give the name of the tribe. ________
Did this person ever get a service from the Indian Health Service, a tribal health program, or urban Indian health program or through a referral from one of these programs? (Yes/No)	If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs or through a referral from one of these programs? (Yes/No)	Certain money received may not be counted for Medicaid or CHIP. Does the income reported in Step 3, include money from any of the following sources? (Yes/No)	If yes, how often and give amount below.
Per capita payments from a tribe that come from natural resources, usage rights, leases or royalties? (Yes/No) $____ ; __Weekly, __Bi-Weekly, __Monthly, __Other	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)? (Yes/No) $____ ; __Weekly, __Bi-Weekly, __Monthly, __Other	Money from selling things that have cultural significance? (Yes/No) $____ ; __Weekly, __Bi-Weekly, __Monthly, __Other	
STEP 5 Please read and sign this application.			
I have provided true answers to all the questions on this form to the best of my knowledge. I know that there may be a penalty if I'm not truthful.	I know that my information on this form will only be used to determine eligibility for health insurance and will be kept private as required by law. I know that I must tell the Health Insurance Marketplace if anything changes (and is different than) what I wrote on this application. I can call 1-800-xxx-xxxx or visit www.placeholder.gov to report any changes.	I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file	I can confirm that no one applying for health insurance on this application is incarcerated (detained or jailed) or living in a medical facility.

Renewal of Coverage	I understand that if I'm eligible for help paying for health insurance, I may also be able to renew the coverage. During the renewal process, the Health Insurance Marketplace will use income data including information from tax returns of household members. This will determine yearly eligibility for help applying for health insurance for the next 5 years. …	…The Marketplace will send me a notice and let me make change. If I don't respond, the Marketplace will continue my eligibility at the level indicated by the data. I understand this renewal process will occur each year for the number of years that I check off below, but I may change my choice at any time by contacting the Marketplace.	___ 5 years ___ 4 years ___ 3 years ___ 2 years ___ 1 year ___ Don't renew my eligibility for help paying for health insurance.
If anyone on this application is eligible for Medicaid:..	**Your right to appeal:** If I think the Health Insurance Marketplace or Medicaid/CHIP has made a mistake, I can appeal its decision…	Sign this application	Signature Date (month/day/year)
You can choose an authorized representative	You can give a trusted friend or partner permission to talk about this application with us, see your information and act for you on matters related to this application. This person is called an "authorized representative."	Do you want to name someone as your authorized representative? (Yes) Name of Authorized Representative, Address, Apt Number, City, State, Zip Code, Phone Number. Your signature, Date	___No. If "no" skip to Step 6.
STEP 6 Mail completed application.			
	Mail your signed application to: Health Insurance Marketplace XXXXX Washington, D.C. 20005	Did you remember to:	___Tell us about everyone in your family & household, even if they don't need insurance? (see page 2 for the list of who to include) ___ Ask your employer about any job-related insurance? ___Sign this application on page 18.

Copy of the 21-page draft federal application: HIX Draft Application for Insurance - Complete