Healthcare Coverage

Please fill out the following details along with the Assistance Application if seeking Healthcare Assistance

Additional Group Details

Is anyone the primary caretaker for a child (under age of 19) in the home?
☐ If yes, who? Caretaker
Child
☐ No

Does anyone live in a medical facility or nursing home?
☐ If yes, who? ☐ No

Was anyone in foster care when they turned 18?
☐ If yes, who? ☐ No ← Only required for applicants

Is anyone applying for health insurance currently incarcerated (detained or jailed)?
☐ If yes, who? ☐ No

American Indian or Alaska Native

← AI/AN family members may not have to pay cost sharing and may get special monthly enrollment periods

Are you or is anyone in your family American Indian or Alaska Native?
☐ If yes, who? ☐ No

If yes, are they a member of a federally recognized tribe?
☐ If yes, Tribe ☐ No

Has anyone ever received a service or referral from the Indian Health Service, a tribal health program, or urban Indian health program?
☐ If yes, who? ☐ No

If no, is anyone eligible to get these services?
☐ If yes, who? ☐ No

Flint Water System

Did anyone in your home consume water from the Flint Water System and live, work, or receive childcare or education at an address that was served by the Flint Water System from April 2014 through present day?
☐ If yes, list below. ☐ No ← For individuals under age 21 or pregnant women. By checking "yes" you are requesting Healthcare

Names	Address Served by Flint Water (Street, City, ZIP Code)	Dates
		MO/YR - MO/YR
	☐ Home ☐ Work ☐ School ☐ Childcare Facility	
	☐ Home ☐ Work ☐ School ☐ Childcare Facility	

Your Name

Healthcare Coverage

Please fill out the following details along with the Assistance Application if seeking Healthcare Assistance

Tax Filers

Does anyone applying plan to file a federal tax return next year? ☐ **If yes, who?** ☐ **No**

← You do not need to file a tax return to receive Healthcare

Name of Primary Tax Filer

- Are they filing jointly with a spouse? ☐ **If yes, who?** Name of Spouse ☐ **No**
- Are they claiming dependents? ☐ **If yes, who?** Name of Dependent(s) ☐ **No**

- Are they filing jointly with a spouse? ☐ **If yes, who?** ☐ **No**
- Are they claiming dependents? ☐ **If yes, who?** ☐ **No**

Dependents

Will anyone applying be claimed as a dependent on someone else's tax return? ☐ **If yes, list below.** ☐ **No**

Dependent	Tax Filer	Relationship to Tax Filer
Name	Name	

Yearly Income

Does anyone's income change from month to month? ☐ **If yes, list below.** ☐ **No**

Who?	Total Estimated Income This Year	Total Estimated Income Next Year
Name		

← If you think it will be different

Healthcare Coverage

Please fill out the following details along with the Assistance Application if seeking Healthcare Assistance

Health Coverage Info

Does anyone need help paying for medical bills from the past 3 months?

☐ **If yes, who?** Name(s) ☐ **No**

Which months? JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC

Did anyone have insurance through a job and lose it in the last 3 months? ☐ **If yes, list below.** ☐ **No**

Who lost coverage?	End Date	Reason Insurance Ended
Name	MM / YYYY	

Is anyone currently enrolled in health coverage (even if not applying)? ☐ **If yes, list below.** ☐ **No**

← Including Medicaid, CHIP/MIChild, Medicare, VA Healthcare Programs, Peace Corps, Employer Insurance, TRICARE (unless you have direct care or Line of Duty), and Other

Type + Name of Coverage	Person Covered	Policy #
	Name	

If Medicare, do you want help paying Medicare premiums? Y | N

If employer insurance: Is this COBRA coverage? Y | N

Is this a retiree health plan? Y | N

If other, is this a limited benefit plan (such as a school accident policy)? Y | N

To make it easier to determine your Healthcare eligibility in future years, do you agree to the use of IRS data for automatic renewals? ☐ **Yes** ☐ **No**

← This allows the Marketplace and the State of Michigan to use income data (including information from tax returns). See Info Booklet (Pg 8) for more details

If yes, for how many years? 5 4 3 2 1