Health Coverage & Help Paying Costs

Application for More Than One Person

THINGS TO KNOW

Use this application to see what insurance choices you qualify for

- **Free or low-cost coverage from Medicaid or the Kentucky Children's Health Insurance Program (KCHIP)**
- **Payment Assistance that can help you pay for your health coverage**
- **Affordable health insurance plans that offer comprehensive coverage to help you stay well**

Who is this application for?

Members of a household (spouses, partners, children, other) who:

- **Live in Kentucky and plan to stay in Kentucky**
- **Are included on your tax return, even if they don't live with you**
- **Live with you, even if taxes are not filed**

Apply faster online

Apply faster online at **www.kynect.ky.gov.**

What you may need to apply

- Your social security number (or document number if you are a legal immigrant)
- Employer and income information (for example, paystubs, W-2 forms, award letter, or wage and tax statements)

Why do we ask for this information?

We ask about your **Social Security Number (SSN)**, your **income** and other information to see if you qualify for and if you can get any help paying for your health coverage costs.
If you need help getting an SSN, call 1-800-772-1213 or visit **socialsecurity.gov**. TTY users should call 1-800-325-0778.

We'll keep all the information you give us private, as required by law. Social security numbers are used to verify your income and to do computer matches with other agencies such as Kentucky Department of Employment Services, the Internal Revenue Service and other matching sources. Social Security Numbers will not be used to report anyone to the United States Citizenship and Immigration Services (USCIS).

What happens next?

- Mail or fax your completed, signed application to:

  Kynect Health Coverage
  P.O. Box 2104
  Frankfort, KY 40602

  Fax: 1-502-573-2007

- **If you do not have all the information we ask for, submit your application anyway**. We will contact you for the missing information if we cannot complete the determination based on the information you give us.
- **If we can make a determination,** we will send you detailed information about the steps you will need to follow to select a plan. You will need to go online, call us, or get assistance from an insurance agent or kynector to enroll in a plan.

To get help

- **Online**: **www.kynect.ky.gov**
- **By phone:** Call Customer Service at **1-855- 4kynect (459-6328)**
- **In person:** Find a list of places near where you live by visiting our website or calling us.
- **Contact an insurance agent or kynector:** Visit our website or call 1-855-4kynect (459-6328) for a list of insurance agents and kynectors near you.
- **Español:** Llame a nuestro Servicio al Cliente gratis al **1-855- 4kynect (459-6328)**
- **TTY** users call **1-855-459-6328**

Health Coverage & Help Paying Costs

Application for More Than One Person

STEP 1 Tell Us about Yourself (the Responsible Party)

Complete this part of the application with information about the Responsible Party (even if the Responsible Party is not applying for coverage). If you are completing this application for someone else, you must use **Appendix B** to enter your contact information.

1. First name, Middle initial, Last name & Suffix **(as it appears on your Social Security card)**

2. Social Security Number (SSN)	**We need your SSN if you want coverage and have a SSN**. Giving us your SSN can be helpful if you don't want health coverage too since it can speed up the application process.

3. **If you want coverage** and SSN is not provided, select the reason for not providing it.

☐Religious Objection ☐ Applied for SSN ☐ Is not eligible to receive an SSN
☐Do not have an SSN and may only be issued an SSN for a valid non-work reason ☐ Refuse to provide SSN
☐I do not want to provide, as I am not applying for coverage

4. If you are applying for health coverage, check here ☐ and answer all questions.
If you are **not applying** for health coverage, **do not answer** questions 26-34 on the next page.

5. Date of Birth (mm/dd/yyyy)	6. Sex ☐ Male ☐ Female

7. Do you live in Kentucky and plan to stay in Kentucky? **(Only required if you want coverage)** ☐Yes ☐ No

8. Home Address - ☐ **Check here if you do not have a Home Address. You will still have to enter a Mailing Address below.**

9. City	10. State	11. Zip Code	12. County

13. Mailing Address (**Only required if different from home address**)

14. City	15. State	16. Zip Code	17. County

18. Primary Phone Number ☐ Home ☐ Work ☐ Cell	19. Secondary Phone Number ☐ Home ☐ Work ☐ Cell
20. ☐ Check here to opt-out of receiving kynect text message alerts to your primary phone number.	☐ Check here to opt-out of receiving kynect text message alerts to your secondary phone number.
21. Preferred Spoken Language (if not English)	22. Preferred Written Language (if not English)

23. **Form 1095-A** is sent by kynect to you and the IRS to report enrollment information and the amount of payment assistance a household has received during the coverage year, if any. **Form 1095-B** can be requested by accessing www.kynect.ky.gov or by contacting DCBS for each person in the household who had Medicaid coverage during the year. The forms are sent via postal mail, or if you create an account on kynect, we can notify you via email instead that the form(s) is ready for viewing. If you would like to be notified via email, enter your email address:

_____

24. Do you, the Responsible Party, plan to file a federal income tax return NEXT YEAR?
(*You can apply for health insurance even if you don't file a federal income tax return*.)

☐ **YES**. **If yes**, answer questions a–d. ☐**NO**. **If no**, skip to question d.

a. What will be your filing status? ☐ Married Filing Jointly ☐ Married Filing Separately ☐ Single ☐Head of Household

b. If married, what is your spouse's name? _____

c. Do you have any tax dependents? ☐Yes ☐No
If yes, list name(s) of dependent(s): _____

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d. Are you claimed as a dependent on someone else's tax return? ☐Yes ☐No
If yes, list the name of the tax filer: _____
How are you related to the tax filer? _____

25. Are you a Parent/Caretaker of someone in this household? ☐Yes ☐No
If yes, please list the name of the household member: _____

Answer the following questions only if you want coverage:

26. Are you offered health coverage from a job (including someone else's job, like a spouse's job)?
☐ Yes. **If yes**, you will need to complete and include **Appendix A** with this application. ☐ No

27.Are you currently enrolled or have offer of Individual Coverage Health Reimbursement Arrangement (ICHRA) or Qualified Small Employer HRA (QSEHRA)?
☐ Yes. **If yes**, you will need to complete **Step 3 HRA questions** in this application. ☐ No

28. Do you want help paying for medical bills from the last 3 months? ☐Yes ☐ No
If yes, which month(s)?_____

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

30. If you are a U.S. citizen or national, are you a naturalized or derived citizen? ☐ Yes ☐ No
If yes, Provide information for one of the below.
☐ Naturalization Certificate
- Naturalization Certificate number: _____
- Immigrant number:_____

☐ Certificate of Citizenship: _____
- Certificate of Citizenship number**:** _____
- Immigrant number:_____

31. If you are not a U.S. citizen or U.S. national, do you have an eligible immigration status?
☐ **Yes**. Answer questions a–d below.
a) Immigration Document Type: _____
b) Document ID Number: _____
c) Have you lived in the U.S. since 1996? ☐ Yes ☐ No
d) What date did you obtain your current immigration status? (mm/dd/yyyy)_____

32. Do you have an emergency medical condition? ☐Yes ☐No

33. Are you a veteran or active-duty member of the U.S. military? ☐ Yes ☐ No

34. Are you of Hispanic, Latino or Spanish origin? **(OPTIONAL)** ☐Yes ☐No

35. Race - **(OPTIONAL)**

☐ White	☐ American Indian	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Alaska Native	☐ Japanese	☐ Other Asian	☐ Samoan
☐ Chinese	☐ Asian Indian	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander

36. If you have lost a household member recently, you may be able to get help paying for his/her medical bills. Please give us the following information about the deceased family member:
Name:_____ Date of Birth:_____
Sex: ☐Male ☐Female
Is this person of Hispanic, Latino or Spanish origin? **(OPTIONAL)** ☐Yes ☐No
Race **(OPTIONAL)**:_____

STEP 2 Other Members of the Household

Next, you will need to give us information about the other members of your household (include all members of your household, even if they do not want health coverage). Include spouse, children, and others who live in Kentucky and plan to stay in Kentucky, are included on your tax return (even if they don't live with you), and live in your household, even if taxes are not filed. If you need to include more than four persons on this application, attach additional pages with their information.

Get started with the members of your tax household.

Person 2

1. First name, Middle initial, Last name & Suffix **(as it appears on Social Security card)**

2. Relationship to you

3. Social Security Number (SSN)

We need PERSON 2's SSN if PERSON 2 wants coverage and has a SSN. Giving us the SSN can be helpful if not applying for health coverage too since it can speed up the application process.

4. **If PERSON 2 wants coverage** and SSN is not provided, select reason for not providing it.

☐ Religious Objection ☐ Applied for SSN ☐ Newborn without SSN ☐ Is not eligible to receive an SSN
☐ Do not have an SSN and may only be issued an SSN for a valid non-work reason ☐ Refuse to provide SSN
☐ I do not want to provide, as I am not applying for coverage

5. If PERSON 2 is applying for health coverage, check here ☐ and answer all questions.
If PERSON 2 is **not applying** for health coverage, **do not answer** questions 12-20.

6. Date of Birth (mm/dd/yyyy)

7. Sex
☐ Male ☐ Female

8. Does PERSON 2 live at the same address as the RESPONSIBLE PARTY?
☐ Yes. **If yes,** do not enter an address below. ☐No. **If no**, enter PERSON 2's address below.

9. Home Address

10. Mailing Address (**Required if different from Home Address**)

11. Does PERSON 2 plan to file a federal income tax return NEXT YEAR?
(Individuals can apply for health insurance even if they don't file a federal income tax return.)

☐ **YES**. **If yes**, answer questions a–d. ☐**NO**. **If no**, skip to question d.

a. What will be PERSON 2's filing status? ☐ Married Filing Jointly ☐ Married Filing Separately ☐ Single ☐Head of Household

b. If married, what is the spouse's name? _____

c. Does PERSON 2 have any tax dependents? ☐Yes ☐No
If yes, list name(s) of dependent(s): _____

d. Is PERSON 2 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 2 related to the tax filer? _____

12. Are you a Parent/Caretaker of someone in this household? ☐Yes ☐No
If yes, please list the name of the household member: _____

13. Is PERSON 2 offered health coverage from a job (including someone else's job, like a parent's or spouse's job)?
☐ Yes. **If yes**, you will need to complete and include **Appendix A** with this application. ☐ No

14. Is PERSON 2 currently enrolled or have offer of Individual Coverage Health Reimbursement Arrangement (ICHRA) or Qualified Small Employer HRA (QSEHRA)?

Yes. **If yes**, you will need to complete **Step 3 HRA questions** in this application. ☐ No

15. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐Yes ☐ No
If yes, which month(s)? _____

16. Is PERSON 2 a U.S. citizen or a U.S. national?
☐ Yes ☐ No

17. If a U.S. citizen or national, is PERSON 2 a naturalized or derived citizen? ☐ Yes ☐ No
If yes, Provide information for one of the below.
☐ Naturalization Certificate
- Naturalization Certificate number: _____
- Immigrant number: _____

☐ Certificate of Citizenship: _____
- Certificate of Citizenship number: _____

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	• Immigrant number: _____

18. If not a U.S. citizen or U.S. national, does PERSON 2 have an eligible immigration status?
☐ **Yes**. Answer questions a–d below.
a) Immigration Document Type: _____
b) Document ID Number: _____
c) Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No
d) What date did you obtain your current immigration status? (mm/dd/yyyy) _____

19. Does PERSON 2 have an emergency medical condition? ☐Yes ☐No

20. Is PERSON 2 a veteran or active-duty member of the U.S. military? ☐ Yes ☐ No

21. Is PERSON 2 of Hispanic, Latino or Spanish origin? **(OPTIONAL)** ☐Yes ☐No

22. Race - **(OPTIONAL)**

☐ White	☐ American Indian	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Alaska Native	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Asian Indian	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
☐ Chinese				

Person 3

1. First name, Middle initial, Last name & Suffix **(as it appears on Social Security card)**

2. Relationship to you

3. Social Security Number (SSN)

We need PERSON 3's SSN if PERSON 3 wants coverage and has a SSN. Giving us the SSN can be helpful if not applying for health coverage too since it can speed up the application process.

4. **If PERSON 3 wants coverage** and SSN is not provided, select reason for not providing it.

☐ Religious Objection ☐ Applied for SSN ☐ Newborn without SSN ☐ Is not eligible to receive an SSN
☐ Do not have an SSN and may only be issued an SSN for a valid non-work reason ☐ Refuse to provide SSN
☐ I do not want to provide, as I am not applying for coverage

5. If PERSON 3 is applying for health coverage, check here ☐ and answer all questions.
If PERSON 3 is **not applying** for health coverage, **do not answer** questions 12-20.

6. Date of Birth (mm/dd/yyyy)

7. Sex
☐ Male ☐ Female

8. Does PERSON 3 live at the same address as the RESPONSIBLE PARTY?
☐ Yes. **If yes,** do not enter an address below. ☐No. **If no**, enter PERSON 3's address below.

9. Home Address

10. Mailing Address (**Required if different from Home Address**)

11. Does PERSON 3 plan to file a federal income tax return NEXT YEAR?
(Individuals can apply for health insurance even if they don't file a federal income tax return.)

☐ **YES**. **If yes**, answer questions a–d. ☐**NO**. **If no**, skip to question d.

a. What will be PERSON 3's filing status? ☐ Married Filing Jointly ☐ Married Filing Separately ☐ Single ☐Head of Household

b. If married, what is the spouse's name? _____

c. Does PERSON 3 have any tax dependents? ☐Yes ☐No
If yes, list name(s) of dependent(s): _____

d. Is PERSON 3 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 3 related to the tax filer? _____

12. Are you a Parent/Caretaker of someone in this household? ☐Yes ☐No
If yes, please list the name of the household member: _____

13. Is PERSON 3 offered health coverage from a job (including someone else's job, like a parent's or spouse's job)?
☐ Yes. **If yes**, you will need to complete and include Appendix A with this application. ☐ No

14. Is PERSON 3 currently enrolled or have offer of Individual Coverage Health Reimbursement Arrangement (ICHRA) or Qualified Small Employer HRA (QSEHRA)?

☐ Yes. **If yes**, you will need to complete **Step 3 HRA questions** in this application. ☐ No

15. Does PERSON 3 want help paying for medical bills from the last 3 months? ☐Yes ☐ No
If yes, which month(s)? _____

16. Is PERSON 3 a U.S. citizen or a U.S. national?
☐ Yes ☐No

17. If a U.S. citizen or national, is PERSON 3 a naturalized or derived citizen? ☐ Yes ☐ No
If yes, Provide information for one of the below.
☐ Naturalization Certificate
- Naturalization Certificate number: _____
- Immigrant number: _____

☐ Certificate of Citizenship: _____
- Certificate of Citizenship number: _____

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	• Immigrant number: _____

18. If not a U.S. citizen or U.S. national, does PERSON 3 have an eligible immigration status?
☐ **Yes**. Answer questions a–d below.
a) Immigration Document Type: _____
b) Document ID Number: _____
c) Has PERSON 3 lived in the U.S. since 1996? ☐ Yes ☐ No
d) What date did you obtain your current immigration status? (mm/dd/yyyy) _____

19. Does PERSON 2 have an emergency medical condition? ☐Yes ☐No

20. Is PERSON 3 a veteran or active-duty member of the U.S. military? ☐ Yes ☐ No

21. Is PERSON 3 of Hispanic, Latino or Spanish origin? **(OPTIONAL)** ☐Yes ☐No

22. Race - **(OPTIONAL)**

☐ White	☐ American Indian	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Alaska Native	☐ Japanese	☐ Other Asian	☐ Samoan
☐ Chinese	☐ Asian Indian	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander

Person 4

1. First name, Middle initial, Last name & Suffix **(as it appears on Social Security card)**

2. Relationship to you

3. Social Security Number (SSN)

We need PERSON 4's SSN if PERSON 4 wants coverage and has a SSN. Giving us the SSN can be helpful if not applying for health coverage too since it can speed upthe application process.

4. **If PERSON 4 wants coverage** and SSN is not provided, select reason for not providing it.

☐ Religious Objection ☐ Applied for SSN ☐ Newborn without SSN ☐ Is not eligible to receive an SSN
☐ Do not have an SSN and may only be issued an SSN for a valid non-work reason ☐ Refuse to provide SSN
☐ I do not want to provide, as I am not applying for coverage

5. If PERSON 4 is applying for health coverage, check here ☐ and answer all questions.
If PERSON 4 is **not applying** for health coverage, **do not answer** questions 12-20.

6. Date of Birth (mm/dd/yyyy)

7. Sex
☐ Male ☐ Female

8. Does PERSON 4 live at the same address as the RESPONSIBLE PARTY?
☐ Yes. **If yes,** do not enter an address below. ☐No. **If no**, enter PERSON 4's address below.

9. Home Address

10. Mailing Address (**Required if different from Home Address**)

11. Does PERSON 4 plan to file a federal income tax return NEXT YEAR?
(Individuals can apply for health insurance even if they don't file a federal income tax return.)

☐**YES**. **If yes**, answer questions a–d. ☐**NO**. **If no**, skip to question d.

a. What will be PERSON 4's filing status? ☐ Married Filing Jointly ☐ Married Filing Separately ☐ Single ☐Head of Household

b. If married, what is the spouse's name? _____

c. Does PERSON 4 have any tax dependents? ☐Yes ☐No
If yes, list name(s) of dependent(s): _____

d. Is PERSON 4 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 4 related to the tax filer? _____

12. Are you a Parent/Caretaker of someone in this household? ☐Yes ☐No
If yes, please list the name of the household member: _____

13. Is PERSON 4 offered health coverage from a job (including someone else's job, like a parent's or spouse's job)?
☐ Yes. **If yes**, you will need to complete and include **Appendix A** with this application. ☐ No

14. Is PERSON 4 currently enrolled or have offer of Individual Coverage Health Reimbursement Arrangement (ICHRA) or Qualified Small Employer HRA (QSEHRA)?

☐ Yes. **If yes**, you will need to complete **Step 3 HRA questions** in this application. ☐ No

15. Does PERSON 4 want help paying for medical bills from the last 3 months? ☐Yes ☐ No
If yes, which month(s)? _____

16. Is PERSON 4 a U.S. citizen or a U.S. national?

☐ Yes ☐No

17. If a U.S. citizen or national, is PERSON 4 a naturalized or derived citizen? ☐ Yes ☐ No
If yes, Provide information for one of the below.
☐ Naturalization Certificate
- Naturalization Certificate number: _____
- Immigrant number: _____

☐ Certificate of Citizenship: _____

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	• Certificate of Citizenship number: _____ • Immigrant number: _____

18. If not a U.S. citizen or U.S. national, does PERSON 4 have an eligible immigration status?
☐ **Yes**. Answer questions a–d below.
a) Immigration Document Type: _____
b) Document ID Number: _____
c) Has PERSON 4 lived in the U.S. since 1996? ☐ Yes ☐ No
d) What date did you obtain your current immigration status? (mm/dd/yyyy) _____

19. Does PERSON 2 have an emergency medical condition? ☐Yes ☐No

20. Is PERSON 4 a veteran or active-duty member of the U.S. military? ☐Yes ☐No

21. Is PERSON 4 of Hispanic, Latino or Spanish origin? **(OPTIONAL)** ☐Yes ☐No

22. Race - **(OPTIONAL)**

☐ White	☐ American Indian	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Alaska Native	☐ Japanese	☐ Other Asian	☐ Samoan
☐ Chinese	☐ Asian Indian	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander

STEP 3 Additional Questions

If the answer to the following questions is yes for more than one person, use additional sheets of paper to give us the details.

1. Is anyone that is applying for health coverage on this application **currently in prison or jail** or has been released in the past three months?

☐ **YES**. **If yes**, answer questions a–d. ☐ **NO**. **If no**, go to question 2.

a. Who? _____

b. When did this person enter prison? (mm/dd/yyyy) _____

c. When did this person leave prison? (mm/dd/yyyy) _____

d. Is this person currently waiting for a decision on charges? ☐Yes ☐No

2. Has anyone on this application had a **pregnancy end** (giving birth or losing a pregnancy) in the past three months or is **currently pregnant**?

☐ **YES. If yes,** answer questions a–d. ☐ **NO. If no,** go to question 3.

a. Who? _____

b. What is the due date or the last date of pregnancy? (mm/dd/yyyy) _____

c. How many children are/were expected with this pregnancy? _____

d. Would this person like to be referred to WIC (a program that offers food to women, infants & children)? ☐Yes ☐No

3. Is anyone on this application **American Indian or Alaska Native**?

☐ **YES. If yes,** complete **Appendix C** and mail it with this application. ☐ **NO. If no,** go to question 4.

4. Does anyone applying for health coverage on this application need help with activities of daily living (like bathing, dressing, etc.) or live in a medical facility or nursing home?

☐ **YES. If yes,** who? _____ ☐ **NO. If no,** go to question 5.

5. Is anyone that is applying for coverage on this application **blind or permanently disabled**?

☐ **YES. If yes,** who? _____ ☐ **NO. If no,** go to question 6.

6. Does anyone in your household that is applying for health coverage on this application currently have **other healthcare coverage,** including dental and major medical coverage that is not Medicaid or KCHIP?

☐ **YES. If yes,** answer questions a–h. ☐ **NO. If no,** go to question 7.

a. Who? _____

b. Type of coverage _____

c. Name of policy holder _____

d. Name of insurance company _____

e. Address of insurance company _____

f. Policy number _____

g. Coverage start date _____

h. Coverage end date _____

7. Was anyone in your household receiving Medicaid when he/she became too old to be eligible for foster care placement? ☐ **YES. If yes,** who? _____

In what state did he/she live? _____ How old was he/she? _____

☐ **NO. If no,** go to **Step 4**.

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EMPLOYEE and EMPLOYER Information

Health Reimbursement Arrangement (HRA): Give us information about the HRA.

8. Employee Name (First, Middle, Last)		
9. Employer Name	10. Employer Identification Number (EIN)	
11. Employer Address		
12. City	13. State	14. Zip Code
15. Employer Contact Name	16. Employer Contact Phone Number	

17. Who all have offer of HRA by this employer?

a. Does this employer currently **offer HRA** to anyone on your health coverage application?
☐**YES. If yes**, list the names of the persons who are **offered HRA (Check the box if offered coverage in ICHRA or QSEHRA for each person below)**
☐ an Individual Coverage HRA (ICHRA) ☐ a Qualified Small Employer HRA (QSEHRA)
Name:
Name:
☐ **NO**. **If no**, go to j.

18. Who are enrolled in HRA by this employer?

b. Does this employer currently offer HRA to anyone on your health coverage application?
☐**YES. If yes**, list the names of the persons who are **offered HRA (Check the box if offered coverage in ICHRA or QSEHRA for each person below)**
☐ an Individual Coverage HRA (ICHRA) ☐ a Qualified Small Employer HRA (QSEHRA)
Name:
Name:
☐ **NO**. **If no**, go to j.

19. Tell us about the HRA provided by this employer

a. What is the Start Date and the End Date of the HRA?
   i. HRA start date (mm/dd/yyyy): _____
   ii. HRA end date (mm/dd/yyyy): _____

b. What is the maximum self-only amount of reimbursement offered by this employer? $_____

c. How often will this amount be available? ☐Weekly ☐Twice a month ☐Monthly

d. If you have an offer of ICHRA and are not yet enrolled,
   i. Will you on [60 days from current date] be able to use the HRA? ☐ Yes ☐ No
   ii. Do you plan to opt-out of this HRA, if found eligible for payment assistance? ☐ Yes ☐ No

STEP 4 Income and Deductions

Use additional sheets of paper if you need to add more than two jobs.

Income from Job 1	1. Who earns this income?	2. Who is this person's employer?

3. What is the **gross** amount this person makes (**before** taxes)?
$

4. How often? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly

5. **IF SELF-EMPLOYED**
a. Type of work _____

b. **Gross** Income _____
c. Self-employment **Expenses** _____
d. **NET** income (Gross minus expenses)

e. How often? _____

Income from Job 2	6. Who earns this income?	7. Who is this person's employer?

8. What is the **gross** amount this person makes (before taxes)?
$

9. How often? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly

10. **IF SELF-EMPLOYED**
a. Type of work _____

b. **Gross** Income _____
c. Self-employment **Expenses** _____
d. **NET** income (Gross minus expenses)

e. How often? _____

11. **Additional Income:** Give us information about any additional income that household members on this application may receive. Do not include income from child support, Supplemental Security Income (SSI),veteran's income, or Worker's Compensation. **If none, leave blank.**

Type of Income	Who Receives it?	How Much?	How Often?
☐ Social Security		$	☐ Weekly ☐ Biweekly ☐ Twice a month ☐ Monthly ☐ Quarterly
☐ Pensions		$	☐ Weekly ☐ Biweekly ☐ Twice a month ☐ Monthly ☐ Quarterly
☐ Interest or Dividend		$	☐ Weekly ☐ Biweekly ☐ Twice a month ☐ Monthly ☐ Quarterly
☐ Disability Payments		$	☐ Weekly ☐ Biweekly ☐ Twice a month ☐ Monthly ☐ Quarterly
☐ Unemployment		$	☐ Weekly ☐ Biweekly ☐ Twice a month ☐ Monthly ☐ Quarterly
☐ Other _____		$	☐ Weekly ☐ Biweekly ☐ Twice a month ☐ Monthly ☐ Quarterly

12. **Household Deductions:** Give us information about things that members of your household pay and that can be deducted on an income tax return. Giving us this information could make the cost of healthinsurance lower. **If none, leave blank.**

Type of Deduction	Who?	How much?	How often?
☐ Alimony Paid		$	☐ Weekly ☐ Twice a month ☐ Monthly
☐ Student Loan Interest		$	☐ Weekly ☐ Twice a month ☐ Monthly
☐ Other		$	☐ Weekly ☐ Twice a month ☐ Monthly

If you need help with your application or to apply faster online, go to www.kynect.ky.gov or call **1-855-4kynect (459-6328)**. Para ayuda en Español, llame gratis al 1-855-4kynect (459-6328).

13. **Yearly Household Income**: What is your estimated **yearly** household income for the coverage year (including any monthly changes, bonuses, seasonal income, etc., and excluding total deductions)?

$ _____

STEP 5 Sign and Date this Application

- I am signing this application under penalty of perjury which means I have given true answers to all the questions on this form to the best of my knowledge and belief. I know that I may be subject to penalties under federal and/or state law if I provide false and/or untrue information.
- I know that I must tell kynect if anything changes from what I wrote on this application within 30 days of the change. I can visit **kynect.ky.gov** or call **1-855-4kynect (459-6328)** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- If I think kynect has made a mistake, I can appeal its decision. To appeal means to tell someone at kynect 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 under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I understand that kynect will check my answers using information in databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or any other trusted source. If the information does not match, I may be asked to send proof.

Renewal of coverage in future years: To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow kynect to use income data, including information from tax returns and other trusted data sources. kynect will send me a notice, let me make any changes, and I can opt out at any time.
Yes, renew my eligibility automatically for the next: (select one)
☐ 5 years (maximum allowed) ☐4 years ☐3 years ☐2 years ☐1 year
☐ Do not use information from tax returns or other data sources to renew my coverage.

Consent on Termination of Coverage: If anyone on my application is enrolled in kynect and is later found to have other qualifying health coverage (like Medicare, Medicaid, or KCHIP), kynect will automatically end their kynect medical plan and dental coverage. I acknowledge that this will help make sure that anyone who is found to have other qualifying coverage will not stay enrolled in kynect medical and dental coverage where they would have to pay full cost. ☐**Yes**, I agree ☐**No**, I disagree

Voter Registration: If I am not registered to vote or not registered where I currently live, I can choose to register to vote by checking yes below. If I check yes, I will receive a voter registration application in the mail. Checking yes or no below does not affect the outcome of this application.
☐ **Yes**, I want to apply to register to vote. An application will be mailed to me. ☐**No**, I don't want to register to vote.

If anyone on this application is eligible for Medicaid or KCHIP:

- I understand that if Medicaid pays for a medical expense, any other health insurance or legal settlement payments will go to Medicaid to reimburse it for the expense.
- I understand that my application may be reviewed to make sure that eligibility was determined correctly. If my application is reviewed, I must cooperate with the review.
- Does any child on this application have a parent living outside of the home? ☐Yes ☐No
- If yes, I give the Cabinet for Health and Family Services (CHFS), Child Support Office, the right to enforce medical support from the child's absent parent(s). If I think that cooperating with the Child Support Office will harm me or my children, I can tell CHFS and I may not have to cooperate.

Signature	Date (mm/dd/yyyy)