APPLICATION FOR HEALTH COVERAGE AND HELP PAYING COSTS

DEPARTMENT OF HEALTH AND HUMAN SERVICES

SFN 1909 (7-2023)

THINGS TO KNOW

Use this application to see what coverage choices you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost insurance from Medicaid

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 applyforhelp.nd.gov
- 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.

Apply faster online

Apply faster online at applyforhelp.nd.gov

What you may need to apply

- Social Security Numbers (or document numbers for any eligible 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.

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.**

What happens next?

Send your complete, signed application and documentation to the Customer Support Center address on page 12. **If you don't have all the information we ask for, sign and submit your application anyway**. We'll follow-up with you within 1-2 weeks. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, visit applyforhelp.nd.gov or call **1-844-854-4825**. Filling out this application doesn't mean you have to buy health coverage**.**

Get help with this application

- **Online**: applyforhelp.nd.gov
- **Telephone**: Call our Help Center at **1-844-854-4825**.
- **In person**: There may be counselors in your area who can help. Visit our website or call **1-844-854-4825** for more information.
- **En Español**: Llame a nuestro centro de ayuda gratis al **1-844-854-4825**.
- Contact your local Human Service Zone. See the Application for Assistance Guidebook for a list of Human Service Zone offices.

NEED HELP WITH YOUR APPLICATION? Visit applyforhelp.nd.gov or call us at **1-844-854-4825**. Para obtener una copia de este formulario en Español, llame **1-844-854-4825**. If you need help in a language other than English, call **1-844-854-4825** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-366-6888**.

APPLICATION FOR HEALTH COVERAGE AND HELP PAYING COSTS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 1909 (7-2023)

Clear Fields

Step 1 Tell Us About You

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

1. First Name, Middle Name, Last Name and Suffix			
2. Home Address (Leave blank if you don't have one)			3. Apartment or Suite Number
4. City	5. State	6. ZIP Code	7. County
8. Mailing Address (If different from home address)			9. Apartment or Suite Number
10. City	11. State	12. ZIP Code	13. County
14. Home Telephone Number	15. Work or Message Telephone Number		16. Cell Phone Number

*** If you are applying for Health Care Coverage and you have entered your residential and mailing address as 'General Delivery', or 'Homeless', or have left it blank, your mail will be sent to the local Human Service Zone office. You will need to arrange to pick up your mail at the location Human Service Zone office on a weekly basis. If you do not pick up your mail for three(3) weeks, your case may be closed due to loss of contact. ****

Would You Like to Receive Text and E-mail Notification

All email and text messages that contain Protected Health Information (PHI) or other confidential information are transmitted encrypted (secure) unless you request and consent to receive unencrypted (unsecure) email and text messages.

The privacy and security of email and text messages cannot be guaranteed. There is some risk that any PHI or other confidential information contained in an email or text message may be misdirected, disclosed to, or intercepted by an unauthorized third party. You should not agree to email and text messages unless you are willing to accept these risks.

The Department of Health and Human Services is not responsible for any fees imposed by your email and text message service providers, email or text messages that are not received due to technical failure, or the improper disclosure of PHI or other confidential information that is not a result of our negligence.

You are responsible for notifying your case worker of any changes to your contact information and if you wish to terminate this request.

I request the following communications (check all that apply):

- ☐ Notice of review for continued eligibility in enrolled programs, or need for full application to determine program eligibility. ☐ Email ☐ Text Message
- ☐ Regular and ongoing communications regarding application, eligibility, enrollment, and participation in enrolled programs. ☐ Email ☐ Text Message

I accept the associated risks and consent to receive:

- ☐ Encrypted (secure) email and text messages as indicated above.
- ☐ Unencrypted (unsecure) email and text messages as indicated above. I understand that unencrypted (unsecure) means the added security protections that safeguard the contents of emails and text messages are removed.

E-Mail Address	Text Message Number
Signature	Date
Preferred Language (Written)	Preferred Language (Spoken)

Step 2 Tell Us About Your Family

What 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).

For adults who need coverage.
Include these people even if they aren't applying for health coverage themselves:

- Any spouse
- Any children under age 21, including stepchildren, who live with you
- Any other person on the same federal income tax return, (including any children over age 21 that are claimed on a parent's tax return)

For children under age 21 who need coverage.
Include these people even if they arent applying for health coverage themselves:

- Any parent (or stepparent) they live with
- Any sibling they live with
- Any spouse they live with
- Any son or daughter they live with, including stepchildren
- Any other person on the same federal income 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 yourself, then add other adults and children. If you have more than 4 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.

Step 2: Person 1 (Start with yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 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.

1. First Name, Middle Name, Last Name and Suffix		2. Relationship to You SELF
3. Date of Birth	4. Sex ☐ Male ☐ Female	5. Social Security Number

We need the Social Security Number if you want health coverage and have a SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit ssa.gov. TTY users should call 1-800-325-0778.

6. Do you plan to file a federal income tax return NEXT YEAR? ☐ Yes - Please answer questions a-c ☐ No - Skip to question c		*(You can still apply for health insurance even if you don't file a federal income tax return.)*
a. Will you file jointly with a spouse? ☐ Yes ☐ No	If yes, Name of Spouse	
b. Will you claim any dependents on your tax return? ☐ Yes ☐ No	If yes, Name(s) of Dependents	
c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No		If yes, Name of 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?	
8. Do you need health coverage? *(Even if you have insurance, there might be a program with better coverage or lower costs.)* ☐ Yes - Answer all questions below ☐ No - Skip to income questions on next page. Leave the rest of this page blank.		
9. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No		
10. Are you a U.S. Citizen or U.S. National? ☐ Yes ☐ No	11. Are you a naturalized or derived citizen? (This usually means you were born outside the U.S.) ☐ Yes - Complete a and b below ☐ No - Continue to Q12	
a. Alien Number	b. Certificate Number	

Step 2: Person 1 (Continue with yourself)

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

Document Type	ID Number
Immigration Document Type	Status Type (optional)
Write Your Name as it Appears on Your Immigration Document	
Alien or I-94 Number	Card Number or Passport Number
SEVIS ID or Expiration Date (optional)	Other (category code or country of issuance)

Have you lived in the U.S. since 1996? ☐ Yes ☐ No

Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

13. Do you want help paying for medical bills from the last 3 months?
☐ Yes ☐ No

14. Do you live with at least one child under the age of 19, and are you the main person taking care of this child(ren)?
☐ Yes ☐ No

If yes, Name of Child(ren)

15. Are you a full-time student? ☐ Yes ☐ No

16. Were you in foster care at age 18 or older? ☐ Yes ☐ No If yes, when: What State:

17. **If Hispanic/Latino, Ethnicity (OPTIONAL - Check all that apply)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other - Specify:

18. **Race (OPTIONAL - Check all that apply)**

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

Current Job and Income Information

☐ Employed
If you're currently employed, tell us about your income. Start with question 19.

☐ Not Employed
Skip to question 27.

☐ Self-employed
Skip to question 28.

Current Job 1

19. Employer Name			20. Employer Telephone Number	
Address	City		State	ZIP Code

21. Wages/Tips (before taxes)

Pay Period
☐ Hourly ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly

22. Average Hours Worked Each WEEK

Step 2: Person 1 (Continue with yourself)

Current Job 2 (If you have more jobs and need more space, attach another sheet of paper.)

23. Employer Name			24. Employer Telephone Number	
Address		City	State	ZIP Code
25. Wages/Tips (before taxes)	Pay Period ☐ Hourly ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly			
26. Average Hours Worked Each WEEK				
27. In the past year, did you: ☐ Change Jobs ☐ Stop Working ☐ Start Working Fewer Hours ☐ None of These				

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

a. Type of Work
b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

29. Other Income This Month Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support or Supplemental Security Income(SSI).

NOTE: (Alimony Received is Only for divorces finalized before 1/1/2019)

	Amount	How Often?		Amount	How Often?
☐ None					
☐ Unemployment	$		☐ Alimony Received	$	
☐ Pensions	$		☐ Net Farming/Fishing	$	
☐ Social Security	$		☐ Net Rental/Royalty	$	
☐ Retirement Accounts	$		☐ Other Income	$	
			Type:		

30. Deductions Check all that apply, and give the amount and how often you pay it.

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. **NOTE:** You shouldn't include a cost that you already considered in your answer to net self-employment (question 28b).

NOTE: (Alimony Paid is Only for divorces finalized before 1/1/2019)

	Amount	How Often?		Amount	How Often?
☐ Alimony Paid	$		☐ Other Adjusted Gross Income Deductions	$	
☐ Student Loan Interest	$		Type:		
☐ Tax Deductible Tuition and Fees	$				

31. Yearly Income Complete only if your income changes from month to month.

If you don't expect changes to your monthly income, skip to the next person.

Your Total Income **This** Year	Your Total Income **Next** Year (if you think it will be different)

Step 2: Person 2

Complete Step 2 for your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 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.

1. First Name, Middle Name, Last Name and Suffix		2. Relationship to You
3. Date of Birth	4. Sex ☐ Male ☐ Female	5. Social Security Number

We need the Social Security Number if you want health coverage and have a SSN.

6. Does Person 2 live at the same address as you? ☐ Yes ☐ No	If no, List Address
7. Does Person 2 plan to file a federal income tax return NEXT YEAR? ☐ Yes - Please answer questions a-c ☐ No - Skip to question c	*(You can still apply for health insurance even if you don't file a federal income tax return.)*
a. Will Person 2 file jointly with a spouse? ☐ Yes ☐ No	If yes, Name of Spouse
b. Will Person 2 claim any dependents on his or her tax return? ☐ Yes ☐ No	If yes, Name(s) of Dependents
c. Will Person 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No	If yes, Name of Tax Filer
How is Person 2 related to the tax filer?	
8. Is Person 2 pregnant? ☐ Yes ☐ No	If yes, how many babies are expected during this pregnancy?
9. Does Person 2 need health coverage? ☐ Yes - Answer all questions below	*(Even if they have insurance, there might be a program with better coverage or lower costs.)* ☐ No - Skip to income questions on next page. Leave the rest of this page blank.
10. Does Person 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No	
11. Is Person 2 a U.S. Citizen or U.S. National? ☐ Yes ☐ No	12. Is Person 2 a naturalized or derived citizen? (This usually means you were born outside the U.S.) ☐ Yes - Complete a and b below ☐ No - Continue to Q13
a. Alien Number	b. Certificate Number
13. If Person 2 is not a U.S. citizen or U.S. national, do they have eligible immigration status ? ☐ Yes - Enter document type and ID number below:	
Document Type	ID Number
Immigration Document Type	Status Type (optional)
Write Your Name as it Appears on Your Immigration Document	
Alien or I-94 Number	Card Number or Passport Number
SEVIS ID or Expiration Date (optional)	Other (category code or country of issuance)
Has Person 2 lived in the U.S. since 1996? ☐ Yes ☐ No	Is Person 2, or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No
14. Does Person 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No	
15. Does Person 2 live with at least one child under the age of 19, and are they the main person taking care of this child(ren)? ☐ Yes ☐ No	
If yes, Name of Child(ren)	
16. Was Person 2 in foster care at age 18 or older? ☐ Yes ☐ No If yes, when:	What State:

Step 2: Person 2 (continued)

Only answer questions 17 and 18 if PERSON 2 is 22 or younger. If Person 2 is 23 or older, start with question 19.

17. Did Person 2 have insurance through a job and lose it within the past 3 months?
☐ Yes ☐ No

a. If yes, End Date	b. Reason the Insurance Ended	18. Is Person 2 a full-time student? ☐ Yes ☐ No

19. **If Hispanic/Latino, Ethnicity (OPTIONAL - Check all that apply)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other - Specify:

20. **Race (OPTIONAL - Check all that apply)**

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

Current Job and Income Information

☐ Employed
If Person 2 is currently employed, tell us about their income. Start with question 21.

☐ Not Employed
Skip to question 29.

☐ Self-employed
Skip to question 30.

Current Job 1

21. Employer Name			22. Employer Telephone Number	
Address		City	State	ZIP Code
23. Wages/Tips (before taxes)	Pay Period ☐ Hourly ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly			
24. Average Hours Worked Each WEEK				

Current Job 2 (If you have more jobs and need more space, attach another sheet of paper.)

25. Employer Name			26. Employer Telephone Number	
Address		City	State	ZIP Code
27. Wages/Tips (before taxes)	Pay Period ☐ Hourly ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly			
28. Average Hours Worked Each WEEK				

29. In the past year, did Person 2:
☐ Change Jobs ☐ Stop Working ☐ Start Working Fewer Hours ☐ None of These

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

a. Type of Work

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

Step 2: Person 2 (continued)

31. Other Income This Month Check all that apply, and give the amount and how often you get it.
NOTE: You don't need to tell us about child support or Supplemental Security Income(SSI).
NOTE: (Alimony Received is Only for divorces finalized before 1/1/2019)

	Amount	How Often?
☐ None		
☐ Unemployment	$	
☐ Pensions	$	
☐ Social Security	$	
☐ Retirement Accounts	$	

	Amount	How Often?
☐ Alimony Received	$	
☐ Net Farming/Fishing	$	
☐ Net Rental/Royalty	$	
☐ Other Income	$	

Type:

32. Deductions Check all that apply, and give the amount and how often you pay it.
If Person 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. **NOTE:** You shouldn't include a cost that you already considered in your answer to net self-employment (question 30b).
NOTE: (Alimony Paid is Only for divorces finalized before 1/1/2019)

	Amount	How Often?
☐ Alimony Paid	$	
☐ Student Loan Interest	$	
☐ Tax Deductible Tuition and Fees	$	

	Amount	How Often?
☐ Other Adjusted Gross Income Deductions	$	

Type:

33. Yearly Income Complete only if Person 2's income changes from month to month.
If you don't expect changes to Person 2's monthly income, skip to next person or Step 3.

Person 2's Total Income This Year	Person 2's Total Income Next Year (if you think it will be different)

Step 2: Person 3

Complete Step 2 for your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 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.

1. First Name, Middle Name, Last Name and Suffix		2. Relationship to You
3. Date of Birth	4. Sex ☐ Male ☐ Female	5. Social Security Number

We need the Social Security Number if you want health coverage and have a SSN.

6. Does Person 3 live at the same address as you? ☐ Yes ☐ No	If no, List Address
7. Does Person 3 plan to file a federal income tax return NEXT YEAR? ☐ Yes - Please answer questions a-c ☐ No - Skip to question c	*(You can still apply for health insurance even if you don't file a federal income tax return.)*
a. Will Person 3 file jointly with a spouse? ☐ Yes ☐ No	If yes, Name of Spouse
b. Will Person 3 claim any dependents on his or her tax return? ☐ Yes ☐ No	If yes, Name(s) of Dependents
c. Will Person 3 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No	If yes, Name of Tax Filer
How is Person 3 related to the tax filer?	
8. Is Person 3 pregnant? ☐ Yes ☐ No	If yes, how many babies are expected during this pregnancy?
9. Does Person 3 need health coverage? ☐ Yes - Answer all questions below	*(Even if they have insurance, there might be a program with better coverage or lower costs.)* ☐ No - Skip to income questions on next page. Leave the rest of this page blank.
10. Does Person 3 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No	
11. Is Person 3 a U.S. Citizen or U.S. National? ☐ Yes ☐ No	12. Is Person 3 a naturalized or derived citizen? (This usually means you were born outside the U.S.) ☐ Yes - Complete a and b below ☐ No - Continue to Q13
a. Alien Number	b. Certificate Number
13. If Person 3 is not a U.S. citizen or U.S. national, do they have eligible immigration status ? ☐ Yes - Enter document type and ID number below:	
Document Type	ID Number
Immigration Document Type	Status Type (optional)
Write Your Name as it Appears on Your Immigration Document	
Alien or I-94 Number	Card Number or Passport Number
SEVIS ID or Expiration Date (optional)	Other (category code or country of issuance)
Has Person 3 lived in the U.S. since 1996? ☐ Yes ☐ No	Is Person 3, or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No
14. Does Person 3 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No	
15. Does Person 3 live with at least one child under the age of 19, and are they the main person taking care of this child(ren)? ☐ Yes ☐ No	
If yes, Name of Child(ren)	
16. Was Person 3 in foster care at age 18 or older? ☐ Yes ☐ No If yes, when:	What State:

Step 2: Person 3 (continued)

Only answer questions 17 and 18 if PERSON 3 is 22 or younger. If Person 3 is 23 or older, start with question 19.

17. Did Person 3 have insurance through a job and lose it within the past 3 months?
☐ Yes ☐ No

a. If yes, End Date	b. Reason the Insurance Ended	18. Is Person 3 a full-time student? ☐ Yes ☐ No

19. **If Hispanic/Latino, Ethnicity (OPTIONAL - Check all that apply)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other - Specify:

20. **Race (OPTIONAL - Check all that apply)**

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

Current Job and Income Information

☐ Employed If Person 3 is currently employed, tell us about their income. Start with question 21.	☐ Not Employed Skip to question 29.	☐ Self-employed Skip to question 30.

Current Job 1

21. Employer Name			22. Employer Telephone Number	
Address	City		State	ZIP Code
23. Wages/Tips (before taxes)	Pay Period ☐ Hourly ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly			
24. Average Hours Worked Each WEEK				

Current Job 2 (If you have more jobs and need more space, attach another sheet of paper.)

25. Employer Name			26. Employer Telephone Number	
Address	City		State	ZIP Code
27. Wages/Tips (before taxes)	Pay Period ☐ Hourly ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly			
28. Average Hours Worked Each WEEK				

29. In the past year, did Person 3:
☐ Change Jobs ☐ Stop Working ☐ Start Working Fewer Hours ☐ None of These

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

a. Type of Work

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

Step 2: Person 3 (continued)

31. Other Income This Month Check all that apply, and give the amount and how often you get it.
NOTE: You don't need to tell us about child support or Supplemental Security Income(SSI).
NOTE: (Alimony Received is Only for divorces finalized before 1/1/2019)

	Amount	How Often?
☐ None		
☐ Unemployment	$	
☐ Pensions	$	
☐ Social Security	$	
☐ Retirement Accounts	$	

	Amount	How Often?
☐ Alimony Received	$	
☐ Net Farming/Fishing	$	
☐ Net Rental/Royalty	$	
☐ Other Income	$	

Type:

32. Deductions Check all that apply, and give the amount and how often you pay it.
If Person 3 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. **NOTE:** You shouldn't include a cost that you already considered in your answer to net self-employment (question 30b).
NOTE: (Alimony Paid is Only for divorces finalized before 1/1/2019)

	Amount	How Often?
☐ Alimony Paid	$	
☐ Student Loan Interest	$	
☐ Tax Deductible Tuition and Fees	$	

	Amount	How Often?
☐ Other Adjusted Gross Income Deductions	$	

Type:

33. Yearly Income Complete only if Person 3's income changes from month to month.
If you don't expect changes to Person 3's monthly income, skip to next person or Step 3.

Person 3's Total Income This Year	Person 3's Total Income Next Year (if you think it will be different)

If you have more than 4 people to include, make a copy of Step 2: Person 4 (pages 8 and 9) and complete.

Step 2: Person 4

Complete Step 2 for your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 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.

1. First Name, Middle Name, Last Name and Suffix		2. Relationship to You
3. Date of Birth	4. Sex ☐ Male ☐ Female	5. Social Security Number

We need the Social Security Number if you want health coverage and have a SSN.

6. Does Person 4 live at the same address as you? ☐ Yes ☐ No	If no, List Address
7. Does Person 4 plan to file a federal income tax return NEXT YEAR? ☐ Yes - Please answer questions a-c ☐ No - Skip to question c	*(You can still apply for health insurance even if you don't file a federal income tax return.)*
a. Will Person 4 file jointly with a spouse? ☐ Yes ☐ No	If yes, Name of Spouse
b. Will Person 4 claim any dependents on his or her tax return? ☐ Yes ☐ No	If yes, Name(s) of Dependents
c. Will Person 4 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No	If yes, Name of Tax Filer
How is Person 4 related to the tax filer?	
8. Is Person 4 pregnant? ☐ Yes ☐ No	If yes, how many babies are expected during this pregnancy?
9. Does Person 4 need health coverage? ☐ Yes - Answer all questions below	*(Even if they have insurance, there might be a program with better coverage or lower costs.)* ☐ No - Skip to income questions on next page. Leave the rest of this page blank.
10. Does Person 4 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No	
11. Is Person 4 a U.S. Citizen or U.S. National? ☐ Yes ☐ No	12. Is Person 4 a naturalized or derived citizen? (This usually means you were born outside the U.S.) ☐ Yes - Complete a and b below ☐ No - Continue to Q13
a. Alien Number	b. Certificate Number
13. If Person 4 is not a U.S. citizen or U.S. national, do they have eligible immigration status ? ☐ Yes - Enter document type and ID number below:	
Document Type	ID Number
Immigration Document Type	Status Type (optional)
Write Your Name as it Appears on Your Immigration Document	
Alien or I-94 Number	Card Number or Passport Number
SEVIS ID or Expiration Date (optional)	Other (category code or country of issuance)
Has Person 4 lived in the U.S. since 1996? ☐ Yes ☐ No	Is Person 4, or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No
14. Does Person 4 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No	
15. Does Person 4 live with at least one child under the age of 19, and are they the main person taking care of this child(ren)? ☐ Yes ☐ No	
If yes, Name of Child(ren)	
16. Was Person 4 in foster care at age 18 or older? ☐ Yes ☐ No If yes, when:	What State:

Step 2: Person 4 (continued)

Only answer questions 17 and 18 if PERSON 4 is 22 or younger. If Person 4 is 23 or older, start with question 19.

17. Did Person 4 have insurance through a job and lose it within the past 3 months?
☐ Yes ☐ No

a. If yes, End Date	b. Reason the Insurance Ended	18. Is Person 4 a full-time student? ☐ Yes ☐ No

19. **If Hispanic/Latino, Ethnicity (OPTIONAL - Check all that apply)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other - Specify:

20. **Race (OPTIONAL - Check all that apply)**

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

Current Job and Income Information

☐ Employed If Person 4 is currently employed, tell us about their income. Start with question 21.	☐ Not Employed Skip to question 29.	☐ Self-employed Skip to question 30.

Current Job 1

21. Employer Name			22. Employer Telephone Number	
Address		City	State	ZIP Code
23. Wages/Tips (before taxes)	Pay Period ☐ Hourly ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly			
24. Average Hours Worked Each WEEK				

Current Job 2 (If you have more jobs and need more space, attach another sheet of paper.)

25. Employer Name			26. Employer Telephone Number	
Address		City	State	ZIP Code
27. Wages/Tips (before taxes)	Pay Period ☐ Hourly ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly			
28. Average Hours Worked Each WEEK				

29. In the past year, did Person 4:
☐ Change Jobs ☐ Stop Working ☐ Start Working Fewer Hours ☐ None of These

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

a. Type of Work
b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

Step 2: Person 4 (continued)

31. Other Income This Month Check all that apply, and give the amount and how often you get it.
NOTE: You don't need to tell us about child support or Supplemental Security Income(SSI).
NOTE: (Alimony Received is Only for divorces finalized before 1/1/2019)

	Amount	How Often?
☐ None		
☐ Unemployment	$	
☐ Pensions	$	
☐ Social Security	$	
☐ Retirement Accounts	$	

	Amount	How Often?
☐ Alimony Received	$	
☐ Net Farming/Fishing	$	
☐ Net Rental/Royalty	$	
☐ Other Income	$	

Type:

32. Deductions Check all that apply, and give the amount and how often you pay it.
If Person 4 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. **NOTE:** You shouldn't include a cost that you already considered in your answer to net self-employment (question 30b).
NOTE: (Alimony Paid is Only for divorces finalized before 1/1/2019)

	Amount	How Often?
☐ Alimony Paid	$	
☐ Student Loan Interest	$	
☐ Tax Deductible Tuition and Fees	$	

	Amount	How Often?
☐ Other Adjusted Gross Income Deductions	$	

Type:

33. Yearly Income Complete only if Person 4's income changes from month to month.
If you don't expect changes to Person 4's monthly income, skip to next person or Step 3.

Person 4's Total Income This Year	Person 4's Total Income Next Year (if you think it will be different)

Step 3 American Indian or Alaska Native (AI/AN) Family Member(s)

1. Are you or is anyone in your family American Indian or Alaska Native?

☐ Yes - Go to Appendix B ☐ No - Skip to Step 4

Step 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. Is anyone enrolled in health coverage now from the following?

☐ Yes - Check the type of coverage and write the person(s)' name(s) next to the coverage they have ☐ No

☐ Medicaid _____

☐ Medicare _____

☐ Employer Insurance _____

☐ TRICARE (Don't check if you have direct care or Line of Duty) _____

☐ VA Health Care Programs _____

☐ Peace Corps _____

Name of Health Insurance	Policy Number	Is this COBRA coverage? ☐ Yes ☐ No	Is this a retiree health plan? ☐ Yes ☐ No

☐ Other _____

Name of Health Insurance	Policy Number	Is this a limited-benefit plan (like a school accident policy)? ☐ Yes ☐ No

2. Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone else's job, such as a parent or spouse.

☐ Yes - You'll need to complete and include Appendix A. Is this a state employee benefit plan? ☐ Yes ☐ No

☐ No - Continue to Step 5

Estate Recovery

State and Federal law requires the Department of Health and Human Services (Department) to make claims against the estate of a Medicaid member who: (1) was age 55 or older when the individual received Medicaid services; (2) who has been permanently institutionalized and received services, regardless of age; or (3) is a spouse of a Medicaid member who was age 55 or older or permanently institutionalized when the Medicaid benefits were provided. Effective August 1, 2015, except for the portion of the payment made to a private carrier for nursing facility services, home and community-based services and hospital and prescription drug services received while in a nursing home or while receiving home and community-based services, the Department may not file a claim against the estate to recover payments made on behalf of members who received coverage through a private carrier. Effective January 1, 2020, pharmacy services are no longer part of the coverage through a private carrier and are provided by the Department and are subject to Medicaid estate recovery. Individuals eligible under the Medicaid Expansion coverage receive their coverage through a private carrier.

Step 5 Read and Sign This Application

I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, the person identified below is incarcerated.

Provide the Name of the Person Incarcerated

We need this information to check your eligibility for help paying for health coverage if you 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. If the information doesn't match, we may ask you to send us 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 the Human Service Zone Office to use income data, including information from tax returns. Human Service Zone Office or State Office will send me a notice, let me make changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next
☐ 5 years (the maximum number of years allowed) ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year
☐ Don't use information from tax returns to renew my coverage

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? ☐ Yes ☐ 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.

My Right to Appeal
If I think the Health Insurance Marketplace or Medicaid has made a mistake, I can appeal this decision. To appeal means to tell someone at the Health Insurance Marketplace or Medicaid 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. I know that I can find out how to appeal by contacting the local Human Service Zone office or the state agency at 1-844-854-4825. My eligibility and other important information will be explained to me.

The U.S. Department of Health and Human Services (HHS) prohibits discrimination against its customers, employees, and applicants for employment on the basis of race, color, national origin, age, disability, sex, gender identity, sexual orientation, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited basis will apply to all programs and/or employment activities.)

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write:
Centralized Case Management Operations
US Department Of Health And Human Services
200 Independence Ave SW
Room 509F HHH BLDG
Washington D.C. 20201

or call 1-800-368-1019 or (800) 537-7697 (TTY)

or email: ocrcomplaint@hhs.gov

HHS is an equal opportunity provider and employer.

I reviewed and understand my rights and responsibilities as explained in the Guidebook. www.applyforhelp.nd.gov

I agree to the terms and conditions listed below:

I declare under penalty of perjury, the information on this application is correct. This includes information about identity, citizenship and alien status of the household members applying for assistance.

I understand that alien status information and other information will be verified when discrepancies are found. The alien status of applicant household members may be subject to verification by USCIS through the submission of information from the application to USCIS. Verification received may affect eligibility and level of benefits.

I understand the information I provide on or with this application is subject to verification by federal, state and local officials to determine if the information is correct. If any of the information is incorrect, assistance may be denied and I may be subject to criminal prosecution for knowingly providing incorrect information.

I agree to report to the Customer Support Center office any changes in income, assets, or living arrangements as required. I understand I will not receive a deduction for any allowable expenses I do not report and verify.

The Department of Health and Human Services (HHS) is prohibited from discriminating on the basis of race, color, sex including gender identity and sexual orientation, age, disability, national origin, religion, or status with respect to marriage or public assistance, and in some cases political beliefs.

To file a complaint of discrimination regarding a program offered by HHS, submit a written complaint to:
Department of Health and Human Services
Legal Division
600 E. Boulevard Ave Dept. 325
Bismarck ND 58505-0250

or call (701) 328-2311 or 711 TTY or FAX: (701) 328-2173

email: dhslau@nd.gov

I authorize any person having custody or knowledge of the information relating to me or other household members to disclose any required information other than protected health information, to any authorized agent of the Department of Health and Human Services. I/We authorize Child Support to release any records of child support payments with this authorization is as valid as the original.

☐ I understand that by checking this box and typing my name below, I am signing this SFN 1909 Application For Health Coverage And Help Paying Costs electronically. I agree that my electronic signature is the legal equivalent of my handwritten signature.

Signature	Date
Other Signature (Spouse, Guardian, or Other Adult)	Date

Note: If you would like to designate an Authorized Representative, complete Appendix C.

Step 6 Mail Completed Application

Return your signed and dated form to your local human service zone office
OR
Submit by mail to:
Department Of Health and Human Services
Customer Support Center
PO Box 5562
Bismarck ND, 58506
OR FAX: (701)-328-1006
OR Email: applyforhelp@nd.gov

For questions call Customer Support Center at: 1-866-614-6005
Human service zone office locations can be found here: https://www.hhs.nd.gov/human-service/zones

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.

EMPLOYEE INFORMATION

1. Employee Name (First, Middle, Last)	2. Employee Social Security Number

EMPLOYER INFORMATION

3. Employer Name		4. Employer Identification Number (EIN)
5. Address		6. Employer Telephone Number
7. City	8. State	9. ZIP Code
10. Who can we contact about employee health coverage at this job?		
11. Telephone Number (if different from above)	12. Email Address	

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

☐ No (stop here and complete the rest of the application) ☐ Yes (continue)

Date Eligible to Enroll in Coverage (if you are in a waiting or probationary period)

List the names of anyone else who is eligible for coverage from this job

Name	Name	Name

Tell us about the **health plan** offered by this employer

14. Do the plans offered by the employer meet the minimum value standard*?

☐ YES (go to question 15) ☐ No

15. How much would the employee have to pay for the lowest cost plan offered **to the employee only** that meets the minimum value standard*? Don't include family plans.

Employee would pay this premium (NOTE: Enter the lowest amount the employee would pay for health coverage)
Employee would pay this amount: ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Once a Month ☐ Quarterly ☐ Yearly

16. **If other household members are listed for question 13:** How much would the employee pay for the lowest-cost plan that covers the employee and the household members listed in question 13? If the employer offers wellness programs, enter the premium that the employee would pay if the employee got the maximum discount for any tobacco cessation programs and didn't get any other discounts based on wellness programs.

Employee would pay this premium
Employee would pay this amount: ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Once a Month ☐ Quarterly ☐ Yearly

* A health plan meets the minimum value standard if pays at least 60% of total cost of the medical services for a standard population and offers substantial covearge of hospital and doctor services. Most job-based plans meet the minimum value standard.

EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even it it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security Number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

EMPLOYEE INFORMATION

The **employee** needs to fill out this section.

1. Employee Name (First, Middle, Last)	2. Employee Social Security Number

EMPLOYER INFORMATION (ask the employer for this information)

3. Employer Name		4. Employer Identification Number (EIN)
5. Address		6. Employer Telephone Number
7. City	8. State	9. ZIP Code
10. Who can we contact about employee health coverage at this job?		
11. Telephone Number (if different from above)	12. Email Address	

13. Is the employee currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

☐ No (stop and return this form to employee) ☐ Yes (continue)

Date Eligible to Enroll in Coverage (if the employee is not eligible today, including as a result of a waiting or probationary period)

Tell us about the **health plan** offered by this employer

14. Do the plans offered by the employer meet the minimum value standard*?

☐ YES (go to question 15) ☐ No (STOP and return this form to employee)

15. How much would the employee have to pay for the lowest cost plan offered **to the employee only** that meets the minimum value standard*? Don't include family plans.

Employee would pay this premium (NOTE: Enter the lowest amount the employee would pay for health coverage)

Employee would pay this amount:

☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Once a Month ☐ Quarterly ☐ Yearly

16. **If other household members are listed for question 13:** How much would the employee pay for the lowest-cost plan that covers the employee and the household members listed in question 13? If the employer offers wellness programs, enter the premium that the employee would pay if the employee got the maximum discount for any tobacco cessation programs and didn't get any other discounts based on wellness programs.

Employee would pay this premium

Employee would pay this amount:

☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Once a Month ☐ Quarterly ☐ Yearly

* A health plan meets the minimum value standard if pays at least 60% of total cost of the medical services for a standard population and offers substantial covearge of hospital and doctor services. Most job-based plans meet the minimum value standard.

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 and 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 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	
1. Name	First Name	Middle Name	First Name	Middle Name
	Last Name		Last Name	
2. Member of federally recognized tribe?	☐ Yes - Tribe Name: _____ ☐ No		☐ Yes - Tribe Name: _____ ☐ No	
3. Has this person ever gotten a service from 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	Amount		Amount	
	How Often?		How Often?	
	Income Type ☐ Self-Employment ☐ Rental or Royalty ☐ Farming or Fishing ☐ Other		Income Type ☐ Self-Employment ☐ Rental or Royalty ☐ Farming or Fishing ☐ Other	

APPENDIX C

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 your Human Service Zone office. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of Authorized Representative (First Name, Middle Name, Last Name)			
2. Address			3. Apartment or Suite Number
4. City	5. State	6. ZIP Code	7. Telephone Number
8. Organization Name			9. ID Number (if applicable)

By signing, you allow this person to sign your application, get official information about the application, and act for you on all future matters with this agency.

10. Signature	11. Date

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certificated application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application Start Date	2. First Name, Middle Name, Last Name, and Suffix
3. Organization Name	4. ID Number (if applicable)