Health Coverage & Help Paying Costs

Application for One Person

THINGS TO KNOW

Use this application to see what insurance choices you qualify for

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

Who is this application for?

Single individuals who:

- **Live in Kentucky and plan to stay in Kentucky**
- **Do not have any dependents and cannot be claimed as a dependent on someone else's tax return**

Apply faster online

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

What you may need to apply

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

Why do we ask for this information?

We ask about your **Social Security Number (SSN)**, your **income** and other information to see if you qualify for and if you can get any help paying for your health coverage costs.

If you need help getting an SSN, call 1-800-772-1213 or visit **socialsecurity.gov**. TTY users should call 1-800-325-0778.

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

What happens next?

- Mail or fax your completed, signed application to:

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

  Fax: 1-502-573-2007

- **If you 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.

To get help

- **Online**: **www.kynect.ky.gov**
- **By phone:** Call Customer Service at **1-855- 4kynect (459-6328)**
- **In person:** Find a list of places near where you live by visiting our website or calling us.
- **En Español:** Llame a nuestro Servicio al Cliente gratis al **1-855- 4kynect (459-6328)**
- **For TTY services call 1-855-459-6328**

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STEP 1 Tell Us about Yourself

If someone else is helping you fill out this application, use **Appendix B** to give us that person's information.)

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

2. Social Security Number (SSN)

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

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

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

6. Do you live in Kentucky and plan to stay in Kentucky? ☐Yes ☐ No

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

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

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

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

17. Primary Phone Number ☐ Home ☐ Work ☐ Cell	18. Secondary Phone Number ☐ Home ☐ Work ☐ Cell

19. ☐ Check here to opt-out of receiving kynect text message alerts to your primary phone number.	☐ Check here to opt-out of kynect text message alerts to your secondary phone number.

20. Preferred Spoken Language (if not English)	21. Preferred Written Language (if not English)

22. **1095-A** is sent by kynect to you and the IRS to report enrollment information and the amount of payment assistance a household has received during the coverage year, if any. **Form 1095-B** is can be requested by accessing www.kynect.ky.gov or by contacting DCBS if you had Medicaid coverage during the year. The forms 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:

23. Have you had a pregnancy end (giving birth or losing a pregnancy) in the past three months or are you currently pregnant? ☐Yes. **If yes**, answer questions a–c. ☐No
a. What is the due date or the last date of pregnancy? (mm/dd/yyyy) _____

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

c. Would you like to be referred to the program that offers food to Women, Infants and Children (WIC)? ☐Yes ☐No

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

25. Are you currently enrolled or have offer of Individual Coverage Health Reimbursement Arrangement (ICHRA) or Qualified Small Employer HRA (QSEHRA)?
☐ Yes. If yes, you will need to **complete Step 4** in this application. ☐ No

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

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

☐ **YES**. **If yes**, answer questions a & b. ☐**NO**. **If no**, go to question b.

a. Will you file as a single person with no dependents? ☐Yes ☐No
If No, **stop using this form**. Use the *Health Coverage & Help Paying Costs Application for More Than One Person* to include your tax dependents (even if you do not want to apply for health coverage for them.)

b. Are you claimed as a dependent on someone else's tax return? ☐Yes ☐No
If Yes, **stop using this form.** You will need to apply for coverage with the person claiming you on their tax return (even if that person does not want coverage.)

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

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

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

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

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

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

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

34. Race **(OPTIONAL)**

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

35. Are you American Indian or Alaska Native?
☐Yes. If **yes,** complete **Appendix C** and mail it with this application. ☐No

36. Are you currently in prison or jail or have you been released in the past three months?

☐ Yes. **If yes**, answer questions a–c. ☐No

a. When did you enter prison? (mm/dd/yyyy) _____

b. When did you leave prison? (mm/dd/yyyy) _____

c. Are you currently waiting for a decision on charges? ☐Yes ☐No

37. Do you need help with activities of daily living (like bathing, dressing, etc.) or live in a medical facility or nursing home?

☐ Yes ☐No

38. Are you blind or permanently disabled? ☐Yes ☐No

39. Were you receiving Medicaid when you became too old to be eligible for foster care placement? ☐Yes ☐No

If yes, in what state were you living? _____ How old were you?

40. If you are filling out this application on behalf of a person who recently passed away, enter the deceased person's date of death: _____

STEP 2 Current Job and Income Information

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

Income from Job 1

1. Who is your employer?

2. What is the **gross** amount you make (**before** taxes)?
$

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

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

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

e. How often?

Income from Job 2

5. Who is your employer?

6. What is the **gross** amount you make (before taxes)?
$

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

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

☐ **Gross** Income _____
☐ Self-employment **Expenses** _____
☐ **NET** income (Gross minus expenses) _____

e. How often?

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

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

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

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

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

$ _____

STEP 3 Other Healthcare Coverage

Do you have health coverage now, including **dental and major medical coverage** that is not Medicaid or KCHIP?

☐ YES. **If yes**, complete the information below. ☐NO.

Type of coverage _____ Policy Number _____

Name of policy holder_____ Coverage start date

Name of insurance company Coverage end date

Insurance Company's Address _____

STEP 4 Health Reimbursement Arrangement (HRA)

EMPLOYEE and EMPLOYER Information

1. Employee Name (First, Middle, Last)		
2. Employer Name		3. Employer Identification Number (EIN)
4. Employer Address		
5. City	6. State	7. Zip Code
8. Employer Contact Name	9. Employer Contact Phone Number	

Tell us about the HRA provided by this employer

10. What type of HRA is this?
☐ an Individual Coverage HRA (ICHRA) ☐ a Qualified Small Employer HRA (QSEHRA)
11. What is the Start Date and the End Date of the HRA?
a. HRA start date (mm/dd/yyyy): _____
b. HRA end date (mm/dd/yyyy): _____
12. What is the maximum self-only amount of reimbursement offered by this employer? $_____
13. How often will this amount be available? ☐Weekly ☐Twice a month ☐Monthly
14. If you have an offer of ICHRA and are not yet enrolled,
a. Will you on [60 days from current date] be able to use the HRA? ☐ Yes ☐ No
b. Do you plan to opt-out of this HRA, if found eligible for payment assistance? ☐ Yes ☐ No

STEP 5 Sign and Date this Application

- I am signing this application under penalty of perjury which means I have given true answers to all the questions on this form to the best of my knowledge and belief. I know that I may be subject to penalties under federal 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.
- If I think kynect has made a mistake, I can appeal its decision. To appeal means to tell someone at kynect that I think the action is wrong, and ask for a fair review of the action. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I understand that kynect will check my answers using information in databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or any other trusted source. If the information does not match, I may be asked to send proof.

Renewal of coverage in future years: To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow kynect to use income data, including information from tax returns and other trusted data sources. kynect will send me a notice, let me make any changes, and I can opt out at any time.
Yes, renew my eligibility automatically for the next: (select one)

☐ 5 years (maximum allowed) ☐4 years ☐3 years ☐2 years ☐1 year

☐ Do not use information from tax returns or other data sources to renew my coverage.

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

Voter Registration: If I am not registered to vote or not registered where I currently live, I can choose to register to vote by checking yes below. If I check yes, I will receive a voter registration application in the mail. Checking yes or no below does not affect the outcome of this application.

☐ **Yes**, I want to apply to register to vote. An application will be mailed to me. ☐**No**, I don't want to register to vote.

If I am eligible for Medicaid:

- I understand that if Medicaid pays for a medical expense, any other health insurance or legal settlement payments will go to Medicaid to reimburse it for the expense.
- I understand that my application may be reviewed to make sure that eligibility was determined correctly. If my application is reviewed, I must cooperate with the review.

Signature	Date (mm/dd/yyyy)

Commonwealth of Kentucky
Cabinet for Health & Family Services
Department for Community Based Services

kynect Resources Needs Assessment

The following is an additional resource needs assessment that is **voluntary** and does not impact your Medicaid benefits. This assessment helps us to identify and understand other needs you and your household may have that can impact your health and connect you with community resources/services/programs that may be helpful, such as transportation, utilities, food, childcare, etc. You may review your results by logging into your kynect account at https://kynect.ky.gov/resources or by calling 2-1-1 to be referred to community resources/services/programs.

onto their kynect account online at https://kynect.ky.gov/resources or by calling 2-1-1.

Circle the letter that best describes your situation:

1. **Which best describes your housing situation?**

   a. I do not have stable housing.
   b. I am temporarily living with a friend or family member.
   c. I am currently not paying my rent/mortgage and in danger of eviction.
   d. I am paying my rent/mortgage, but it is unaffordable (over 30% of income).
   e. I am currently utilizing a rent/mortgage assistance program.
   f. I pay my rent/mortgage without difficulty.

2. **Which best describes your housing utilities (water, electricity, heating) situation?**

   a. I do not have housing/do not have utilities for my housing situation.
   b. My utilities are often shut off due to not paying.
   c. I use programs that help pay for my utilities.
   d. I have trouble paying for my utilities, but I mostly am able to pay.
   e. I can pay my utilities so that they are never turned off.

3. **Which best describes your current employment situation?**

   a. No job.
   b. I have temporary, seasonal, or part-time work that does NOT meet my needs; I need more employment.
   c. Full-time with no benefits or benefits that do not meet my needs.
      (Note: Benefits may include medical, dental, and vision insurance and retirement packages)
   d. I have temporary, seasonal, or part-time work that DOES meet my needs; I do not need more employment.
   e. Full-time with benefits that meet my needs.

4. **Which best describes your income situation?**

   a. No income.
   b. My income is irregular.
   c. My income is not enough to meet my needs.
   d. I can meet my basic needs with help from assistance programs.
   e. I can meet my basic needs without assistance.
   f. My income meets my needs, is well-managed, and I can save.

5. **Which best describes your food situation?**

a. I am unable to get food.
b. I can get food, but do not have the space or time to prepare a meal.
c. My household receives help for food such as SNAP (food stamps) or other food assistance.
d. I can meet my basic food needs, but I require occasional assistance such as a food pantry.
e. I can meet my basic food needs without assistance.
f. I can choose to purchase any food my household desires.

6. **Which best describes your childcare situation?**

a. I need childcare, but I am not able to afford childcare at this time.
b. I can afford Childcare, but the Childcare options are unreliable or inaccessible.
c. Childcare is provided by a personal friend or family member.
d. I can select quality childcare of my choice.
e. I do not need childcare at this time.

7. **Which best describes your level of education?**

a. I have no high school diploma/GED, or need help with reading and writing.
b. I have a high school diploma/GED, but language is a barrier.
c. I have a high school diploma/GED, but I need additional education/training to improve my job situation.
d. I have completed the education/training necessary for employment.
e. I am currently in high school or an education/training institution.

8. **Which best describes your health care coverage?**

a. I have no medical coverage and need coverage as soon as possible.
b. I have no medical coverage and no immediate need for coverage.
c. Some members of my household (such as children) have medical coverage, but I would like help in understanding how to use it.
d. Some members of my household (such as children) have medical coverage, and we understand how to use it.
e. All members of my household are covered by affordable health insurance, but I would like help understanding how to use it.
f. All members of my household are covered by affordable health insurance, and we understand how to use it.

9. **Which best describes your transportation situation?**

a. I do not have any access to transportation.
b. I have a car but cannot drive it or it is unreliable.
c. I use public transportation or a bike, but it is inconvenient or limited.
d. I do not need help with transportation.

10. **Do you need resources related to mental well-being?**

a. Yes, I am in need of assistance with my mental well-being.
b. No**-** I am not in need of assistance with my mental well-being.

11. **Do you need resources related to substance use?**

    a. Yes, I am in need of resources for Substance Use.

    b. No, I am not in need of resources for Substance Use.

12. **Do you need resources related to Domestic Violence?**

    a. Yes, I am in need of resources for Domestic Violence.

    b. No, I am not in need of resources for Domestic Violence.

13. **Which best describes your situation for care of the elderly and/or the disabled?**

    a. I have immediate need for assistance for either myself or someone who is in my care because of age or disability.
    b. I or someone in my care could use assistance with care because of age or disability.
    c. I have no need for assistance with care for the elderly/disabled.

14. **Which best describes your children's school experience?**

    a. I have one or more school-aged children not enrolled in school.
    b. My child or children are enrolled in school but only attend some of the time.
    c. My child or children are enrolled and attending classes most or all of the time.
    d. I do not have school aged children.

15. **Which best describes your ability to fulfill your basic needs daily?**

    a. I do not have the ability to meet basic needs such as food, clothing, or a place to bath regularly.
    b. I can meet a few, but not all of my basic needs.
    c. I am able to fulfill most but not all of my basic needs.
    d. I am able to meet all of my basic needs daily.

16. **Which best describes your social connections and friendships?**

    a. I am isolated and/or I do not want to interact with people.
    b. I would like to be more involved with family or groups but need more information or support.
    c. I have strong family/social supports and/or I am actively involved in my community or support groups.

17. **Which best describes your need for legal support?**

    a. I have outstanding warrant(s) or have charges pending.
    b. I am fully compliant with probation or parole terms.
    c. I have no felony criminal history or have had no criminal justice involvement in more than 12 months.

18. **Which best describes your parenting skills?**

    a. I need resources to improve my parenting skills.
    b. My parenting skills are adequate or well developed.
    c. I do not have children.