## Start application here *(use blue or black ink only)*

## Step 1: Tell us about the adult who will be our main contact for this application

First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)*

**Home** address | Apartment #

City *(home address)* | State | ZIP code | County

☐ Check here if you do not have a home address. You must give us a mailing address below.

☐ Check here if your mailing address is the same as your home address.
***If it is not the same***, you must give us your mailing address below.

**Mailing** address or P.O. Box *(if different from home address)* | Apartment #

City *(mailing address)* | State | ZIP code | County

Best phone number to reach you ☐ Home ☐ Cell ☐ Work
Number: ( ) –

Other phone number ☐ Home ☐ Cell ☐ Work
Number: ( ) –

What language should we write to you in?

What language do you want us to speak to you in?

How would you like to get information about this application?

☐ Phone ☐ Mail ☐ Email Email address: _____

Infants less than one year old are eligible for Medi-Cal if their mother was on Medi-Cal or AIM at the time of delivery. You do not need to fill out an application to get Medi-Cal for an infant born to a mother with Medi-Cal or AIM at the time of delivery. Call your county social services office when your baby is born to make sure your baby is covered. Or fill out the information below.

*Optional: If the following information is provided, the infant may be automatically eligible for Medi-Cal. You do not have to fill out Step 2 of this application for the infant.*

Are you applying for a child less than 1 year old? ☐ Yes ☐ No

*If yes,* did the child's mother have Medi-Cal or AIM when the child was born? ☐ Yes ☐ No

*If yes,* will the child's mother be listed on this application? ☐ Yes ☐ No

*If yes,* the mother is Person #_____ on this application

*If no,* what is the mother's first and last name? _____

Please provide the mother's Medi-Cal number, AIM number, or SSN _____

0460687

**¿Preguntas?** Llame a Covered California al **1-800-300-1506** (TTY: 1-888-889-4500). La llamada es gratuita. Usted puede llamar de lunes a viernes de 8 a.m. a 6 p.m. y los sábados de 8 a.m. a 5 p.m. O visite **CoveredCA.com**.

## Step 2: Tell us about yourself and your family

Your income and family size help us decide what programs you qualify for. With this information, we can make sure everyone gets the best coverage possible.

**You must include these people on this application:**

- Your spouse
- Your children who live with you
- All parents living in the home with their child
- Anyone on your federal income tax return, if you file one. You don't need to file taxes to apply for health insurance.

★ If you are claimed as a dependent on someone else's tax return, you must include all members of the tax filing household that claimed you, and any family members living with you.

★ Anyone else who lives with you – for example, a boyfriend, girlfriend, or roommate – will need to file his or her **own** application if they want health insurance.

**Complete Step 2 for each person in your family. Start with yourself!**

- To apply for more than four people on this application, **make a copy of pages 6–8** for each additional person.
- We'll keep all your information private, as required by law. We'll use personal information only to see if you qualify for health insurance. You do not need to provide the immigration status or Social Security number (SSN) for those in your family who are not applying for health insurance.

### Person 1 *Tell us about yourself*

First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)* | Relationship to you **Self**

Are you: ☐ Male ☐ Female

Are you: ☐ Single ☐ Never married ☐ Married ☐ Divorced ☐ Registered domestic partner ☐ Separated ☐ Widowed

Date of birth *(month / day / year)*

Are you pregnant? ☐ Yes ☐ No *If yes,* how many babies are expected? _____

What is the expected delivery date? _____

### Applying for health insurance *Even if you have insurance now, you might find better coverage or lower costs.*

▶ Are you applying for health insurance for yourself? ☐ **Yes** *If yes,* answer the questions below. ☐ **No** *If no,* go to the next page.

★ Social Security number (SSN)

___ ___ ___ – ___ ___ – ___ ___ ___ ___

If you do not have an SSN, what is the reason?

☐ Adoption Taxpayer Identification Number (ATIN) _____

☐ Individual Taxpayer Identification Number (ITIN) _____

☐ Religious exemption ☐ I do not qualify for an SSN

★ You must provide a Social Security number (SSN) if you or a family member wish to apply for health insurance, or if you file taxes as head of household. We use Social Security numbers (SSNs) to check income and other information. Even if you are not applying, giving your SSN will help us review your application faster.

If someone who is applying does not have an SSN and would like help getting one, call **1-800-300-1506** (TTY: 1-888-889-4500) or visit **CoveredCA.com**.

***Person 1** continued on next page*

## Step 2: Person 1 *(continued)*

### Federal income tax information *If you don't file taxes, you can still qualify for free or low-cost insurance through Medi-Cal. We will keep your information private. We will use your information only to decide if you qualify for health insurance.*

Are you going to file taxes for the **benefit** year?
☐ Yes ☐ No
*If yes,* how will you file?
☐ Head of household ☐ Single
☐ Married filing jointly ☐ Married filing separately

Does anyone claim you as a dependent on their taxes? ☐ Yes ☐ No
*If yes,* who?
☐ Person # _____ on this application
☐ This person is a parent without custody
☐ This person is a parent without custody who is not listed on this application

Do you have other health insurance or are you offered insurance through a job? ☐ Yes ☐ No
*If yes,* fill out Attachment B on pages 22 and 23.

Do you have a physical, mental, emotional, or developmental disability? ☐ Yes ☐ No *See FAQ #26 for more information on what it means to have a disability.*

Do you need help with long-term care or home and community-based services? ☐ Yes ☐ No

Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No
If you are **not** a U.S. citizen or U.S. national, answer these questions:
Do you have satisfactory immigration status? ☐ Yes ***To see if you have satisfactory status,*** *go to Attachment E on page 26 for a list. Then write the document information here. In most cases your document ID number will be your Alien Registration Number.*

Document type: _____ ID number: _____
Country of issuance: _____ Expiration date: _____
Name as it appears on the document: _____

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

Are you, your spouse, or an unmarried dependent child an honorably discharged veteran or active-duty member of the U.S. armed forces? ☐ Yes ☐ No

Do you receive Medicare benefits? ☐ Yes ☐ No

Did you have a medical expense in the last 3 months that you need help paying for? ☐ Yes ☐ No

Do you live with any children under the age of 19? ☐ Yes ☐ No
*If yes,* do you take care of the child or children? ☐ Yes ☐ No

Are you 18 to 20 years old and a full-time student? ☐ Yes ☐ No
Are you 18 to 26 years old? ☐ Yes ☐ No *If yes,* were you in foster care in any state on your 18th birthday? ☐ Yes ☐ No
Are you 18 years old or younger? ☐ Yes ☐ No How many parents live with you? _____

Are you temporarily living out of state? ☐ Yes ☐ No

If you would like to choose a health insurance plan now, check here ☐ and fill out Attachment D on page 25.

### Tell us about your race *Please tell us about yourself. This information is confidential and will only be used to make sure that everyone has the same access to health care. It will not be used to decide what health insurance you qualify for.*

What is your race? *(Optional: Check all that apply)*

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Cambodian
☐ Chinese
☐ Filipino
☐ Hmong
☐ Japanese
☐ Korean
☐ Laotian
☐ Vietnamese
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other _____

Are you of Hispanic, Latino, or Spanish origin? *(Optional)* ☐ Yes ☐ No
*If yes,* check which ones:
☐ Mexican, Mexican American, Chicano
☐ Salvadoran ☐ Guatemalan
☐ Cuban ☐ Puerto Rican
☐ Other Hispanic, Latino or Spanish origin: _____

☆ ☐ Check here if you are a **federally recognized** American Indian or Alaska Native, and fill out Attachment A on pages 20 and 21.

***Person 1*** *continued on next page*

## Step 2: Person 1 *(continued)*

### Tell us about your current job and how you get money *Attach an extra page if you need more space.*

Do you work now? ☐ **Yes** *If yes,* answer the questions below. ☐ **No** *If no,* go to other income on this page.

» **Where do you work now?** *If you have more jobs, attach another sheet of paper.*

**JOB 1:** How do you get paid? ☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____
☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ One-time payment

| Employer name *(Optional)* | How much do you get paid (before taxes)? $ |
|---|---|

**JOB 2:** How do you get paid? ☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____
☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ One-time payment

| Employer name *(Optional)* | How much do you get paid (before taxes)? $ |
|---|---|

» **Are you self-employed?**

**JOB 1:** Are you self-employed? ☐ **Yes** *If yes,* answer the questions below. ☐ **No** *If no,* go to other income on this page.

| Type of work | How much *net income* will you get from self-employment this month? Amount: $_____<br>*Net income* means the profits left over after expenses are paid. *Attachment E on page 26 lists what could be counted.* |
|---|---|

**JOB 2:** Are you self-employed? ☐ **Yes** *If yes,* answer the questions below. ☐ **No** *If no,* go to other income on this page.

| Type of work | How much *net income* will you get from self-employment this month? Amount: $_____<br>*Net income* means the profits left over after expenses are paid. *Attachment E on page 26 lists what could be counted.* |
|---|---|

» **Do you have other income?** *Other income is money you get from something other than your job. Do not include child support payments, veteran's payments, or Supplemental Security Income (SSI). Go to Attachment E on page 26 to see examples of other income.*

Do you have other income? ☐ **Yes** *If yes,* answer the questions below. ☐ **No** *If no,* go to income change on this page.

| **Where does this income come from?** | **How often do you get paid?** *(check one)* | **How much?** |
|---|---|---|
| | ☐ Hourly: How many hours per week?_____ ☐ Every two weeks<br>☐ Daily: How many days per week?_____ ☐ Twice a month<br>☐ Weekly ☐ Monthly ☐ One-time payment | $ |
| | ☐ Hourly: How many hours per week?_____ ☐ Every two weeks<br>☐ Daily: How many days per week?_____ ☐ Twice a month<br>☐ Weekly ☐ Monthly ☐ One-time payment | $ |

» **Does your income change from month to month?** *If it does, answer the two questions below.*

| What do you expect your total income to be ***this*** year? *(**Optional**)* $ | If you expect your income to change ***next*** year, what will the new total income be? *(**Optional**)* $ |
|---|---|

» **Do you have deductions?** *If you pay for certain things that can be deducted on a federal income tax return, telling us about them may lower the cost of health insurance. Do not include self-employment expenses. Attachment E on page 26 lists other types of deductions.*

Do you have deductions? ☐ **Yes** *If yes,* answer the questions below. ☐ **No** *If no,* go to the next page.

| **Type of deduction** | **How often do you get or pay for this deduction?** *(check one)* | **How much?** |
|---|---|---|
| ☐ Alimony paid<br>☐ Student loan interest<br>☐ Other | ☐ Hourly: How many hours per week?_____ ☐ Every two weeks<br>☐ Daily: How many days per week?_____ ☐ Twice a month<br>☐ Weekly ☐ Monthly ☐ One-time payment | $ |
| ☐ Alimony paid<br>☐ Student loan interest<br>☐ Other | ☐ Hourly: How many hours per week?_____ ☐ Every two weeks<br>☐ Daily: How many days per week?_____ ☐ Twice a month<br>☐ Weekly ☐ Monthly ☐ One-time payment | $ |

## Step 2

## Person 2 *Tell us about **the next person** living in your home.*

***If you have more than four people** on this application, make a copy of pages 6–8 for each additional person.*

| First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)* | Relationship to you |
|---|---|---|---|---|
| | | | | |

☐ Check here if this person's home address is the same as the main contact's home address.
***If it is not the same**, you must give us this person's home address below.*

**Home** address — Apartment #

| City (home address) | State | ZIP code | County |
|---|---|---|---|
| | | | |

☐ Check here if this person does not have a home address. You must give us a mailing address below.

☐ Check here if this person's mailing address is the same as the main contact's mailing address.
***If it is not the same**, you must give us this person's mailing address below.*

**Mailing** address or P.O. Box *(if different from home address)* — Apartment #

| City (mailing address) | State | ZIP code | County |
|---|---|---|---|
| | | | |

Best phone number to reach this person ☐ Home ☐ Cell ☐ Work
Number: ( ) –

Other phone number ☐ Home ☐ Cell ☐ Work
Number: ( ) –

Email address:

What language should we write to this person in?

What language does this person want us to speak to him or her in?

Is this person: ☐ Male ☐ Female

Is this person: ☐ Single ☐ Never married ☐ Married ☐ Divorced ☐ Registered domestic partner ☐ Separated ☐ Widowed

Date of birth *(month / day / year)*

Is this person pregnant? ☐ Yes ☐ No *If yes,* how many babies are expected? _____
What is the expected delivery date? _____

### Applying for health insurance *Even if this person has insurance now, you might find better coverage or lower costs.*

▶ Is this person applying for health insurance? ☐ **Yes** *If yes,* answer the questions below. ☐ **No** *If no,* SSN information is optional.

✳ Social Security number (SSN)
___ ___ ___ – ___ ___ – ___ ___ ___ ___

If this person does not have an SSN, what is the reason?
☐ Adoption Taxpayer Identification Number (ATIN) _____
☐ Individual Taxpayer Identification Number (ITIN) _____
☐ Religious exemption ☐ Child less than 1 year old ☐ Does not qualify for an SSN

### Federal income tax information *If this person didn't file taxes, he or she can still qualify for free or low-cost insurance through Medi-Cal. We will keep the information private and use it only to decide if the person qualifies for health insurance.*

Is this person going to file taxes for the **benefit** year?
☐ Yes ☐ No *If yes,* how will he or she file?
☐ Head of household ☐ Single ☐ Dependent
☐ Married filing jointly ☐ Married filing separately

Does anyone claim this person as a dependent on their taxes? ☐ Yes ☐ No
*If yes,* who?
☐ Person # _____ on this application
☐ This person is a parent without custody
☐ This person is a parent without custody who is not listed on this application

***Person 2** continued on next page*

## Step 2: Person 2 *(continued)*

Does this person have other health insurance or is this person offered insurance through a job? ☐ Yes ☐ No
*If yes,* fill out Attachment B on pages 22 and 23.

Do you have a physical, mental, emotional, or developmental disability? ☐ Yes ☐ No *See FAQ #26 for more information on what it means to have a disability.*

Do you need help with long-term care or home and community-based services? ☐ Yes ☐ No

Is this person a U.S. citizen or U.S. national? ☐ Yes ☐ No

If this person is **not** a U.S. citizen or U.S. national, answer these questions:

Does this person have satisfactory immigration status? ☐ Yes ***To see if this person has satisfactory status,*** *go to Attachment E on page 26 for a list. Then write the document information here. In most cases your document ID number will be your Alien Registration Number.*

Document type: _____ ID number: _____

Country of issuance: _____ Expiration date: _____

Name as it appears on the document: _____

Has this person lived in the U.S. since 1996? ☐ Yes ☐ No

Is this person, this person's spouse, or an unmarried dependent child an honorably discharged veteran or active-duty member of the U.S. armed forces? ☐ Yes ☐ No

Does this person receive Medicare benefits? ☐ Yes ☐ No

Did this person have a medical expense in the last 3 months that he or she needs help paying for? ☐ Yes ☐ No

Does this person live with any children under the age of 19? ☐ Yes ☐ No
*If yes,* does this person take care of the child or children? ☐ Yes ☐ No

Is this person 18 to 20 years old and a full-time student? ☐ Yes ☐ No

Is this person 18 to 26 years old? ☐ Yes ☐ No
*If yes,* was this person in foster care in any state on his or her 18th birthday? ☐ Yes ☐ No

Is this person 18 years old or younger? ☐ Yes ☐ No How many parents live with this person? _____

Is this person temporarily living out of state? ☐ Yes ☐ No

### Tell us about this person's race

What is this person's race? ***(Optional:*** *Check all that apply)*

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Vietnamese
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other _____

Is this person of Hispanic, Latino, or Spanish origin? *(Optional)* ☐ Yes ☐ No

*If yes,* check which ones:

- ☐ Mexican, Mexican American, Chicano
- ☐ Salvadoran ☐ Guatemalan
- ☐ Cuban ☐ Puerto Rican
- ☐ Other Hispanic, Latino or Spanish origin: _____

☆ ☐ Check here if this person is a **federally recognized** American Indian or Alaska Native, and fill out Attachment A on pages 20 and 21.

***Person 2*** *continued on next page*

## Step 2: Person 2 *(continued)*

### Tell us about this person's current job and how he or she gets money *Attach an extra page if you need more space.*

Does this person work now? ☐ **Yes** *If yes,* answer the questions below. ☐ **No** *If no,* go to other income on this page.

#### Where does this person work now? *If he or she has more jobs, attach another sheet of paper.*

**JOB 1:** How does this person get paid? ☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____
☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ One-time payment

| Employer name *(Optional)* | How much does this person get paid (before taxes)? $ |
|---|---|

**JOB 2:** How does this person get paid? ☐ Hourly: How many hours per week?_____ ☐ Daily: How many days per week?_____
☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ One-time payment

| Employer name *(Optional)* | How much does this person get paid (before taxes)? $ |
|---|---|

#### Is this person self-employed?

**JOB 1:** Is this person self-employed? ☐ **Yes** *If yes,* answer the questions below. ☐ **No** *If no,* go to other income on this page.

| Type of work | How much *net income* will this person get from self-employment this month? Amount: $_____<br>*Net income* means the profits left over after expenses are paid. *Attachment E on page 26 lists what could be counted.* |
|---|---|

**JOB 2:** Is this person self-employed? ☐ **Yes** *If yes,* answer the questions below. ☐ **No** *If no,* go to other income on this page.

| Type of work | How much *net income* will this person get from self-employment this month? Amount: $_____<br>*Net income* means the profits left over after expenses are paid. *Attachment E on page 26 lists what could be counted.* |
|---|---|

#### Does this person have other income? *Other income is money you get from something other than your job. Go to Attachment E on page 26 to see examples of other income. Do not include child support payments, veteran's payments, or Supplemental Security Income (SSI).*

Does this person have other income? ☐ **Yes** *If yes,* answer the questions below. ☐ **No** *If no,* go to income change on this page.

| Where does this income come from? | How often does this person get paid? *(check one)* | How much? |
|---|---|---|
| | ☐ Hourly: How many hours per week?_____ ☐ Every two weeks<br>☐ Daily: How many days per week?_____ ☐ Twice a month<br>☐ Weekly ☐ Monthly ☐ One-time payment | $ |
| | ☐ Hourly: How many hours per week?_____ ☐ Every two weeks<br>☐ Daily: How many days per week?_____ ☐ Twice a month<br>☐ Weekly ☐ Monthly ☐ One-time payment | $ |

#### Does this person's income change from month to month? *If it does, answer the two questions below.*

| What do you expect this person's total income to be ***this*** year? *(Optional)* $ | If you expect this person's income to change ***next*** year, what will the new total income be? *(Optional)* $ |
|---|---|

#### Does this person have deductions? *If this person pays for certain things that can be deducted on a federal income tax return, telling us about them may lower the cost of health insurance. Do not include self-employment expenses. Attachment E on page 26 lists other types of deductions.*

Does this person have deductions? ☐ **Yes** *If yes,* answer the questions below. ☐ **No** *If no,* go to the next page.

| Type of deduction | How often does this person get this deduction? *(check one)* | How much? |
|---|---|---|
| ☐ Alimony paid<br>☐ Student loan interest<br>☐ Other | ☐ Hourly: How many hours per week?_____ ☐ Every two weeks<br>☐ Daily: How many days per week?_____ ☐ Twice a month<br>☐ Weekly ☐ Monthly ☐ One-time payment | $ |
| ☐ Alimony paid<br>☐ Student loan interest<br>☐ Other | ☐ Hourly: How many hours per week?_____ ☐ Every two weeks<br>☐ Daily: How many days per week?_____ ☐ Twice a month<br>☐ Weekly ☐ Monthly ☐ One-time payment | $ |

## Step 2: Person 3 *Tell us about **the next person** living in your home.*

First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)* | Relationship to you

☐ Check here if this person's home address is the same as the main contact's home address.
***If it is not the same***, you must give us this person's home address below.

**Home** address | Apartment #

City (home address) | State | ZIP code | County

☐ Check here if this person does not have a home address. You must give us a mailing address below.

☐ Check here if this person's mailing address is the same as the main contact's mailing address.
***If it is not the same***, you must give us this person's mailing address below.

**Mailing** address or P.O. Box *(if different from home address)* | Apartment #

City (mailing address) | State | ZIP code | County

Best phone number to reach this person ☐ Home ☐ Cell ☐ Work
Number: ( ) –

Other phone number ☐ Home ☐ Cell ☐ Work
Number: ( ) –

Email address:

What language should we write to this person in?

What language does this person want us to speak to him or her in?

Is this person: ☐ Male ☐ Female

Is this person: ☐ Single ☐ Never married ☐ Married ☐ Divorced ☐ Registered domestic partner ☐ Separated ☐ Widowed

Date of birth *(month / day / year)*

Is this person pregnant? ☐ Yes ☐ No *If yes*, how many babies are expected? _____
What is the expected delivery date? _____

### Applying for health insurance *Even if this person has insurance now, you might find better coverage or lower costs.*

▶ Is this person applying for health insurance? ☐ **Yes** *If yes*, answer the questions below. ☐ **No** *If no*, SSN information is optional.

Social Security number (SSN)
___ ___ ___ – ___ ___ – ___ ___ ___ ___

If this person does not have an SSN, what is the reason?
☐ Adoption Taxpayer Identification Number (ATIN) _____
☐ Individual Taxpayer Identification Number (ITIN) _____
☐ Religious exemption ☐ Child less than 1 year old ☐ Does not qualify for an SSN

### Federal income tax information *If this person didn't file taxes, he or she can still qualify for free or low-cost insurance through Medi-Cal. We will keep the information private and use it only to decide if the person qualifies for health insurance.*

Is this person going to file taxes for the **benefit** year?
☐ Yes ☐ No *If yes*, how will he or she file?
☐ Head of household ☐ Single ☐ Dependent
☐ Married filing jointly ☐ Married filing separately

Does anyone claim this person as a dependent on their taxes? ☐ Yes ☐ No
*If yes*, who?
☐ Person # _____ on this application
☐ This person is a parent without custody
☐ This person is a parent without custody who is not listed on this application

***Person 3** continued on next page*

## Step 2: Person 3 *(continued)*

### Applying for health insurance *Even if this person has insurance now, you might find better coverage or lower costs.*

▶ Is this person applying for health insurance? ☐ **Yes** *If yes,* answer the questions below. ☐ **No** *If no,* go to the next page.

Does this person have other health insurance or is this person offered insurance through a job? ☐ Yes ☐ No
*If yes,* fill out Attachment B on pages 22 and 23.

Do you have a physical, mental, emotional, or developmental disability? ☐ Yes ☐ No *See FAQ #26 for more information on what it means to have a disability.*

Do you need help with long-term care or home and community-based services? ☐ Yes ☐ No

Is this person a U.S. citizen or U.S. national? ☐ Yes ☐ No

If this person is **not** a U.S. citizen or U.S. national, answer these questions:

Does this person have satisfactory immigration status? ☐ Yes ***To see if this person has satisfactory status,*** *go to Attachment E on page 26 for a list. Then write the document information here. In most cases your document ID number will be your Alien Registration Number.*

Document type: _____ ID number: _____

Country of issuance: _____ Expiration date: _____

Name as it appears on the document: _____

Has this person lived in the U.S. since 1996? ☐ Yes ☐ No

Is this person, this person's spouse, or an unmarried dependent child an honorably discharged veteran or active-duty member of the U.S. armed forces? ☐ Yes ☐ No

Does this person receive Medicare benefits? ☐ Yes ☐ No

Did this person have a medical expense in the last 3 months that he or she needs help paying for? ☐ Yes ☐ No

Does this person live with any children under the age of 19? ☐ Yes ☐ No
*If yes,* does this person take care of the child or children? ☐ Yes ☐ No

Is this person 18 to 20 years old and a full-time student? ☐ Yes ☐ No

Is this person 18 to 25 years old? ☐ Yes ☐ No
*If yes,* was this person in foster care in any state on his or her 18th birthday? ☐ Yes ☐ No

Is this person 18 years old or younger? ☐ Yes ☐ No How many parents live with this person? _____

Is this person temporarily living out of state? ☐ Yes ☐ No

### Tell us about this person's race

What is this person's race? *(Optional: Check all that apply)*

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Vietnamese
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other _____

Is this person of Hispanic, Latino, or Spanish origin? *(Optional)* ☐ Yes ☐ No

*If yes,* check which ones:

- ☐ Mexican, Mexican American, Chicano
- ☐ Salvadoran ☐ Guatemalan
- ☐ Cuban ☐ Puerto Rican
- ☐ Other Hispanic, Latino or Spanish origin: _____

✻ ☐ Check here if this person is a **federally recognized** American Indian or Alaska Native, and fill out Attachment A on pages 20 and 21.

***Person 3*** *continued on next page* ❯❯