



Lighthouse.Ai

Guiding the way to government benefits

100M+ have unmet health & social needs



2/3 don't get benefits they're eligible for

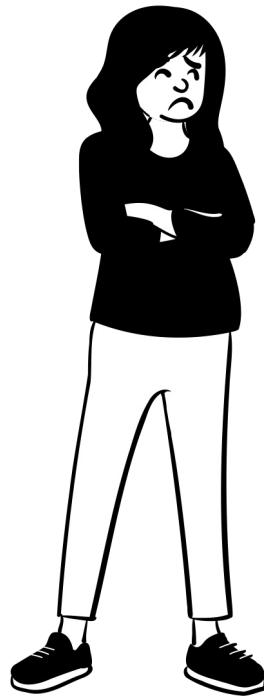




**Heating
Assistance**



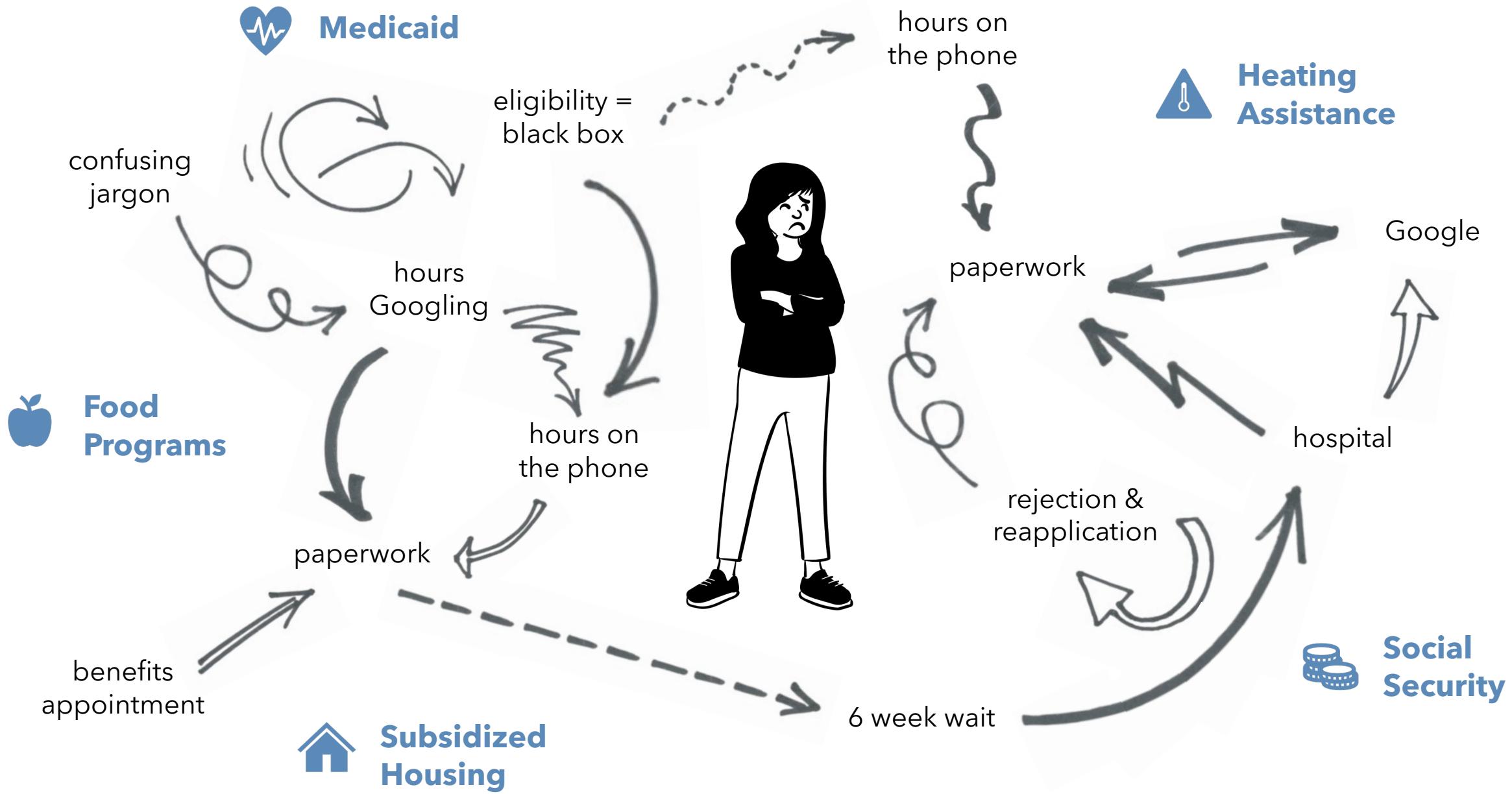
**Food
Programs**



**Subsidized
Housing**



**Social
Security**



Laborious & Time-consuming

Please print using black or dark ink only.
Mark each box [] as appropriate, with an "X", like this → .

STEP 2: PERSON 1 Start with yourself

Complete Step 2: PERSON 1 for yourself.

1. First name	Middle name	Last name	Suffix	Relationship to PERSON 1 SELF
2. Date of birth (mm/dd/yyyy)		3. Gender (Optional) <input type="checkbox"/> Male <input type="checkbox"/> Female	4. Social Security Number (SSN)	
5. Name of spouse if married				

As a condition of eligibility, a Social Security Number (SSN) must be provided for each individual (including children) applying for medical assistance. The SSN will help process the application automatically.

6. Do you plan to file a federal income tax return NEXT YEAR?
(You can still apply for health insurance even if you do not file a federal income tax return.)

- Yes. If yes, please answer questions a-c. No. If no, skip to question c.
- Will you file jointly with a spouse? Yes No If yes, write name of spouse: _____
 - Will you claim any tax dependents on your tax return? Yes No
If yes, write name(s) of dependents: _____
 - Will you be claimed as a tax dependent on someone's tax return? Yes No
If yes, write the name of the tax filer: _____
How are you related to the tax filer: _____

7. Are you pregnant? Yes No

If yes, how many babies are expected during this pregnancy? _____ Expected Due Date: _____

8. Are you applying for medical assistance? (Even if you have other insurance, there might be a program with better coverage or lower costs.)
 Yes. If yes, answer all the questions below (9-19). No. If no, SKIP to the income questions on page 4.

9. If applying for insurance are you a resident of Hawaii? Yes No

10. Does this person have a spouse or parent that lives outside the household? Yes No

11. Were you ever in an accident? If so, are you still incurring medical expenses because of it? Yes No

Questions for Aged (65 or older), Blind, Disabled/Long-Term Service and Support:

12. Do you have a disability that will last more than twelve (12) months? Yes No
- Do you currently receive long-term care nursing services? Yes, in a nursing facility Yes, in my home in the community
 - Have you received long term care nursing services in the last three (3) months? Yes. If yes, what dates? _____
 - Do you think you need long term care nursing services now? Yes No
 - Do you receive Supplemental Security Income (SSI)? Yes No

13. Did you receive any medical services in the past three (3) months immediately prior to the date of this application?
 Yes. If yes, what dates? _____ No

14. Are you a U.S. citizen or U.S. national? Yes No

15. If you are not a U.S. citizen or U.S. national, do you have eligible immigration status? If Yes, enter document type and ID number below:

Immigration document type (i.e. I-551, Visa, etc.)	Status type (optional)
--	------------------------

Name as it appears on your immigration document

Alien or I-94 Number	Passport number or other card number
----------------------	--------------------------------------

SEVIS ID or Expiration Date (optional)

Other (category code or country of issuance)

16. Provide the date of entry to the U.S. found on your immigration document listed in question 15. (mm/dd/yyyy)
- Are you a citizen of the Federated States of Micronesia Republic of the Marshall Islands or Republic of Palau? Yes No
 - Are you, your spouse or parent, a veteran, or an active-duty member of the U.S. military? Yes No

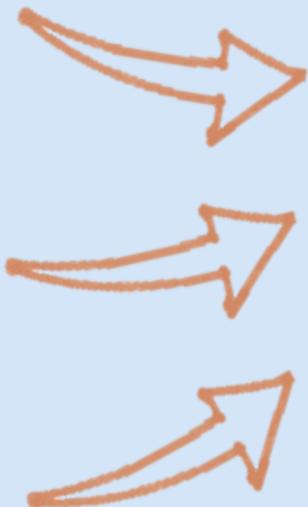
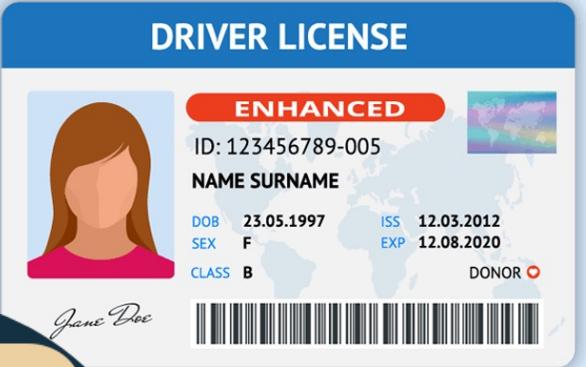
17. Were you in Foster Care, or receiving Kinship or State Adoption assistance and receiving Medicaid when you turned 18 or older? Yes No

18. If Hispanic/Latino, ethnicity (OPTIONAL: mark all that apply.)

- Mexican Mexican American Chicano/a Puerto Rican Cuban Other: _____

19. Race (OPTIONAL: mark all that apply)

- | | | | | |
|---------------------------------------|---|-----------------------------------|--------------------------------------|---|
| <input type="checkbox"/> White | <input type="checkbox"/> Black or African American | <input type="checkbox"/> Filipino | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Guamanian or Chamorro |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Japanese | <input type="checkbox"/> Other Asian | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> Korean | <input type="checkbox"/> Samoan | <input type="checkbox"/> Other: _____ |



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Name as it appears on your immigration document _____

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SEVIS ID or Expiration Date (optional)	Other (category code or country of issuance)

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<input type="checkbox"/> Asian Indian	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Other Pacific Islander
<input type="checkbox"/> Chinese	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Korean	<input type="checkbox"/> Samoan	<input type="checkbox"/> Other: _____



Guiding the way through paperwork
to help you maximize your benefits

You may qualify for:

- Health programs (like Medicaid)
- Food programs (like SNAP)
- Heating assistance
- Housing / rental assistance
- Disability programs

... and more!

**CHECK YOUR
ELIGIBILITY**

*We can help you apply in
minutes, instead of weeks.*



Upload Other Documents



Now, upload documents you already have:

- ID
- Paystubs
- Tax Returns
- Bills, etc.

Your Documents:

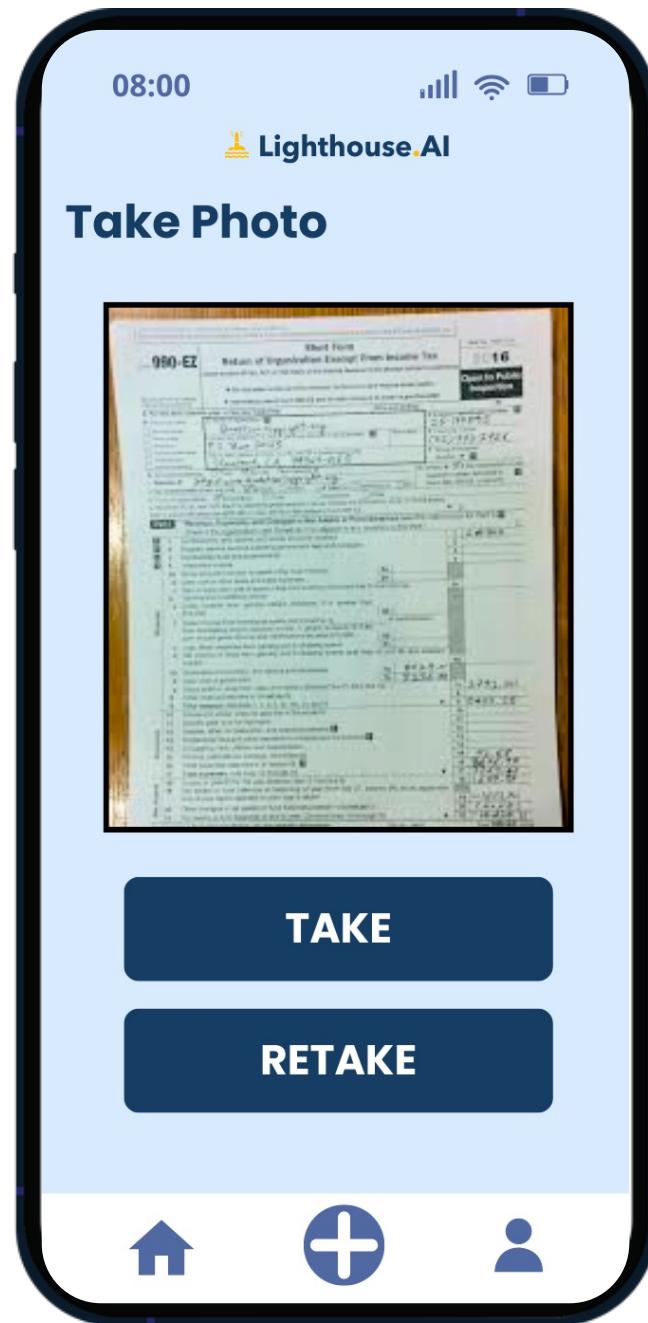
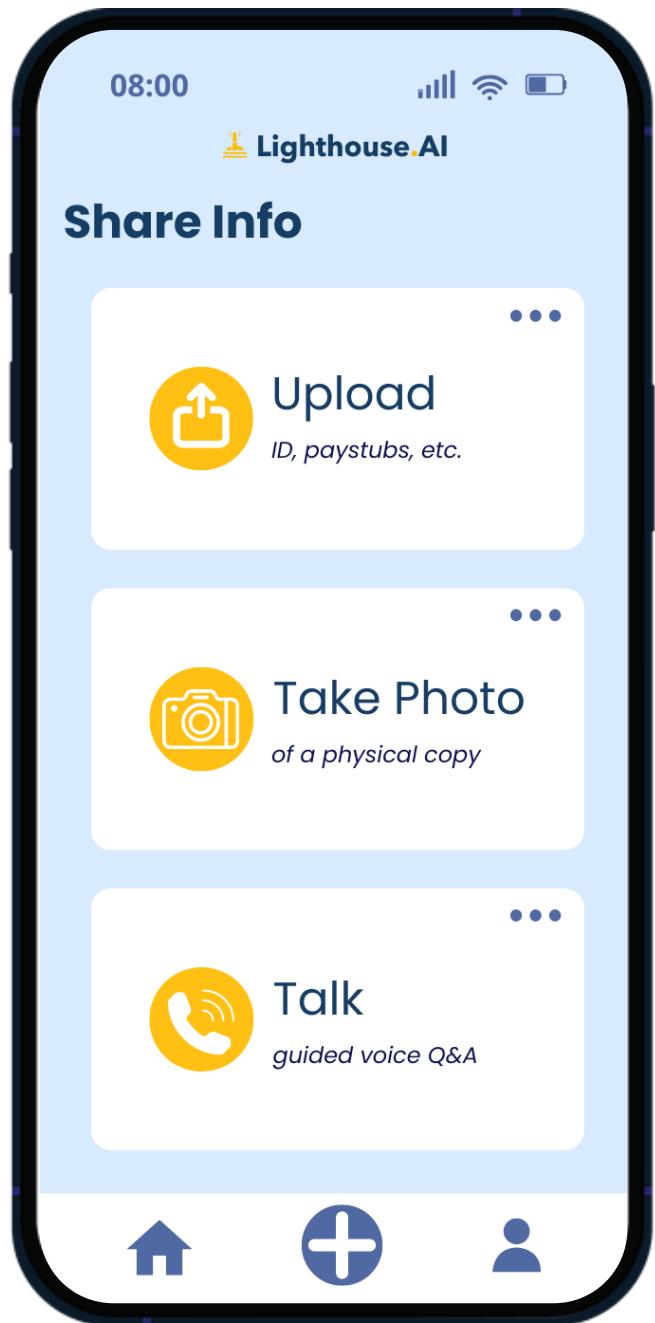


drivers_license.png



paystub.pdf

CONTINUE





Your Medicaid Application (So Far!)

PAGE 2 / 24

Mark each box [] as appropriate, with an "X", like this →

STEP 2: PERSON 1 (Continue with yourself)

Job & Income Information

Employed

If you are currently employed, tell us about your income. Start with question 20.

Self-employed

Skip to question 28.

Not employed

Skip to question 29.

JOB 1: Please enter job income even if your job(s) status changed in the past year from the date of this application.

Check any of the following that have occurred within the last year

Changed jobs Stopped working Started working fewer hours None of these

Start Date: _____ End Date: _____

21. Employer phone number: () -

20. Employer name and address:

LITTLE CAESAR'S, 2424 S Beretania St, Honolulu, HI, 96826, United States

22. Wages/tips (before taxes): Hourly Weekly Every 2 weeks Twice a month Monthly

\$678.85 every two weeks

23. Average hours worked each WEEK:

JOB 2: If you have more jobs and need more space, attach another sheet of paper.

Start Date: _____ End Date: _____

25. Employer phone number: () -

24. Employer name and address:

26. Wages/tips (before taxes): Hourly Weekly Every 2 weeks Twice a month Monthly

\$

27. Average hours worked each WEEK:

Please attach proof of your business excise tax license, gross income, and receipts of self-employment expenses to determine net income. If documents are not attached, you will be contacted for the information.

28. If self-employed, answer the following questions:

a. Type of work: _____ b. How much net income (gross income minus allowable expenses) will you get this month from self-employment? _____
\$ _____

29. OTHER INCOME THIS MONTH: Check all that apply, the amount, and how often received.

NOTE: You do not need to tell us about child support, veteran's payment or SSI monthly income

Unemployment \$ _____ How often? _____

Net farming/fishing \$ _____

How often?

Your Medicaid application is
70% complete!

How would you like continue?



BY GUIDED CHAT



BY PHONE



DOWNLOAD NOW

Demo!