Healthcare Coverage

Fill out the following details along with the Assistance Application if seeking Healthcare Assistance

Additional Group Details

Is anyone the primary caretaker for a child (under age of 19) in the home? ___ If yes, who? ________ ___ No

Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc), live in a medical facility or nursing home, or are you medically frail? ___ If yes, who? ________ ___ No

Was anyone in foster care when they turned 18? ___ If yes, who? ________ ___ No ← Only required for applicants

Is anyone applying for health insurance currently incarcerated (detained or jailed)? ___ If yes, who? ________ ___ No

American Indian or Alaska Native

← AI/AN family members may not have to pay cost sharing and may get special monthly enrollment periods

Are you or is anyone in your family American Indian or Alaska Native? ___ If yes, who? ________ ___ No

If yes, are they a member of a federally recognized tribe? ___ If yes, ________ ___ No

Has anyone ever received a service or referral from the Indian Health Service, a tribal health program, or urban Indian health program? ___ If yes, who? ________ ___ No

If no, is anyone eligible to get these services? ___ If yes, who? ________ ___ No

Flint Water System

Did anyone in your home consume water from the Flint Water System and live, work, or receive childcare or education at an address that was served by the Flint Water System from April 2014 through present day? ___ If yes, list below. ___ No ← For individuals under age 21 or pregnant women. By checking "yes" you are requesting Healthcare

Names	Address Served by Flint Water (Street, City, Zip code)	Dates
	___ Home ___ Work ___ School ___ Childcare Facility	
	___ Home ___ Work ___ School ___ Childcare Facility	

Your Name:

Individual ID #:

Healthcare Coverage

Fill out the following details along with the Assistance Application if seeking Healthcare Assistance

Tax Filers

Does anyone applying plan to file a federal tax return next year? ___ If yes, who? ___ No

← You do not need to file a tax return to receive Healthcare

Name of Primary Tax Filer ____________________

- Are they filing jointly with a spouse? ___ If yes, who? Name of Spouse ____________________ ___ No
- Are they claiming dependents? ___ If yes, who? Name of Dependent(s) ____________________ ___ No

____

- Are they filing jointly with a spouse? ___ If yes, who? ____________________ ___ No
- Are they claiming dependents? ___ If yes, who? ____________________ ___ No

Dependents

Will anyone applying be claimed as a dependent on someone else's tax return? ___ If yes, list below. ___ No

Dependent	Tax Filer	Relationship to Tax Filer
Name	Name	

Yearly Income

Does anyone's income change from month to month? ___ If yes, list below. ___ No

Who?	Total Estimated Income This Year	Total Estimated Income Next Year
Name		

← If you think it will be different

Michigan Department of Health and Human Services

Your Name:
Individual ID #:

MDHHS-1171-HC (Rev. 1-20) Previous edition obsolete.

Healthcare Coverage

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Health Coverage Info

Does anyone need help paying for medical bills from the past 3 months?

___ If yes, who? Name(s) ___ No

Which months? JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC

Did anyone have insurance through a job and lose it in the last 3 months? ___ If yes, list below. ___ No

Who lost coverage?	End Date	Reason Insurance Ended
	MM/YYYY	

Is anyone currently enrolled in health coverage (even if not applying)? ___ If yes, list below. ___ No

← Including Medicaid, CHIP/MIChild, Medicare, VA Healthcare Programs, Peace Corps, Employer Insurance, TRICARE (unless you have direct care or Line of Duty), and Other

Type + Name of Coverage	Person Covered	Policy #
	Name	

If Medicare, do you want help paying Medicare premiums? Y | N

If employer insurance: Is this COBRA coverage? Y | N

Is this a retiree health plan? Y | N

If other, is this a limited benefit plan (such as a school accident policy)? Y | N

To make it easier to determine your Healthcare eligibility in future years, do you agree to the use of IRS data for automatic renewals?

___ Yes ___ No

← This allows the Marketplace and the State of Michigan to use income data (including information from tax returns). See Info Booklet (Pg 8) for more details

If yes, for how many years? 5 4 3 2 1

Your Name:

Individual ID #:

Healthcare Coverage

← This page is not required. See Info Booklet (Pg 10) for definitions and information about exemptions and work requirements

You may list more than one exemption (reason to be excused)

Michigan law now requires you to tell us you completed work or other activities, such as a job search, monthly to receive healthcare. If a person meets an exemption, they will be excused from having to meet certain Healthy Michigan Plan requirements.

List the following exemptions that apply to members of your household:

___ **Pregnant** or was pregnant in the last two months

___ **Medically frail** (including disability, living in a nursing home, having a complex medical condition, homeless, and survivors of domestic violence)

___ **Main caretaker for a family member under 6**

___ **A full-time student**

___ **Under age 21 and was in Michigan foster care**

___ **In prison or jail** in the last 6 months

___ **Unemployment benefits** from State of Michigan

___ **Temporary or permanent disability** payments from a private insurer or the government

___ **Good cause** (disability, illness or hospitalization of yourself or a family member in the house)

___ **A medical condition** that limits work approved by a doctor

___ **Caring for a dependent with a disability** and doctors order for full-time care (including family members)

___ **Caring for a person who cannot make decisions for themselves**

Who?	Exemption
Name	
Name	

List the 80 hours of work or activity that members of your household completed:

← Complete this section for each person who has previously lost Healthy Michigan Plan eligibility for failing to meet work requirements for three months in a calendar year. You may list more than one activity for the month.

___ **Have a job** (part-time, full-time or self-employment)

___ **Student** (GED, college, computer classes, etc.)

___ **Looking for a job**

___ **Volunteering**

___ **Job training**

___ **In a tribal employment program**

___ **In rehab** (substance abuse)

___ **In vocational training** (apprenticeship, clinical, or other trade school)

___ **Have an internship**

Who?	Activity	Most recent date of completion
Name		
Name		

Michigan Department of Health and Human Services

Your Name:

Individual ID #:

Healthcare Coverage

If you need assistance, take a copy of this page to your employer and have them help you fill it out

Information on this page won't impact your application. It will be passed on to the federal government to determine your eligibility for APTC (Advanced Premium Tax Credits)

Health Coverage From Jobs

Complete this page if someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Is anyone in the household offered health insurance from a job? ___ **If yes, list below.** ___ **If no, skip this page.**
(This includes coverage from someone elses' job, such as a parent of a spouse)

Name ______________ - - ______________
Employee | Employee Social Security #

Name ______________ ______________ ______________
Employer | Employer Identification # (EIN) | Address of Employer

Name ______________ ( ) - ______________ @ ______________
Employer Contact | Phone # of Employer Contact | Email of Employer Contact
(This should be the person or department who manages employee benefits)

Can the employee get coverage now or sometime in the next 3 months? ___ **If yes, when?** ___/___/___ ___ **No**

List everyone who is eligible for coverage from this job Name(s) ______________

Does the employer offer a health plan that pays at least 60% of the total costs of benefits (the minimum value standard for health plans)? ___ **Yes** ___ **No**

If yes, how much would the employee have to pay for the lowest cost plan that meets the minimum value standard?

$ ______ per Wk 2Wks 2x/Mo Mo Qr Yr ← Don't include family plans. If the employer offers wellness programs, enter the premium that the employee would pay if they got the maximum discount for a tobacco cessation program

Will the employer make any changes for the new plan year (if you know)? ___ **If yes, list below.** ___ **No**

___ **Employer won't offer health coverage**

Date of change ___/___/___

___ **The premium amount will change for the lowest cost plan that meets the minimum value standard**

Date of change ___/___/___ Employee would pay this premium $ ______ per Wk 2Wks 2x/Mo Mo Qr Yr

Michigan Department of Health and Human Services

Your Name:
Individual ID #: