OMB No. 0938-1191
Expires: XX/XXXX

Electronic application annotated outline

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1191 (expires XX/XXXX). The time required to complete this information collection is estimated to average between 15-30 minutes, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ******CMS Disclosure**** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325).**

Electronic application annotated outline

I. **Marketplace account**: Individuals must create an account to use the electronic 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 electronic application.

III. **Get started**: Gathers contact information for the application.

IV. **Help applying for coverage**: Collects information about application counselors, navigators, and other assistance.

V. **Help paying for coverage**: Asks whether people want help paying for coverage.

VI. **You're applying for coverage for these people**: 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 APTC, Medicaid, and the Children's Health Insurance Program (CHIP).

VIII. **More about this household**: Collects additional information about the household for eligibility determinations.

IX. **Income**: Collects income information.

X. **Discrepancies**: Collects information on any income or other discrepancies between what an individual reported and data sources.

XI. **APTC program questions**: Only displayed if someone appears APTC 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.

XII. **Medicaid & CHIP specific questions**: Only displayed if someone appears Medicaid or CHIP eligible. Collects information for determining or assessing eligibility for Medicaid or CHIP.

XIII. **Review & sign**: Printable review and summary of the application, agreements, and signatures. Displays eligibility results for each individual.

XIV. **Enroll "To-do" list:** For each individual, displays next steps to complete enrollment.

XV. **Plan enrollment (for APTC or QHP eligible applicants)**: Displays tobacco questions, compare and select plan(s), etc.

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

XVI. **Who needs coverage:** Creates a list of all people applying for coverage in the household.

XVII. **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.

XVIII. **Review & sign**: Printable review and summary of the application, agreements, and signatures. Displays eligibility results for each individual.

XIX. **Enroll "To-do" list**: For each individual, displays next steps to complete enrollment.

XX. **Plan enrollment**: Displays tobacco questions, compare and select plan(s), etc.

Contents

I. Marketplace account 6
A. Create an account 6
B. Transition to a full account 6
C. Account settings 7
D. Report a life change 7
II. Privacy 8
Privacy & use of your information 8
III. Get started 9
A. Contact information 9
B. Contact home address 9
C. Contact mailing address 9
D. Contact phone 10
E. Contact preferences 10
IV. Help applying for coverage 11
V. Help paying for coverage 12
A. Help paying for coverage 12
B. Who needs coverage 12
C. Income screener (Get help with costs) *optional* 12
VI. You're applying for coverage for these people 13
VII. Tell us about each person 14
A. [FNLNS]'s information 14
B. Citizenship/immigration status 15
C. Family & household 19
D. Parent/caretaker relatives 25
E. Other addresses 26
F. Race & ethnicity 27
VIII. More about this household 28
IX. Income 30
X. Discrepancies 37

XI. APTC program questions 38
A. Tax filer & other information (APTC eligible) 38
B. Health coverage (APTC eligible) 39
C. Employer health coverage (APTC eligible) 40
D. Employer health coverage detail 42
E. Employer contact information (APTC eligible) 44
F. American Indian/Alaska Native (APTC eligible) 45
G. Special Enrollment Periods 45
XII. Medicaid & CHIP specific questions 47
A. Medicaid specific questions 48
B. CHIP specific questions 49
XIII. Review & sign 50
A. Review application 50
B. Sign & submit 50
C. Eligibility results 51
XIV. Enroll “To-do” list 53
XV. Plan enrollment (for APTC or QHP eligible applicants) 53
Non-financial assistance questions 56
XVI. Who needs coverage 56
XVII. Tell us about each person 57
A. [FNLNS] personal information 57
B. Citizenship/immigration status 58
C. Race & ethnicity 61
D. Other addresses 61
E. American Indian/Alaska Native 62
F. Special Enrollment Periods 63
XVIII. Review & sign 64
A. Review application 64
B. Sign & submit 65
C. Eligibility results 65
XIX. Enroll “To-do” list 67
XX. Plan enrollment 67

I. Marketplace account

Note to reviewers: To access the Marketplace electronic application, the individual filling out the application must first set up their Marketplace account. There are two parts to setting up a Marketplace account. The first part lets individuals establish a relationship with the Marketplace. They can access or update contact information, set communication preferences, and browse and compare plans in a secure environment without requiring identity proofing. The second part requires the individual to give additional information to transition to a full account, which enables them to submit an application and get eligibility results, and enroll in a plan, if applicable. Consumers can choose to view their eligibility determination notice in their user account as well. To create a full account, the individual must verify their 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 Marketplace 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. Consumers who use the Marketplace Call Center to apply for coverage can later set up an electronic account to access their application.

A. Create an account

(Display for users setting up an account.)

1. Create account *(Display check box.)*
   a. Name:
      i. First name: ____________________
      ii. Last name: ____________________
   b. Email address: _________________
   c. Password: _________________
   d. Confirm password: ________________
   e. Security questions: (*Choose 3 sets from a selection of questions.*)
   f. Security question answers: (*Answers to the 3 questions provided by the individual.*)

B. Transition to a full account

(Display for user's additional account creation information. A full Marketplace account is required to create and submit an electronic application.)

1. Tell us about yourself *(Display check box. Information that was provided in subsection "A" account will be prepopulated.)*
   a. Name:
      i. First name: ____________________
      ii. Middle:____________________*optional*
      iii. Last name: ____________________
      iv. Suffix: *(Display dropdown menu of suffixes.) optional*
         1. Jr.
         2. Sr.
         3. III
         4. IV
   b. Date of birth: MM/DD/YYYY
   c. SSN *optional*: __________
   d. Email address: __________

e. Address:
    i. Street address: ____________________
    ii. Apt./Ste. #:__________________*optional*
    iii. City: ____________________
    iv. State: *(Display dropdown menu of states.)*
    v. ZIP code: ____________________
f. Preferred phone number: (___)___-____Ext.____*optional*
g. Phone type: (Display dropdown menu)
    a. Home
    b. Cell
    c. Work

2. ID proofing process *(This process includes challenge questions.)*

C. Account settings

(The user may select text or email as a way to get notifications and marketing emails from his/her "Marketplace account." The user can also select his/her preferred spoken and written languages.)

D. Report a life change

(Display section if the applicant previously completed an application and now indicates that he/she wants to report a change, as required in section XVIII ["Review & sign"]. To do this, he/she will select their completed application, then "Report a Life Change.")

1. Have you had any changes like these?
    - You moved to a different state
    - You lost your job, got a new job, or your income changed
    - You or one of your dependents turned 26
    - You had family changes, like a new baby or a divorce

    Important: Check your income information frequently. Your eligibility for help with costs is based on factors including your household income. Accurate information will help you get the right amount of help and avoid differences when you file your federal income tax return. Choose an option below to continue:

    a. Report a move to a new state *(If selected, display "i.")*
        i. Moving to a new state
        If you're moving to a new state, apply for coverage in your new state first. This prevents a temporary gap in your coverage.

        Apply for coverage in your new state

        If you moved to a state that uses HealthCare.gov, select CONTINUE, then select the year and new state to start a new application.

        If you moved to a state with its own Marketplace website, apply there first.

        After you enroll in your new state, write down your coverage start date. Then return to this application and go to "My Plans & Programs" to end your older coverage.

b. Change how we send information to you *(If selected, display "i.")*

    i. Change the way we send information to you

        This won't affect information that's saved in your Marketplace account. If you have a new phone number or email address, be sure to tell your plan and update your Marketplace account under My Profile.

        - Change the email address or phone number where you get Marketplace messages
        - Add or remove phone text messaging alerts
        - Start or stop getting paper notices in the mail

        Select CONTINUE to make changes.

c. Report a change in my household's income, size, or other information *(If selected, the user is taken back to their application to make changes, starting at section II ["Privacy."])*

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 ["Get 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

Privacy & use of your information

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 (DHS), 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. Get started

A. Contact information

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

1. Name:
    a. First name : ____________________
    b. Middle:____________________*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 [“Marketplace account”], and allow for editing.)*

B. Contact home address

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

1. Home address:
    a. Street address: ____________________
    b. Apt./Ste. #:____________________*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. What is your mailing address?
    a. *(Display populated address.)*
    b. Other address *(Display check box. If selected, display “i-vi.”)*
        i. Street address: ____________________
        ii. Apt./Ste. #:____________________*optional*
        iii. City: ____________________
        iv. State: *(Display dropdown menu of states.)*
        v. ZIP code: ____________________
        vi. County: *(Display dropdown selection of potential counties, if ZIP code crosses more than one county.)*

D. Contact phone

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

1. Is (XXX-XXX-XXXX) your preferred number?
    a. Yes *(If selected, skip to item 3.)*
    b. No *(If selected, continue to item 2.)*

2. Phone number: (___)____-_____Ext.____*optional*

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

4. Second phone number: (___)____-_____Ext.____*optional*

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

E. Contact preferences

1. Preferred spoken language: *optional*
    a. *(Display dropdown menu of languages; default to English.)*
        i. English
        ii. Spanish
        iii. Vietnamese
        iv. Tagalog
        v. Russian
        vi. Portuguese
        vii. Arabic
        viii. Chinese
        ix. French
        x. French Creole
        xi. German
        xii. Gujarati
        xiii. Hindi
        xiv. Korean
        xv. Polish
        xvi. Urdu
        xvii. Other

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 this website? *(Display option buttons.)*

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 *(If selected, display "i.")*
      i. Messaging rates will apply.
      ii. Cell phone:____-_____-_____*(Prepopulate phone number.)*
   b. Email
      i. Use this email address: *(Prepopulate email address.) (Display check box.)*
      ii. Email:____________*(Populate email address if check box is selected.)*
      iii. Re-enter email address: ___________

IV. Help applying for coverage

1. 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:______________________*optional*
         3. Last name: ______________________
         4. Suffix *(Display dropdown menu of suffixes.) optional*
      ii. Organization name:____________*optional*
      iii. ID number:_________*optional*
   b. Certified application counselor *(If selected, display "i-iii.")*
      i. Name:
         1. First name: ______________________
         2. Middle:______________________*optional*
         3. Last name: ______________________
         4. Suffix *(Display dropdown menu of suffixes.) optional*
      ii. Organization name:____________*optional*
      iii. ID number:_________*optional*
   c. Non-Navigator assistance personnel *(If selected, display "i-iii.")*
      i. Name:
         1. First name: ______________________
         2. Middle:______________________*optional*
         3. Last name: ______________________
         4. Suffix *(Display dropdown menu of suffixes.) optional*
      ii. Organization name:____________*optional*
      iii. ID number:_________*optional*
   d. Agent or broker *(If selected, display "i-v.")*
      i. Name:
         1. First name: ______________________
         2. Middle:______________________*optional*
         3. Last name: ______________________
         4. Suffix *(Display dropdown menu of suffixes.) optional*

        ii. Organization name:____________*optional*
        iii. ID number:_________*optional*
        iv. FFM User ID:_________*optional*
        v. NPN number: _________
    e. None of these people
2. We need to make sure that only people who have your permission are viewing the application. Enter a security response. Choose only information that you'll know.
    a. Question 1: *(Display challenge questions.)*
    b. Answer 1: ___________

V. Help paying for coverage

A. Help paying for coverage

1. Do you want to find out if you can get help paying for health coverage?
   Even working families can pay less for health coverage. You may be eligible for a free or low-cost plan, or a new kind of tax credit that can be used to lower your monthly premiums right away.
    a. Yes. You'll answer questions about your income to see what help you qualify for. (*If selected, continue to subsection "B" ["Who needs coverage," then follow the financial assistance question sequence].)*
    b. No. You'll answer fewer questions, but you won't get help paying for coverage. (*If selected, continue to subsection "B" ["Who needs coverage," then follow the non-financial assistance question sequence].)*
    c. I'm not sure. Answer 2 questions, and we'll help you figure out your next steps. (*If selected, continue to subsection "B" ["Who needs coverage], then "C" ["Income screener"].)*

B. Who needs 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.)*

C. Income screener (Get help with costs) *optional*

Note to reviewers: These questions are only asked if the person checks that he/she isn't sure if he/she wants to apply for help paying for coverage in the question in subsection "A" ["Help paying for coverage."] This 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 a new kind of tax credit that can be used to lower your monthly premiums right away. Answer 2 optional questions to see if you can get a break on costs. To skip this step, select Back to return to the previous question.

1. How many people are on your federal income tax return this year? (If you aren't filing taxes, tell us how many people live with you, including yourself.) You don't have to file taxes to apply for coverage.

   (Functionality for "+" and "–" signs.)

2. Based on your best guess, do you expect your total household income to be less than [Equivalent to 400% of the federal poverty level in dollars for family size listed plus buffer] for this year?
   a. Yes *(If selected, display "i.")*
      i. We encourage you to apply to see what help you can get paying for health coverage. Based on what you told us, you may be eligible to get help paying for health coverage through the Marketplace. We encourage you to apply for this help. To get help paying for coverage, select "yes" on the next question.
   b. No *(If selected, display "i.")*
      i. Based on what you told us, your income may be too high to get help paying for health coverage. You can still get a good deal on insurance from the Marketplace, and you won't pay higher costs or be denied coverage for pre-existing conditions.
   c. I don't know *(If selected, display "i.")*
      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 Marketplace. To get help paying for coverage, select "yes" on the next question.

VI. You're applying for coverage for these people

(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.

Select "ADD A PERSON" below to add each member of your household who's applying for health coverage.

1. Add a person applying for coverage:
   a. Name:
      i. First name: ____________________
      ii. Middle:____________________*optional*
      iii. Last name: ____________________
      iv. Suffix: *(Display dropdown menu of suffixes.) optional*

2. Date of birth: MM/DD/YYYY

3. Relationship to [Application filer FNLNS] *(Dropdown, default is blank.)*
   a. Spouse
   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 QHP eligible after the income section, display subsequent list of relationships allowed for plan enrollment to choose from in section XI ["APTC 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 XI ["APTC program questions"], subsection "A" ["Tax filer & other information"].)*

(Repeat items 1-3 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]'s information

1. What is [FNLNS]'s sex?
   a. Male
   b. Female

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 Social Security at 1-800-722-1213. TTY users should call 1-800-325-0778.

a. Enter [FNLNS]'s Social Security number *optional*
Social Security number:____-___-____

3. *(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. Do you want to provide [FNLNS]'s Social Security Number?
      i. Yes *(If selected, display below and item 5.)*
         1. Enter [FNLNS]'s Social Security Number *optional*
            Social Security Number:____-___-____
      ii. No *(If selected, continue to item 4.)*

4. *(Display if applicant or non-applicant chooses to not enter an SSN on item 2 or 3.)*
Are you sure? It's important to enter the Social Security Numbers (SSNs) for everyone on your application, if they have them. Entering SSNs make the application process go smoother and faster by allowing the Marketplace to check your information automatically. If you don't enter SSNs for people who have them, you may need to provide more information later.
   a. Continue without SSN *(If selected, skip to section "B" [Citizenship/immigration status"], if applicable.)*
   b. Back *(If selected, go back to item 3 to change response to "Yes.")*

5. *(Display item for everyone who enters an SSN on item 2 or item 3.)*
Is [FNLNS] the same name that appears on [his/her] Social Security card?
   a. Yes *(If selected, skip to subsection "B" ["Citizenship/immigration status"], if applicable.)*
   b. No *(If selected, continue item 6.)*

6. *(Display item if "b" was selected in item 5.)*
Enter the same name as shown on [FNLNS]'s Social Security card:
   a. Name:
      i. First name: ____________________
      ii. Middle: ____________________
      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" ["Citizenship/immigration status"], if applicable.)

B. 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 "C" ["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 “C” [“Family & household.”])*

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 here if [FNLNS] has eligible immigration status:
   a. *(Display check box.)*
      i. *(If check box is selected, display “1.”)*
         1. If this person's immigration status isn't listed here, he or she may still be able to get help paying for emergency services, including for labor and delivery if they have a baby. In some states, pregnant women may also be able to get health care coverage.
      ii. *(If check box isn’t selected, display “1.”)*
         1. Immigration Status *optional*

            Did you forget to check the immigration status box?
            If you select "yes" - you will be given a chance to check the "eligible immigration status" box. To see a list of eligible immigration statuses, [click here] *(hyperlink)*.

            If you select "no" - you can continue with the application. You might still be able to get help paying for emergency services, which will include labor and delivery, if you have a baby. In some states, pregnant women may also be able to get health care coverage.

            a. Yes, I'll check the box for immigration status now. *(If selected, continue to item 5.)*
            b. No, I want to continue without checking the box for an immigration status. *(If selected, skip to subsection “C” [“Family & household.”])*

      If [FNLNS]'s immigration status isn't on the list, then [he/she] may still be able to get help paying for services if [he/she] has an emergency [or is pregnant].

5. Document type: (Select one.) *(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.)

    (If "a-l" is selected in item 5, display values in "5.i-ix" based on document type selected, then continue to item 6.)

    (If "m. Other documents or status types" is selected in item 5, then continue to item 6.)

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

6. *(Display if "a-l" is selected in item 5.)*
Does [FNLNS] also have any of these documents or status types? (Select all that apply.)

(Display if "m. Other documents or status types" is selected in item 5.)
Does [FNLNS] have any of these documents or status types? (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 (DHS)
    h. Other *(Displayed if "m. Other documents or status types" is selected in item 5.*

If selected, display "i-ii.")

    i. Document description: ____________________
    ii. Enter one of these numbers:
        1. Alien number: ____________________
        2. 1-94 number: ____________________

  i. None of these *(If selected, disable a-h selections above)*

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

7. 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:____________________*optional*
        iii. Last name: ____________________
        iv. Suffix: *(Display dropdown menu of suffixes.) optional*

9. *(Display item if applicant checked "eligible immigration status" and the applicant has a birth date prior to August 22, 1996.)*
   Has [FNLNS] lived in the U.S. since 1996? *optional*
    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

11. *(Display if appropriate document numbers in "5.i-ix" weren't provided.)*
    Are you sure?
    It's important to enter as many fields from your immigration documents as possible, even though some fields may be labeled "optional." Entering all of your document information makes the application process go smoother and faster, helps make sure your eligibility results are correct, and may prevent you from needing to come back later and provide more information.
    a. Continue without adding more (*If selected, continue to item 12.*)
    b. Back (*If selected, go back to item 5.*)

12. *(Display item if applicant checked "eligible immigration status" and the Department of Homeland Security indicates that the five-year bar applies, but can't determine if five-year bar was met.)*
    When did [FNLNS] get [his/her] current immigration status? *optional*
    a. Month (*Display dropdown menu of months.*)
    b. Year (*Display dropdown menu of years.*)

13. *(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

(After clicking "Save & continue" in section VII ["Tell us about each person"], retries of the citizenship and immigration document numbers may occur if any information was unable to be verified with the Department of Homeland Security.)

C. 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.

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, but you'll need to file next year if you want to get a premium tax credit to help pay for coverage now.
    a. Yes
    b. No *(If selected, and spouse was listed in applicant list, skip to item 4.)*
    Remember: If you select "No," you won't qualify for a premium tax credit. If you want to see if you can get help paying for coverage, select "Yes." Then, you'll need to file a federal income tax credit to compare ("reconcile") any advanced payments of the premium tax credit (APTC) you took with that you were eligible for based on your actual income for [coverage year.]

2. *(Display item if no other applicant indicated relationship of "spouse" or "domestic partner" to household contact in section VI ["You're applying for coverage for these people"].)*
    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 [“You’re applying for coverage for these people”].)*
   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:____________________*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:____________________*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 “D” [“Parent/caretaker relatives”].)*
      i. Who are [FNLNS] and [Spouse Name]’s dependents?
         1. *(Display all other applicant names, and allow multi-select.)*
         2. Someone else *(If selected, display “a-c.”)*
            a. Name of dependent:
               i. First name: ____________________
               ii. Middle:____________________*optional*
               iii. Last name: ____________________
               iv. Suffix: *(Display dropdown menu of suffixes.) optional*
            b. Date of birth: MM/DD/YYYY
            c. 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 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 "D" ["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 their claiming tax filer.
   a. Spouse *(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 or QHP, display subsequent list of relationships allowed for plan enrollment to choose from in section XI ["APTC program questions"], subsection "A" ["Tax filer & other information"].)*
   q. Other unrelated *(If selected, and both household members are applicants who look eligible for APTC or QHP, display subsequent list of relationships allowed for plan enrollment to choose from in section XI ["APTC 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 claims [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 15 for non-filer questions.)*
      i. Who is [Dependent FNLNS]'s other parent or stepparent? *(Allow selection of up to 2 checkboxes.)*
         1. *(Display all household members older than applicant as options.)*
         2. Someone else *(If selected, display "a-c.")*
            a. Name of parent or stepparent:
               i. First name: ____________________
               ii. Middle:____________________*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 a tax credit 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 may apply for a tax credit?
    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 1-800-318-2596, or print a paper application at HealthCare.gov to mail in. You can also continue with this application now to see if [Tax filer(s) name(s)] can get a tax credit 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:____________________ *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, continue to item 14. If selected and household contact is the son/daughter/stepchild of household contact who is under age 21, skip to item 16 for non-filer questions.)*
        i. Remember: If you select "No," you won't qualify for a premium tax credit.
           If you want to see if you can get help paying for coverage, select "Yes." Then, you'll need to file a federal income tax return to compare ("reconcile") any advanced payments of the premium tax credit (APTC) you took with what you were eligible for based on your actual income for 2016.

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:____________________ *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.)*

(Items 15-17 are for non-filing households.)

15. *(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 16.)*

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:____________________*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 16.)*

16. *(Display item if non-filer household is being built and applicant is under age 21.)*
    Does [Applicant FNLNS] live with brothers or sisters who are under age [state age]? (Include stepbrothers, stepsisters, half-brothers, half-sisters).
    a. Yes *(If selected, display "i," then continue to item 17.)*
        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-b.")*
                a. Name of brother or sister:
                    i. First name: ____________________
                    ii. Middle:____________________*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 17.)*

17. *(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 "D" ["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 "D" ["Parent/caretaker relatives"].)*

(Logic for subsequent applicants within subsection "C" ["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 "15" in subsection "C" ["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.

D. Parent/caretaker relatives

Note to reviewers: This section collects information on relationships to determine whether a person may qualify for Medicaid based on the parent/caretaker category. The age of dependent children may be substituted as 18 (instead of 19) in the logic of items 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 "E" ["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 "E" ["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?
   Select "Yes" if this person cares for a child under 19 – like a son, daughter, or other tax dependent. Some adults can get more help paying for coverage if they take care of a child.
    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 "E" ["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. Someone else not listed above *(Display check box. If selected, display "i-vi," then continue to item 3.)*
    i. First name: ____________________
    ii. Middle:____________________*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, . Repeat as needed for multiple such children.)*
   [FNLNS] is the *(Display relationship dropdown menu; default to "parent.")* of this child.
   a. Parent
   b. Stepparent
   c. Brother/sister
   d. Uncle/aunt
   e. Nephew/niece
   f. First cousin
   g. Grandparent
   h. Other relative
   i. 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.)*
   Do any of these children live with more than one parent, through birth or adoption? *optional*
   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. Allow multi-select. If a name is selected, display b.*
   b. About how many hours per week does each parent work?
      i. Parent 1: _
      ii. Parent 2: _

E. Other addresses

Note to reviewers: This section collects addresses for all applicants. States have developed different definitions of "temporary absence" for Medicaid and CHIP residency.

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, if applicable.)*
   b. [Any other address entered for another applicant] *(If selected, skip to item 4, if applicable.)*
   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.)*

Enter [FNLNS]'s home address

a. Street address: ____________________
b. Apt./Ste. #:____________________*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.)*
   Enter [FNLNS]'s mailing address
   a. Street address: ____________________
   b. Apt./Ste. #:____________________*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 "F" ["Race & ethnicity"].)*
      If you don't provide an address in [state], it will affect your eligibility for health coverage.

5. *(Display item if "a" was selected in item 4).*
   Where will [FNLNS] live in [state of application]? *optional*
   a. Street: __________________
   b. Suite: ______________
   c. City: ____________________
   d. ZIP code: ____________________
   e. County: *(Display dropdown selection of potential counties if "b" is completed, but ZIP code crosses more than one county.)*

F. Race & ethnicity

This information will be used to help the U.S. Department of Health and Human Services (HHS) better understand and improve the health of 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 *(If selected, display "a.")*
    a. Ethnicity: ____________________

b. No

2. What is [FNLN]'s 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 *(If selected, display "i.")*
      i. Race: ____________________

(Repeat this section for each member of the household.)

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 former foster care eligibility group established by the Affordable Care Act.

1. Do any of these people below have a physical disability or mental health condition that limits their ability to work, attend school, or take care of their daily needs? *optional*

   If a person needs help only because they're too young to do these things for themselves, don't select their name.
   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. Do any of these people need help with activities of daily living (like bathing, dressing, and using the bathroom), or live in a nursing home or other medical facility? *optional*
   a. *(Display each applicant name with a check box, and allow multi-select.)*
   b. None of these people *(Disable list of names.)*

3. Were any of these people found not eligible for Medicaid or the Children's Health Insurance Program (CHIP) in the past 90 days? Or, were any of them found not eligible for Medicaid or CHIP due to their immigration status since October 1, 2013?

   Check the box only if a person was found not eligible for this coverage by their state, not by the Marketplace.
    a. *(Display each applicant name with a check box, and allow multi-select.)* *(If a name is selected and applicant did not attest to being a U.S. citizen or U.S. national, display "i.")*
        i. Was this person found not eligible by their state because of their immigration status?
            1. Yes
            2. No
    b. None of these people *(Disable list of names.)*

4. Did any of these people apply for coverage between [Open Enrollment start date MM/DD/YYYY] – [Open Enrollment end date MM/DD/YYYY]? (Select their name if they applied through their state or the Marketplace.)
    a. *(Display each applicant name with a check box, and allow multi-select.)*
    b. None of these people *(Disable list of names.)*

5. *(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 6.)*
    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 7.)*
    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 7.)*
    d. None of these people *(Disable list of names. If selected, skip to item 7.)*

6. *(Display item if applicant aged 18-22 was selected in item 4 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 8.)*
    b. No *(If selected, continue to item 7.)*

7. *(Display item if "b" was selected in item 6 and there isn't already a parent on the application whose address is listed in the state of application.)*
   Does one or more of [Applicant]'s parents live in [State of application]?
    a. Yes
    b. No

8. 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.)*

9. 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 10.)*
   b. None of these people *(Disable list of names. If selected, skip to item 11.)*

10. *(Display item if an applicant was indicated in item 9 or a non-applicant was indicated in item 9 in a state that has taken up the option to count more than one unborn baby in a Medicaid household size in case there is a pregnant non-applicant.)*
    How many babies is [Name selected in item 9] expecting during this pregnancy?
    a. *(Display dropdown menu of 1-8. Default to 1.)*

11. Were any of these people ever in foster care?
    a. *(Display names of applicants aged 18-25 with check boxes, and allow multi-select. If a name was selected, continue to item 12.)*
    b. None of these people *(Disable list of names.)*

12. *(Display item if an applicant name was selected in item 11.)*
    In what state was [Applicant name] in the foster care system?
    a. *(Display dropdown menu of states. Default to State of application.)*

13. *(Display item if state selected in item 12 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] (Medicaid)?
    a. Yes *(If selected, continue to item 14.)*
    b. No *(If selected, skip to section IX ["Income"].)*

14. *(Display item if "a" was selected in item 13.)*
    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.)*

IX. 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.

1. *(Display item for the household contact 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.)

a. 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.)*
   a. ADD INCOME FOR [FNLNS] *(Display button.)*

3. What type of income would you like to add?
   (Display each income type ["a-l"] onscreen. After information is entered for the income type, another dropdown shows up for the user to select an additional income type.)
   a. Job *(If selected, continue to item 4.)*
   b. Retirement *(If selected, skip to item 5.)*
   c. Rental or royalty income *(If selected, skip to item 6.)*
   d. Self-employment *(If selected, skip to item 7.)*
   e. Pension *(If selected, skip to item 8.)*
   f. Farming or fishing income *(If selected, skip to item 9.)*
   g. Social Security benefits *(If selected, skip to item 10.)*
   h. Capital gains *(If selected, skip to item 11.)*
   i. Alimony received *(If selected, skip to item 12.)*
   j. Unemployment *(If selected, skip to item 13.)*
   k. Investment income *(If selected, skip to item 14.)*
   l. Other income *(If selected, skip to item 15.)*

4. *(Display item if "a" ["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 you get as well as any one-time amounts this month, like a bonus or a severance payment.
      i. Amount: $__________
   c. How often does [FNLNS] get 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: _____

5. *(Display item if "b" ["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

6. *(Display item if "c" ["Rental or royalty income"] was selected in item 3.)*
   a. How much does [FNLNS] get from net rental or royalty income (the profit after subtracting costs)?
      i. Amount: $_____
      ii. Profit or Loss: (*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

7. *(Display item if "d" ["Self-employment"] was selected in item 3.)*
   a. How much net income (profits once expenses are paid) will [FNLNS] get from this self-employment this month? 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:____________________*optional*
      ii. Amount: $_____
      iii. (*Display dropdown menu.*)
         1. Profit
         2. Loss

8. *(Display item if "e" ["Pension"] was selected in item 3.)*
   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

9. *(Display item if "f" ["Farming or fishing income"] was selected in item 3.)*
   a. How much does [FNLNS] get from net farming or fishing income (the profit after subtracting costs)?
   b. Amount: $_____
   c. Profit or Loss: (*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

10. *(Display item if "g" ["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?
       (Display dropdown menu.)
       i. One time only
       ii. Monthly
       iii. Yearly

11. *(Display item if "h" ["Capital gains"] was selected in item 3.)*
    a. How much does [FNLNS] expect to get from net capital gains (the profit after subtracting capital losses) this year?
       i. Amount: $_____
       ii. Profit or loss: (*Display dropdown menu.*)
          1. Profit
          2. Loss

12. *(Display item if "i" ["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

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

14. *(Display item if "k" ["Investment income"] was selected in item 3.)*
    a. How much does [FNLNS] get from investment income, like interest and dividends?
        i. Amount: $_____
    b. How often?
       (Display dropdown menu.)
        i. One time only
        ii. Monthly
        iii. Quarterly
        iv. Yearly

15. *(Display item if "l" ["Other income"] was selected in item 3, and allow multi-select.)*
    Which type of income would you like to add? *(Display drop down menu.)*
    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).

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 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

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?
      a. Amount: _____
    2. How often does [FNLNS] get this amount?
      (*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.)*
  a. Does [FNLNS] pay for any of these deductions? *(Display each deduction income type ["i-iii"] onscreen.)*
    i. Alimony
    ii. Student loan interest
    iii. Other

  b. If [FNLNS] pays for certain things that can be deducted on an income tax return, telling us about them could make the cost of health insurance a little lower.
    i. Yes *(If selected, continue to item 18.)*
    ii. No *(If selected, skip to item 19.)*

18. Add deduction for [FNLNS]
What type of deduction would you like to add?
  a. *(Display drop-down menu):*
    i. Alimony
    ii. Student loan interest
    iii. Other *(If selected, display "1-2.")*
      1. Don't include a cost that you already considered when you told us about your net self-employment or rental income.
      2. What deduction do you have?
        a. Deduction: __________
  b. Amount: $_____
  c. How often does [FNLNS] pay this amount?
  (Display dropdown menu.)
    i. Hourly
    ii. Daily
    iii. Weekly
    iv. Every 2 weeks
    v. Monthly

vi. Quarterly
vii. 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?
    - Per capita payments from the tribe that come from natural resources, usage rights, leases or royalties.
    - Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian land by the Department of Interior (including reservations and former reservations).
    - Money from selling things that have cultural significance.

    a. Yes
        i. Enter the amount: *(Display table of income this household member had entered previously and provide a "Tribal amount" column for entering the amount of tribal income from each income source.)*

    b. No

21. *(Display item unless the household member is a tax filer who attested to an annual income on the expedited page.)*
    Based on what you told us, if [FNLNS]'s income is steady month to 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 X ["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. Total yearly amount: $_________
    b. I don't know *(Display check box. If selected, continue to item 23.)*
    You may be asked to provide proof of your income. If you're not sure what your income will be, give us your best guess. Later on, if your income does change, you can report the change.

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. If selected, display "i-ii.")*
        i. Total yearly amount: $_____
        ii. None
    b. None

    (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 your 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. *(Display income types not previously selected, with checkboxes for each type, and allow multi-select.)*

        i. *(Display for each selected income type.)*
           Total yearly amount: __________

        (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.)*

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

X. 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 IX ["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 45 days, 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 IX ["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 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 APTC 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 IX ["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 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 advance premium tax credits, 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.

XI. APTC program questions

A. Tax filer & other information (APTC eligible)

1. *(Display item if applicants are otherwise APTC 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.)*
   To get help paying for health coverage, the people listed below must do at least one of these: File a federal income tax return, file a joint tax return (if married), or be claimed as a dependent on someone else's tax return. You gave us tax filing information for these people. Do you want to change any tax filing information for [coverage year]? *(Display list of applicants who are otherwise eligible for APTC with Yes/No option buttons.)*
   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 APTC in eligibility results.)*

2. *(Display item if applicants are otherwise APTC 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 coverage, [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 APTC in eligibility results.)*

3. *(Display item for each applicant who is potentially eligible to enroll in a Qualified Health Plan. The system will display a different selection of the relationships below based on which relationship the person previously identified in the application. If the person previously selected domestic partner, parent's domestic partner, uncle/aunt, or grandparent, then the system would display c, d, f, g, h, i, and l. If the person previously selected child of a domestic partner, sibling, nephew/niece, first cousin, or grandchild, then the system would display a, b, c, d,e, f, g, h, i, and l. If the person previously selected Other relative or Unrelated, then the system would display all the options below.].*
   Is [Applicant Name 1]'s relationship to [Applicant name 2] also any of the following?
   (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
   l. None of these relationships

B. Health coverage (APTC eligible)

*(Display items for **all** applicants that appear APTC eligible. If QHP eligible, skip to section XI, subsection "E" ["Employer contact information (APTC eligible)"].)*

1. Is [FNLNS] enrolled in health coverage from any of the following?

a. [Name of state Medicaid program] *(If selected, display "i.")*
    i. Don't check this box for "Medicaid" if:
    Your Medicaid coverage will end before [first day of coverage year: MM/DD/YYYY]. You may have received a letter from the Medicaid agency that told you that your coverage would be ending.
    Or
    Your Medicaid coverage only pays for a few benefits, like only family planning services, emergency Medicaid services, TB services, or outpatient hospital services.
b. [Name of state CHIP program] *(If selected, display "i.")*
    i. Don't check this box for the CHIP Program if your CHIP coverage will end before [first day of the coverage year: MM/DD/YYYY]. You may have received a letter from the CHIP agency that told you that your coverage would be ending.
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 these

(If applicant selects "a-f," skip to "E" ["Employer contact information (APTC eligible)".]

C. Employer health coverage (APTC eligible)

1. Is [FNLNS] currently eligible for health coverage through a job (even if it's through COBRA or from another person's job, like a spouse *[display if person is under age 26: or parent/guardian]*)?

   Select "Yes" if you could have enrolled in employer coverage for this year, even if the enrollment period for the employer coverage is over.

   a. Yes *(If selected, continue to item 2 if applying during Open Enrollment prior to the coverage year or item 4.)*
   b. No *(If selected, continue to item 2 if applying during Open Enrollment prior to the coverage year or item 3.)*

2. *(Display during Open Enrollment prior to the coverage year.)*
   Will [FNLNS] be eligible for health coverage from a job during [coverage year=next year] (even if it's through COBRA or 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 skip to item 4.)*
       i. Date [FNLNS]'s coverage could start: MM/DD/YYYY
   b. No *(If selected, skip to skip to section XI, subsection "E" ["Employer contact information (APTC eligible)"].)*
   c. I don't know *(If selected, display "i," then skip to section XI, subsection "E" ["Employer contact information (APTC eligible)"].)*
       i. If you don't know the answer to this question, you can give the Employer Coverage Tool to your employer to help get the information you need to answer this question. You can continue the application now, but you'll need to provide the answers to these questions within 90 days of applying to the Marketplace so we know what coverage you and/or your family qualify for.

3. *(Display if item 1.b. “No” is selected outside Open Enrollment Period.)*
   Will [FNLNS] be eligible for health coverage from a job during [coverage year= current year] (even if it’s through COBRA or 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 (APTC eligible)”].)*
    c. I don’t know *(If selected, skip to section XII, subsection “E” [“Employer contact information (APTC eligible)”].)*

4. Tell us which employer(s) offer(s) health coverage to [FNLNS]:
   Check the box next to each employer that offers coverage. Include any coverage available through your job, or a spouse or parent/guardian’s job.
    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.) (If selected, display “i-iii.”)*
        i. Employer Identification Number (EIN):_____________________*optional*
        ii. Employer’s address:
            1. Street address:_____________________*optional*
            2. Suite number:__________*optional*
            3. City:_____________________*optional*
            4. State: *(Display dropdown menu of states.) optional*
            5. ZIP code:_____________________*optional*
        iii. Phone number: (___)____-_____Ext. ____
    b. Other *(If selected, display “i-iv.”)*
        i. Employer name: _____________________
        ii. Employer Identification Number (EIN):_____________________*optional*
        iii. Employer’s address:
            1. Street address:_____________________*optional*
            2. Suite number:__________*optional*
            3. City:_____________________*optional*
            4. State: *(Display dropdown menu of states.) optional*
            5. ZIP code:_____________________*optional*
        iv. Phone number: (___)____-_____Ext. ____

5. Who can we contact about this employer’s coverage? If you’re not sure, ask your employer. *optional*
    a. First name:______________
    b. Middle: ______________
    c. Last name: ______________
    d. Suffix: *(Display dropdown list of suffixes.)*
    e. Phone number (___)____-_____Ext. ____
    f. Contact email address: ___________
    g. Re-enter email address: __________

6. Is [FNLNS] currently enrolled in this [populate employer name where possible or “employer’s”] health coverage?

a. Yes *(If selected, skip to item 8.)*
b. No *(If selected, continue to item 7.)*

7. *(Display if answers "b" to item 6.)*
   Is [FNLNS] currently in a waiting or probationary period?
   a. Yes
      i. When could [FNLNS] enroll in coverage?
         1. Date: (MM/DD/YYYY)
   b. No

8. Is [FNLNS] a current or former employee of this employer?
   a. Yes *(If selected, skip to item 10.)*
   b. No *(If selected, continue to item 9.)*

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

10. What's [[FNLNS]'s or *prepopulate employee's name if identified in item 9, or* [the employee's]] current work status at [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 11.)*
    c. Retired *(If selected, skip to item 12.)*

11. *(Display if "b" was selected in item 10.)*
    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 (APTC eligible)"], if applicable.)*
    b. No (*If selected, skip to subsection "D" ["Employer health coverage detail"]*.)

12. *(Display if "c" was selected in item 10.)*
    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 (APTC eligible)"], if applicable.)*
    b. No (*If selected, continue to subsection "D" ["Employer health coverage detail"].)*

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

D. Employer health coverage detail

Display questions below for each employer selected in subsection "C" ["Employer health coverage (APTC eligible)"] from which applicant indicates he or she currently has access to or will have an offer of employer sponsored coverage. Note: Applicants who say they are enrolled in or have access to COBRA or retiree coverage will not see this section.

(Display this introductory message.)
Tell us about [Employer name]'s health coverage. 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 Tool provide a step-by-step guide 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 (If selected, continue to item 2.)*
    b. *No (If selected and person indicated that they were enrolled in coverage (i.e., selected 6a in subsection "C" ["Employer health coverage (APTC eligible)"]), skip to item 4. If selected and person indicates that they are not enrolled in coverage (i.e., selected 6.b in subsection "C" ["Employer health coverage (APTC eligible)"]), skip to item 5.)*
    c. *I don't know (If selected and no other employer coverage offer exists, skip to subsection "F" ["American Indian/Alaska Native (APTC eligible"], if applicable.)*

2. For the lowest-cost plan available only to [FNLNS] that meets the minimum value standard: Most plans offered by employers meet the minimum value standard. Only tell us about self-only plans offered to this employee.
    a. How much is the premium for this plan?
    If the employer offers wellness programs, enter the premium that the employee would pay if the employee got the maximum discount for any tobacco cessation programs and didn't get any other discounts based on wellness programs.
        i. $_______________
        ii. *(Display check box.)* I don't know
            1. *(Display if "I don't know" is selected.)*
            If you don't know the answer to this question, you can give the Employer Coverage Tool [link to Employer Coverage Tool] to your employer to help get the information you need to answer this question. You can continue the application now, but you'll need to provide the answers to these questions within 90 days of applying to the Marketplace so we know what coverage you and/or your family qualify for.
    b. How often would [FNLNS] pay this amount?
    (*Display dropdown menu.)*
        i. Weekly
        ii. Biweekly
        iii. Twice a month
        iv. Monthly
        v. Quarterly
        vi. Annually

3. Does [FNLNS or "the employee"] expect [Employer name] to make any of these changes to the coverage offered to [FNLNS] in [coverage year]?
    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.")*
   ii. 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 the employee received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
      1. $__________ *(If an amount is entered, continue to "a.")*
         a. How often would the employee pay this amount? (Display dropdown menu.)
            i. Weekly
            ii. Biweekly
            iii. Twice a month
            iv. Monthly
            v. Quarterly
            vi. Annually
   iii. When will [Employer name] make this change?
      1. Date: MM/DD/YYYY

c. I don't know if [Employer name] will make changes *(If selected, display "i.")*
   iv. If you don't know the answer to this question, think about any current offers of coverage you have and whether your employer has notified you that something will change soon. You can also give the Employer Coverage Tool [link to Employer Coverage Tool] to your employer to help get the information you need to answer this question.

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 (APTC eligible)].")*
   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 (APTC eligible)].")*
   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 (APTC eligible)

(Display for all applicants who are in the same tax household as an applicant found preliminarily eligible for APTC because an employer didn't provide health coverage or an employer provided health coverage that wasn't affordable or didn't meet minimum value. Do not display if the applicant provided employer

contact information in subsection "D" ["Employer health coverage detail"]. Allow entry of new employer information or collect employer contact information for each employer listed on the application in item "4.a." of section IX ["Income"]. Repeat until applicant indicates no further employers.)

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

2. *(Display if no employer contact information has been provided.)*
   Tell us more about [FNLNS]'s employer.
   a. Employer name *[Or prepopulate employer name from section IX ["Income"] item "4.a."]*
   b. Employer's address:
      i. Street address:______________________*optional*
      ii. Suite number:_________*optional*
      iii. City:______________________*optional*
      iv. State: *(Display dropdown menu of states.) optional*
      v. ZIP code:______________________*optional*
   c. Employer's phone number: (___)____-____Ext.____*optional*
   d. Employer Identification Number (EIN):_____*optional*

F. American Indian/Alaska Native (APTC 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 APTC or QHP based on income attestation.)

1. Are any of these people a member of a federally recognized tribe?
   (Display APTC 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 state and tribe.
   a. Select a state: *(Display dropdown menu of states.)*
   b. Select tribe name: *(Display button, which populates 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 APTC 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 APTC and QHP eligible individuals to see if they may qualify for a Special Enrollment Period.)

1. Did any of these people recently lose health coverage? *optional*
   a. *(Display check box 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 coverage?
   a. Date: MM/DD/YYYY

3. Are any of these people losing their health coverage in the next 60 days? *optional*
   a. *(Display list of all QHP eligible individuals, and allow multi-select.)*
   b. None of these people

4. (*Display item for each individual selected in item 3*.)
   When will [FNLNS]'s health coverage end?
   Note: Enter the date your current coverage will end. Your Marketplace coverage will start on the first day of the following month. For example, if your current coverage ends December 31, 2014, enter that date here, and your Marketplace coverage will begin on January 1, 2015
   a. Date: MM/DD/YYYY

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

6. *(Display item for each individual selected in item 5.)*
   When did [FNLNS] get married?
   a. Date: MM/DD/YYYY

7. Have any of these people recently been adopted, placed for adoption or placed for foster care? *optional*
   a. *(Display check box list of all QHP eligible individuals, and allow multi-select. If anyone was selected, continue to item 9.)*
   b. None of these people

8. *(Display item for each individual selected in item 7.)*
   When was [FNLNS] adopted, placed for adoption or placed for foster care?
   a. Date: MM/DD/YYYY

9. Did any of these people recently gain eligible immigration status? *optional*
   a. *(Display check box 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 10.)*
   b. None of these people

10. *(Display item for each individual selected in item 9.)*
    When did [FNLNS] get immigration status?
    a. Date: MM/DD/YYYY

11. Did any of these people recently move? *optional*

If an enrolled person is moving out-of-state, consider applying for coverage in your new state first to prevent a temporary gap in coverage.

   a. *(Display check box list of all QHP eligible individuals, and allow multi-select. If anyone was selected, continue to item 12.)*
   b. None of these people

12. *(Display item for each individual selected in item 11.)*
    What is the ZIP code for [FNLNS]'s previous 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.)*

13. *(Display item for each individual selected in item 11.)*
    When was the date of the move?
    a. Date: MM/DD/YYYY

14. Did any of these people recently get released from incarceration (detention or jail)? *optional*
    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

15. *(Display item for each individual selected in item 14.)*
    When was [FNLNS] released from incarceration (detention or jail)?
    a. Date: MM/DD/YYYY

16. [FNLNS], did your household file a [year] tax return and reconcile any premium tax credit you used? *optional*
    a. Yes, [year] premium tax credits were reconciled *(Display checkbox.)*

    Check the box only if all of these apply to you:
    - You used [advance payments of premium tax credits (APTC)] (https://www.healthcare.gov/glossary/advanced-premium-tax-credit/) in [year] to help lower your costs for Marketplace coverage.
    - The tax filer for your household filed a federal income tax return for [year].
    - The tax return filed compared the amount of APTC used in [year] to the rest of the tax return information.

    If all of these don't apply to you, select "SAVE & CONTINUE" without checking the box above.

XII. 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. [*Display* [Coverage from [Employer name]] *identified, if any, in section XII, subsection "C" ["Employer health coverage (APTC eligible)".*]
    b. [Name of Medicaid program in state of application.]
    c. [Name of CHIP program in state of application.]
    d. Medicare
    e. Coverage through an employer *(If selected, continue to item 3.)*
    f. VA health care program or TRICARE
    g. Other full-benefit coverage (which covers benefits like doctor's visits, hospitalizations, and prescription drugs) *(If selected, continue to item 3.)*
    h. 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 "a, d, f, or-g" was selected in item 2; this wording may vary based on type of coverage.)*
    a. What's the policy number? ____________________
    b. What's the member ID? ____________________

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, a tribal health program, or an urban Indian health program or through referral from one of these programs?
    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 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

4. *(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 IX ["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

XIII. 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 they have entered in the application. They 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.)

Read these statements, and select whether you agree or disagree.

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 *(If selected, display "i.")*
      i. Important: If you don't attest to this item, it may impact your eligibility.

2. *(Display item if a parent and his or her child are eligible for Medicaid and an absent parent was indicated for the child.)*
   If a child on this application has a parent living outside of the home, 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 *(If selected, display "i.")*
      i. Important: If you don't attest to this item, it may impact your eligibility.

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's incarcerated (detained or jailed)?
         1. *(Display check box list of applicants.) (If someone was selected, display "a.")*
            a. Is [Name] pending disposition? *(If this item isn't answered, display "1.")*
               i. Yes

ii. No
  1. Important: If you don't attest to this item, it may impact your eligibility.

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, for the next 5 years (the maximum number of years allowed). 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 insurance 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. (Selecting this option may impact your ability to get help paying for health coverage at renewal.) *(If selected, display "a.")*
            a. Important: If you don't attest to this item, it may impact your eligibility.

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 Marketplace account or by calling 1-800-318-2596. TTY users should call 1-855-889-4325. I understand that a change in my information could affect my eligibility for member(s) of my household.
   a. Agree
   b. Disagree *(If selected, display "i.")*
      i. Important: If you don't attest to this item, it may impact your eligibility.

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 *(If selected, display "i.")*
      i. Important: If you don't attest to this item, it may impact your eligibility.

7. *(Display for household contact.)*
   a. [FNLNS]'s electronic signature: ______________________
      Enter your name in the box above.

C. Eligibility results

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

1. Step 1: View Your "Coverage Options at a Glance"

   a. This section gives a quick snapshot of your eligibility. It's important to view your full "Eligibility Results" for more detailed information. Continue to Step 2.
   b. *(Display chart with applicant names and program eligibility information.)*

2. Step 2: View Your "Eligibility Results"
   a. Your "Eligibility Results" contain important information about your Marketplace coverage, including your eligibility for coverage, costs, deadlines, and next steps. If you're eligible for coverage through a Marketplace plan, you'll continue to Step 3 to enroll in coverage after you review your results.
   b. *(Display only if an individual is found eligible for a Special Enrollment Period)*
      You're eligible for a Special Enrollment Period. Select "View Eligibility Results" to find out when you can select a plan or change plans. If you miss the deadline, you may not be able to enroll in a Marketplace plan until the next Open Enrollment, unless you qualify for another Special Enrollment Period.
   c. *(Display button.)*
      "VIEW ELIGIBILITY RESULTS (PDF)" (User selects to open a PDF with detailed eligibility determination notice information.)

3. Step 3: Continue to enrollment *(Display section if at least one person on the application is eligible to enroll in a qualified health plan through the Marketplace.)*
   a. You've finished and submitted your application, and viewed your "Eligibility Results." Next, you'll choose a plan and enroll in coverage.
   b. *(Display button.)*
      CONTINUE TO ENROLLMENT

4. Full Medicaid determination

   (Reveals for determination state)
   Do any of these people want to request a determination for Medicaid as conducted by [State Medicaid Agency Name] on the basis of disability, blindness, or recurring medical needs and bills? *optional*

   (Reveals for assessment state)
   It looks like these people aren't eligible for Medicaid. They can still continue with a Medicaid application if we sent their information to the [State Medicaid Agency Name]. Do any of these people want us to send their information to the [State Medicaid Agency Name] so they can check on Medicaid and The Children's Health Insurance Program (CHIP) eligibility, if applicable?

   (Display list of individuals determined ineligible (determination state) or potentially ineligible (assessment state) with check boxes and "Send to Medicaid Agency" button).

5. What should I do if I think my eligibility results are wrong?
   If you don't agree with what you qualify for, you may be able to file an appeal.

   You can appeal eligibility to buy Marketplace plans and also for enrollment periods. If you're applying for help paying for coverage, you may also have the right to appeal eligibility for tax

credits, cost-sharing reductions, Medicaid eligibility, and CHIP eligibility. If you qualify for tax credits or cost-sharing reductions, you can appeal the amount you're eligible for.

Review your eligibility notice to find appeals instructions for each person in your household, including the number of days you have to file an appeal. Here's important information to consider when filing an appeal:

- You can have someone file or participate in your appeal. That person can be a friend, relative, lawyer, or other person. Or, you can file and participate in your appeal on your own.
- If you file an appeal, you may be able to keep your eligibility for coverage while your appeal is pending.
- The outcome of an appeal could change the eligibility of other members of your household.
- Depending on your state and your eligibility results, you may be able to file an appeal through the Marketplace or you may have to file an appeal with your state Medicaid or CHIP agency.
- [Learn more about how to appeal your Marketplace eligibility results] *(Hyperlink.)* You can also mail an appeal request or your own letter filing an appeal to Health Insurance Marketplace, 465 Industrial Blvd., London, KY 40750-0001.

6. Would you like to register to vote? *optional*
   a. Click here to register to vote. *(Hyperlink to ECA.gov.)*

XIV. Enroll "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 XV ["Plan enrollment"] and additional information. If applicable, this "To-do" list also includes the status of required documents and due date(s) for document submission.)

XV. Plan enrollment (for APTC or QHP eligible applicants)

1. *(Display item if applicant identified an assister in section IV ["Help applying for coverage"].)*
   a. Is [FNLNS of assister] 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.")*
      i. Name:
         1. First name: ____________________
         2. Middle:____________________ *optional*
         3. Last name: ____________________
         4. Suffix *(Display dropdown menu of suffixes.) optional*
      ii. Organization name:___________ *optional*

        iii. ID number:________*optional*

   b. Certified application counselor *(If selected, display "i-iii.")*
      i. Name:
         1. First name: ____________________
         2. Middle:____________________*optional*
         3. Last name: ____________________
         4. Suffix *(Display dropdown menu of suffixes.) optional*
      ii. Organization name:___________
      iii. ID number:________
   c. Non-Navigator assistance personnel *(If selected, display "i-iii.")*
      i. Name:
         1. First name: ____________________
         2. Middle:____________________*optional*
         3. Last name: ____________________
         4. Suffix *(Display dropdown menu of suffixes.) optional*
      ii. Organization name:___________*optional*
      iii. ID number:________*optional*
   d. Agent or broker *(If selected, display "i-v.")*
      i. Name:
         1. First name: ____________________
         2. Middle:____________________*optional*
         3. Last name: ____________________
         4. Suffix *(Display dropdown menu of suffixes.) optional*
      ii. Organization name:___________*optional*
      iii. ID number:__________*optional*
      iv. FFM User ID:_________*optional*
      v. NPN number:_________*optional*
   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 premium tax credit (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.)*

   Read these statements, and select whether you agree or disagree.

I understand that because the premium tax credit 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 the premium tax credit.

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 premium tax credit 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.

a. Agree
b. Disagree

Tax filer signature(s): ____________________

7. *(Display item if APTC eligible on plan selection page. Application filer/Tax filer(s) must select check box indicating agreement with the statement to make final plan selection.)*
I understand that I'm not eligible to get a premium tax credit if I'm found eligible for other minimum essential coverage, like Medicaid. I also understand that if I'm eligible for other minimum essential coverage, I must contact the Marketplace to end my Marketplace coverage and premium tax credit. If I don't the person who files taxes in my household may need to pay back my premium tax credit.

Note to reviewers: The following section displays the questions that appear for users who have indicated that they don't want help paying for health coverage, 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"].)

XVI. Who needs coverage

(Display section if household contact indicated that other family members want 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. You're applying for health coverage for these people
   (Display message) Select "ADD A PERSON" below to add each member of your household who's applying for health coverage.

3. Add a person applying for coverage:
   a. Name:
      i. First name: ____________________
      ii. Middle:____________________*optional*
      iii. Last name: ____________________
      iv. Suffix: *(Display dropdown menu of suffixes.) optional*

4. Date of birth: MM/DD/YYYY

5. Relationship to [Application filer FNLNS]. *(Dropdown, default is blank.)*
   a. Spouse
   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.)

XVII. Tell us about each person

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

A. [FNLNS] personal information

1. What is [FNLNS]'s sex?
   a. Male
   b. Female

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.
   Enter [FNLNS]'s Social Security number *optional*
   Social Security number:____-___-____

3. *(Display if applicant chooses to not enter an SSN on item 2.)* Are you sure? It's important to enter the Social Security Numbers (SSNs) for everyone on your application, if they have them. Entering SSNs make the application process go smoother and faster by allowing the Marketplace to check your information automatically. If you don't enter SSNs for people who have them, you may need to provide more information later. *(Select "Continue without SSN" to proceed without entering an SSN, or "Back" to go back to item 2 and enter an SSN.)*

4. *(Display for everyone on the SSN item 2 page.)*
   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 5.)*

5. *(Display item if "b" was selected in item 4.)*
   Enter the same name as shown on [FNLNS]'s Social Security card.
   a. Name:
      i. First name: ____________________
      ii. Middle: ____________________

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 limited 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

1. Is [FNLNS] a U.S. citizen or U.S. national?
   a. Yes *(If selected and citizenship is verified with SSA, continue to subsection "C" ["Race & ethnicity"]. 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 "C" ["Race & Ethnicity."])*

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 here if [FNLNS] has eligible immigration status:
   a. *(Display check box.)*
      i. *(If check box was selected, display message.)*
      If this person's immigration status isn't listed here, he or she may still be able to get help paying for emergency services, including for labor and delivery if they have a baby. In some states, pregnant women may also be able to get health care coverage.

      ii. *(If check box isn't selected, display message, then continue to item 5.)*

      Immigration Status *optional*

      Did you forget to check the immigration status box?
      If you select "yes" - you will be given a chance to check the "eligible immigration status" box.

      If you select "no" - you can continue with the application. You might still be able to get help paying for emergency services, which will include labor and delivery,

if you have a baby. In some states, pregnant women may also be able to get health care coverage.

1. Yes, I'll check the box for immigration status now. *(If selected, continue to item 5.)*
2. No, I want to continue without checking the box for an immigration status. *(If selected, skip to subsection "C" ["Race & ethnicity"].)*

If [FNLNS]'s immigration status isn't on the list, then [he/she] may still be able to get help paying for services if [he/she] has an emergency [or is pregnant].

5. Document type: (select one.) *(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.)*

   (If "a-l" is selected in item 5, display values in "5.i-ix" based on document type selected, then continue to item 6.)

   (If item "m. Other documents or status types" *is selected in item 5, then continue to item 6.)*

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

6. *(Display if a-l is selected in item 5)* "Does [FNLNS] also have any of these documents or status types? (Select all that apply.)"
   (Display if "m. Other documents or status types" is selected in item 5.) Does [FNLNS] have any of these documents or status types? (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 *(Display if "m. Other documents or status types" is selected in item 5. If selected, display "i-ii.")*
    i. Document description: ____________________
    ii. Enter one of these numbers:
        a. Alien number: ____________________
        b. I-94 number: ____________________
i. None of these *(If selected, disable a-h selections above.)*

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

7. 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:____________________optional
        iii. Last name: ____________________
        iv. Suffix: *(Display dropdown menu of suffixes.)* optional

9. (*Display if appropriate document numbers in 5.i-ix were not provided*.)
   Are you sure?
   It's important to enter as many fields from your immigration documents as possible, even though some fields may be labeled "optional." Entering all of your document information makes the application process go smoother and faster, helps make sure your eligibility results are correct, and may prevent you from needing to come back later and provide more information. To see a list of eligible immigration statuses, *[click here] (hyperlink)*.
    a. Continue without adding more (*If selected, continue to item 10.*)
    b. Back (*If selected, go back to question 5.*)

10. *(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.)*

(After clicking "Save & continue" on section XVII ["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.)

C. Race & ethnicity

Optional information: This information will help the U.S. Department of Health and Human Services (HHS) better understand and improve the health of 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 *(If selected, display "a.")*
                a. Ethnicity: ____________________
    b. No

2. What is [FNLNS]'s 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 *(If selected, display "i.")*
        i. Race: ____________________

(Repeat this section for each member of the household.)

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.)*
   Enter [FNLNS]'s home address
   a. Street address: ____________________
   b. Apt./Ste. #:____________________*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.)*
   Enter [FNLNS]'s mailing address
   a. Street address: ____________________
   b. Apt./Ste. #:____________________*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, display "i.")*
      i. Where will [FNLNS] live in [state]? *optional*
         1. Street: ____________________
         2. Suite: __________________
         3. City: ____________________
         4. State: (Display dropdown menu of states.)
         5. ZIP code: ____________________
   b. No *(If selected, skip to subsection "E" ["American Indian/Alaska Native"].)*

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.)*
   Select state and tribe.
   a. Select a state: *(Display dropdown menu of states.)*
   b. Select 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 to see if they may qualify for a Special Enrollment Period.)

1. Did any of these people recently lose health coverage? *optional*
   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 coverage?
   a. Date: MM/DD/YYYY

3. Are any of these people losing health coverage in the next 60 days? *optional*
   a. *(Display list of QHP eligible individuals, allow multi-select.)*
   b. None of these people

4. (*Display item for each individual selected in item 3*.)
   When will [FNLNS]'s health coverage end?
   Note: Enter the date your current coverage will end. Your Marketplace coverage will start on the first day of the following month. For example, if your current coverage ends December 31, 2014, enter that date here, and your Marketplace coverage will begin on January 1, 2015.
   a. Date: MM/DD/YYYY

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

6. *(Display item for each individual selected in item 5.)*
   When did [FNLNS] get married?
   a. Date: MM/DD/YYYY

7. Have any of these people recently been adopted, placed for adoption or placed for foster care? *optional*
   a. *(Display checkbox list of all QHP eligible individuals, and allow multi-select. If anyone was selected, continue to item 8.)*
   b. None of these people

8. *(Display item for each individual selected in item 7.)*
   When was [FNLNS] adopted, placed for adoption or placed for foster care?
   a. Date: MM/DD/YYYY

9. Did any of these people recently gain eligible immigration status? *optional*
    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 10.)*
    b. None of these people

10. *(Display item for each individual selected in item 9.)*
    When did [FNLNS] get immigration status?
    a. Date: MM/DD/YYYY

11. Did any of these people recently move? *optional*
    If an enrolled person is moving out-of-state, consider applying for coverage in your new state first to prevent a temporary gap in coverage.
    a. *(Display checkbox list of all QHP eligible individuals, and allow multi-select. If anyone was selected, continue to item 12.)*
    b. None of these people

12. *(Display item for each individual selected in item 11.)*
    What is the ZIP code for [FNLNS]'s previous 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.)*

13. *(Display item for each individual selected in item 11.)*
    When was the date of the move?
    a. Date: MM/DD/YYYY

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

15. *(Display item for each individual selected in item 14.)*
    When was [FNLNS] released from incarceration (detention or jail)?
    a. Date: MM/DD/YYYY

XVIII. 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.)

Read these statements, and select whether you agree or disagree.

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's incarcerated (detained or jailed)?
         1. *(Display check box list of applicants.) (If someone was selected, display "a.")*
            a. Is [FNLNS] 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 Marketplace account in the Marketplace or by calling 1-800-318-2596. TTY users should 1-855-889-4325. 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: ____________________
   Enter your name in the box above

C. Eligibility results

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

1. Step 1: View Your "Coverage Options at a Glance"
   a. This section gives a quick snapshot of your eligibility. It's important to view your full "Eligibility Results" for more detailed information. Continue to Step 2.
   b. *(Display chart with applicant names and Marketplace eligibility information.)*

2. Step 2: View Your "Eligibility Results"
   a. Your "Eligibility Results" contain important information about your Marketplace coverage, including your eligibility for coverage, costs, deadlines, and next steps. If you're eligible for coverage through a Marketplace plan, you'll continue to Step 3 to enroll in coverage after you review your results.

b. *(Display only if an individual is found eligible for a Special Enrollment Period)*
You're eligible for a Special Enrollment Period. Select "View Eligibility Results" to find out when you can select a plan or change plans. If you miss the deadline, you may not be able to enroll in a Marketplace plan until the next Open Enrollment, unless you qualify for another Special Enrollment Period.

c. *(Display button.)*
"VIEW ELIGIBILITY RESULTS (PDF)" (User selects to open a PDF of the eligibility determination notice containing detailed information on eligibility results and next steps, such as uploading documentation, if applicable.)

3. Step 3: Continue to enrollment *(Display section if at least one person on the application is eligible to enroll in a qualified health plan through the Marketplace.)*
   a. You've finished and submitted your application, and viewed your "Eligibility Results." Next, you'll choose a plan and enroll in coverage.
   b. *(Display button.)*
   CONTINUE TO ENROLLMENT *(User selects to continue to select a medical and/or dental plan.)*

4. What should I do if I think my eligibility results are wrong?
If you don't agree with what you qualify for, you may be able to file an appeal.

   You can appeal eligibility to buy Marketplace plans and also for enrollment periods. If you're applying for help paying for coverage, you may also have the right to appeal eligibility for tax credits, cost-sharing reductions, Medicaid eligibility, and CHIP eligibility. If you qualify for tax credits or cost-sharing reductions, you can appeal the amount you're eligible for.

   Review your eligibility notice to find appeals instructions for each person in your household, including the number or days you have to file an appeal. Here's important information to consider when filing an appeal:
   - You can have someone file or participate in your appeal. That person can be a friend, relative, lawyer, or other person. Or, you can file and participate in your appeal on your own.
   - If you file an appeal, you may be able to keep your eligibility for coverage while your appeal is pending.
   - The outcome of an appeal could change the eligibility of other members of your household.
   - Depending on your state and your eligibility results, you may be able to file an appeal through the Marketplace or you may have to file an appeal with your state Medicaid or CHIP agency.
   - [Learn more about how to appeal your Marketplace eligibility results] *(Hyperlink.)* You can also mail an appeal request or your own letter filing an appeal to Health Insurance Marketplace, 465 Industrial Blvd., London, KY 40750-0001.

5. Would you like to register to vote? *optional*
   a. Click here to register to vote. *(Hyperlink to ECA.gov.)*

XIX. Enroll “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 XX [“Plan enrollment”] and additional information.. If applicable, this “To-do” list also includes the status of required documents and due date(s) for document submission.)

XX. Plan enrollment

1. *(Display if applicant identified an assister in section IV [“Help applying for coverage”].)*
   a. Is [FNLNS of assister] 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.”)*
      i. Name:
         1. First name: ____________________
         2. Middle:____________________*optional*
         3. Last name: ____________________
         4. Suffix *(Display dropdown menu of suffixes.) optional*
      ii. Organization name:___________*optional*
      iii. ID number:________*optional*
   b. Certified application counselor *(If selected, display “i-iii.”)*
      i. Name:
         1. First name: ____________________
         2. Middle:____________________*optional*
         3. Last name: ____________________
         4. Suffix *(Display dropdown menu of suffixes.) optional*
      ii. Organization name:___________*optional*
      iii. ID number:________*optional*
   c. Non-Navigator assistance personnel *(If selected, display “i-iii.”)*
      i. Name:
         1. First name: ____________________
         2. Middle:____________________*optional*
         3. Last name: ____________________
         4. Suffix *(Display dropdown menu of suffixes.) optional*
      ii. Organization name:___________*optional*
      iii. ID number:________*optional*
   d. Agent or broker *(If selected, display “i-v.”)*
      i. Name:
         1. First name: ____________________
         2. Middle:____________________*optional*
         3. Last name: ____________________
         4. Suffix *(Display dropdown menu of suffixes.) optional*

ii. Organization name:____________*optional*
iii. ID number:___________*optional*
iv. FFM User ID:_________*optional*
v. NPN number:_________*optional*

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.)*