# Attachment A:
# List of Items in the Online Application to Support Eligibility Determinations for Enrollment through the Health Insurance Marketplace and for Medicaid and the Children's Health Insurance Program

Revised: 04/23/2013

# Individual questionnaire annotated outline

I. **My account**: Individuals must create an account to use the online application to apply for coverage through the Health Insurance Marketplace.
II. **Privacy**: Users must indicate they understand how their information is going to be used to continue with the online application.
III. **Getting started**: Gathers contact information for the application.
IV. **Assistance with completing the application**: Collects information about assistors.
V. **Help paying for coverage**: Asks whether people want help paying for coverage.
VI. **Tell us how many people are applying for health coverage**: Creates a list of all people applying for coverage in the household.
VII. **Tell us about each person**: Collects demographic information and determines household composition for the [insert tax credit term], Medicaid, and the Children's Health Insurance Program (CHIP).
VIII. **More about this household**: Collects information about students, disabilities, pregnancies, etc.
IX. **Expedited income**: Collects annual income for individuals who appear eligible for [insert tax credit term].
X. **Current/monthly income**: Collects current monthly income.
XI. **Discrepancies**: Collects information on any income or other discrepancies between what an individual reported and data sources.
XII. **[Insert tax credit term] program questions**: Only displayed if someone appears [insert tax credit acronym] eligible. Collects information about access to employer and non-employer health coverage, Special Enrollment Periods, as well as information about applicants who are American Indian or Alaska Native.
XIII. **Medicaid & CHIP specific questions**: Only display if someone appears Medicaid or CHIP eligible.
XIV. **Incomplete application:** Displays when application isn't completed.
XV. **Review & sign**: Printable review and summary of the application, agreements, and signatures. Displays eligibility results for each individual.
XVI. **Enrollment "To-do" list:** For each individual, displays next steps to complete enrollment, including requests for required documents to be uploaded (if needed).
XVII. **Plan enrollment (for [insert tax credit acronym] or QHP eligible applicants)**: Displays tobacco questions, compare and select plan(s), etc.

The following items are asked if the person checked that he/she didn't want financial assistance. These are required in order to enroll in a qualified health plan on the Marketplace.

XVIII. **Tell us how many people are applying for health coverage**
XIX. **Tell us about each person:** Collects demographic information including other addresses, Special Enrollment Periods, as well as information about applicants who are American Indian or Alaska Native.
XX. **Incomplete application:** Displays when application isn't completed.
XXI. **Review & sign**: Printable review and summary of the application, agreements, and signatures. Displays eligibility results for each individual.
XXII. **Enrollment "To-do" list**: For each individual, displays next steps to complete enrollment, including requests for required documents to be uploaded (if needed).
XXIII. **Plan enrollment**: Displays tobacco questions, compare and select plan(s), etc.

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# I. My account

**Note to reviewers**: To access the Health Insurance Marketplace online application, the individual filling out the application must first set up "My account." There are two parts to setting up "My account". The first part describes the creation of a "lite account." This account lets individuals establish a relationship with the Marketplace. They can use this to access or update contact information, set communication preferences, get notices, and browse and compare plans in a secure environment without requiring identity proofing. During the second part of "My account," setup requires the individual to give additional information to transition to a regular account. This requires the individual to establish identity via an authentication process. The individual enters personal information and answers a set of "challenge" questions. We aren't providing the list of challenge questions to protect the security and integrity of the system. The individual can then start the application process from within his/her "My account." The account creation step may be skipped for individuals applying via phone, where a call center representative is entering information into the electronic application.

## A. Create a lite account

*(Display for users setting up an account. An account is required to create and submit an application.)*

1. Create account *(Display check box.)*
    a. Name:
        i. First name: ____________________
        ii. Middle name: ____________________ *optional*
        iii. Last name: ____________________
        iv. Suffix: *(Display dropdown menu of suffixes.) optional*
            1. Jr.
            2. Sr.
            3. III
            4. IV
    b. Email address: _________________
    c. Confirm email address: __________________
    d. Username: ________________
    e. Password: _________________
    f. Confirm password: ________________
    g. Security questions: (*Choose 4 sets from a selection of questions.*)
    h. Security question answers: (*Answers to the 4 questions provided by the individual.*)

## B. Transition to a full account

*(Display for user's additional account creation information.)*

1. Create account *(Display check box. Information that was provided when creating a lite account will be prepopulated.)*
    a. Name:
        i. First name: ____________________
        ii. Middle name: ____________________ *optional*
        iii. Last name: ____________________
        iv. Suffix: *(Display dropdown menu of suffixes.) optional*
            1. Jr.
            2. Sr.
            3. III

4. IV

b. Address:
   i. Street address: ____________________
   ii. Apartment or suite number: __________________ *optional*
   iii. City: ____________________
   iv. State: *(Display dropdown menu of states.)*
   v. ZIP code: ____________________
c. No home address *(Display check box. If selected, prompt to enter a mailing address.) optional*
d. Phone number: (___) ___-____ Ext. ___ *optional*
e. Second phone number: (___) ___-____ Ext. ___ *optional*
f. Email address: ____________________
g. Social Security number (SSN): ___-___-____ *optional*
h. Date of birth: MM/DD/YYYY

2. Authentication process *(This process includes TBD challenge questions.)*

## C. Account settings

*(The user may select text or email as a method to receive notifications, notices, and marketing emails from his/her "My account." The user can also select his/her preferred spoken and written languages.)*

## D. Add authorized user

*(The primary account holder may add one or more authorized users to his/her account and assign privileges.)*

1. Secondary account holder

*(The primary account holder may select another individual on the application to be a secondary account holder and give them permission to view or edit the application after the application has been submitted. To do this, the primary account holder can provide the secondary account holder's Marketplace account username or email address. For the authority to be official, the secondary account holder will receive an email requiring sign-in to his/her Marketplace account. If the individual doesn't have an existing Marketplace account, the primary account holder can indicate that he/she should receive an email with instructions for setting up a Marketplace account. The primary account holder must also check the box to indicate agreement to the statement below.)*

a. By clicking here, I hereby agree to allow the selected person to act on my behalf to the extent I've identified. I understand that this person will have access to my personal and financial identifying information and all information contained in an application I submit through the Marketplace. *(Display check box.)*

2. Authorized representative

*(The primary account holder may choose any person to be his or her authorized representative. Both the primary account holder and authorized representative must have a "My account" and have their identity authenticated. The primary account holder designates an authorized representative by entering the authorized representative's "My account" username or email when prompted. If the authorized representative doesn't have a username, the primary account*

*holder will be asked to enter the authorized representative's email. The system then sends an email to the authorized representative for confirmation.*

*An individual can also create an account on someone else's behalf by opting to become an authorized representative. He/she will be asked to upload proof of authorized representation status. Once the documentation is verified, that person can act as an authorized representative for the primary account holder.)*

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."

a. Do you want to name someone as your authorized representative? *optional*
    i. Yes *(If selected, continue to "b.")*
    ii. No *(If selected, skip to section II ["Privacy"].)*
b. Does this person already have their own Marketplace account?
    i. Yes *(If selected, display "1.")*
        1. Enter the username or email address for this person's account. You can enter one or both below.
            a. Username:________________
            b. Email address:_____________
    ii. No *(If selected, display "1-3.")*
        1. This person will need to create a Marketplace account in order to get notices and act on your behalf. Enter his or her email address below. We'll send information on how to create an account and become your authorized representative. You can still continue with your application now.
        2. Email address:___________
        3. Re-enter email address:__________
c. Is this person part of an organization helping you apply for coverage? *(If "ii" ("no") was selected in "b" above, display "optional.")*
    i. Yes *(If selected, display "1-2," then continue "d.")*
        1. Organization name: ____________________
        2. Organization ID: ____________________
    ii. No *(If selected, skip to section II ["Privacy"].)*
d. *(If the individual is incapacitated and unable to complete the process of logging in to create a user account and identify an authorized user, an authorized representative can submit paper documentation proof of authority to act on behalf of the individual. The authorized representative must upload the document into "My account" for review.)*
    i. If someone is representing the applicant because [he/she] has a power of attorney or court order, upload the document.
        1. *(Display dropdown menu of document types.)*
            a. Power of attorney
            b. Court order establishing legal guardianship
            c. CMS form to appoint an authorized representative
        2. *(Select file for upload.)*

3. *(The primary account holder then agrees to the statement below by checking the box.)* By clicking here, I hereby agree to allow the selected party to act on my behalf to the extent I've identified. I understand that this person will have access to my personal and financial identifying information and all information contained in an application I submit through the Marketplace. *(Display check box.)*

### E. Change in circumstances

*(Display section if the applicant previously completed an application and now indicates that he/she wants to report a change, as required in section XV ["Review & sign"].)*

1. When you submitted your application, you agreed to report changes that might impact your eligibility for coverage. Do you want to report a change? Click here to see the changes you need to tell us about. *(Display link to help text that lists potential changes.)*
    a. Yes *(If selected, individual is taken through a prepopulated application to update the information.)*
    b. No *(If selected, no further action.)*

2. If you were exempt from getting your own health coverage, do you want to report something that may change that exemption?
    a. *Yes (If selected, display each exemption application that the individual has filed. Individual can select one exemption application at which point he/she will be redirected to that application to update the information.)*
    b. No *(If selected, no further action.)*

**Note to reviewers**: Once an individual sets up an account, he/she can continue the application process. After logging in, the individual will see section II ["Privacy"], followed by section III ["Getting started"]. As part of the privacy step, the individual provides consent for his/her information to be used and retrieved from data sources. He/she also attests that he/she has permission from all other persons listed on the application to allow their information to be used and retrieved during the application process for verifying the household's information to determine eligibility.

## II. Privacy

### A. Privacy & use of your information

*(Display privacy statement & consent language.)*

1. We'll keep your information private as required by law. Your answers on this form will only be used to determine eligibility for health coverage or help paying for coverage. We'll check your answers using the information in our electronic databases and the databases of other federal agencies. If the information doesn't match, we may ask you to send us proof.

    We won't ask any questions about your medical history. Household members who don't want coverage won't be asked questions about citizenship or immigration status.

    IMPORTANT: As part of the application process, we may need to retrieve your information from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. We need this information to check your eligibility for

coverage and help paying for coverage if you want it and to give you the best service possible. We may also check your information at a later time to make sure your information is up to date. We'll notify you if we find something has changed.

2. I agree to have my information used and retrieved from data sources for this application. I have consent for all people I'll list on the application for their information to be retrieved and used from data sources. *(Display check box. Provide links to: "Learn more about your data" and "Privacy Act Statement.")*

# III. Getting started

## A. Contact information

*(Prepopulate from section I ["My account"], and allow for editing.)*

1. Name:
    a. First name : ____________________
    b. Middle name: ___________________ *optional*
    c. Last name: ___________________
    d. Suffix: *(Display dropdown menu of suffixes.) optional*
        i. Jr.
        ii. Sr.
        iii. III
        iv. IV

2. Date of birth: MM/DD/YYYY *(Prepopulate from section I ["My account"], and allow for editing.)*

## B. Contact home address

*(Prepopulate from section I ["My account"], and allow for editing.)*

1. Address:
    a. Street address: ____________________
    b. Apartment or suite number: ____________________ *optional*
    c. City: ____________________
    d. State: *(Display dropdown menu of states.)*
    e. ZIP code: ____________________
    f. County: *(Display dropdown selection of potential counties, if ZIP code crosses more than one county.)*

2. No home address *(Display check box. If selected, prompt to enter a mailing address.) optional*

## C. Contact mailing address

1. Is your mailing address the same as your home address?
    a. Yes *(If selected, skip to subsection "D" ["Contact phone"].)*
    b. No *(If selected, continue to item 2.)*

2. Mailing address:
    a. Street address: ____________________

b. Apartment or suite number: ____________________ *optional*
c. City: ____________________
d. State: *(Display dropdown menu of states.)*
e. ZIP code: ____________________
f. County: *(Display dropdown selection of potential counties, if ZIP code crosses more than one county.)*

## D. Contact phone

(*Prepopulate from section I [“My account”], and allow for editing.*)

1. Phone number: (___) ___-____ Ext. ___

2. Phone type: (Select one.) *(Display dropdown menu of phone types.)*
   a. Cell
   b. Home
   c. Work

3. Second phone number: (___) ___-____ Ext. ___ *optional*

4. Phone type: (Select one.) *(Display dropdown menu of phone types.) optional*
   a. Cell
   b. Home
   c. Work

## E. Contact preferences

1. Preferred spoken language: *optional*
   a. *(Display dropdown menu of languages; default to English.)*

2. Preferred written language: *optional*
   a. *(Display dropdown menu of languages; default to English.)*

3. We need to know the best way to contact you about this application and your health coverage if you’re eligible. Do you want to read your notices about your application on your electronic “My account” on this website? *(Display check boxes.)*
   a. Yes. I want to read my notices online. *(If selected, continue to item 4.)*
   b. No. I want to get paper notices sent to me in the mail.

4. *(Display item if “a” was selected in item 3.)*
   You’ll be contacted when a notice is ready for you on this website. How can we contact you? (*Display check boxes*.)
   a. Text: *(Prepopulate phone number. If selected, display “i.”)*
      i. Messaging rates will apply.
   b. Email: *(Prepopulate email.)*

## F. Authorized representative

**Note to reviewers**: Applicants may identify an authorized user in “My account.” If they don’t, they can do so here. The process routes them back through the same steps that appear in “My account.”

(*Display item if no authorized representative was identified in section I ["My account"].*)
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."

1. Do you want to name someone as your authorized representative?
   a. Yes *(If selected, follow process as outlined in section I ["My account"], item "D.2.")*
   b. No

## IV. Assistance with completing the application

1. Is anyone helping you with this application?
   a. Yes *(If selected, continue to item 2.)*
   b. No *(If selected, skip to section V ["Help paying for coverage"].)*

2. Tell us if you're getting help from one of these people. *(Display option buttons.)*
   a. Navigator *(If selected, display "i-iii.")*
      i. Name:
         1. First name: ____________________
         2. Middle name: ____________________ *optional*
         3. Last name: ____________________
         4. Suffix *(Display dropdown menu of suffixes.) optional*
      ii. Organization name: ___________
      iii. ID number: ________
   b. Certified application counselor *(If selected, display "i-iii.")*
      i. Name:
         1. First name: ____________________
         2. Middle name: ____________________ *optional*
         3. Last name: ____________________
         4. Suffix *(Display dropdown menu of suffixes.) optional*
      ii. Organization name: ___________
      iii. ID number: ________
   c. In-person assistance personnel *(If selected, display "i-iii.")*
      i. Name:
         1. First name: ____________________
         2. Middle name: ____________________ *optional*
         3. Last name: ____________________
         4. Suffix *(Display dropdown menu of suffixes.) optional*
      ii. Organization name: ___________
      iii. ID number: ________
   d. Agent or broker *(If selected, display "i-iv.")*
      i. Name:
         1. First name: ____________________
         2. Middle name: ____________________ *optional*
         3. Last name: ____________________
         4. Suffix *(Display dropdown menu of suffixes.) optional*

ii. Organization name: ___________
iii. FFM User ID: ________
iv. NPN number: ________

e. None of these

# V. Help paying for coverage

## A. Who needs health coverage

1. Who are you applying for health coverage for?
   a. [Household contact] only *(Display check box.)*
   b. [Household contact] & other family members *(Display check box.)*
   c. Other family members, not [Household contact] *(Display check box.)*

2. Do you want to find out if [you/your family] can get help paying for health coverage?
   a. Yes. You'll answer questions about your income to see what help [you/your family] qualif[y/ies] for. (*If selected, skip to section VI ["Tell us how many people are applying for health coverage"].)*
   b. No. You'll answer fewer questions, but you won't get help paying for coverage. (*If selected, continue to subsection "B" ["Income screener"].)*
   c. Not sure? Answer 3 questions to figure out your next steps. (*If selected, continue to subsection "B" ["Income screener"].)*

## B. Income screener (Get help with costs) *optional*

**Note to reviewers:** The next few questions are only asked if the person checks that he/she doesn't want to or isn't sure if he/she wants to apply for help paying for coverage in the question above. The tool helps an applicant decide if he/she should apply for financial assistance. These items aim to promote the use of the financial assistance application for people who initially may not think they qualify. These questions don't determine eligibility and the information isn't stored or used elsewhere.

Even working families can pay less for health coverage. You may be eligible for a free or low-cost plan, or [insert tax credit term] that can be used to lower your monthly premiums right away. Answer these questions to see if you may qualify to get a break on costs.

1. Will you file taxes next year? You don't have to file taxes to apply for coverage.
   a. Yes (*If selected, display "i."*)
      i. How many people will be on your federal income tax return next year?
         1. _____
   b. No (*If selected, display "i."*)
      i. How many people live with you? Include yourself.
         1. _____
   c. I don't know (*If selected, display "i."*)
      i. How many people live with you? Include yourself.
         1. _____

2. Based on your best guess, do you expect your total household income to be less than [equivalent to 420% of the federal poverty level in dollars for family size listed] in [coverage year]?

a. Yes, [my/our] total household income will be **less** than [equivalent amount] in [coverage year] *(If selected, display "i," then continue to item 3.)*
    i. Based on what you told us, you may be eligible to get help paying for health coverage through the Health Insurance Marketplace. We encourage you to apply for this help.
b. No, [my/our] total household income will be more than [equivalent amount] in [coverage year] *(If selected, display "i," then continue to item 3.)*
    i. Based on what you told us, your income may be too high to get help paying for health coverage, but we encourage you to apply for help if you want to be sure. You can still get a good deal on coverage from the Health Insurance Marketplace, and you can't be denied coverage or pay more if you have a pre-existing condition.
c. I don't know *(If selected, display "i," then continue to item 3.)*
    i. We encourage you to apply to see what help you can get paying for health coverage. We'll walk you through questions to find out if you can get help paying for health coverage through the Health Insurance Marketplace.

3. Do you want to see what help [you/your family] may get?
    a. Yes. You'll be asked questions about your income and household to see how much help you may qualify for. *(If selected, go to financial assistance question sequence.)*
    b. No. You'll be asked fewer questions, but you won't get help paying for health coverage. (*If selected, go to non-financial assistance question sequence*.)

## VI. Tell us how many people are applying for health coverage

*(Display section if household contact indicated that other family members want coverage.)*

**Note to reviewers:** "[FNLNS]" stands for "First name, last name, suffix" and indicates that the appropriate person's name will be prepopulated.

1. How many people in your family and household want health coverage? Include yourself.
    a. ___

2. You'll fill out information for each person in your family and household who wants coverage. Tell us about this person:
    a. Name:
        i. First name: ____________________
        ii. Middle name: ____________________ *optional*
        iii. Last name: ____________________
        iv. Suffix: *(Display dropdown menu of suffixes.) optional*

3. Date of birth: MM/DD/YYYY

4. How is [FNLNS] related to [Application filer FNLNS]? (Select one.)
    [FNLNS] is the *(Display relationship dropdown menu)* of [Application filer FNLNS]. *(Default is blank.)*
    a. Husband/wife
    b. Domestic partner

c. Parent
d. Stepparent
e. Parent's domestic partner
f. Son/daughter
g. Stepson/stepdaughter
h. Child of domestic partner
i. Brother/sister
j. Uncle/aunt
k. Nephew/niece
l. First cousin
m. Grandparent
n. Grandchild
o. Other relative *(If selected, and when both applicants appear APTC or QHO eligible after the income section, display subsequent list of relationships allowed for plan enrollment to choose from in section XII["[Insert tax credit term] program questions"], subsection "A" ["Tax filer & other information"].)*
p. Other unrelated *(If selected, and when both applicants appear APTC or QHP eligible after income section, display subsequent list of relationships allowed for plan enrollment to choose from in section XII ["[insert tax credit term] program questions"], subsection "A" ["Tax filer & other information"].)*

*(Repeat items 2-4 for all applicants.)*

## VII. Tell us about each person

**Note to reviewers**: After we know who all the applicants are, the left navigation will show a sub-navigation bar with the household contact's name and additional bars for each applicant's name. For each applicant, we'll ask for personal information that's needed to determine citizenship/immigration status, household size, and address, as well as optional race and ethnicity questions. CMS consumer testing indicated that this type of person-centered flow is more intuitive for users. If based on the questions about household, we determine that we need to ask about non-applicant household members as well, then we'll ask only for the information that's required for the eligibility determination of applicants, such as birthdate and an optional request for a Social Security number to verify income.

*(Repeat for each household member, with the household member's name displayed at the top. Begin with the household contact.)*

### A. [FNLNS] personal information

1. Sex:
   a. Male *(Display check box.)*
   b. Female *(Display check box.)*

2. *(Display item for any household member listed on the applicant list.)*
   We need a Social Security number (SSN) if you want health coverage and have an SSN or can get one. We use SSNs to check income and other information to see who is eligible for help paying for health coverage. If [FNLNS] needs help getting an SSN, visit socialsecurity.gov, or call 1-800-722-1213. TTY users should call 1-800-325-0778.

   *(Display item if a household member* ***isn't*** *listed on the applicant list.)*

Providing your Social Security number (SSN) can be helpful if you don't want health coverage because it can speed up the application process. We use SSNs to check income and other information to see who is eligible for help paying for health coverage. If [FNLNS] needs help getting an SSN, visit socialsecurity.gov, or call 1-800-722-1213. TTY users should call 1-800-325-0778.

a. *(This item is optional for non-applicants.)*
   Social Security number: ___-___-____

3. *(Display item for everyone who enters an SSN.)*
   Is [FNLNS] the same name that appears on [his/her] Social Security card?
   a. Yes *(If selected, skip to subsection "B" ["Medicaid or CHIP enrollment check"], if applicable.)*
   b. No *(If selected, continue item 4.)*

4. *(Display item if "b" was selected in item 3.)*
   Enter the same name as shown on [FNLNS]'s Social Security card:
   a. Name:
      i. First name: ____________________
      ii. Middle name: ____________________
      iii. Last name: ____________________
      iv. Suffix: *(Display dropdown menu of suffixes.)*

*(At this point, non-applicants are done with section VII ["Tell us about each person"], unless an SSN has been entered and not verified by the Social Security Administration (SSA), the system will provide a limited number of opportunities for the user to retry entries for name, date of birth, and SSN. All applicants continue to subsection "B" ["Medicaid or CHIP enrollment check"], if applicable.)*

## B. Medicaid or CHIP enrollment check

*(Display subsection if data sources indicate that one of more of the individuals applying for coverage is already enrolled in Medicaid or CHIP.)*

Our records show that [FNLNS] is currently enrolled in [State Medicaid program name of State CHIP program name]. If [FNLNS] wants to keep [his/her] current health coverage through [State Medicare program name or State CHIP program name], then [he/she] shouldn't apply here.

1. What would you like to do?
   *(Display options buttons.)*
   a. *(Display is [FNLNS] is the only applicant.)*
      Stop this application. [FNLNS] will keep [his/her] current health coverage, and should report any changes to the [State Medicaid program name or State CHIP program name] agency.

      *(Display if there are other applicants on the application.)*
      Remove [FNLNS] as an applicant for health coverage on this application, since [he/she]'s already enrolled in [State Medicaid program name or State CHIP program name]. (Note that I may still need to answer a few more questions about [FNLNS] to see what programs other people may be eligible for.) *(If selected, change [FNLNS] applicant status to "not applying for health coverage." Help text will clarify that*

*[FNLNS] should report any change in circumstances to the State Medicaid or CHIP agency.)*

b. Continue this application, and see what programs [FNLNS] may be eligible for in the Marketplace.

## C. Citizenship/immigration status

1. Is [FNLNS] a U.S. citizen or U.S. national?
   a. Yes *(If selected and citizenship is verified with SSA, skip to subsection "D" ["Family & household"].If selected and citizenship* ***isn't*** *verified with SSA, continue to item 2.)*
   b. No *(If selected, skip to item 4.)*

2. *(Display item if SSA doesn't verify U.S. citizenship or U.S. national status.)*
   Is [FNLNS] a naturalized or derived citizen?
   a. Yes *(If selected, continue to item 3.)*
   b. No *(If selected, inconsistency is found; skip to subsection "D" ["Family & household"], if applicable.)*

3. *(Display item if "a" was selected in item 2.)*
   Document type: (Select one.)
   a. Naturalization certificate *(If selected, display "i-ii.")*
      i. Alien number: ____________________ *(Display check box for "I don't have one.")*
      ii. Naturalization certificate number: ____________________
   b. Certificate of citizenship *(If selected, display "i-ii.")*
      i. Alien number: ____________________ *(Display check box for "I don't have one.")*
      ii. Citizenship certificate number: ____________________

4. Check if [FNLNS] has eligible immigration status: *(Link to explanation of eligible immigration statuses.)*
   a. *(Display check box. If check box was selected, continue to item 5. If check box wasn't selected, show message explaining that this person might be eligible for services if he/she has an emergency or is pregnant, and encourage applicant to review list of eligible statuses available and select an option, if applicable.) (If check box isn't checked, skip to item 11.)*

5. Document type: (Select one.) *(If "a-l" is selected, display values in "5.i-ix." Link to explanation and images of document and status types.)*
   a. Permanent Resident Card ("Green Card," I-551)*
   b. Temporary I-551 Stamp (on passport or I-94, I-94A)*
   c. Machine Readable Immigrant Visa (with temporary I-551 language)*
   d. Employment Authorization Card (EAD, I-766)*
   e. Arrival/Departure Record (I-94, I-94A)*
   f. Arrival/Departure Record in foreign passport (I-94)*
   g. Foreign passport
   h. Reentry Permit (I-327)
   i. Refugee Travel Document (I-571)
   j. Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)

k. Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)
l. Notice of Action (I-797)*
m. Other documents or status types *(Link to "Other documents and status types.") (If selected, continue to item 6.)*

*(*For these document types, allow one selection from item "5.a-l" and one selection from item "6.a-i." Otherwise, display items "5.a-m." If "m" was selected, disable other selections in item 5 and enable list of "other document and status types" below in "6.a-i.")*

*(Display appropriate option based on document type selected. The user will be prompted to provide one or more of the following based on the document type selection.)*

i. Alien number: ____________________
ii. I-94 number: ____________________
iii. Passport or document number: ____________________
iv. Country of issuance: *(Display dropdown list of countries.)*
v. Passport expiration date: MM/DD/YYYY
vi. SEVIS ID number: ____________________
vii. Document description: ____________________
viii. Document expiration date: MM/DD/YYYY
ix. Category code: _______________

6. *(Display item if "m" was selected in item 5; show list of other document and statuses, as follows. For some status types that are unverifiable, the system may ask for the user to upload documents. For some document types, a user can select both a document type from item 5 and one or more statuses from this list.)*
   Do you have any of these documents? [*or* "Do you also have any of these documents?"] (Select all that apply.)
   a. Document indicating a member of a federally recognized Indian tribe or American Indian born in Canada**
   b. Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR)
   c. Office of Refugee Resettlement (ORR) eligibility letter (if under 18)
   d. Cuban/Haitian Entrant
   e. Document indicating withholding of removal
   f. Resident of American Samoa**
   g. Administrative order staying removal issued by the Department of Homeland Security
   h. Other *(If selected, display "i-ii.")*
      i. Description: ____________________
      ii. Alien number OR 1-94 number: ____________________
   i. None of the above

*(** For these document/status types, ask for documents at section XVI ["Enrollment To-do list"].)*

7. *(Display item if "a-h" was selected in item 5.)*
   Is [FNLNS] the same name that appears on [his/her] document?
   a. Yes *(If selected, skip to item 9.)*
   b. No *(If selected, continue to item 8.)*

8. *(Display item if "b" was selected in item 7.)*

Enter the same name as shown on [FNLNS]'s document:

a. Name:
   i. First name: ____________________
   ii. Middle name: ____________________
   iii. Last name: ____________________
   iv. Suffix: *(Display dropdown menu of suffixes.)*

9. *(Display item if "4.a" was checked to indicate "eligible immigration status" and the applicant has a birth date prior to August 22, 1996.)*
   Has [FNLNS] lived in the U.S. since 1996?
   a. Yes
   b. No

10. *(Display item if applicant checked "eligible immigration status" and the Department of Homeland Security indicates that the five-year bar applies.)*
    Is [FNLNS if over age 16] [or FNLNS spouse *if applicable*] [or [FNLNS's parent *if applicable*] an honorably discharged veteran or active-duty member of the military?
    a. Yes
    b. No

*(After clicking "Save & continue" in section VII ["Tell us about each person"], retries of the name, date of birth, and SSN and DHS numbers may occur if any information was unable to be verified.)*

11. *(Display exception message – eligible immigration modal. Display if "4.a" isn't checked.)*
    Did you forget to check the immigration status?
    a. Yes. I'll check the immigration status now. *(If selected, return to "4.a" to allow selection of an immigration status.)*
    b. No. I want to continue without checking an immigration status. *(If selected, display "i.")*
       i. If [FNLNS]'s immigration status isn't on the list, then [FN] may still be able to get help paying for services if [he/she] has an emergency [or is pregnant].

12. *(Display exception message – request SEVIS. Display if the Systematic Alien Verification for Entitlements (SAVE) system returns a request for additional information following entry of immigration documents.)*
    Do you have a Student and Exchange Visitor Information System (SEVIS) ID?
    a. Yes (*If selected, display "i."*)
       i. SEVIS ID: __________ *(Display numeric field; ten digits required.)*
    b. No

## D. Family & household

**Note to reviewers**: The sequencing of items in this section is governed by complex logic to ask the fewest number of questions possible to determine both the tax and Medicaid household of each applicant. Based on consumer testing results and design expertise, instead of completing one household composition section per application, we split the questions out on a per-person basis, so that the application filer is asked relevant household composition questions at the same time that he/she is asked about race/ethnicity, citizenship/immigration, and parent/caretaker relatives for each applicant. Note the relevant year for questions about the tax household is the coverage year, so during initial open enrollment questions would refer to 2014.

We start by building the household and the rest of the personal page for the household contact. We try to provide ways for people to continue with the application even if complete information on both Medicaid and tax household members isn't available, such as when a custodial or non-custodial parent applies and can't attest to the income of the other parent.

*(Display for household contact, and then for additional applicants only as described in the logic note following item 18.)*

1. Does [Household contact] plan to file a federal income tax return for [coverage year]? You don't have to file taxes to apply for coverage.
   a. Yes
   b. No *(If selected, and spouse was listed in applicant list, skip to item 4.)*

2. *(Display item if no other applicant indicated relationship of "spouse" or "domestic partner" to household contact in section VI ["Tell us how many people are applying for health coverage"].)*
   Is [Household contact] married?
   a. Yes (*If selected and a tax filer, continue to item 3. If selected and a non-filer, skip to item 4.*)
   b. No *(If selected and a tax filer, skip to item 5. If selected and a non-filer, skip to item 6.)*

3. *(Display item only if household contact is a married tax filer based on item 2 or attestation of spousal relationship in section VI ["Tell us how many people are applying for health coverage"].)*
   Does [Household contact] plan to file a joint federal income tax return with [his/her] spouse for [coverage year]?
   a. Yes *(If selected, display "i," then skip to item 5.)*
      i. *(Display item if spouse isn't on applicant list.)*
         Who is [Household contact]'s spouse?
         1. Name of spouse:
            a. First name: ____________________
            b. Middle name: ____________________ *optional*
            c. Last name: ____________________
            d. Suffix: *(Display dropdown menu of suffixes.) optional*
         2. Date of birth: MM/DD/YYYY
   b. No *(If selected, continue to item 4.)*

4. *(Display item if married but either a non-filer or a filer not filing a joint return.)*
   Does [Household contact] live with [his/her] spouse?
   a. Yes *(If selected, display "i" only if spouse wasn't identified on applicant list. Then, continue to item 5 if a tax filer or to item 6 if a non-filer.)*
      i. *(Display item if spouse isn't on applicant list.)*
         Who is [Household contact]'s spouse?
         1. Name of spouse:
            a. First name: ____________________
            b. Middle name: ____________________ *optional*
            c. Last name: ____________________

            d. Suffix: *(Display dropdown menu of suffixes.) optional*
        2. Date of birth: MM/DD/YYYY
    b. No *(If selected, continue to item 5 if a tax filer or to item 6 if a non-filer.)*

5. *(Display item for tax filers.)*
   Will [Household contact] [and spouse name *(if married and filing jointly)*] claim any dependents on [his/her/their joint] federal income tax return for [coverage year]?
    a. Yes (*If selected, display "i-ii." Then skip to subsection "E" ["Parent/caretaker relatives"].)*
        i. *(Display all other applicant names, and allow multi-select.)*
        ii. Someone else who isn't applying for health coverage *(If selected, display "1-3.")*
            1. Name of dependent:
                a. First name: ____________________
                b. Middle name: ____________________ *optional*
                c. Last name: ____________________
                d. Suffix: *(Display dropdown menu of suffixes.) optional*
            2. Date of birth: MM/DD/YYYY
            3. Add another dependent *(Display as button.)*
    b. No *(If selected, continue to item 6.)*

6. *(Display item if a non-filer or a filer not claiming a dependent.)*
   Will [Household contact] be claimed as a dependent on someone else's federal income tax return for [coverage year]?
    a. Yes *(If selected, and household contact is an applicant, display "i," then continue to item 7. If selected and household contact is a non-applicant, then he/she is finished with this section; next, the system will skip to the first applicant starting with subsection "A" "[[FNLNS] personal information].")*
        i. Who is the tax filer that will claim [Household contact] on their income tax return?
            1. *(Display all household members.) (If selected, skip to item 8.)*
            2. Someone else who isn't applying for health coverage *(If selected, continue to item 7.)*
    b. No *(If selected and household contact is a tax filer, then he/she is finished with this section; next, if he or she is an applicant, he/she will skip to subsection "E" ["Parent/caretaker relatives"]. If selected and household contact isn't a tax filer, skip to non-filer questions starting at item 16.)*

*(Items 7-14 are for tax dependents.)*

7. *(Display item if household contact is an applicant and a tax dependent, as indicated by "a" on item 6, and tax filer is a non-applicant.)*
   How is [Household contact] related to [Tax filer FNLNS]?
   [FNLNS] is the *(Display relationship dropdown menu)* of [Name of claiming tax filer].
    a. Husband/wife *(If selected, skip to item 14.)*
    b. Domestic partner *(If selected, skip to item 10.)*
    c. Parent *(If selected, skip to item 10.)*
    d. Stepparent *(If selected, skip to item 10.)*
    e. Parent's domestic partner *(If selected, skip to item 10.)*
    f. Son/daughter *(If selected, continue to item 8.)*

g. Stepson/stepdaughter *(If selected, continue to item 8.)*
h. Child of domestic partner *(If selected, skip to item 10.)*
i. Brother/sister *(If selected, skip to item 10.)*
j. Stepbrother/stepsister *(If selected, skip to item 10.)*
k. Uncle/aunt *(If selected, skip to item 10.)*
l. Nephew/niece *(If selected, skip to item 10.)*
m. First cousin *(If selected, skip to item 10.)*
n. Grandparent *(If selected, skip to item 10.)*
o. Grandchild *(If selected, skip to item 10.)*
p. Other relative *(If selected, and both household members are applicants who look eligible for APTC, display subsequent list of relationships allowed for plan enrollment to choose from in section XII ["[Insert tax credit term] program questions"], subsection "A" ["Tax filer & other information"].)*
q. Other unrelated *(If selected, and both household members are applicants who look eligible for APTC, display subsequent list of relationships allowed for plan enrollment to choose from in section XII ["[insert tax credit term] program questions"], subsection "A" ["Tax filer & other information"].)*

8. *(Display item if tax filer is a parent/stepparent of household contact and household contact is an applicant and is under age 21.)*
   Does [Applicant dependent FNLNS] live with the parent or stepparent(s) that claim [FNLNS] on the tax return?
   a. Yes *(If selected, skip to item 12.)*
   b. No *(If selected, continue to item 9.)*

9. *(Display item if household contact is an applicant and is under age 21 and is claimed by a parent.)*
   Does [Dependent FNLNS] live with a parent or stepparent other than [Tax filer(s)]?
   a. Yes *(If selected, display item "i." If selected and household contact lives with tax filer and another parent that doesn't claim him/her as a dependent, after "i," skip to item 14 for non-filer questions.)*
      i. Select [Household contact]'s parents and stepparent(s) that live with [Household contact]. *(Allow selection of up to two checkboxes.)*
         1. *(Display all household members older than applicant as options.)*
         2. Someone else who isn't applying for health coverage *(If selected, display "a-c.")*
            a. Name of parent or stepparent:
               i. First name: ____________________
               ii. Middle name: ____________________ *optional*
               iii. Last name: ____________________
               iv. Suffix: *(Display dropdown menu of suffixes.) optional*
            b. Date of birth: MM/DD/YYYY
            c. Relationship: *(Display check boxes.)*
               i. Parent
               ii. Stepparent
   b. No *(If selected and household contact lives with a parent tax filer, skip to item 14. If selected, and household contact doesn't live with tax filer, skip to item 16.)*

10. *(Display item if the household contact is an applicant and a tax dependent, and the claiming tax filer is a non-applicant, and isn't the custodial parent or spouse of the household contact.)*
    You must provide information about [Tax filer (and tax filer spouse if there is one)]'s income and about who else is on the tax return to get [insert tax credit term] to help pay for health coverage for [Household contact]. However, you can continue with this application without telling us more about [Tax filer] to see if you can get covered by [Names of state Medicaid and CHIP programs].
    Do you want to provide the claiming tax filer's information, so the tax filer can apply for [insert tax credit term]?
    a. Yes *(If selected, skip to item 12.)*
    b. No *(If selected, skip to item 16.)*

11. *(Display item if household contact is an applicant and under 21, is claimed by an applicant non-custodial parent, and lives with a non-applicant parent. After displaying message, continue to item 12.)*
    [Dependent FNLNS] may be eligible for Medicaid or the Children's Health Insurance Program (CHIP) through the parent they live with. That parent can also file an application. To do so, the parent can create a Marketplace account (hyperlink), call 1-800-XXX-XXXX, or print a paper application at HealthCare.gov/paperapp to mail in. You can also continue with this application now to see if [Tax filer(s) name(s)] can get [insert tax credit term] to pay for health coverage for [Dependent FNLNS] instead.

12. *(Display item if information is being provided about household contact's tax filer.)*
    Is [Tax filer] married?
    a. Yes *(If selected, continue to item 13.)*
    b. No *(If selected, and tax filer isn't the parent/stepparent of the household contact, skip to item 15. If selected, and tax filer is the parent/stepparent of household contact who is under age 21, then return to item 9.)*

13. *(Display item if tax filer is married.)*
    Does [Tax filer] plan to file a joint federal income tax return with a spouse for [coverage year]?
    a. Yes *(If selected, display "i" and then continue to item 14)*
        i. Who is [tax filer]'s spouse?
            1. First name: ____________________
            2. Middle name: ____________________ *optional*
            3. Last name: ____________________
            4. Suffix: *(Display dropdown menu of suffixes.) optional*
            5. Date of birth: MM/DD/YYYY
    b. No *(If selected, and tax filer isn't the parent of a household contact who is under age 21, then continue to item 14. If selected and household contact is the son/daughter/stepchild of household contact who is under age 21, then skip to item 16 for non-filer questions.)*

14. *(Display item if household contact is an applicant, claimed as a dependent and household contact answered "a" to item 10, or the claiming tax filer(s) are applicants.)*

Will [Tax filer *(and spouse if there is one)*] claim any other dependents on [his/her/their] federal income tax return for [coverage year]?

a. Yes *(If selected, display "i-ii," then continue to item 15.)*
    i. *(Display all household members not already in completed tax households, and allow multi-select.)*
    ii. Someone else who isn't applying for health coverage *(If selected, display "1-5.")*
        1. First name: ____________________
        2. Middle name: ____________________ *optional*
        3. Last name: ____________________
        4. Suffix: *(Display dropdown menu of suffixes.) optional*
        5. Date of birth: MM/DD/YYYY
b. No *(If selected, continue to item 15.)*

15. *(Item 15 is about expected tax household changes.)*
*(Display item if application is being completed during an open enrollment period beginning in October 2014 or later, if household contact is a tax filer.)*
Will [Tax filer(s)] claim different dependents on the [2nd possible coverage year] tax return?
    a. Yes. [Tax filer(s)] plan[(s)] to change who [Tax filer(s)] claim[(s)] as a dependent on [his/her/their] tax return *(If selected, display "i." If household contact is child or spouse of the tax filer, he/she is finished with this section; next, he/she will skip to subsection "E" ["Parent/caretaker relatives"]. If household contact isn't the child or spouse of the tax filer, continue with non-filer questions at item 16.)*
        i. Who will [Tax filer(s)] claim on [his, her, or their] tax return for [2nd possible coverage year]?
            1. *(Display all household members as options, and allow multi-select.)*
            2. Someone else who isn't applying for health coverage *(If selected, display "a-b.")*
                a. Name of dependent:
                    i. First name: ____________________
                    ii. Middle name: ____________________ *optional*
                    iii. Last name: ____________________
                    iv. Suffix: *(Display dropdown menu of suffixes.) optional*
                b. Date of birth: MM/DD/YYYY
    b. No, no plan to change *(If selected, and household contact is child or spouse of the tax filer, then he/she is finished with this section; next, he/she will skip to subsection "E" ["Parent/caretaker relatives"]. If household contact isn't the child or spouse of the tax filer, continue with non-filer items starting at item 16.)*
    c. I don't know *(If selected, and household contact is child or spouse of the tax filer, then they're finished with this section; next, they'll skip to subsection "E" ["Parent/caretaker relatives"]. If household contact isn't the child or spouse of the tax filer, continue with non-filer items starting at item 16.)*

*(Items 16-18 are for non-filing households.)*

16. *(Display item if household contact is less than 21 years old **and** a non-filer not claimed as a dependent **or** if applicant is less than 21 years old **and** the household contact isn't the custodial child or spouse of the tax filer.)*
Does [Applicant FNLNS] live with [his/her] parent and/or stepparent?

a. Yes *(If selected, display "i," and continue to item 17.)*
    i. Select [household contact]'s parents and stepparent(s) that live with [household contact].
        1. *(Display all household members older than applicant as options, and allow multi-select.)*
        2. Someone else who isn't applying for health coverage *(If selected, display "a-c.")*
            a. Name of parent or stepparent:
                i. First name: ____________________
                ii. Middle name: ____________________ *optional*
                iii. Last name: ____________________
                iv. Suffix: *(Display dropdown menu of suffixes.) optional*
            b. Date of birth: MM/DD/YYYY
            c. Relationship: *(Display check boxes.)*
                i. Parent
                ii. Stepparent

b. No *(If selected, continue to item 17.)*

17. *(Display item if non-filer household is being built and applicant is under age 21.)*
    Does [Applicant FNLNS] live with brothers or sisters?
    a. Yes *(If selected, display "i," then continue to item 18.)*
        i. Who is a brother or sister living with [Applicant dependent FNLNS]?
            1. *(Display all household members older than applicant as options, and allow multi-select.)*
            2. Someone else who isn't applying for health coverage *(If selected, display "a-c.")*
                a. Name of parent or stepparent:
                    i. First name: ____________________
                    ii. Middle name: ____________________ *optional*
                    iii. Last name: ____________________
                    iv. Suffix: *(Display dropdown menu of suffixes.) optional*
                b. Date of birth: MM/DD/YYYY
    b. No *(If selected, continue to item 18.)*

18. *(Display item if non-filer household is being built.)*
    Does [household contact FNLNS] live with [his/her] son, daughter, stepson, or stepdaughter?
    a. Yes *(If selected, display "i-ii," then continue to subsection "E" ["Parent/caretaker relatives"].)*
        i. *(Display all appropriate household members as options.)*
        ii. Someone else who isn't applying for health coverage *(If selected, display "1-3.")*
            1. Name of son, daughter, stepson, or stepdaughter:
                a. First name: ____________________
                b. Middle name: ____________________ *optional*
                c. Last name: ____________________
                d. Suffix: *(Display dropdown menu of suffixes.) optional*
            2. Date of birth: MM/DD/YYYY
            3. Add another child (*Display button.*)

b. No *(If selected, continue to subsection "E" ["Parent/caretaker relatives"].)*

***(Logic for subsequent applicants within subsection "D" ["Family & household"])***

*(If the subsequent applicant is the spouse of any previous applicant or the spouse of the household contact, and is filing a joint tax return with his/her spouse, then skip this section. If subsequent applicant is a tax filer filing jointly, claiming any previous applicant as a dependent, skip this section. If subsequent applicant is a tax dependent of the household contact, and is the child/stepchild of the household contact, and is under age 19, the only additional question needed is whether the subsequent applicant is married (if so, ask if the spouse lives with the subsequent applicant). If subsequent applicant is a tax dependent of the household contact, but not a child, stepchild, or spouse of the household contact, go to non-filer questions above at item "14.a" in subsection "D" ["Family & household"].*

*In all other situations, questions listed above should be asked if relevant to find out the subsequent applicant's tax household, or Medicaid household if there's an exception to the tax household per 42 CFR 435.603. To do so, substitute the appropriate name where "household contact" is referred to above. When asking questions above of a subsequent applicant, it may be necessary to ask additional relationship questions between household members. When asking questions of an applicant under age 18, begin by asking about tax dependency rather than tax filing, and ask marriage questions at the end.*

## E. Parent/caretaker relatives

**Note to reviewers:** The age of dependent children may be substituted as 18 (instead of 19) in the logic of questions 1-5 for states that don't count full-time students age 18 as dependent children. These questions will be optional, but if unanswered, the applicant won't be flagged for the parent/caretaker relative category for Medicaid eligibility.

*(If the applicant is under age 19, skip to subsection "F" ["Other addresses"]. If the applicant has indicated that he/she lives with a child under 19 and claims him/her as a tax dependent, then:*

- *If the child's relationship to the applicant hasn't already been provided and the state has taken up an option to limit the allowable relationships of a caretaker relative to a dependent child, skip to item 3.*
- *If relationship is known or not needed, skip to subsection "F" ["Other addresses"].*

1. Does [FNLNS] live with one or more children under age [19], and is [he/she] the main person taking care of that child or children?
   a. Yes *(If selected, and if there are any children under age 19 listed on the application, continue to item 2. If there are no children under age 19 listed, skip to item "2.b.")*
   b. No *(If selected, skip to subsection "F" ["Other addresses"].)*

2. Who does [FNLNS] live with and take care of?
   a. *(Display check boxes with names of all applicants and non-applicants under age 19 on the application, and allow multi-select.)*
   b. Another child *(Display check box. If selected, display "i-vi," then continue to item 3.)*
      i. First name: ____________________
      ii. Middle name: ____________________ *optional*
      iii. Last name: ____________________
      iv. Suffix: *(Display dropdown menu of suffixes.) optional*
      v. Date of birth: MM/DD/YYYY

vi. Add another child *(Display as a button. If selected, repeat "i-vi.")*

3. *(Display item for each child for whom the applicant assumes primary responsibility [indicated in answer to item 1 or item 2 or via backend logic derived from subsection "D" ["Family & household"] and who is under age 19, and the child's relationship to this applicant hasn't already been provided, and the state has taken up an option to limit the allowable relationships of a caretaker relative to a dependent child. Repeat as needed for multiple such children.)*
   [Applicant name] is the *(Display relationship dropdown menu; default to "parent.")* of [Child name].
   a. Parent
   b. Stepparent
   c. Brother/sister
   d. Uncle/aunt
   e. Nephew/niece
   f. First cousin
   g. Grandparent
   h. Brother-in-law/sister-in-law
   i. Stepbrother/stepsister
   j. Other relative
   k. Other unrelated

4. *(Display item if the state hasn't eliminated the deprivation requirement for a child under age 19 to be considered a "dependent child," for each child for whom the applicant assumes primary responsibility and who is under age 19 and who meets the state's relationship test, and if it's unknown whether the child lives with his or her parents.)*
   Do any of these children live with more than one parent, through birth or adoption?
   a. *(Display checkboxes with list of children for whom the applicant assumes primary responsibility and who are under age 19 and who meets the state's relationship test, and if it's unknown whether the child lives with his or her parents. Allow multi-select.)*

## F. Other addresses

**Note to reviewers:** States have developed divergent definitions of "temporary absence" for Medicaid and CHIP residency. The Marketplace may tailor help text to state-specific rules to help people understand how to answer item 4 about living outside the state temporarily if adequate information is available to do so.

1. *(Skip this section for the household contact because their address has already been provided. Display for all other applicants.)*
   What's [FNLNS]'s home address? *(Display prepopulated addresses if available.)*
   a. [Address for household contact] *(If selected, skip to item 4.)*
   b. [Any other address entered for another applicant] *(If selected, skip to item 4.)*
   c. Other address *(If selected, continue to item 2.)*
   d. No home address *(If selected, skip to item 3.)*

2. *(Display item if "c" was selected in item 1.)*
   What's [FNLNS]'s home address?
   a. Street address: ____________________

b. Apartment or suite number: ____________________ *optional*
c. City: ____________________
d. State: *(Display dropdown menu of states.)*
e. ZIP code: ____________________
f. County: *(Display dropdown selection of potential counties, if ZIP code crosses more than one county.)*

3. *(Display item if "d" was selected in item 1.)*
   What's [FNLNS]'s mailing address?
   a. Street address: ____________________
   b. Apartment or suite number: ____________________ *optional*
   c. City: ____________________
   d. State: *(Display dropdown menu of states.)*
   e. ZIP code: ____________________
   f. County: *(Display dropdown selection of potential counties, if ZIP code crosses more than one county.)*

4. *(Display item if applicant lists any address in item 1 or 2 for an applicant outside state of application.)*
   Is [FNLNS] living outside [State of application] temporarily?
   a. Yes *(If selected, continue to item 5.)*
   b. No *(If selected, skip to subsection "G" ["Ethnicity & race"].)*

5. *(Display item if "a" was selected in item 4).*
   Where will [FNLNS] live in [State of application]?
   a. City: ____________________
   b. ZIP code: ____________________
   c. I don't know *(If selected, disable "a" and "b" above.)*
   d. County: *(Display dropdown selection of potential counties if "b" is completed, but ZIP code crosses more than one county.)*

## G. Ethnicity & race

Optional information: This information will help the U.S. Department of Health and Human Services (HHS) better understand and improve the health or and health care for all Americans. Providing this information won't impact your eligibility for health coverage, your health plan options, or your costs in any way.

1. Is [FNLNS] of Hispanic, Latino, or Spanish origin? *optional*
   a. Yes *(If selected, display "i.")*
      i. Ethnicity: (Check all that apply.)
         *(Display check boxes.)*
         1. Cuban
         2. Mexican, Mexican American, or Chicano/a
         3. Puerto Rican
         4. Other: ____________________
   b. No

2. Race: (Check all that apply.) *optional*

*(Display check boxes.)*

a. American Indian or Alaska Native
b. Asian Indian
c. Black or African American
d. Chinese
e. Filipino
f. Guamanian or Chamorro
g. Japanese
h. Korean
i. Native Hawaiian
j. Other Asian
k. Other Pacific Islander
l. Samoan
m. Vietnamese
n. White
o. Other: ____________________

## VIII. More about this household

**Note to reviewers:** Items 1 and 2 in this section screen applicants for Medicaid eligibility on a basis other than modified adjusted gross income (MAGI). The items about full-time students will be asked in accordance with state Medicaid agency options taken up for students in relation to household composition, maximum age of dependent children for parent/caretaker relative status, and residency rules. The items on American Indian/Alaska Native status were developed with the office of Tribal Affairs following tribal consultation and focus groups. The items on foster care are based on the new former foster care eligibility group established by the Affordable Care Act.

1. Do any of these people have a physical disability or mental health condition that limits their ability to work, attend school, or take care of their daily needs? (Click here for help answering this question.) *optional*
   a. *(Display each applicant name with a check box, and allow multi-select.*) *(If any name is left unselected, continue to item 2. If all names are selected, skip to item 3.)*
   b. None of these people *(Disable list of names.) (If selected, continue to item 2.)*

2. *(Display item if any name is left unselected in item 1.)*
   Do any of these people need help with activities of daily living (like bathing, dressing, and using the bathroom), or live in a medical facility or nursing home? *optional*
   a. *(Display each applicant name with a check box, and allow multi-select.*)
   b. None of these people *(Disable list of names.)*

3. *(Display item if there's at least one person listed on the application who fits into categories "a-d" below.)*
   Are any of these people full-time students?
   a. *(If state has adopted a restriction on residency for students going to school in their state, display each applicant aged 18-22 with a check box, and allow multi-select. If selected, continue to item 4.)*
   b. *(Display each potential parent/caretaker relative child who is age 18, even if non-applicant or not in household with a check box, and allow multi-select. If selected, skip to item 5.)*

   c. *(Display each non-applicant aged 19 or 20 if the state has elected to include such full-time students as children for purposes of household composition with a check box, and allow multi-select. If selected, skip to item 5.)*
   d. None of these people *(Disable list of names. If selected, skip to item 5.)*

4. *(Display item if applicant aged 18-22 was selected in item 3 and if state has adopted a restriction on residency for students going to school in their state.)*
   Does [Applicant name selected above] have a parent living in the same state where [Applicant name] goes to school?
   a. Yes *(If selected, skip to item 6.)*
   b. No *(If selected, continue to item 5.)*

5. *(Display item if "b" was selected in item 4 and there isn't already a parent on the application whose address is listed in the state of application.)*
   Do one or both of [Applicant]'s parents live in [State of application]?
   a. Yes
   b. No

6. Are any of these people American Indian or Alaska Native?
   a. (*Display all applicants and non-applicants, prepopulate with checkmarks those who have already selected AI/AN on the race and ethnicity questions, and allow multi-select.)*
   b. None of these people *(Disable list of names.)*

7. Are any of these people pregnant? *optional*
   a. *(Display names of each applicant and non-applicant female with a check box, and allow multi-select. For each person selected, display item 8.)*
   b. None of these people *(Disable list of names. If selected, skip to item 9.)*

8. *(Display item if an applicant was indicated in item 7 or a non-applicant was indicated in item 7 in a state that has taken up option to count more than one unborn baby in Medicaid household size in case of a pregnant non-applicant.)*
   How many babies is [Name selected in item 7] expecting during this pregnancy?
   a. *(Display dropdown menu of 1-8. Default to 1.)*

9. Were any of these people ever in foster care? *optional*
   a. *(Display names of applicants aged 18-25 with check boxes, and allow multi-select. If a name was selected, continue to item 10.)*
   b. None of these people *(Disable list of names.)*

10. *(Display item if an applicant name was selected in item 9.)*
    In what state was [Applicant name] in the foster care system?
    a. *(Display dropdown menu of states. Default to State of application.)*

11. *(Display item if state selected in item 10 is the same as state of application, or state Medicaid agency has chosen to allow other states' foster care recipients into their former foster care eligibility group.)*
    Was [Applicant name] getting health care through [Name of state Medicaid program]?
    a. Yes *(If selected, continue to item 12.)*

b. No *(If selected, skip to section IX [“Expedited income”].)*

12. *(Display item if “a” was selected in item 11.)*
    How old was [Applicant name] when [he/she] left the foster care system?
    a. *(Display dropdown of ages less than and equal to current applicant age, up to age 21. Default to x.)*

## IX. Expedited income

**Note to reviewers:** This process was developed for tax filers whose income tax data indicates that the household income is above a certain amount so the household doesn’t need to answer questions about current/monthly income. If the annual income attested to in this section places all household members in the [insert tax credit acronym]income range, then any dependents’ income would be collected in section X [“Current/monthly income”] and added to the household income if the dependent’s income was higher than the IRS filing requirement.

*(Display this section if all of the following conditions apply. Otherwise, skip this section and go to section X [“Current/monthly income”] for each household member:*

- *Medicaid household and tax household are the same*
- *IRS tax data is available*
- *Tax filer(s) isn’t an AI or AN*
- *Tax data shows income above the Medicaid/CHIP FPL limit relevant to each applicant for whom this tax filer’s income will count. )*

1. *(Display item to single filers.)*
   Do you expect [FNLNS]’s yearly income to be the same as what was reported on [his/her] [year of last federal income tax return] federal income tax return?

   *(Display item to joint filers.)*
   Do you expect [FNLNS] and [Spouse FNLNS]’s yearly income to be the same as what was reported on [his/her] [year of last federal income tax return] federal income tax return?

   *(Display options to all.)*
   a. Yes
   b. No *(If selected and a single tax filer, continue to “i.” If selected, and joint filers, skip to “ii.”)*
      i. What do you expect [FNLNS]’s yearly income will be in [coverage year]?
         1. [FNLNS]: Amount: $_____
         2. [Spouse FNLNS]: Amount: $_____
         3. I don’t know *(Display check box. If selected, skip to section X [“Current/monthly income”].)*
      ii. What do you expect [FNLNS]’s and [Spouse FNLNS]’s yearly income will be in [coverage year]?
         1. [FNLNS]: Amount: $_____
         2. [Spouse FNLNS]: Amount: $_____
         3. I don’t know *(Display check box. If selected, skip to section X [“Current/monthly income”].)*

c. I don't know *(Display check box. If selected, skip to section X ["Current/monthly income"].)*

*(If tax filer(s) income amount entered for coverage year is equal to or higher than amount for each applicant in this tax filer's household to be above the Medicaid/CHIP FPL limit in the relevant state and state Medicaid/CHIP agencies elect to consider reasonably predictable future changes in income, continue to next household member's income if applicable. If amount entered is equal to or higher than amount for each applicant in this tax filer's household to be above the Medicaid/CHIP FPL limit in the relevant state and state Medicaid/CHIP agencies haven't elected to consider reasonably predictable future changes in income, continue to item 2. If amount entered is lower, skip to section X ["Current/monthly income"].)*

2. Is [FNLNS]'s [if joint, display names of both filers] income (before taxes) for this month more than [monthly FPL threshold amount]?
   a. Yes *(If selected, collect any dependents' incomes in section X ["Current/monthly income"], then skip to section XII ["([insert tax credit acronym] program questions"].)*
   b. No *(If selected, continue to section X ["Current/monthly income"].)*

## X. Current/monthly income

**Note to reviewers:** These income questions were developed in consultation with IRS experts, based on a balance of obtaining an accurate MAGI amount while maximizing simplicity and minimizing burden on both applicants and the determination entity.

*(Skip this section and go to section XII ["([insert tax credit acronym] program questions"] for a tax filer if results of section IX ["Expedited income"] indicate that all applicants for whom the tax filer's income is being considered are in the [insert tax credit acronym]-income range.)*

1. *(Display item for each person with available current income data.)*
   Review our records of [FNLNS]'s income, and edit if necessary.

   *(Display the type of current income, accompanied by the employer name, address, phone number, Employer Identification Number (if applicable), the amount [before taxes] and frequency, and allow deletion of an income source or edits to the amount or frequency. The frequency dropdown would mirror that provided for application filer-entered income, as below.)*
   The income information above is correct. *(Display check box.)*

2. *(Display item for each person with no prepopulated current income data.)*
   Does [FNLNS] have any of the following income? *(Display list of current income types below question.*

   *(Display item for each person with prepopulated current income data.)*
   Does [FNLNS] have another income source? *(Display list of current income types below question.)*
   a. Yes *(If selected, continue to item 3.)*
   b. No *(If selected, skip to the next household member's income screen, or skip to section XI ["Discrepancies"] if no other household members are left.)*

3. *(Display item if "a" was selected in item 2. Display pop-up modal box with title "Add income for [FNLNS].")*
   What type of income would you like to add?
   *(Display each income type ["a-m"] in a dropdown. After information is entered for the income type, another dropdown shows up for the user to select an additional income type.)*
   a. None *(If selected, skip to item 16.)*
   b. Job *(If selected, continue to item 4.)*
   c. Self-employment *(If selected, skip to item 5.)*
   d. Social Security benefits *(If selected, skip to item 6.)*
   e. Unemployment *(If selected, skip to item 7.)*
   f. Retirement *(If selected, skip to item 8.)*
   g. Pension *(If selected, skip to item 9.)*
   h. Capital gains *(If selected, skip to item 10.)*
   i. Investment income *(If selected, skip to item 11.)*
   j. Rental or royalty income *(If selected, skip to item 12.)*
   k. Farming or fishing income *(If selected, skip to item 13.)*
   l. Alimony received *(If selected, skip to item 14.)*
   m. Other income *(If selected, skip to item 15.)*

4. *(Display item if "b" ["Job"] was selected in item 3.)*
   a. Name of employer: ____________________
   b. How much does [FNLNS] get paid (before taxes are taken out)? Tell us about the regular pay from all jobs that [FNLNS] gets as well as any one-time amounts this month, like a bonus or a severance payment.
      i. Amount: $__________
   c. How often does [FNLNS] get paid this amount?
      *(Display dropdown menu.)*
      i. Hourly *(If selected, continue to "d.")*
      ii. Daily *(If selected, continue to "d.")*
      iii. Weekly
      iv. Every 2 weeks
      v. Twice a month
      vi. Monthly
      vii. Yearly
      viii. One time only
   d. *(Display item if "i" or "ii" was selected in "c.")*
      How much does [FNLNS] usually work per week at this job?
      *(Display frequency based on selection in "c.")*
      i. Hours per week
      ii. Days per week
   e. Add another job *(Display button.)*

5. *(Display item if "c" ["Self-employment"] was selected in item 3.)*
   a. How much net income (profits once business expenses are paid) will [FNLNS] get from this self-employment this month? (Click here for hints about what to subtract to get the net amount.) If the costs for this self-employment are more than the amount [FNLNS] expects to earn, you can enter a negative number.
      i. Type of work: ____________________

ii. Amount: $_____
iii. (*Display dropdown menu.*)
1. Profit
2. Loss

6. *(Display item if "d" ["Social Security benefits"] was selected in item 3.)*
   a. How much does [FNLNS] get from Social Security? Don't include Supplemental Security Income (SSI).
      i. Amount: $_____
   b. How often does [FNLNS] get this amount?
      *(Display dropdown menu.)*
      i. One time only
      ii. Monthly
      iii. Yearly
   c. Add another Social Security benefit amount *(Display button.)*

7. *(Display item if "e" ["Unemployment"] was selected in item 3.)*
   a. From what state government or former employer does [FNLNS] get unemployment benefits?
      i. ____________________
   b. How much does [FNLNS] get?
      i. Amount: $_____
   c. How often does [FNLNS] get this amount?
      *(Display dropdown menu.)*
      i. Weekly *(If selected, display "d.")*
      ii. One time only
      iii. Monthly *(If selected, display "d.")*
      iv. Yearly
   d. *(Display if "i" or "iii" selected for "c.")*
      Is there a date that the unemployment benefits are set to expire?
      i. Yes *(If selected, display "1.")*
         1. Date: MM/DD/YYYY
      ii. No
   e. Add another unemployment source *(Display button.)*

8. *(Display item if "f" ["Retirement"] was selected in item 3.).*
   a. How much does [FNLNS] get from retirement account(s)? Include amounts received as a distribution from a retirement investment even if [FNLNS] isn't retired.
      i. Amount: $_____
   b. How often does [FNLNS] get this amount?
      *(Display dropdown menu.)*
      i. One time only
      ii. Weekly
      iii. Every 2 weeks
      iv. Twice a month
      v. Monthly
      vi. Yearly

9. *(Display item if "g" ["Pension"] was selected in item 3. Help text will indicate certain types of pensions that aren't taxable and don't need to be included).*
    a. How much does [FNLNS] get from this pension account?
        i. Amount $______
    b. How often does [FNLNS] get this amount?
       *(Display dropdown menu.)*
        i. One time only
        ii. Weekly
        iii. Every 2 weeks
        iv. Twice a month
        v. Monthly
        vi. Yearly

10. *(Display item if "h" ["Capital gains"] was selected in item 3. We'll provide help text to indicate examples of capital gains that should and shouldn't be reported.)*
    a. How much does [FNLNS] expect to get from net capital gains (the profit after subtracting capital losses) this month?
        i. Amount: $_____
        ii. (*Display dropdown menu.*)
            1. Profit
            2. Loss
    b. How much does [FNLNS] expect to get from net capital gains (the profit after subtracting capital losses) this year?
        i. Amount: $_____
        ii. (*Display dropdown menu.*)
            1. Profit
            2. Loss

11. *(Display item if "i" ["Investment income"] was selected in item 3. We'll provide help text to indicate examples of investment income that should and shouldn't be reported.)*
    a. How much does [FNLNS] get from investment income, like interest and dividends?
        i. Amount: $_____
    b. How often does [FNLNS] get this amount?
       *(Display dropdown menu.)*
        i. One time only
        ii. Weekly
        iii. Monthly
        iv. Quarterly
        v. Yearly

12. *(Display item if "j" ["Rental or royalty income"] was selected in item 3. We'll provide help text to indicate examples of rental/royalty income that should and shouldn't be reported.)*
    a. How much does [FNLNS] get from net rental or royalty income (the profit after subtracting costs)? (Click here to learn how to get the net amount.)
        i. Amount: $_____
        ii. (*Display dropdown menu*.)
            1. Profit
            2. Loss

b. How often does [FNLNS] get this amount?
*(Display dropdown menu.)*
    i. One time only
    ii. Weekly
    iii. Every 2 weeks
    iv. Twice a month
    v. Monthly
    vi. Yearly

13. *(Display item if "k" ["Farming or fishing income"] was selected in item 3. We'll provide help text to indicate examples of farming/fishing income that should and shouldn't be reported.)*
    a. How much does [FNLNS] get from net farming or fishing income (the profit after subtracting costs)? (Click here to learn how to get the net amount.)
    b. Amount: $_____
    c. (*Display dropdown menu.)*
        i. Profit
        ii. Loss
    d. How often does [FNLNS] get this amount?
    *(Display dropdown menu.)*
        i. One time only
        ii. Weekly
        iii. Every 2 weeks
        iv. Twice a month
        v. Monthly
        vi. Yearly

14. *(Display item if "l" ["Alimony received"] was selected in item 3.)*
    a. How much does [FNLNS] get from alimony?
        i. Amount: $_____
    b. How often does [FNLNS] get this amount?
    *(Display dropdown menu.)*
        i. One time only
        ii. Weekly
        iii. Every 2 weeks
        iv. Twice a month
        v. Monthly
        vi. Yearly

15. *(Display item if "m" ["Other income"] was selected in item 3, and allow multi-select.)*
    Which other type of income does [FNLNS] get?
    a. Canceled debts *(If selected, skip to "16.a.")*
    b. Court awards *(If selected, skip to "16.a.")*
    c. Jury duty pay *(If selected, skip to "16.a.")*
    d. Cash support from [Name of tax filer(s)] *(Display if [FNLNS] is a tax dependent of someone other than his/her parent or spouse) (If selected, skip to "16.a.")*
    e. Gambling, prizes, or awards *(If selected, skip to "16.a.")*
    f. Other *(If selected, display "i," then continue to "16.c.")*

        i. You don't need to tell us about child support, veteran's payments, or Supplemental Security Income (SSI). Click here to learn more about what not to list.

16. *(Display item for income types indicated in item 15. Display only "16.a" and "16.b" if "a-e" were selected in item 15.)*
    a. How much?
        i. Amount: $_____
    b. How often?
       *(Display dropdown menu.)*
        i. One time only
        ii. Weekly
        iii. Every 2 weeks
        iv. Twice a month
        v. Monthly
        vi. Yearly
    c. (*Display item if "f" [Other] was selected in item 15*.)
       Is any of this income from a scholarship or grant used to pay for educational expenses?
        i. Yes *(If selected, display "1-2.")*
            1. How much? _____
            2. How often?
               (*Display dropdown menu*.)
                a. One time only
                b. Weekly
                c. Every 2 weeks
                d. Twice a month
                e. Monthly
                f. Yearly
        ii. No

17. *(Display item for all applicants.)*
    Does [FNLNS] pay alimony, student loan interest, or other deductions that get reported on the front page of a federal income tax return form 1040? This could make the cost of coverage a little lower.
    a. Yes *(If selected display checkboxes and allow multi-select, then continue to item 18.)*
        i. Alimony
        ii. Student loan interest
        iii. Other deduction [FNLNS] could take on [his/her] [coverage year] tax return
    b. No

18. *(Display item if "i," "ii," or "iii" was selected in "17.a.")*
    a. How much?
        i. Amount: $_____
    b. How often?
       *(Display dropdown menu.)*
        i. One time only
        ii. Weekly
        iii. Every 2 weeks

iv. Twice a month
v. Monthly
vi. Yearly

19. *(Display item if any income was reported.)*
[FNLNS's income summary table with calculated monthly income amounts.]

20. *(Display item if [FNLNS] is American Indian or Alaska Native, and has reported income above.)*
Is any of this income from these sources? *(Display check boxes for "a-c.")*
a. Per capita payments from the tribe that come from natural resources, usage rights, leases or royalties *(If selected, display "20.d.")*
b. 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) *(If selected, display "20.d.")*
c. Money from selling things that have cultural significance *(If selected, display "20.d.")*
d. Select income type: *(Display table of income this household member has entered.)*

21. *(Display item unless the household member is a tax filer who attested to an annual income on the expedited page. If household member attested to annual income on the expedited income page, skip to item 25*.)
Based on what you told us, if [FNLNS]'s income is steady each month, then it's about [amount] per year. Is this how much you think [FNLNS] will get in [coverage year]?
a. Yes *(If selected, continue to next applicant's income or section XI ["Discrepancies"].)*
b. No *(If selected, continue to item 22.)*

22. *(Display item if "b" was selected in item 21.)*
Based on what you know today, how much do you think [FNLNS] will make in [coverage year]?
a. Amount: $_________
b. I don't know *(If selected, continue to item 23.)*

23. *(Display item if "b" was selected in item 22.)*
Which income type do you expect to change?
a. *(Display only the income types that this household member attested to for monthly income, with checkboxes for each type, and allow multi-select.)*
b. *(Display for each selected income type.)*
In [coverage year] it will be about this much: ___________

*(Display hyperlink)* Yearly income calculator (*If hyperlink selected, display a pop-up window with monthly boxes for user to enter amount of income for that type in relevant months. Allow user to indicate profit or loss. Display button labeled "total" which adds up the boxes.)*

24. *(Display item if "b" was selected in item 22.)*
You've told us that [FNLNS]'s current monthly income doesn't include any of the following. Is there another type of income that may start in a future month? *(Display list of income types not attested to previously.)*
a. Yes *(If selected, display "i-ii.")*

    i. Which type? *(Display dropdown menu of income types not previously selected, and allow multi-select.)*
    ii. *(Display for each selected income type.)*
    How much will this income be in [coverage year]? $__________

    *(Display hyperlink)* Yearly income calculator *(If hyperlink selected, display a pop-up window with monthly boxes for user to enter amount of income for that type in relevant months. Allow user to indicate profit or loss. Display button labeled "total" which adds up the boxes)*

b. No

25. *(Display per person income summary with current and yearly income totals.)*

## XI. Discrepancies

*(Display section after income information is complete for each household member and the available electronic income data isn't reasonably compatible with the household income attestation for any applicant. All questions in this section are optional. Help text will indicate that answering these questions can help speed up the application process.)*

1. *(Display item if a prepopulated job for this household member was deleted in section X ["Current/monthly income"], item 1, and if a household in which this individual's income is counted has attested to income that puts any applicant in Medicaid or CHIP range, while data put that individual above Medicaid/CHIP range.)*
   Did [FNLNS] stop working at [Employer] within the last [#] months, permanently or temporarily?
   a. Yes *(If selected, repeat items 1-4 for other applicants as needed, then skip to item 6 or 10, depending on whether tax data is available.)*
   b. No *(If selected, continue to item 2.)*

2. *(Display item if "b" was selected in item 1.)*
   Did [FNLNS] ever work at [Employer]?
   a. Yes *(If selected, skip to item 5.)*
   b. No *(If selected, repeat items 1-4 for other applicants as needed, then skip to item 6 or 10, depending on whether tax data is available.)*

3. *(Display item if prepopulated monthly income from a job for this household member was reduced in section X ["Current/monthly income"], item 1.)*
   Have [FNLNS]'s hours decreased at [Employer] during the last [#] months, permanently or temporarily?
   a. Yes *(If selected, repeat items 1-4 for other applicants as needed, then skip to item 6 or 10, depending on whether tax data is available.)*
   b. No *(If selected, continue to item 4.)*

4. *(Display item if "b" was selected in item 3.)*
   Has [FNLNS]'s wage or salary been cut at [Employer] during the last [#] months, permanently or temporarily?

a. Yes *(If selected, repeat items 1-4 for other applicants as needed, then skip to item 6 or 10, depending on whether tax data is available.)*
b. No (*If selected, continue to item 5.)*

5. *(Display item if "b" was selected in item 4.)*
Is there another reason for why [FNLNS]'s job income is lower than what our electronic records show?
*(Help text will explain the data source.)*
a. ____________________

6. *(Display item if tax data is being used for income verification, and neither tax data nor current income data were reasonably compatible with income attestation)*
Did [FNLNS] [*(Display if married filing jointly)* or FNLNS] or *[(Display if dependent had filing requirement in tax year*) dependent FNLNS] stop working, work less hours, or change jobs since [last available tax return year]?
a. Yes *(If selected, skip to item 10.)*
b. No *(If selected and attested household income is in the Medicaid/CHIP range using reasonably predictable changes, continue to item 7. If selected and household income is in the [insert tax credit acronym]-range, or in the Medicaid/CHIP range and household income isn't based on reasonably predictable change, skip to item 8.)*

7. *(Display item if annual income was entered for this household member in section X ["Current/monthly income"], item 22; the state considers reasonably predictable future changes in income; attested household income is in the Medicaid/CHIP range for an applicant in the household and isn't reasonably compatible; and either "b" was selected, or there's no tax data available.)*
Why is [FNLNS]'s income in other months during [coverage year] different than this month's income?
a. ______________________

8. *(Display item if "b" was selected in item 6 and not attesting to Medicaid/CHIP level income under reasonably predictable changes methodology.)*
Why will [FNLNS]'s [*(Display if married filing jointly)* and FNLNS]'s or *[(Display if dependent had filing requirement in tax year*) dependent FNLNS]'s income be different in [coverage year] than it was in [tax year for which there's data]?
a. ______________________

9. *(Display item if applicant's tax household is more than 3 people larger than the tax household size reported by the IRS from the most recent available return data.)*
Why will [FNLNS] claim more dependents in [coverage year] than [FNLNS] claimed in [IRS reported tax year]?
a. ____________________

10. *(Display one high-level "Income summary page" for all household members.)*

**Note to reviewers:** The following sections appear after the user has completed the income section. Based on income, each applicant is determined potentially eligible for a particular program, such as the[insert tax credit term] , Medicaid, or CHIP. Depending on the program for which the person is

potentially eligible, the system will display appropriate questions. This is to minimize the burden on applicants by only asking questions that apply to a particular person's eligibility determination.

# XII. [insert tax credit term] program questions

## A. Tax filer & other information ([insert tax credit acronym] eligible)

1. *(Display item if the claiming tax filer hasn't entered a Social Security number on his/her personal page and one or more members of his/her tax household are eligible for [insert tax credit acronym].)*
   [FNLNS of tax filer] indicated [he/she] is the claiming tax filer for [FNLNS of applicant(s)], but a Social Security number (SSN) hasn't been entered for [Tax filer name]. Providing an SSN may help [FNLNS of applicant(s)] get help paying for health insurance coverage. The SSN you provide won't be used to verify citizenship or immigration status. Does [FNLNS of tax filer] want to provide one now?
   a. Yes *(If selected, display "i.")*
      i. SSN: ___-___-____
   b. No

2. *(Display item if applicants are otherwise [insert tax credit acronym] eligible, but haven't identified that they expect to file taxes or be claimed as a dependent on someone else's tax return for the coverage year.)*
   For [Applicant(s) names] to get help paying for health insurance, each person must file a tax return or be claimed as a dependent on someone else's tax return. Do you want to change your answers about how [FNLNS of applicant(s)] will file taxes for [coverage year]?
   a. Yes *(If selected, return to section VII ["Tell us about each person"], and allow users to make changes to their responses.)*
   b. No *(If selected, will be determined ineligible for [insert tax credit acronym] in eligibility results.)*

3. *(Display item if applicants are otherwise [insert tax credit acronym] eligible, but are married and haven't identified that they expect to file a joint tax return.)*
   For [Applicant(s) names] to get help paying for health insurance, [he/she] must file a joint federal income tax return with [his/her] spouse. Do you want to change your answers about how [Applicant(s) names] will file taxes for [coverage year]?
   a. Yes *(If selected, return to section VII ["Tell us about each person"], and allow users to make changes to their responses.)*
   b. No *(If selected, will be determined ineligible for [insert tax credit acronym] in eligibility results.)*

4. *(Display item if applicant is [insert tax credit acronym] or QHP eligible and indicated he/she is living outside the [State of application] and didn't provide a city, ZIP code, and county in section VII, subsection "F" ["Other addresses"].)*
   Where will [FNLNS] live in [State of application]?
   a. City: ____________________
   b. ZIP code: ____________________

   c. County: *(Display dropdown selection of potential counties if ZIP code crosses more than one county.)*

5. *(Display item for each person where application filer selected "p" ["Other unrelated"] or as a relationship during any questions in section VII, subsection "D" ["Family & household"].*
   You selected "other relative" and "other unrelated" for the relationship of [FNLNS] to [FNLNS]. Select one of these options to describe the relationship of [FNLNS] to [FNLNS]:
   *(Select relationship from radio button.)*
   a. Adopted son/daughter
   b. Foster child
   c. Guardian
   d. Court-appointed guardian
   e. Former spouse
   f. Collateral dependent
   g. Sponsored dependent
   h. Dependent of a minor dependent
   i. Ward
   j. Other relative
   k. Unrelated

## B. Health coverage ([insert tax credit acronym] eligible)

*(Display items for* ***all*** *applicants that appear [insert tax credit acronym] eligible. If QHP eligible, skip to section XII, subsection "E" ["Employer contact information ([insert tax credit acronym] eligible)"].)*

1. Is [FNLNS] enrolled in health coverage from any of the following?
   a. [Name of state Medicaid program]
   b. [Name of state CHIP program]
   c. Medicare
   d. TRICARE (Don't choose this if you have Direct Care or Line of Duty.)
   e. VA health care program
   f. Peace Corps
   g. Individual insurance (non-group coverage)
   h. None of the above

*(If applicant selects "a-f," skip to "E" ["Employer contact information ([insert tax credit acronym] eligible)".]*

## C. Employer health coverage ([insert tax credit acronym] eligible)

*(Display a link to a printable "Employer coverage tool." The employee can use this tool to collect necessary information from his/her employer to complete the employer health coverage questions.)*

1. Is [FNLNS] currently eligible for health coverage through a job (even if it's from another person's job, like a spouse [display if person is under age 26: or parent/guardian])?
   a. Yes *(If selected, continue to item 2 or 3 depending on when applicant applies.)*
   b. No *(If selected, continue to item 2 or 3 depending on when applicant applies.)*

2. *(Display during October-December each year starting October 2013.)*

Will [FNLNS] be eligible for health coverage from a job during [coverage year=next year] (even if it's from another person's job, like a spouse *[(display if person is under age 26) or parent/guardian]*?

a. Yes *(If selected, display "i," then continue to item 4.)*
    i. Date [FNLNS]'s coverage could start: MM/DD/YYYY
b. No *(If selected, skip to skip to section XII, subsection "E" ["Employer contact information ([insert tax credit acronym] eligible)"].)*
c. I don't know *(If selected, skip to section XII, subsection "E" ["Employer contact information ([insert tax credit acronym] eligible)"].)*

3. *(Display outside an open enrollment period and during January-March 2014 of initial open enrollment.)*
   Will [FNLNS] be eligible for health coverage from a job during [coverage year= current year] (even if it's from another person's job, like a spouse *[(display if person is under age 26) or parent/guardian]?*
   a. Yes *(If selected, display "i," then continue to item 4.)*
      i. Date [FNLNS]'s coverage could start: MM/DD/YYYY
   b. No *(skip to section XII, subsection "E" ["Employer contact information ([insert tax credit acronym] eligible)"].)*
   c. I don't know *(If selected, skip to section XII, subsection "E" ["Employer contact information ([insert tax credit acronym] eligible)"].)*

4. Tell us which employer(s) offer(s) health coverage to [FNLNS]:
   a. *(Where possible, prepopulate check box list of the following information obtained from electronic data source or provided in income section. Or, allow user to add another employer that offers health coverage, if no employer can be prepopulated.)*
      i. Employer: ____________________
      ii. Employer's address:
         1. Street address: ____________________
         2. City: ____________________
         3. State: *(Display dropdown menu of states.)*
         4. ZIP code: ____________________
      iii. Employer's phone number: (___) ___-____ Ext. ___
      iv. Employer Identification Number (EIN): ____________________

5. Who can we contact about this employer's health coverage? If you're not sure, ask your employer. *optional (Display employer name with "Same as above" check box, or display "a-d" if user prepopulated employer information isn't available.)*
   a. Name:_____________
   b. Phone number (___) ___-____ Ext. ___
   c. Contact email address: __________
   d. Re-enter email address: _________

6. Is [FNLNS] currently enrolled in this employer's health coverage?
   a. Yes
   b. No

7. Which of these people is the employee at this job? *(Display prepopulated list of applicants and non-applicants in [FNLNS]'s tax household.)*
   a. [FNLNS]
   b. *(Display any tax household members older than 16.)*
   c. None of these people

8. What's (*prepopulate employee's name if identified in item 7, or* [the employee's]) current work status at this employer? (Select one.)
   (*Display dropdown menu.)*
   a. Currently working at this employer *(If selected, continue to subsection "D" ["Employer health coverage detail"].)*
   b. No longer working at this employer *(If selected, continue to item 10.)*
   c. Retired *(If selected, skip to item 10.)*

9. *(Display if "b" was selected in item 8 and item 6 indicates that FNLNS is enrolled.)*
   Is the coverage from [Employer name] COBRA coverage?
   a. Yes *(If selected and no other employer coverage offer exists, skip to subsection "F" ["American Indian/Alaska Native ([insert tax credit acronym] eligible)"].)*
   b. No (*If selected, skip to subsection "D" ["Employer health coverage detail"]*.)

10. *(Display if "c" was selected in item 8 and item 6 indicates that FNLNS is enrolled.)*
    Is [FNLNS]'s coverage from [Employer name] a retiree health plan?
    a. Yes (*If selected and no other employer coverage offer exists, skip to subsection "F" ["American Indian/Alaska Native ([insert tax credit acronym] eligible)"].)*
    b. No (*If selected, continue to subsection "D" ["Employer health coverage detail"].)*

11. Add another employer
    *(Display check box.) (If selected, repeat items 4-10.)*

## D. Employer health coverage detail

*(Display if "a" was selected in items 1-3 of subsection "C" ["Employer health coverage [insert tax credit acronym]" and entered employer coverage information in items 4-10. Display the questions below for each employer selected.)*

*(Reveal the following introductory message during October-December 2013.)*
Tell us about [Employer name]'s health coverage for [coverage year=next year]. First, print out and take the Employer coverage tool *(link to "Employer coverage tool")* to [Employer name] to collect the information you need for this section for using the tool to fill out the application. Instructions on the employer coverage form provide step-by-step instructions for using the tool to answer the questions in this section.

*(Reveal the following introductory message during January-March 2014 of initial open enrollment, outside an open enrollment period, and during annual open enrollment.)*
Tell us about [Employer name]'s health coverage for [coverage year=current year]. First, print out and take the Employer coverage tool *(link to "Employer coverage tool")* to [Employer name] to collect the information you need for this section. Instructions on the employer coverage tool provide step-by-step instructions for using the tool to answer the questions in this section.

1. Does [Employer name] offer a health plan that meets the minimum value standard?
   a. Yes
   b. No (*If selected and no other employer coverage offer exists*, *skip to subsection "F" ["American Indian/Alaska Native ([insert tax credit acronym] eligible)"].*)
   c. I don't know (*If selected and no other employer coverage offer exists, skip to subsection "F" ["American Indian/Alaska Native ([insert tax credit acronym] eligible"].*)

2. For the lowest-cost plan available to the employee that meets the minimum value standard: (Only tell us about plans that aren't family plans.)
   a. How much would the employee have to pay in premiums for this plan?
      If the employer has wellness programs, provide the premium that the employee would pay if [he/she] received the maximum discount for any tobacco cessation programs and didn't receive any other discounts based on wellness programs.
      i. $_______________ *(If selected, continue to item 3.)*
      ii. *(Display check box.)* I don't know *(If selected and if there's no other employer offer of coverage, stop and skip to next section.)*
   b. How often would [FNLNS] pay this amount?
      (*Display dropdown menu.)*
      i. Weekly
      ii. Every 2 weeks
      iii. Twice per month
      iv. Monthly
      v. Quarterly
      vi. Yearly

3. Does [FNLNS] expect [Employer name] to make any of these changes to the coverage offered to [FNLNS] in [coverage year]? (*Display check boxes.*)
   a. [Employer name] will no longer offer health coverage *(If selected, display "i.")*
      i. What will be the last day [Employer name] offers coverage?
         1. Date: MM/DD/YYYY
   b. [Employer name] will change the cost of premiums for the lowest-cost plan available to the employee that meets minimum value. (Only tell us about plans that aren't family plans.) *(If selected, display "i.")*
      i. How much will the employee have to pay in premiums for this plan? If the employer has wellness programs, provide the premium that the employee would pay if [he/she] received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
         1. $__________
            a. How often would [FNLNS] pay this amount?
               (Display dropdown menu.)
               i. Weekly
               ii. Every 2 weeks
               iii. Twice per month
               iv. Monthly
               v. Quarterly
               vi. Yearly
      ii. When will [Employer name] make this change?

1. Date: MM/DD/YYYY
c. I don't know if [Employer name] will make changes
d. [Employer name] won't make any of these changes

4. *(Display if "a" was selected in item 6 from subsection "C" ["Employer health coverage [insert tax credit acronym.]"])*
   Does [FNLNS] expect to drop [Employer Name's] health coverage in [coverage year]?
   a. Yes *(If selected, display "i.")*
      i. What's [FNLNS]'s last day of coverage through [Employer Name]'s health plan?
         1. Date: MM/DD/YYYY
   b. No

5. *(Display if "b" was selected in item 6 from subsection "C" ["Employer health coverage [insert tax credit acronym.]"])*
   Is [FNLNS] is planning to enroll in [Employer Name's] health coverage in [coverage year]?
   a. Yes *(If selected, display "i.")*
      i. What's the first day [FNLNS] will be covered by [Employer Name]'s health plan?
         1. Date: MM/DD/YYYY
   b. No

## E. Employer contact information ([insert tax credit acronym] eligible)

*(Display for all applicants who: identified an employer in item "4.a" of section X ["Current/monthly income"]; are in the same tax household as an applicant found preliminarily eligible for [insert tax credit acronym] because an employer didn't provide health coverage or an employer provided health coverage that wasn't affordable or didn't meet minimum value; AND, the user didn't provide employer contact information in subsection "D" ["Employer health coverage detail"]. Repeat collection of employer contact information for each employer listed on the application in accordance with these specifications.)*

1. *(Display employer contact information retrieved from current source of income data source.)*
   a. Employer's phone number: (___)___ -____ Ext.____

   *(Display if no employer contact information has been provided.)*
   a. [Employer name from section X ["Current/monthly income"] item "4.a."]
   b. Employer's address:
      i. Street address: ____________________
      ii. City: ____________________
      iii. State: *(Display dropdown menu of states.)*
      iv. ZIP code: ____________________
   c. Employer's phone number: (___) ___-____ Ext. ___
   d. Employer Identification Number (EIN): ____

## F. American Indian/Alaska Native ([insert tax credit acronym] eligible)

*(Display items in this section if someone has been identified as AI/AN in section VIII ["More about this household"] and is potentially eligible for [insert tax credit acronym] or QHP based on income attestation.)*

1. Are any of these people a member of a federally recognized tribe?
   *(Display [insert tax credit acronym] and QHP eligible applicants who indicated they were AI/AN in section VIII [“More about this household”] with “Yes/No” radio buttons for each, and allow multi-select.)*
   a. Yes
   b. No

2. *(Display item if “a” was selected for one or more individuals in item 1.)*
   Select a state and tribe.
   a. State: *(Display dropdown menu of states.)*
   b. Tribe name: *(Display list of tribe names.)*

3. *(Display item if “a” was selected for one or more of the individuals in item 1.)*
   Who is a member of the [name of tribe] tribe?
   a. *(Display list of all [insert tax credit acronym] and QHP eligible individuals with check boxes.)*
   b. All of the above

*(Show items 2 and 3 as needed to identify state and tribe for each individual identified as AI/AN in item 1.)*

## G. Special Enrollment Periods

*(Display section for all [insert tax credit acronym] and QHP eligible individuals beginning on November 1, 2013, to see if they may qualify for a Special Enrollment Period.)*

1. Did any of these people lose health coverage in the last 60 days?
   a. *(Display check box list of all [insert tax credit acronym] and QHP eligible individuals, and allow multi-select. If anyone was selected, continue to item 2.)*
   b. None of these people

2. *(Display item for each individual selected in item 1.)*
   When did [FNLNS] lose health coverage?
   a. Date: MM/DD/YYYY

3. *(Display item for each individual selected in item 1.)*
   Did [FNLNS] lose health coverage because [he/she] didn’t pay premiums?
   a. Yes
   b. No

4. Are any of these people going to lose their health coverage in the next 60 days?
   a. *(Display list of all [insert tax credit acronym] and QHP eligible individuals, and allow multi-select.)*
   b. None of these people

5. (*Display item for each individual selected in item 4*.)
   When will [FNLNS]’s health coverage end?
   a. Date: MM/DD/YYYY

6. Did any of these people get married in the last 60 days?
   a. *(Display check box for all married [insert tax credit acronym] and QHP eligible individuals, and allow multi-select. If anyone was selected, continue to item 7.)*
   b. None of these people

7. *(Display item for each individual selected in item 6.)*
   When did [FNLNS] get married?
   a. Date: MM/DD/YYYY

8. Have any of these people been adopted or placed for adoption in the last 60 days?
   a. *(Display check box list of all [insert tax credit acronym] and QHP eligible individuals, and allow multi-select. If anyone was selected, continue to item 9.)*
   b. None of these people

9. *(Display item for each individual selected in item 8.)*
   When was [FNLNS] adopted or placed for adoption?
   a. Date: MM/DD/YYYY

10. Did any of these people gain eligible immigration status in the last 60 days?
    a. *(Display check box list of all [insert tax credit acronym] and QHP eligible individuals who selected that they had eligible immigration status, and allow multi-select. If anyone was selected, continue to item 11.)*
    b. None of these people

11. *(Display item for each individual selected in item 10.)*
    When did [FNLNS] gain eligible immigration status?
    a. Date: MM/DD/YYYY

12. Did any of these people move in the last 60 days?
    a. *(Display check box list of all [insert tax credit acronym] and QHP eligible individuals, and allow multi-select. If anyone was selected, continue to item 13.)*
    b. None of these people

13. *(Display item for each individual selected in item 12.)*
    What was the ZIP code [and county if applicable] of [FNLNS]'s last address?
    a. ZIP code: _____
    b. County *(Display if system verifies address and finds that ZIP code covers more than one county, the system will provide an option for the user to select the correct county.)*

14. *(Display item for each individual selected in item 12.)*
    When did [he/she] move?
    a. Date: MM/DD/YYYY

15. Did any of these people get released from incarceration (detention or jail) in the last 60 days?
    a. *(Display check box list of all [insert tax credit acronym] and QHP eligible individuals, and allow multi-select. If anyone was selected, continue to item 16.)*
    b. None of these people

16. *(Display item for each individual selected in item 15.)*
    When was [FNLNS] released from incarceration (detention or jail)?
    a. Date: MM/DD/YYYY

## XIII. Medicaid & CHIP specific questions

**Note to reviewers:** States may choose to collect some of the information in this section post-eligibility when it doesn't affect eligibility. The American Indian and Alaska Native (AI/AN) questions were written by the Tribal Affairs group following an all-tribes consultation.

*(Display this section for each applicant that's potentially eligible for Medicaid or CHIP based on attestations and system logic. Questions may be optional.)*

1. Some people qualify to get help even if they already have health coverage. Does [FNLNS] have health coverage now?
   a. Yes *(If selected, continue to item 2.)*
   b. No

2. *(Display item if "a" was selected in item 1.)*
   What health coverage does [FNLNS] have now?
   a. [Plan already identified, if any, in section XII, subsection "C" ["Employer health coverage [insert tax credit acronym] eligible.]
   b. [Name of CHIP program in state of application.]
   c. Medicare
   d. Coverage through an employer *(If selected, continue to item 3.)*
   e. VA health care program or TRICARE
   f. Other full-benefit coverage (which covers benefits like doctor's visits, hospitalizations, and prescription drugs) *(If selected, continue to item 3.)*
   g. Other limited benefit coverage (like a school accident policy) *(If selected, continue to item 3.)*

3. *(Display item if "e," "g," or "h" was selected in item 2.)*
   What's the name of [FNLNS]'s health plan?
   a. ____________________

4. *(Display item if "d-h" was selected in item 2; this wording may vary based on type of coverage.)*
   What's the [policy number/member ID]?
   a. ____________________

5. *(Display item if applicant is American Indian or Alaska Native (AI/AN) and potentially eligible for Medicaid or CHIP.)*
   Has [FNLNS] ever gotten a health service from the Indian Health Service, a tribal health program, or urban Indian health program or through a referral from one of these programs?
   a. Yes
   b. No *(If selected, continue to item 6.)*

6. *(Display item if "b" was selected in item 5.)*

Is [FNLNS] eligible to get health services from the Indian Health Service or a tribal health organization?

a. Yes
b. No

## A. Medicaid specific questions

*(Display the items in this section for each applicant who is potentially eligible for Medicaid based on attestations and system logic.)*

1. Do you want help paying for [FNLNS]'s medical bills from the last 3 months? *optional*
    a. Yes
    b. No

2. *(Display item if applicant is potentially eligible for Medicaid through the VIII group category, and is a custodial parent of a non-applicant child under age 19, 20, or 21—age limit at state option-- or caretaker relative of a dependent child who isn't applying for coverage.)*
    Some people may qualify to get help even if they already have health coverage. Do any of these people have health coverage now?
    a. *(Display each relevant non-applying child name with a checkbox, and allow multi-select.)*
    b. None of these people

3. *(Display item if the potentially Medicaid-eligible individual is a non-citizen in a state which requires 40 work quarters and applicant's own SSN, via the match with the Social Security Administration (SSA) through the Federal Data Services Hub, hasn't provided enough quarters to meet the requirement. These questions are all optional.)*

    *(Display item if FNLNS is married and spouse's SSN isn't on the application.)*
    [FNLNS] could get free or low-cost health coverage if [he/she] has enough of a work history in the U.S. on [his/her] own or through a family member. We checked [FNLNS]'s work history because you gave us [his/her] Social Security number (SSN). We can also check the work history for [FNLNS]'s family members if you give us the SSN of [FNLNS]'s parent or spouse (and he or she agrees you may use their SSN for this purpose). Would you like to give an SSN now? *optional*

    *(Display item if FNLNS isn't married.)*
    [FNLNS] could get free or low-cost health coverage if [he/she] has enough of a work history in the U.S. on [his/her] own or through a family member. We checked [FNLNS]'s work history because you gave us [his/her] Social Security number (SSN). We can also check the work history for [FNLNS]'s family members if you give us the SSN of [FNLNS]'s father or mother. Would you like to give an SSN now? *optional*
    a. Yes *(If selected, display "i.")*
        i. Name *(Choose from list if there's a known or potential parent or spouse on application. Include option "Someone else.")*
        ii. *(Display only if "Someone else" was selected in "i.")*
            1. First name: _______________
            2. Middle name: ______________
            3. Last name: ________________
            4. Suffix: *(Display dropdown menu of suffixes.)*

5. Date of birth: MM/DD/YYYY
6. SSN: ___-__-____
7. *(Display item if FNLNS is married and the relationship the person identified in "i" or "ii" is unknown.)*
   How is [FNLNS] related to [Application filer FNLNS]? (Select one.)
   [FNLNS] is the *(Display relationship dropdown menu of parent or spouse. Default to blank.)* of [Application filer FNLNS].

b. No

4. *(Display item if any parent or caretaker relative is potentially eligible for Medicaid and his or her dependent child is also potentially eligible for Medicaid and that child lives with 0 or 1 parent.)*
   Does [Child name] have a parent living outside the home?
   a. Yes
   b. No

5. *(Display item if applicant is potentially eligible for the parent/caretaker relative category and the dependent child lives with 2 parents and the state has a deprivation requirement and no parent has been identified as underemployed or unemployed via section X ["Current/monthly income"].)*
   How many hours per week do [Child's name]'s parents work?
   a. Parent 1: __
   b. Parent 2: __

## B. CHIP specific questions

*(Display section for each applicant potentially eligible for CHIP based on attestations and system logic.)*

1. *(Display item if state has a waiting period for CHIP and applicant potentially eligible for CHIP isn't a pregnant woman.)*
   Did [FNLNS] have health coverage through a job that ended in the last [number of months of waiting period] months?
   a. Yes *(If selected, continue to item 2.)*
   b. No *(If selected, skip to item 3.)*

2. *(Display item if "a" was selected in item 1.)*
   Why did that coverage end? *optional*
   a. The parent no longer works for the employer that offered the coverage
   b. The employer stopped offering coverage
   c. The employer stopped offering coverage to dependents (kids)
   d. The coverage was too expensive
   e. [FNLNS] had medical needs not covered by the other coverage
   f. Other: ____________________

3. *(Display item if state of application hasn't taken up option to cover all otherwise eligible CHIP applicants with access to state employee benefits.)*
   Is [FNLNS] offered the [State of application] state employee health benefit plan through a job or a family member's job?
   a. Yes

b. No

## XIV. Incomplete application

*(Display section when an application isn't completed. This happens when a person completes the process through section VII ["Tell us how many people are applying for coverage]" and clicks on "Save & close." It also occurs when a person leaves a required field blank for the second time and clicks "Save & continue.")*

1. Do you want to go on? We encourage you to complete your application to get coverage through the Marketplace. To complete your application, choose one of these: (Select one.)
   a. Get help completing your application now *(If selected, display "i-iii.")*
      i. Go to online live chat for help *(If selected, link to online chat.)*
      ii. Call the help desk for help now *(If selected, display help desk contact.)*
      iii. Find in-person help near you *(If selected, link to in-person help locator.)*
   b. Save the application now.
   Come back another time to finish and get your results. Important: open enrollment closes on [MM/DD/YYYY] for some health coverage programs. *(Link to "Save & continue.")*
   c. Sign and submit now without finishing.
   You'll hear from us about how to complete your application. Important: open enrollment closes on [MM/DD/YYYY] for some health coverage programs. *(Navigate to "Sign & submit," but don't display the "Eligibility result" page.)*

## XV. Review & sign

**Note to reviewers:** This section describes the summary, signature, and results pages of the application, and is more focused on displaying information rather than asking questions.

### A. Review application

*(The application filers are provided a list of all the data that he/she has entered in the application. He/she can review the details and click to navigate back to the section to make changes.)*

### B. Sign & submit

*(Display option buttons for the user to indicate agreement or disagreement for each statement below and sign electronically. If a user disagrees with a statement additional questions may appear or the user may be notified that his/her eligibility for programs could be impacted.)*

1. *(Display item if applicants are eligible for Medicaid.)*
   If anyone on this application enrolls in Medicaid, I'm giving the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I'm also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.
   a. Agree
   b. Disagree

2. *(Display item if a parent and his or her child are eligible for Medicaid and an absent parent was indicated for the child.)*
   I know I'll 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 the agency and I may not have to cooperate.

   a. Agree
   b. Disagree

3. No one applying for health coverage on this application is incarcerated (detained or jailed).
   a. Agree
   b. Disagree *(If box is checked, display "i.")*
      i. Who is incarcerated (detained or jailed)?
         1. *(Display check box list of applicants.) (If someone was selected, display "a.")*
            a. Is this person pending disposition?
               i. Yes
               ii. No

4. *(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 Marketplace to use income data, including information from tax returns. The Marketplace will send me a notice, let me make any changes, and I can opt out at any time.
   a. Agree
   b. Disagree *(If selected, display "i.")*
      i. I give permission for my eligibility for help paying for health coverage to be renewed for a period of:
         1. 1 year
         2. 2 years
         3. 3 years
         4. 4 years
         5. 5 years
         6. Don't use tax data to renew my eligibility for help paying for health coverage.

5. I know that I must tell the program I'll be enrolled in if information I listed on this application changes. I know I can make changes in "My account" in the Marketplace or by calling 1-800-XXX-XXXX. I understand that a change in my information could affect my eligibility for member(s) of my household.
   a. Agree
   b. Disagree

6. I'm signing this application under penalty of perjury, which means I've provided true answers to all of the questions to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.
   a. Agree
   b. Disagree

7. *(Display for household contact.)*
   a. [FNLNS]'s electronic signature: ____________________

## C. Eligibility results

*(Display summary table which includes all individuals on the application, including applicants and non-applicants.)*

1. Eligible for *(Display list of individuals who are eligible for programs by program.)*
   a. Qualified health plans
      i. Marketplace health plans *(Display list of individuals eligible to enroll in a qualified health plan, their eligible status and timing for enrollment, and a link to more information.)*
      ii. [insert tax credit term] *(Display list of individuals eligible for [insert tax credit acronym], their eligible or pending status, the maximum amount they're eligible for, and a link to more information.)*
      iii. Cost-sharing reductions *(Display list of individuals eligible for cost-sharing reductions, their eligible or pending status, and a link to more information.)*
   b. [State Medicaid program name]
      i. Eligible individuals *(Display list of individuals eligible for Medicaid, their eligible or pending status, and link to information on next steps.)*
   c. [State Medicaid based on disability or age program name]
      i. Eligible individuals *(Display list of individuals eligible for Medicaid, their eligible or pending status, and link to information on next steps.)*
   d. [State Emergency Medicaid program name]
      i. Eligible individuals *(Display list of individuals eligible for Medicaid, their eligible or pending status, and link to information on next steps.)*
   e. [State CHIP program]
      i. Eligible individuals *(Display list of individuals eligible for CHIP, their eligible or pending status, and link to information on next steps.)*

2. Not eligible for *(Display list of individuals applying for coverage who were determined ineligible for a program and provide a link to "More information & appeals" for an explanation of why they were determined ineligible and provide them information on appeals.)*

   [FNLNS1]
   [Not eligible for program name 1]
   [Not eligible for program name 2]
   (*Display link to "More information & appeals.")*

   [FNLNS2]
   [Not eligible for program name 1]
   [Not eligible for program name 2]
   (*Display link to "More information & appeals.")*

   More information & appeals
   a. If I think the Health Insurance Marketplace or Medicaid/Children's Health Insurance Program (CHIP) has made a mistake, I can appeal its decision. To appeal means to tell someone at the Marketplace or Medicaid/CHIP that I think the action is wrong and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Marketplace at 1-800-XXX-XXXX. I know that I can be represented in the process by

someone other than myself. My eligibility and other information will be explained to me. Find out more about how to appeal *(hyperlink).*

   b. Following federal law, discrimination isn't 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 hhs.gov/ocr/office/file *(hyperlink).*

3. Not applying for coverage *(Display list of individuals who were either not applying for coverage or were determined to need to complete their own application based on their relationship to the household contact.)*

   [FNLNS1]
   [Not applying for coverage or separate application required]
   (*Display link to "More information.")*

   [FNLNS2]
   [Not applying for coverage or separate application required]
   (*Display link to "More information*.")

4. *(Skip this item if all applicants are potentially eligible for Medicaid or the State Medicaid agency is the entity processing this application.)*

   *(Display "More information" in an assessment state.)*
   It looks like [FNLNS of all applicants not assessed eligible for Medicaid] [isn't/aren't] eligible for Medicaid. [He/she/they] can still continue with the Medicaid applications if we send this application to the [Name of Medicaid agency]. Do [FNLNS of all applicants not assessed eligible for Medicaid] want us to send their information to the [Name of Medicaid agency] so they can check on Medicaid eligibility?
   a. Yes. We'll send the application to the Medicaid agency electronically. This can happen while you continue with your enrollment in a health plan through the Marketplace.
   b. No. I don't want [FNLNS of each applicant] checked further for Medicaid and want to withdraw my application for Medicaid. The [Name of Medicaid agency] won't see your application.

   *(Display "More information" in a determination state)*
   Do any of these people want to request a determination for Medicaid for [FNLNS] as conducted by [name of the State Medicaid Agency] on the basis of-disability, blindness, or recurring medical needs and bills?
   a. *(List applicants not assessed or not determined potentially eligible for Medicaid; allow multi-select.)*
   b. None of these people

5. Does anyone in the household want to register to vote? *optional*
   a. Yes *(If selected, display "i.")*
      i. Click here to register to vote (Link to blank voter registration form.)
   b. No

## XVI. Enrollment “To-do” list

*(The user continues from the “To-do” list page that includes tasks tailored to each individual to complete his/her application and enrollment process. No additional questions are asked on the “To-do” list page. For APTC or QHP eligible individuals, this page includes tasks to enroll in a health plan and links to section XVII [“Plan enrollment”] and additional information. For Medicaid or CHIP eligible individuals, this page includes the state specific process for next steps from the State Medicaid or CHIP agency and links for additional information. If applicable, this “To-do” list also includes the status of required documents and due date(s) for document submission.)*

## XVII. Plan enrollment (for APTC or QHP eligible applicants)

1. *(Display item if applicant identified an assistor in section IV [“Assistance with completing the application”].)*
   a. Is [FNLNS of assistor] still helping you with this application?
      i. Yes *(If selected, skip to item 3.)*
      ii. No *(If selected, continue to “b.”)*
   b. Are you being helped by a different person?
      i. Yes *(If selected, continue to item 2.)*
      ii. No *(If selected, skip to item 3.)*

2. Tell us if you’re getting help from one of the people: *(Display option buttons.)*
   a. Navigator *(If selected, display “i-iii.”)*
      i. Name:
         1. First name: _____________________
         2. Middle name: _____________________ *optional*
         3. Last name: _____________________
         4. Suffix *(Display dropdown menu of suffixes.) optional*
      ii. Organization name:___________
      iii. ID number:________
   b. Certified application counselor *(If selected, display “i-iii.”)*
      i. Name:
         1. First name: _____________________
         2. Middle name: _____________________ *optional*
         3. Last name: _____________________
         4. Suffix *(Display dropdown menu of suffixes.) optional*
      ii. Organization name:___________
      iii. ID number:________
   c. In-person assistance personnel *(If selected, display “i-iii.”)*
      i. Name:
         1. First name: _____________________
         2. Middle name: _____________________ *optional*
         3. Last name: _____________________
         4. Suffix *(Display dropdown menu of suffixes.) optional*
      ii. Organization name:___________
      iii. ID number:________
   d. Agent or broker *(If selected, display “i-iv.”)*
      i. Name:
         1. First name: _____________________
         2. Middle name: _____________________ *optional*

            3. Last name: ____________________
            4. Suffix *(Display dropdown menu of suffixes.) optional*
        ii. Organization name: ___________
        iii. FFM User ID: ________
        iv. NPN number: ________
    e. None of these

3. Within the past 6 months, have you used tobacco regularly (4 or more times per week on average)? Don't count religious or ceremonial uses.
    a. Yes *(If selected, continue to item 4.)*
    b. No (*If selected, skip to item 5.)*

4. *(Display item if "a" was selected in item 3.)*
   When was the last time you used tobacco regularly?
    a. Date: MM/DD/YYYY

5. *(User reviews and selects plan(s) (health and/or dental only) and identifies which applicants will be on each plan, if more than one plan was selected.)*

6. *(Display item if APTC eligible. User selects amount of advance payments of the APTC they want paid each month to his/her insurer and applied to plan premiums. Primary tax filer(s) must review and sign the following attestation.)*

   I understand that because [insert tax credit term] will be paid on my behalf to reduce the cost of health coverage for myself and/or my dependents:
   - I must file a federal income tax return in [coverage year +1] for the tax year [coverage year].
   - If I'm married at the end of [coverage year], I must file a joint income tax return with my spouse.

   I also expect that:
   - No one else will be able to claim me as a dependent on their [coverage year] federal income tax return.
   - I'll claim a personal exemption deduction on my [coverage year] federal income tax return for any individual listed on this application as a dependent who is enrolled in coverage through this Marketplace and whose premium for coverage is paid in whole or in part by advance payments.

   If any of the above changes, I understand that it may impact my ability to get a [insert tax credit term].

   I also understand that when I file my [coverage year] federal income tax return, the Internal Revenue Service (IRS) will compare the income on my tax return with the income on my application. I understand that if the income on my tax return is lower than the amount of income on my application, I may be eligible to get an additional [insert tax credit term] amount. On the other hand, if the income on my tax return is higher than the amount of income on my application, I may owe additional federal income tax.

Tax filer signature(s): ____________________

**Note to reviewers:** This section displays the questions that appear for users who have indicated that they don't want help paying for health insurance, and are applying to enroll in a qualified health plan through the Health Insurance Marketplace.

## Non-financial assistance questions

*(Display if "b" was selected in item "3.b" of section V ["Help paying for coverage"].)*

## XVIII. Tell us how many people are applying for health coverage

*(Display section if household contact indicated that other family members want coverage.)*

1. How many people in your family and household want health coverage? Include yourself.
   a. ___

2. You'll fill out information for each person in your family and household who wants coverage. Tell us about this person.
   a. Name:
      i. First name: ____________________
      ii. Middle name: ____________________ *optional*
      iii. Last name: ____________________
      iv. Suffix: *(Display dropdown menu of suffixes.) optional*

3. Date of birth: MM/DD/YYYY

4. How is [FNLNS] related to [Application filer FNLNS]? (Select one.)
   [FNLNS] is the *(Display relationship dropdown menu; default to blank)* of [Application filer FNLNS].
   a. Husband/wife
   b. Domestic partner
   c. Parent
   d. Stepparent
   e. Parent's domestic partner
   f. Son/daughter
   g. Stepson/stepdaughter
   h. Child of domestic partner
   i. Brother/sister
   j. Uncle/aunt
   k. Nephew/niece
   l. First cousin
   m. Grandparent
   n. Grandchild
   o. Other relative (*If selected, display subsequent list of relationships that are allowed for plan enrollment.*)

p. Other unrelated (*If selected, display subsequent list of relationships that are allowed for plan enrollment.*)
   i. Adopted son/daughter
   ii. Foster child
   iii. Guardian
   iv. Court-appointed guardian
   v. Former spouse
   vi. Collateral dependent
   vii. Sponsored dependent
   viii. Dependent of a minor dependent
   ix. Ward
   x. Other relative
   xi. Unrelated

*(Repeat items 2-4 for all applicants.)*

# XIX. Tell us about each person (non FA)

*(Repeat for each applicant, with the household member's name displayed at the top. Begin with the household contact.)*

## A. [FNLNS] personal information (non FA)

1. Sex:
   a. Male *(Display check box.)*
   b. Female *(Display check box.)*

2. We need a Social Security number (SSN) if you want health coverage and have an SSN or can get one. We use SSNs to check citizenship. If [FNLNS] needs help getting an SSN, visit socialsecurity.gov, or call 1-800-722-1213. TTY users should call 1-800-325-0778.
   a. Social Security number: ___-___-____

3. *(Display for everyone who enters an SSN.)*
   Is this [FNLNS] the same name that appears on [his/her] Social Security card?
   a. Yes *(If selected, skip to subsection"B" ["Citizenship & immigration status"].)*
   b. No *(If selected, continue to item 4.)*

4. *(Display item if "b" was selected in item 3.)*
   Enter the same name as shown on [FNLNS]'s Social Security card.
   a. Name:
      i. First name: ____________________
      ii. Middle name: ____________________
      iii. Last name: ____________________
      iv. Suffix: *(Display dropdown menu of suffixes.)*

*(At this point, if an SSN has been entered and not verified by the Social Security Administration (SSA), the system will provide a limit number of opportunities for the user to retry entries for name, birthdate, and SSN. All applicants continue to subsection "B" ["Citizenship/immigration status"].)*

## B. Citizenship/immigration status (non FA)

1. Is [FNLNS] a U.S. citizen or U.S. national?
   a. Yes *(If selected and citizenship was verified with SSA, continue to subsection "C" ["Ethnicity & race"]. If selected and citizenship wasn't verified with SSA, continue to item 2.)*
   b. No *(If selected, skip to item 4.)*

2. *(Display item if SSA doesn't verify U.S. citizenship or U.S. national status.)*
   Is [FNLNS] a naturalized or derived citizen?
   a. Yes *(If selected, continue to item 3.)*
   b. No *(If selected, inconsistency is found.)*

3. *(Display item if "a" was selected in item 2).*
   Document type: (Select one.)
   a. Naturalization certificate *(If selected, display "i-ii.")*
      i. Alien number: ____________________ *(Display check box for "I don't have one.")*
      ii. Naturalization certificate number: ____________________
   b. Certificate of citizenship *(If selected, display "i-ii.")*
      i. Alien number: ____________________ *(Display check box for "I don't have one.")*
      ii. Citizenship certificate number: ____________________

4. Check if [FNLNS] has eligible immigration status: *(Link to explanation of eligible immigration statuses.)*
   a. *(Display check box. If check box was selected, continue to item 5. If check box wasn't selected, prompt user to review list of eligible statuses available through help text and select an option, if applicable.)*

5. Document type: (select one.) *(If "a-l" was selected, display values shown in "5.i-ix" below. Link to explanation and images of document and status types.)*
   a. Permanent Resident Card ("Green Card," I-551)*
   b. Temporary I-551 Stamp (on passport or I-94, I-94A)*
   c. Machine Readable Immigrant Visa (with temporary I-551 language)*
   d. Employment Authorization Card (EAD, I-766)*
   e. Arrival/Departure Record (I-94, I-94A)*
   f. Arrival/Departure Record in foreign passport (I-94)*
   g. Foreign passport
   h. Reentry Permit (I-327)
   i. Refugee Travel Document (I-571)
   j. Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)
   k. Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)
   l. Notice of Action (I-797)*
   m. Other documents or status types *(Link to "Other documents & status types.") (If selected, continue to item 6.)*

   *(*For these document types allow one selection from item "5.a-m" and one selection from item "6.a-h." Otherwise, display items "5.a-l." If "m" was selected, disable*

*selections in item 5 and enable list of "Other document & status types" below in "6.a.-h.")*

*(Display appropriate option based on document type selected. The user will be prompted to provide one or more of the following based on the document type selection.)*

i. Alien number: ____________________
ii. I-94 number: ____________________
iii. Passport or document number: ____________________
iv. Country of issuance: *(Display dropdown list of countries.)*
v. Passport expiration date: MM/DD/YYYY
vi. SEVIS ID number: ____________________
vii. Document description: ____________________
viii. Document expiration date: MM/DD/YYYY
ix. Category code: ________________

6. *(Display item if "m" was selected in item 5; show list of other documents and statuses, as follows. For some status types that are unverifiable, the system may ask for the user to upload documents. For some document types, a user can select both a document type from item 5 and one or more statuses from this list.)*
   Do you have any of these documents? [*or* "Do you also have any of these documents?"] (Select all that apply.)
   a. Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR)
   b. Office of Refugee Resettlement (ORR) eligibility letter (if under 18)
   c. Cuban/Haitian Entrant
   d. Document indicating withholding of removal
   e. Resident of American Samoa *(If selected, ask for documents at document upload.)***
   f. Administrative order staying removal issued by the Department of Homeland Security
   g. Other *(If selected, display "i-ii.")*
      i. Description: ____________________
      ii. Alien number OR I-94 number: ____________________
   h. None of the above

   (***For these document/status types, ask for documents at section XXII ["Enrollment To-do list"].*)

7. *(Display item for everyone who selects a verifiable immigration document type.)*
   Is [FNLNS] the same name that appears on [his/her] document?
   a. Yes *(If selected, skip to subsection "C" ["Ethnicity & race"].)*
   b. No *(If selected, continue to item 8.)*

8. *(Display item if "b" was selected in item 7.)*
   Enter the same name as shown on [FNLNS]'s document.
   a. Name:
      i. First name: ____________________
      ii. Middle name: ____________________
      iii. Last name: ____________________

iv. Suffix: *(Display dropdown menu of suffixes.)*

*(After clicking "Save & continue" on section XIX ["Tell us about each person (non FA)"], retries of the name, date of birth, and SSN and DHS numbers may occur if any information was unable to be verified.)*

## C. Ethnicity & race (non FA)

Optional information: This information will help the U.S. Department of Health and Human Services (HHS) better understand and improve the health or and health care for all Americans. Provided this information won't impact your eligibility for health coverage, your health plan options, or your costs in any way.

1. Is [FNLNS] of Hispanic, Latino, or Spanish origin? *optional*
   a. Yes *(If selected, display "i.")*
      i. Ethnicity: (Check all that apply.)
         *(Display check boxes.)*
         1. Cuban
         2. Mexican, Mexican American, or Chicano/a
         3. Puerto Rican
         4. Other: ____________________
   b. No

2. Race: (Check all that apply.) *optional*
   *(Display check boxes.)*
   a. American Indian or Alaska Native
   b. Asian Indian
   c. Black or African American
   d. Chinese
   e. Filipino
   f. Guamanian or Chamorro
   g. Japanese
   h. Korean
   i. Native Hawaiian
   j. Other Asian
   k. Other Pacific Islander
   l. Samoan
   m. Vietnamese
   n. White
   o. Other: ____________________

## D. Other addresses

1. What's [FNLNS]'s home address? *(Display prepopulated addresses if available.)*
   a. [Address for household contact] *(If selected, skip to item 4.)*
   b. [Any other address entered for another applicant] *(If selected, skip to item 4.)*
   c. Other address *(If selected, continue to item 2.)*
   d. No home address *(If selected, skip to item 3.)*

2. *(Display item if "c" was selected in item 1.)*

What's [FNLNS]'s home address?

a. Street address: ____________________
b. Apartment or suite number: ____________________ *optional*
c. City: ____________________
d. State: *(Display dropdown menu of states.)*
e. ZIP code: ____________________
f. County: *(Display dropdown selection of potential counties, if ZIP code crosses more than one county.)*

3. *(Display item if "d" was selected in item 1.)*
   What's [FNLNS]'s mailing address?
   a. Street address: ____________________
   b. Apartment or suite number: ____________________ *optional*
   c. City: ____________________
   d. State: *(Display dropdown menu of states.)*
   e. ZIP code: ____________________
   f. County: *(Display dropdown selection of potential counties, if ZIP code crosses more than one county.)*

4. *(Display item if applicant lists any address in item 1 or 2 for an applicant outside state of application.)*
   Is [FNLNS] living outside [State of application] temporarily?
   a. Yes *(If selected, continue to item 5.)*
   b. No *(If selected, skip to subsection "E" ["American Indian/Alaska Native"].)*

5. *(Display item if "a" was selected in item 4.)*
   Where will [FNLNS] live in [State of application]?
   a. City: ____________________
   b. ZIP code: ____________________
   c. I don't know *(If selected, disable "a" and "b" above.)*
   d. County: *(Display dropdown selection of potential counties if "b" is completed, but ZIP code crosses more than one county.)*

## E. American Indian/Alaska Native

1. Are any of these people a member of a federally recognized tribe?
   *(Display QHP eligible applicants with "Yes/No" radio buttons for each, and allow multi-select.)*
   a. Yes
   b. No

2. *(Display item if "a" was selected for one or more individuals in item 1.)*
   Please select a state and tribe.
   a. State: *(Display dropdown menu of states.)*
   b. Tribe name: *(Display dropdown menu of tribe names.)*

3. *(Display item if "a" was selected for one or more of the individuals in item 1.)*
   Who is a member of the [name of tribe] tribe?

a. *(Display list of all QHP eligible individuals with check boxes.)*
b. All of the above

*(Show items 2 and 3 as needed to identify state and tribe for each individual identified as AI/AN in item 1.)*

## F. Special Enrollment Periods

*(Display section for all applicants in the non-financial assistance section beginning on November 1, 2013, to see if they may qualify for a Special Enrollment Period.)*

1. Did any of these people lose health insurance in the last 60 days?
   a. *(Display checkbox list of all QHP eligible individuals, and allow multi-select. If anyone was selected, continue to item 2.)*
   b. None of these people

2. *(Display item for each individual selected in item 1.)*
   When did [FNLNS] lose health insurance?
   a. Date: MM/DD/YYYY

3. *(Display item for each individual selected in item 1.)*
   Did [FNLNS] lose health insurance because [he/she] didn't pay premiums?
   a. Yes
   b. No

4. Are any of these people going to lose their health coverage in the next 60 days?
   a. *(Display list of QHP eligible individuals, allow multi-select.)*
   b. None of these people

5. (*Display item for each individual selected in item 4*.)
   When will [FNLNS]'s health coverage end?
   a. Date: MM/DD/YYYY

6. Did any of these people get married in the last 60 days?
   a. *(Display check box for all QHP eligible individuals, and allow multi-select. If anyone was selected, continue to item 7.)*
   b. None of these people

7. *(Display item for each individual selected in item 6.)*
   When did [FNLNS] get married?
   a. Date: MM/DD/YYYY

8. Have any of these people been adopted or placed for adoption in the last 60 days?
   a. *(Display checkbox list of all QHP eligible individuals, and allow multi-select. If anyone was selected, continue to item 9.)*
   b. None of these people

9. *(Display item for each individual selected in item 8.)*
   When was [FNLNS] adopted or placed for adoption?

a. Date: MM/DD/YYYY

10. Did any of these people gain eligible immigration status in the last 60 days?
    a. *(Display checkbox list of all QHP eligible individuals who selected that they had eligible immigration status, and allow multi-select. If anyone was selected, continue to item 11.)*
    b. None of these people

11. *(Display item for each individual selected in item 10.)*
    When did [FNLNS] gain eligible immigration status?
    a. Date: MM/DD/YYYY

12. Did any of these people move in the last 60 days?
    a. *(Display checkbox list of all QHP eligible individuals, and allow multi-select. If anyone was selected, continue to item 13.)*
    b. None of these people

13. *(Display item for each individual selected in item 12.)*
    What was the ZIP code [and County if applicable] of [FNLNS]'s last address?
    a. ZIP code: _____
    b. County *(Display if system verifies address and finds that ZIP code covers more than one county. The system will provide an option for the user to select the correct county.)*

14. *(Display item for each individual selected in item 12.)*
    When did [he/she] move?
    a. Date: MM/DD/YYYY

15. Did any of these people get released from incarceration (detention or jail) in the last 60 days?
    a. *(Display check box list of all QHP eligible individuals, and allow multi-select. If anyone was selected, continue to item 16.)*
    b. None of these people

16. *(Display item for each individual selected in item 15.)*
    When was [FNLNS] released from incarceration (detention or jail)?
    a. Date: MM/DD/YYYY

## XX. Incomplete application (non FA)

*(Display section when an application isn't completed. This happens when a person has completes the process through section VII ["Tell us how many people are applying for coverage"] and clicks on "Save & close." It also occurs when a person leaves a required field blank for the second time and clicks "Save & continue.")*

1. Do you want to go on? We encourage you to complete your application to get coverage through the Marketplace. To complete your application, choose one of these: (Select one.)
    a. Get help completing your application now. *(If selected, display "i-iii." Display further details on getting help.)*
        i. Go to online live chat for help (*If selected, link to online chat.*)

ii. Call the help desk for help now (*If selected, display help desk contact.*)
iii. Find in-person help near you (*If selected, link to in-person help locator.*)

b. Save the application now.
Come back another time to finish and get your results. Important: open enrollment closes on [MM/DD/YYYY] for some health coverage programs. *(Link to "Save & continue.")*

# XXI. Review & sign

**Note to reviewers:** This section describes the summary, signature, and results pages of the application, and is more focused on displaying information rather than asking questions.

## A. Review application

*(The application filer is provided with a list of all the data that he/she has entered in the application. He/she can review the details and click to navigate back to the section to make changes.)*

## B. Sign & submit

*(Display option buttons for the user to indicate agreement or disagreement for each statement below and sign electronically. If a user disagrees with a statement, additional questions may appear or the user may be notified that his/her eligibility for programs could be impacted.)*

1. No one applying for health coverage on this application is incarcerated (detained or jailed).
   a. Agree
   b. Disagree *(If box is checked, display "i.")*
      i. Who is incarcerated (detained or jailed)?
         1. *(Display check box list of applicants.) (If someone was selected, display "a.")*
            a. Is this person pending disposition?
               i. Yes
               ii. No

2. I know that I must tell the program I'll be enrolled in if information I listed on this application changes. I know I can make changes in "My account" in the Marketplace or by calling 1-800-XXX-XXXX. I understand that a change in my information could affect my eligibility for member(s) of my household.
   a. Agree
   b. Disagree

3. I'm signing this application under penalty of perjury, which means I've provided true answers to all of the questions to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.
   a. Agree
   b. Disagree

4. *(Display for household contact.)*
   [FNLNS]'s electronic signature: ____________________

## C. Eligibility results

*(Display summary table which includes all applicants on the application.)*

1. Eligible for qualified health plans *(Display list of individuals eligible to enroll in a qualified health plan, their eligible status and timing for enrollment, and a link to more information.)*

2. Not eligible for qualified health plans *(Display list of individuals applying for coverage who were determined ineligible for enrollment in a qualified health plan and provide a link to "More information & appeals" for an explanation of why they were determined ineligible and provide them information on appeals.)*

   [FNLNS1]
   [Not eligible for program name 1]
   (*Display link to "More information & appeals."*)

   [FNLNS2]
   [Not eligible for program name 1]
   (*Display link to "More information & appeals."*)

   *More information & appeals*

   a. If I think the Health Insurance Marketplace or Medicaid/Children's Health Insurance Program (CHIP) has made a mistake, I can appeal its decision. To appeal means to tell someone at the Marketplace or Medicaid/CHIP that I think the action is wrong and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Marketplace at 1-800--XXX-XXXX. I know that I can be represented in the process by someone other than myself. My eligibility and other information will be explained to me. Find out more about how to appeal *(hyperlink).*
   b. Following federal law, discrimination isn't 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 hhs.gov/ocr/office/file *(hyperlink).*

3. Does anyone in the household want to register to vote? *optional*
   b. Yes *(If selected, display "i.")*
      i. Click here register to vote *(Link to blank voter registration form.)*
   c. No

# XXII. Enrollment "To-do" list

*(The user continues from the "To-do" list page that includes tasks tailored to each individual to complete his/her application and enrollment process. No additional questions are asked on the "To-do" list page. For APTC or QHP eligible individuals, this page includes tasks to enroll in a health plan and links to section XXIII ["Plan enrollment"] and additional information. For Medicaid or CHIP eligible individuals, this page includes the state specific process for next steps from the State Medicaid or CHIP agency and links for additional information. If applicable, this "To-do" list also includes the status of required documents and due date(s) for document submission.)*

## XXIII. Plan enrollment

1. *(Display if applicant identified an assistor in section IV ["Assistance with completing the application"].)*
    a. Is [FNLNS of assistor] still helping you with this application?
        i. Yes *(If selected, skip to item 3.)*
        ii. No *(If selected, continue to "b.")*
    b. Are you being helped by a different person?
        i. Yes *(If selected, continue to item 2.)*
        ii. No *(If selected, skip to item 3.)*

2. Tell us if you're getting help from one of these people *(Display option buttons.)*
    a. Navigator *(If selected, display "i-iii.")*
        ii. Name:
            1. First name: ____________________
            2. Middle name: ____________________ *optional*
            3. Last name: ____________________
            4. Suffix *(Display dropdown menu of suffixes.) optional*
        iii. Organization name: ___________
        iv. ID number: ________
    b. Certified application counselor *(If selected, display "i-iii.")*
        i. Name:
            1. First name: ____________________
            2. Middle name: ____________________ *optional*
            3. Last name: ____________________
            4. Suffix *(Display dropdown menu of suffixes.) optional*
        ii. Organization name: ___________
        iii. ID number: ________
    c. In-person assistance personnel *(If selected, display "i-iii.")*
        i. Name:
            1. First name: ____________________
            2. Middle name: ____________________ *optional*
            3. Last name: ____________________
            4. Suffix *(Display dropdown menu of suffixes.) optional*
        ii. Organization name:___________
        iii. ID number:________
    d. Agent or broker *(If selected, display "i-iv.")*
        i. Name:
            1. First name: ____________________
            2. Middle name: ____________________ *optional*
            3. Last name: ____________________
            4. Suffix *(Display dropdown menu of suffixes.) optional*
        ii. Organization name: ___________
        iii. FFM User ID: ________
        iv. NPN number: ________
    e. None of these

3. Within the past 6 months, have you used tobacco regularly (4 or more times per week on average)? Don't count religious or ceremonial uses.
    a. Yes *(If selected, continue to item 4.)*
    b. No *(If selected, skip to item 5.)*

4. *(Display item if "a" was selected in item 3.)*
   When was the last time you used tobacco regularly?
    a. Date: MM/DD/YYYY

5. *(User reviews and selects plan(s) (health and/or dental only) and identifies which applicants will be on each plan, if more than one plan was selected.)*