



Health Coverage Application No Help Paying Costs

THINGS TO KNOW

<p>Who can use this application?</p>	<p>Anyone who needs health coverage and does not want to apply for financial assistance can use this application.</p> <p>You can buy health insurance coverage using this application if:</p> <ol style="list-style-type: none"> 1. You have legal citizenship or are lawfully present 2. You live in Kentucky and plan to stay in Kentucky 3. You are not incarcerated <p>If someone is helping you fill out this application, you may need to complete Appendix B.</p>
<p>To get help with costs</p>	<p>You need to use the <i>Health Coverage & Help Paying Costs</i> application to get help with costs. You could qualify for:</p> <ul style="list-style-type: none"> • Payment Assistance that can help you pay for your health coverage • Free or low-cost coverage from Medicaid or the Kentucky Children’s Health Insurance Program (KCHIP) <p>You may qualify for a free or low-cost program even if you earn as much as \$94,000 a year (for a family of 4). Visit www.kynect.ky.gov or call 1-855-4kynect (459-6328) to learn more.</p>
<p>Apply faster online</p>	<p>Apply faster online at www.kynect.ky.gov</p>
<p>What happens next?</p>	<ul style="list-style-type: none"> • Mail or fax your completed, signed application to: <ul style="list-style-type: none"> Kentucky Office of the Health Benefit and Information Exchange P.O. Box 2104 Frankfort, KY 40602 Fax: 1-502-573-2005 • If you don’t 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.
<p>To get help with this application</p>	<ul style="list-style-type: none"> • 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. • En Español: Llame a nuestro Servicio al Cliente gratis al 1-855- 4kynect (459-6328) • For TTY services call 1-855-326-4654



Health Coverage Application

No Help Paying Costs

STEP 1 Tell Us about Yourself

Complete this step with information about the person that will be the contact on this application (even if the person 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 reason for not providing it.

- Religious Objection
- Not eligible to receive SSN due to alien status
- Applied for SSN
- Do not have an SSN and may only be issued an SSN for a valid non-work reason
- Refuse to provide SSN

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 25-28.

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

6. Gender
 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 allow kynect to send text message alerts to your primary phone number.

21. Check here to allow kynect to send text message alerts to your secondary phone number.

22. Preferred Spoken Language (if not English)

23. Preferred Written Language (if not English)

24. **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. This form will be sent to you via postal mail, or if you create an account on kynect, we can notify you via email instead that the form is ready for viewing. If you would like to be notified via email, enter your email address: _____

25. Are you a U.S. citizen or national?

- Yes No

26. If you are not a U.S. citizen or national, do you have 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. Are you a veteran or active-duty member of the U.S. military? Yes No



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

28. Race - (OPTIONAL)

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

STEP 2 Other Members of the Household

Use additional sheets of paper if you need to add more members of your 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 Not eligible to receive SSN due to alien status Applied for SSN Newborn without SSN
 Do not have an SSN and may only be issued an SSN for a valid non-work reason Refuse to provide SSN

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 11-14.

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

7. Gender

- Male Female

8. Does PERSON 2 live at the same address as you?

- 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. Is PERSON 2 a U.S. citizen or national?

- Yes No

12. If not a U.S. citizen or national, does PERSON 2 have 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. Is PERSON 2 a veteran or active-duty member of the U.S. military? Yes No

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

14. Race - (OPTIONAL)

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



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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. <input type="checkbox"/> Religious Objection <input type="checkbox"/> Not eligible to receive SSN due to alien status <input type="checkbox"/> Applied for SSN <input type="checkbox"/> Newborn without SSN <input type="checkbox"/> Do not have an SSN and may only be issued an SSN for a valid non-work reason <input type="checkbox"/> Refuse to provide SSN			
5. If PERSON 3 is applying for health coverage, check here <input type="checkbox"/> and answer all questions. If PERSON 3 is not applying for health coverage, do not answer questions 11-14.			
6. Date of Birth (mm/dd/yyyy)		7. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
8. Does PERSON 3 live at the same address as you? <input type="checkbox"/> Yes. If yes , do not enter an address below. <input type="checkbox"/> No. If no , enter PERSON 3's address below.			
9. Home Address		10. Mailing Address (Required if different from home address)	
11. Is PERSON 3 a U.S. citizen or national? <input type="checkbox"/> Yes <input type="checkbox"/> No		12. If not a U.S. citizen or national, does PERSON 3 have immigration status? <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No d. Is PERSON 3 a veteran or active-duty member of the U.S. military? <input type="checkbox"/> Yes <input type="checkbox"/> No	
13. Is PERSON 3 of Hispanic, Latino or Spanish origin? (OPTIONAL) <input type="checkbox"/> Yes <input type="checkbox"/> No			
14. Race - (OPTIONAL) <input type="checkbox"/> White <input type="checkbox"/> American Indian <input type="checkbox"/> Filipino <input type="checkbox"/> Vietnamese <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Black or African American <input type="checkbox"/> Alaska Native <input type="checkbox"/> Japanese <input type="checkbox"/> Other Asian <input type="checkbox"/> Samoan <input type="checkbox"/> Chinese <input type="checkbox"/> Asian Indian <input type="checkbox"/> Korean <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander			

STEP 3 Additional Questions

If you answer 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**?

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



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

YES. If yes, answer questions a-b. **NO.** If no, go to question 3.

- a. Who? _____
- b. Is this person a member of a federally recognized tribe, band, nation, community or other group?
 Yes. If yes, answer questions c-d. No. If no, go to question 3.
- c. What tribe? _____
- d. What state is this tribe primarily located in? _____

3. 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–g. **NO.** If no, go to Step 4.

- a. Who? _____
- b. Type of coverage _____
- c. Name of policy holder _____
- d. Name of insurance company _____
- e. Policy number _____
- f. Coverage start date _____
- g. Coverage end date _____

STEP 4 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 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 Social Security and the Department of Homeland Security and/or any other trusted source. If the information does not match, I may be asked to send proof.

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.

Signature	Date (mm/dd/yyyy)
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