Family-Related Medical Assistance Application



Fl Vrida KidCare

Form Approved DCF No. CF-ES 2370, Sep 2015 [65A-1.205, F.A.C.]





Use this application to see what coverage choices you qualify for

- Free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP)
- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage



Who can use this application?

- Use this application to apply for anyone in your family,
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- If you're single, you may be able to use a short form.
- Visit <u>HealthCare.gov.</u>
- 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.
- If someone is helping you fill out this application, you may need to complete Appendix C.



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.



Apply faster online

Apply faster online at www.myflorida.com/accessflorida.



What you may need to apply

- 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, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family
- If we ask you for documents, please send copies. Do not send originals.



What happens next?

Send your complete, signed application to the address on page 7.

If you don't have all the information we ask for, sign and submit

your application anyway. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, visit

www.myflorida.com/accessflorida or call **1-866-762-2237**. Filling out this application doesn't mean you have to buy health coverage.



Get help with this application

- Online: www.myflorida.com/accessflorida
- Phone: Call our Call Center at 1-866-762-2237.
- In person: There may be Community Partners in your area who can help.
- Visit our website or call
 1-866-762-2237 for more information.



NEED HELP WITH YOUR APPLICATION? Visit www.mvflorida.com/accessflorida or call us at 1-866-762-2237. Para obtener una copia de este formulario en Español, llame 1-866-762-2237. If you need help in a language other than English, call 1-866-762-2237 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-995-8771.

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STEP 1 Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

1. First name, Middle name, Last name & Su	ıffix			
2. Date of birth (mm/dd/yyyy)		3. Sex Male	Female	
4. Social Security number (SSN)		If none, date SSN	applied for (mm/de	1/vvvv)
We need this if you want health coverage and ha up the application process. We use SSNs to check wants help getting an SSN, call 1-800-772-1213 or v	ve a SSN. Providing your	SSN can be helpful if you d	on't want health cove	
5. Home address (Leave blank if you don't h	nave one.)			partment or suite numbe
7. City	8. State	9. ZIP code	10. County	
11. Mailing address (if different from home ad	ddress)		12. A	partment or suite numbe
13. City	14. State	15. ZIP code	16. County	
17. Home Phone number		18. Cell phone number		
		() -		
19. Email address:				
Do you want to get information about this a	pplication by email? [Yes No		
20. What is your preferred spoken or written	languago (if not Engli	ab)2		
What is your preferred spoken or written	i ialiguage (ir not Engli	sn)?		
 Do you plan to file a federal income tax i federal income tax return.) 	return NEXT YEAR? (You can still apply for he	ealth insurance eve	n if you don't file a
YES. If yes, please answer questions a-	-c.	NO. If no, skip to que	estion c.	
a. Will you file jointly with a spouse? 🗌 Ye	es 🗌 No			
If yes, name of spouse:				
b. Will you claim any dependents on your to	ax return? 🗌 Yes 🔲 I	No		
If yes, list name(s) of dependents:				
c. Will you be claimed as a dependent on s	someone's tax return?	☐ Yes ☐ No		
If yes, please list the name of the tax file	er:			
How are you related to the tax filer? —				
22. Are you pregnant? 🗌 Yes 🔲 No a. If y	es, how many babies a	re expected during this	pregnancy?	
23. Do you need health coverage? (Even if you have insurance, there might be				
YES. If yes, answer all the questions be	elow.	NO. If no, SKIP to t Leave the rest of th	he income question	ns on page 2.
24. Do you have a physical, mental, or emotio chores, etc.) or live in a medical facility or nur	onal health condition the	nat causes limitations in	activities (like bath	ing, dressing, daily
25. Are you a U.S. citizen or U.S. national? 🔲 Y	∕es □ No			
25. Are you a U.S. citizen or U.S. national? Ye. Ref. If you aren't a U.S. citizen or U.S. national Yes. Fill in your document type and ID n	I, do you have eligible	immigration status?		
	I, do you have eligible	immigration status? b. Document ID numb	or.	

NEED HELP WITH YOUR APPLICATION? Visit www.myflorida.com/accessflorida or call us at 1-866-762-2237. Para obtener una copia de este formulario en Español, llame 1-866-762-2237. If you need help in a language other than English, call 1-866-762-2237 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-995-8771.

STEP 1 (Continue with yourself)

- S - Harris Hold D	aving for modical	hills from the lest 7			
		bills from the last 3 mo			
			are you the main pers	on taking care	of this child? Yes No
29. Are you a full-time s			I ∐ Yes	ou in Florida fo	ster care at age 18 or older?
31. If Hispanic/Latino, e Mexican Mexican	ethnicity (OPTION n American 🔲 C	IAL—check all that app	can Cuban C	Othor	
32. Race (OPTIONAL—			edii	other	
☐ White ☐ Black or African American	American In Alaska Nativ	dian or Filipino	☐ Vietnam☐ Other A:☐ Native H	sian	Guamanian or Chamorro Samoan Other Pacific Islander
Current Job &	Chinese	io una ati a m			Other
_	income in	ormation			
Employed If you're currently of us about your inco question 33.	employed, tell ome. Start with	Not employed Skip to questi		Self-emp Skip to q	loyed uestion 43.
CURRENT JOB 1:					
33. Employer name and	address				34. Employer phone number
35. Wages/tips (before t	axes) 🗌 Hourly	☐ Weekly ☐ Every	2 weeks Twice a	a month M	onthly Yearly
36. Average hours worke	ed each WEEK				
CURRENT JOB 2: (If	f you have more i	obs and need more spa	co attach another sk		
37. Employer name and a	addross	- The trial freed friore spa		eet of paper.)	
					38. Employer phone number () –
39. Wages/tips (before to	axes)	☐ Weekly ☐ Every	2 weeks 🔲 Twice a	month M	onthly Yearly
		☐ Weekly ☐ Every	2 weeks 🔲 Twice a	month M	onthly Yearly
P 40. Average hours worke	ed each WEEK				
P	ed each WEEK y income is differ	ent from the income yo	u listed above, use th	is space to tell	us why.
40. Average hours worke 11. If your normal monthly 12. In the past year, did y	ed each WEEK y income is differ	ent from the income yo		is space to tell	
39. Wages/tips (before to a second se	ed each WEEK y income is difference you:	ent from the income yo obs	u listed above, use the Start working feworking feworking feworking feworking feworking feworking paid) will you	er hours \(\sum \) N et income (prouglet from this	us why. one of these fits once business expenses are self-employment this month?
2. In the past year, did y 3. If self-employed, answa. Type of work 4. OTHER INCOME 1 OTE: You do not need to	you: Change jower the following	ent from the income your bobs Stop working questions:	u listed above, use the Start working fework b. How much no paid) will you	er hours Net income (pro	us why. one of these fits once business expenses are self-employment this month?
2. In the past year, did y 3. If self-employed, anso a. Type of work 4. OTHER INCOME 1 OTE: You do not need to upplemental Security Income	you: Change jower the following	ent from the income your bobs Stop working questions:	u listed above, use the Start working fework b. How much no paid) will you	er hours Net income (pro	us why. one of these fits once business expenses are self-employment this month?
O. Average hours worke 1. If your normal monthly 2. In the past year, did y 3. If self-employed, answ a. Type of work 4. OTHER INCOME 1 OTE: You do not need to upplemental Security Income None Unemployment	you: Change jower the following THIS MONTH: to tell us about chicome (SSI).	ent from the income you be Stop working questions: Check all that apply, and I'd support, Veteran's Advisor often?	u listed above, use the Start working fework b. How much no paid) will you	er hours Net income (prouget from this d how often yourment, worker	us why. Jone of these fits once business expenses are self-employment this month? Juget it. s' compensation, or
2. In the past year, did y 3. If self-employed, anso a. Type of work 4. OTHER INCOME 1 OTE: You do not need to upplemental Security Income None Unemployment Pensions	you: Change jower the following THIS MONTH: to tell us about chicome (SSI).	ent from the income you be Stop working questions: Check all that apply, and lid support, Veteran's Additional points.	b. How much n paid) will you	et income (prou get from this d how often your syment, worker ing \$	us why. one of these fits once business expenses are self-employment this month? u get it. s' compensation, or How often?
2. In the past year, did y 3. If self-employed, answa. Type of work 4. OTHER INCOME 1 OTE: You do not need to applemental Security Income Unemployment Pensions Social Security	you: Change jower the following THIS MONTH: to tell us about change (SSI). \$ How \$ How	ent from the income you be Stop working questions: Check all that apply, and I'd support, Veteran's Advisor often?	b. How much n paid) will you start working few start working few did not be the same and ministration (VA) part of the same start of the s	et income (prou get from this d how often you ment, worker ing \$	us why. lone of these fits once business expenses are self-employment this month? ou get it. s' compensation, or How often? How often?
2. In the past year, did y 3. If self-employed, anso a. Type of work 4. OTHER INCOME 1 OTE: You do not need to upplemental Security Income None Unemployment Pensions	you: Change jower the following THIS MONTH: to tell us about change (SSI). \$ How \$ How \$ How	ent from the income you be Stop working questions: Check all that apply, and id support, Veteran's Additional often?	b. How much n paid) will you start working few start working will you start and ministration (VA) patch will be start working with the start working start	et income (prou get from this d how often youngent, workering \$	us why. one of these fits once business expenses are self-employment this month? u get it. s' compensation, or How often?

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STEP 1 (Continue with yourself)

45. DEDUCTIONS: Check all that apply, and give the amount a	nd how often you get it					
r you pay for certain things that can be deducted on a federal incoverage a little lower. Note : Refer to the Adjusted Gross Income You shouldn't include a cost that you already considered in your ar	ome tax return, telling us about them could make the cost of health					
Alimony paid \$ How often? Other deductions \$ How often? Type:						
46. YEARLY INCOME: Complete only if your income changes If you don't expect changes to your monthly income, skip to the ne	fram month to					
Your total income this year \$	Your total income next year (if you think it will be different)					

THANKS! This is all we need to know about you.

STEP 2 Tell us about your family.

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage).

DO Include:

- Your spouse
- Your children under 21 who live with you
- · Your unmarried partner who needs health coverage
- 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 unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- 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

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with other adults and children.

IF YOU HAVE MORE THAN 2 PEOPLE IN YOUR FAMILY, YOU'LL NEED TO MAKE A COPY OF THE PAGES AND ATTACH THEM.

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.

Health Care Coverage for your Family



8

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STEP 2: NEXT PERSON

Complete Step 2 for your spouse/partner, and children who live with you and/or anyone included on your federal income tax return if you file one. See page 3 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you. **NOTE: If you have more than two people to include, make a copy of Step 2: Next Person and complete.**

1. First name, Middle name, Last name, & S	Suffix			2. Relationship to you?
				Januariania La you.
3. Date of birth (mm/dd/yyyy)		4. Sex Male Fema	ale	
5. Social Security number (SSN)		If none date SSN	l applied for	
We need this if you want health covera	ge for this person and t	hey have an SSN,	applied for	
Does the NEXT PERSON live at the sam If no, list address;	e address as you? 🗌 Ye	s No		
7. Does the NEXT PERSON plan to file a for	adoral Income towards	Almara area		
(Tou can still apply for health insurance	even if you don't file a fe	ederal income tax return.)		
YES. If yes, please answer questions	a-c.	NO. If no, skip to ques	stion c.	
a. Will the NEXT PERSON file jointly wit	th a spouse? 🗌 Yes 🔲	No		
If yes, name of spouse:				
b. Will the NEXT PERSON claim any dep		x return? Yes No		
If yes, list name(s) of dependents:				
c. Will the NEXT PERSON be claimed as	a dependent on someo	ne's tax return? 🗌 Yes 🔲	No	
If yes, please list the name of the tax	filer:			
How is the NEXT PERSON related to	the tax filer?			
3. Is the NEXT PERSON pregnant? Yes	☐ No a. If yes, how r	nany babies are expected o	during this pregna	ncv?
. Does the NEXT PERSON need health co	verage?			· · · · · · · · · · · · · · · · · · ·
(Even if they have insurance, there might				
YES. If yes, answer all the questions		NO. If no, SKIP to the in Leave the rest of this pa	age blank.	
Does the NEXT PERSON have a physica dressing, daily chores, etc) or live in a m	l, mental, or emotional h nedical facility or nursing	ealth condition that causes home? Yes No	limitations in act	ivities (like bathing,
. Is the NEXT PERSON a U.S. citizen or U.S				
2. If the NEXT PERSON isn't a U.S. citizen of	or U.S. national do they	have eligible immigration of		
Yes. Fill in their document type and ID nu	mber below.	nave engible inimigration si	tatus?	
a. Document type		b. Document ID number		
c. Has the NEXT PERSON lived in the U.S	since 1996? Yes N	o d. Is the NEXT PERSON or active-duty member in t	their spouse or par	ent a veteran or an
3. Does the NEXT PERSON want help	14. Does the NEXT PER	SON live with at least one	15 Was the NEW	T DEDCOM: EL
paying for medical bills from the last 3 months?	orma ander the age	or io, and are they the	foster care as	age 18 or older?
Yes No	main person taking	care of this child?	Yes N	
	Yes No			
help you get access to specialized care, if other health condition that has lasted or is	expected to last at least	iz months, please answer t	the following thre	e (3) questions
. Is this NEXT PERSON limited or prevented Yes No	ed in any way in his or h	er ability to do the same th	ings most childre	of the same age do:
Does the NEXT PERSON need to get spe counseling for an emotional, developme	cial therapy, such as phental, or behavioral prob	ysical, occupational or spe	ech therapy, or t	eatment or
Does the NEXT PERSON need or use more of the same age? Yes No			vices than is usu	al for most children
Is the NEXT PERSON a full-time student?	? Yes No		والبرواسوالية	
If Hispanic/Lating attacks to a service				
. If Hispanic/Latino, ethnicity (OPTIONAL Mexican Mexican American Chica	. —	Cuban Other		
NEED HELP WITH YOUR APPLICATION				
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THE TOTAL	-check all that apply.)			
☐ White ☐ Black or African American	American Indian o Alaska Native Asian Indian Chinese	r	☐ Vietnamese☐ Other Asian☐ Native Hawaiiar	Guamanian or Chamorro Samoan Other Pacific Islander Other
Now, te	ell us about any	income from th	e NEXT PERSON	
Current Job &	Income Inform	nation		
if the NEXT PERSO employed, tell us ab Start with question	out their income.	Not employed Skip to question		Self-employed Skip to question 32.
URRENT JOB 1:				
22. Employer name an	d address			27 Fmml
				23. Employer phone number
4. Wages/tips (before	e taxes)	Weekly Every 2 we	eeks Twice a month	Monthly Yearly
5. Average hours wor	ked each WEEK			
URRENT JOB 2:	(If the NEXT PERSON ha	as more jobs and needs	more space, attach anot	her sheet of paper.)
6. Employer name and	d address			27. Employer phone number
				() -
8. Wages/tips (before	taxes) Hourly	Weekly Fvery 2 we	.t. [] = .	
			PKS I I I WICO a month	I Manthi. Dist. 1
			eks	☐ Monthly ☐ Yearly
			eks 🔲 Iwice a month	☐ Monthly ☐ Yearly
9. Average hours work	ked each WEEK			
9. Average hours work	ked each WEEK			☐ Monthly ☐ Yearly Se this space to tell us why.
9. Average hours work	ked each WEEK			
9. Average hours work	ked each WEEK	ome is different from th	e income listed above, us	se this space to tell us why.
9. Average hours work 0. If the NEXT PERSO 1. In the past year, did	ked each WEEK N'S normal monthly income the NEXT PERSON:	ome is different from th		se this space to tell us why.
9. Average hours work 0. If the NEXT PERSO 1. In the past year, did 2. If self-employed, an	ked each WEEK	ome is different from th	e income listed above, us vorking \(\Boxed{\omega}\) Start workin	se this space to tell us why. In a second s
9. Average hours work 0. If the NEXT PERSO 1. In the past year, did	ked each WEEK N'S normal monthly income the NEXT PERSON:	ome is different from th	e income listed above, us vorking	se this space to tell us why. In g fewer hours None of these The opening servences are persented in the servences are servences.
9. Average hours work O. If the NEXT PERSO I. In the past year, did 2. If self-employed, an a. Type of work	ked each WEEK N'S normal monthly income the NEXT PERSON:	ome is different from th Change jobs Stop v	e income listed above, us vorking	ng fewer hours None of these ne (profits once business expenses a PERSON get from this self-employm
9. Average hours work 10. If the NEXT PERSO 1. In the past year, did 12. If self-employed, an 13. Type of work 14. OTHER INCOME	ked each WEEK N'S normal monthly incoming the NEXT PERSON:	ome is different from the Change jobs Stop we stions:	e income listed above, us vorking	se this space to tell us why. In grewer hours None of these The profits once business expenses a person get from this self-employment. The profits once business expenses a person get from this self-employment.
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9. Average hours work 10. If the NEXT PERSO 2. In the past year, did 2. If self-employed, and a. Type of work 3. OTHER INCOME 2. You do not need	ked each WEEK N'S normal monthly incoming the NEXT PERSON:	ome is different from the Change jobs Stop we stions:	e income listed above, us vorking	se this space to tell us why. In grewer hours None of these The profits once business expenses a person get from this self-employments.
D. Average hours work D. If the NEXT PERSO In the past year, did If self-employed, and a. Type of work OTHER INCOME TE: You do not need None	ked each WEEK N'S normal monthly incoming the NEXT PERSON:	Change jobs Stop vestions:	e income listed above, us vorking Start working b. How much net incompaid) will the NEXT F this month? this month?	se this space to tell us why. In grewer hours None of these The (profits once business expenses a person get from this self-employment) The the NEXT PERSON gets it. The or Supplemental Security Income (States)
2. Average hours work 2. If the NEXT PERSO 2. In the past year, did 3. If self-employed, and a. Type of work 3. OTHER INCOME 3. Type do not need 4. None 4. Unemployment 6. Pensions	ked each WEEK N'S normal monthly incoming the NEXT PERSON: The NEXT PERSON: THIS MONTH: Check to tell us about child support to the tell us abou	Change jobs Stop vestions: Sk all that apply, and give poort, veteran's payment on?	e income listed above, us vorking Start working b. How much net incompaid) will the NEXT F this month? this month? the amount and how of workers' compensation Net farming/fishing \$	se this space to tell us why. In grewer hours None of these The (profits once business expenses at the profits once business expenses at the profits self-employment of the profits of th
2. If the NEXT PERSO 2. In the past year, did 3. If self-employed, and a. Type of work 3. OTHER INCOME 3. The past year and the past year and the past year and the past year, did 4. If self-employed, and an	the NEXT PERSON: THIS MONTH: Check to tell us about child superson to tell us about child su	Change jobs Stop vestions: Sk all that apply, and give poort, veteran's payment on?	e income listed above, us working Start working b. How much net incompaid) will the NEXT F this month? the amount and how of workers' compensation Net farming/fishing Net rental/royalty s	se this space to tell us why. In grewer hours None of these The (profits once business expenses a person get from this self-employment of the NEXT PERSON gets it. The supplemental Security Income (State of State of
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NEED HELP WITH YOUR APPLICATION? Visit www.myflorida.com/accessflorida or call us at 1-866-762-2237. Para obtener una copia de este formulario en Español, llame 1-866-762-2237. If you need help in a language other than English, call 1-866-762-2237 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-995-8771.

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f you don't expect changes	omplete only if the NEXT PERSO to the NEXT PERSON's monthly	DN's income changes from month to month. income, add another person or skip to the next section.
The NEXT PERSON'S total in	come this year	The NEXT PERSON'S total income next year (if you think it will different)
THA	NKS! This is all we nee	s to know about the NEXT PERSON
STEP 3 A	merican Indian or A	laska Native (AI/AN) family member(s)
Are you or is anyone	e in your family America	an Indian or Alaska Native?
] If No, skip to Step 4.		
Yes. If yes, go to Appen	dix B.	
STEP 4 M	ur Eamily's Hoalth	
	our Family's Health (
	anyone who needs health cover	
Is anyone enrolled in health YES. If yes, check the type	h coverage now from the follow	ing? ne(s) next to the coverage they have. \[\bigcup \text{NO.} \]
	and the steel half	_
		- ·
— TRIOARE (DOITE CHECK II	you have direct care or Line of Du	Is this COBRA coverage? 🗌 Yes 🔲 No
☐ VA health care programs		Is this a retiree health plan? ☐ Yes ☐ No☐ Other
		Name of person insured:
		Policy number:
		ls this a limited-benefit plan (like a school accident policy
s anyone listed on this appl	lication officer I by Ith	Yes No
		from a job? Check yes even if the coverage is from someone else's
☐ YES. If yes, you'll need to ☐ NO.	complete and include Appendix	A. Is this a state employee benefit plan? Yes No
		en in the last two months for any of these reasons?
1. The cost of an applicant chof your family's income.	ild's health insurance is more than 5%	- The street of providing the applicable child's coverage canceled
2. Domestic violence led to t	ne loss of coverage for an applicant c	hild. 7. The applicant child's coverage ended because the shild received the
applicant child.	ded employer-sponsored coverage fo	P An applicant of the
4. The coverage does not cov	er the applicant child's health care ne insurance coverage for an applicant o	eds. our c, would cause serious disability, loss of function, or death
is deceased.	sa. and coverage for an applicant of	child 9. The applicant child's parent canceled COBRA coverage or the COBRA coverage reached its legal limit. 10. A non-custodial parent dropped the applicant child's coverage.

NEED HELP WITH YOUR APPLICATION? Visit www.mvflorida.com/accessflorida or call us at 1-866-762-2237. Para obtener una copia de este formulario en Español, llame 1-866-762-2237. If you need help in a language other than English, call 1-866-762-2237 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-995-8771.

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STEP 5 Read & sign this application.

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal and state law if I provide false and/or untrue
- I know that I must report if anything changes (and is different than) what I wrote on this application. I understand that a change in my information could affect the eligibility for 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. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not,

If not,	
is incarcerated.	
(name of person)	
know this information will be used to check my eligibility for help paying for health coverage if I choose to apply Well I	

this information will be used to check my eligibility for help paying for health coverage if I choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. We will not tell the United States Citizenship and Immigration Services (USCIS) about the immigration status of those living in your household who are not applying. If the information doesn't match, we may ask you to send us proof.

I understand that the information will be kept confidential in accordance with Florida and federal law.

I authorize the release of personal, financial, and medical information for determining eligibility, conducting research, or providing health care treatment, payment and administration.

I attest that the information provided on this application establishes the identity of children under age 16.

I have read and understood my rights and responsibilities as they apply to the Medicaid program.

If anyone on this application is eligible for Medicaid

- · I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home? \square Yes \square No
- 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 Medicaid and I may not have to cooperate.

You can apply to register to vote here

If you are not registered to vote where you live now, would you like to register to vote here today? Check YES if you would like to apply to register to vote or update your voter registration information. If you check the NO box or do not check a box, you will be considered to have decided not to apply to register to vote or update your voter registration information. Checking YES, NO, or leaving this question blank will not affect your receipt of benefits.

☐ Yes	ΠNo
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Notice of Rights

Help: If you would like help in filling out your voter registration application, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration application in private.

Benefits: If you are applying for public assistance from this agency, applying to register, or declining to register to vote will not affect the amount of assistance you will be provided by this agency.

Privacy: Your decision not to register or update your record and the location where you applied to register or update your voter registration record is confidential and may only be used for voter registration purposes.

Formal Complaint: If you believe someone has interfered with either your right to apply to register or to decline to register to vote, your right to privacy in deciding whether to apply to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with: Florida Secretary of State, Division of Elections, NVRA Administrator, R.A. Gray Building, 500 S. Bronough Street, Tallahassee, Florida 32399-0250. Forms for filing a complaint are available at http://election.dos.state.fl.us/nvra/ index.shtml or call 1-850-245-6200.

[Authority: National Voter Registration Act (42 U.S.C. 1973 gg); ss. 97.023, 97.058 and 97.0585, F.S.]

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STEP 5 Read & sign this application.

My right to appeal

If I think the Department of Children & Families has made a mistake, I can appeal its decision. To appeal means to tell someone at the Department of Children & Families that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Department of Children & Families at 1-866-762-2237. 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.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in Appendix C. You must sign both lines.

Signature	Date (mm/dd/yyyy)
Signature	
o grident	Date (mm/dd/yyyy)
Certify under penalty of porjugations all the children live in	

I certify under penalty of perjury that all the children listed on this application are who I claim them to be.

STEP 6

Mail completed application.

Mail your signed application to:

ACCESS Central Mail Center P.O. Box 1770 Ocala, FL 34478-1770

NEED HELP WITH YOUR APPLICATION? Visit www.myflorida.com/accessflorida or call us at 1-866-762-2237. Para obtener una copia de este formulario en Español, llame 1-866-762-2237. If you need help in a language other than English, call 1-866-762-2237 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-995-8771.

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APPENDIX A

Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the **job** that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

1. Employee name (First, Middle, Last)		2	. Employee S	ocial Security number
EMPLOYER Information				
3. Employer name			Carala and	
			. Employer id	entification Number (EIN)
5. Employer address		6	. Employer ph	one number
7.00)	-
7. City	8. S	tate	9	. ZIP code
O. Who can we contact about employee he	ealth coverage at this job?			
Phone number (if different from above)	12. Email address			
) =	12. Littali address			
3. Are you currently eligible for coverage of				
	eligible for coverage from this jo		(mm/	dd/yyyy)
Name:	eligible for coverage from this jo Name:	b.	(mm/	
	eligible for coverage from this jo Name:	b.	(mm/	
Name: No (Stop here and go to Step 5 in the	eligible for coverage from this jo Name: application)	b.	(mm/	
Name: No (Stop here and go to Step 5 in the ell us about the health plan offered. Does the employer offer a health plan the	eligible for coverage from this jo Name: application) d by this employer. at meets the minimum value sta	ndard*? 🗀 Yo	Name:	
Name: No (Stop here and go to Step 5 in the ell us about the health plan offered). Does the employer offer a health plan the employer has wellness programs and the employer has wellness programs.	eligible for coverage from this jo Name: application) d by this employer. at meets the minimum value staminimum value standard* offere	ndard*? Yes	(mm/	't include family plans):
Name: No (Stop here and go to Step 5 in the left us about the health plan offered. Does the employer offer a health plan the first the employer has wellness programs, p discount for any tobacco cessation program. How much would the employee have	Name: application) d by this employer. at meets the minimum value staminimum value standard* offere rovide the premium that the employer and did not receive any other to pay in premiums for this place to pay in premiums for this place to pay in premiums for this place.	ndard*? Yes d only to the e aployee would p her discounts b	Name:NoNoNoNoNo well with the sased on well reasons with the reasons well reasons well reasons well reasons with the reasons well reasons well reasons well reasons with the reasons well reasons well reasons well reasons with the reasons well reasons well reasons well reasons with the reasons well reasons well reasons well reasons with the reasons well reasons well reasons well reasons with the reasons well reasons well reasons well reasons well reasons with the reasons well reasons well reasons well reasons with the reasons well reason	o't include family plans): received the maximum ness programs.
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*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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APPENDIX B

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
Name (First name, Middle name, Last name)	First Middle	First Middle
	Last	Last
2. Member of a federally recognized tribe?	Yes If yes, tribe name	Yes If yes, tribe name
3. Has this person ever gotten 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	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
 4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application 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?

A	_		_	
AP				
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			- 4	

Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact the Marketplace. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First r	name, Middle name, Last name)	
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number		
		¥
8. Organization name		9. ID number (if applicable)
By signing, you allow this person to sign you on all future matters with this agend	n your application, get official informati cv.	ion about this application, and act for
10. Your signature	-	11. Date (mm/dd/yyyy)
For certified application counselo	rs, navigators, agents, and broke	rs only.
Complete this section if you're a certified somebody else.	d application counselor, navigator, agent	t, or broker filling out this application for
1. Application start date (mm/dd/yyyy)		
2. First name, Middle name, Last name, & Suff	fix	
3. Organization name		4. ID number (if applicable)

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ACCESS Central Mail Center P.O. Box 1770 Ocala, Florida 34478-1770

1-866-762-2237

NONPROFIT ORG. U.S. POSTAGE PAID TALLAHASSEE, FL PERMIT NO. 801

It's easier to apply online at: www.myflorida.com/accessflorida