kynect
Kentucky's Healthcare Connection

Health Coverage & Help Paying Costs

Application for One Person

THINGS TO KNOW

Use this application to see what insurance choices you qualify for	• **Free or low-cost insurance from Medicaid or the Kentucky Children's Health Insurance Program (KCHIP)** • **Payment Assistance that can help you pay for your health coverage** • **Affordable health insurance plans that offer comprehensive coverage to help you stay well**
Who is this application for?	Single individuals who: • **Live in Kentucky and plan to stay in Kentucky** • **Do not have any dependents and cannot be claimed as a dependent on someone else's tax return**
Apply faster online	Apply faster online at **www.kynect.ky.gov.**
What you may need to apply	• Your social security number (or document number if you are a legal immigrant) • Employer and income information (for example, paystubs, W-2 forms, or wage and tax statements)
Why do we ask for this information?	We ask about your **Social Security Number (SSN)**, your **income** and other information to see if you qualify for and if you can get any help paying for your health coverage costs. **If you need help getting an SSN,** call 1-800-772-1213 or visit **socialsecurity.gov**. TTY users should call 1-800-325-0778. **We'll keep all the information you give us private, as required by law.**
What happens next?	• Mail or fax your completed, signed application to: **Kentucky Office of the Health Benefit and Information Exchange** **P.O. Box 2104** **Frankfort, KY 40602** **Fax: 1-502-573-2005** • **If you don't have all the information we ask for, submit your application anyway**. We will contact you for the missing information if we cannot complete the determination based on the information you give us. • **If we can make a determination,** we will send you detailed information about the steps you will need to follow to select a plan. You will need to go online, call us, or get assistance from an insurance agent or kynector to enroll in a plan.
To get help	• **Online**: **www.kynect.ky.gov** • **By phone:** Call Customer Service at **1-855- 4kynect (459-6328)** • **In person:** Find a list of places near where you live by visiting our website or calling us. • **En Español:** Llame a nuestro Servicio al Cliente gratis al **1-855- 4kynect (459-6328)** • **For TTY services call 1-855-326-4654**

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STEP 1 Tell Us about Yourself

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

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

2. Social Security Number (SSN) | **We need your SSN if you want coverage and have a SSN**. We use SSNs to check income and other information to see if you are eligible for help with health coverage costs.

3. If you **want coverage** and SSN is not provided, select reason for not providing it.
☐ Religious Objection ☐ Not eligible to receive SSN due to alien status ☐ Applied for SSN
☐ Does not have an SSN and may only be issued an SSN for a valid non-work reason ☐ Refuse to provide SSN

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

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

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

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

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

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

17. Primary Phone Number ☐ Home ☐ Work ☐ Cell ( ) | 18. Secondary Phone Number ☐ Home ☐ Work ☐ Cell ( )

19. ☐ Check here to allow kynect to send text message alerts to your primary phone number. | 20. ☐ Check here to allow kynect to send text message alerts to your secondary phone number.

21. Preferred Spoken Language (if not English) | 22. Preferred Written Language (if not English)

23. **Form 1095-A** is sent by kynect to you and the IRS to report enrollment information and the amount of payment assistance a household has received during the coverage year, if any. **Form 1095-B** is sent by the Department for Medicaid Services if you had Medicaid coverage during the year. The forms will be sent to you via postal mail, or if you create an account on kynect, we can notify you via email instead that the form is ready for viewing. If you would like to be notified via email, enter your email address: _____

24. Have you had a pregnancy end (giving birth or losing a pregnancy) in the past three months or are you currently pregnant? ☐Yes. **If yes**, answer questions a–c. ☐No
a. What is the due date or the last date of pregnancy? (mm/dd/yyyy) _____
b. How many children are/were expected with this pregnancy? _____
c. Would you like to be referred to the program that offers food to Women, Infants and Children (WIC)? ☐Yes ☐No

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

26. Do you want help paying for medical bills from the last 3 months? ☐Yes ☐ No

If yes, which month(s)? _____

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

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

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

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

28. Are you a U.S. citizen or national?

☐ Yes ☐ No

29. If you are not a U.S. citizen or national, do you have immigration status?
☐ **Yes**. Answer questions a–d below.
a. Immigration Document Type: _____
b. Document ID Number: _____
c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No
d. Are you a veteran or active-duty member of the U.S. military? ☐ Yes ☐ No

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

31. Race **(OPTIONAL)**

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

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

33. Are you currently in prison or jail or have you been released in the past three months?
☐Yes. **If yes**, answer questions a–c. ☐No
a. When did you enter prison? (mm/dd/yyyy) _____
b. When did you leave prison? (mm/dd/yyyy) _____
c. Are you currently waiting for a decision on charges? ☐Yes ☐No

33. Do you need help with activities of daily living (like bathing, dressing, etc.) or live in a medical facility or nursing home?
☐ Yes ☐ No

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

35. Were you receiving Medicaid when you became too old to be eligible for foster care placement? ☐ Yes ☐ No
If yes, in what state were you living? _____ How old were you? _____

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

STEP 2 Current Job and Income Information

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

Income from Job 1	1. Who earns this income?	2. Who is this person's employer?

3. What is the **gross** amount this person makes (**before** taxes)?
$

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

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

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

e. How often? _____

Income from Job 2	6. Who earns this income?	7. Who is this person's employer?

8. What is the **gross** amount this person makes (**before** taxes)?
$

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

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

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

e. How often? _____

11. **Additional Income:** List here any additional income you may receive, give the amount and how often you get it. Do not include income from child support, Supplemental Security Income (SSI), veteran's income, or Worker's Compensation. **If none, leave blank.**

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

12. **Household Deductions:** Give us information about things that you pay and that can be deducted on an income tax return. Giving us this information could make the cost of health insurance lower.

Type of Deduction	How Much?	How Often?		
☐ Alimony Paid	$ _____	☐Weekly	☐Twice a month	☐Monthly
☐ Student Loan Interest	$ _____	☐Weekly	☐Twice a month	☐Monthly

13. **Yearly Income**: What is your estimated **yearly** income for the coverage year (including any monthly changes, bonuses, seasonal income, etc.)?

$ _____

STEP 3 Other Healthcare Coverage

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

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

Type of coverage _____ Policy Number _____

Name of policy holder _____ Coverage start date _____

Name of insurance company _____ Coverage end date _____

Insurance Company's Address _____

STEP 4 Sign and Date this Application

- I am signing this application under penalty of perjury which means I have given true answers to all the questions on this form to the best of my knowledge and belief. I know that I may be subject to penalties under federal law if I provide false and/or untrue information.
- I know that I must tell kynect if anything changes from what I wrote on this application within 30 days of the change. I can visit **kynect.ky.gov** or call **1-855-4kynect (459-6328)** to report any changes.
- If I think kynect has made a mistake, I can appeal its decision. To appeal means to tell someone at kynect that I think the action is wrong, and ask for a fair review of the action. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I understand that kynect will check my answers using information in databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or any other trusted source. If the information does not match, I may be asked to send proof.

Renewal of coverage in future years: To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow kynect to use income data, including information from tax returns and other trusted data sources. kynect will send me a notice, let me make any changes, and I can opt out at any time.
Yes, renew my eligibility automatically for the next: (select one)
☐ 5 years (maximum allowed) ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year
☐ Do not use information from tax returns or other data sources to renew my coverage.

Voter Registration: If I am not registered to vote or not registered where I currently live, I can choose to register to vote by checking yes below. If I check yes, I will receive a voter registration application in the mail. Checking yes or no below does not affect the outcome of this application.
☐ **Yes**, I want to apply to register to vote. An application will be mailed to me. ☐**No**, I don't want to register to vote.

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

Signature	Date (mm/dd/yyyy)

If you need help with your application or to apply faster online, go to **www.kynect.ky.gov** or call **1-855-4kynect (459-6328)**. Para ayuda en Español, llame gratis al 1-855-4kynect (459-6328).