

Other Forms Packet

FHIAP can only discuss your case with you or someone you name. The person you name can give or get information about your case, and may receive copies of the letters FHIAP sends you if you tell us to. You can have more than one person named to help you with your case. Fill out a separate form for each person.

I, (name of applicant) _____

allow (name of person) _____

to discuss my case with FHIAP staff and this person **may** or **may not** receive copies of any letters sent by FHIAP.

Relationship to applicant:

Health insurance agent (producer) Other: _____
(relationship)

Their address: _____

City: _____ State: _____ ZIP: _____

Phone: _____

E-mail (if one is available): _____

Applicant signature: _____ Date: _____

Reservation number: _____

Please mail or FAX this signed form to FHIAP. (Keep a copy for yourself.)

FAX: 866-843-8936

FHIAP

P.O. Box 5880

Salem, OR 97304-0880

Dear Employer:

You may have employees now or in the future who apply to the state Family Health Insurance Assistance Program (FHIAP) for help paying their share of the health insurance premium. FHIAP helps uninsured Oregonians afford private health insurance. We need information about your health benefits to determine whether your employee can use a FHIAP subsidy to enroll in your health plan. If you have questions about this form, please call the benchmark specialist at 888-564-9669. Or, e-mail: fhiap.mail@state.or.us.

Reason for sending FHIAP this form:

- An employee asked me to fill out this form so he/she can apply to FHIAP
- I want to know if my plan meets the benchmark so I can share FHIAP with my employees in the future
- My benefits just changed and I need to “benchmark” the new plan

Employee name (if applicable):	Reservation number (if known):	
Employer name:	Employer Identification Number (EIN):	
Employer address:	Industry:	
City:	State:	ZIP:
Benefit contact person:	Contact phone number:	
Address:	Fax number:	
City:	State:	ZIP:
Benefit contact person’s e-mail:		

Please make a copy of this form for each medical and prescription plan offered.

Health Insurance Company: _____ Plan purchase pending? Yes No

Policy number? _____

(If a plan purchase is pending, please provide the number as soon as possible.)

What type of health benefit plan is offered or being purchased?

- Traditional-indemnity Preferred Provider Option (PPO) Health Maintenance Organization (HMO)
- Point of Service (POS) Exclusive Provider Option (EPO) Other *(please specify)* _____

In which month do you conduct annual open enrollment? _____

How often does the employer change the plan benefits? Annually Other (please specify) _____

If benefits are changed annually, in which month does the change take effect? _____

This is not the FHIAP application. Call 888-564-9669 and ask for marketing to request applications for your employees.

Does the employer contribute to the premium for **employee** coverage? Yes No
If yes, how much is contributed (approximate dollar amount)? _____

Does the employer contribute to the premium for **dependent** coverage? Yes No
If yes, how much is contributed (approximate dollar amount)? _____

Is anyone in this family currently enrolled in your health benefit plan? Yes No
If yes, who? _____ Effective date: _____

Original effective date of coverage in employer's health insurance plan for employee: _____ Family: _____

Please attach the following:

- Rate sheet showing all combinations (employee, employee/spouse, family, etc.) You will be asked specific information about the employee on an Enrollment Verification (EV) form. If the plan purchase is pending, please send the information as soon as it's available.
- Copy of **both** the **Medical and Prescription Summary Plan Description** or the **Benefit Booklet** provided by the health insurance company. We need a copy for each plan you offer.

Once your plan is reviewed and approved, we won't need to see additional copies of the benefit information until next year, unless there is a change in the health benefits. If your health benefit plan meets our benchmark and is eligible for a FHIAP subsidy, you will receive an Enrollment Verification Form to complete for each approved employee or family.

However, after reviewing the materials, we may need more information about your benefits. If you sign below, we can contact the health insurance carrier or plan administrator directly for answers to our questions.

Authorized Permission

The Family Health Insurance Assistance Program (FHIAP) has my permission to contact my health insurance carrier or plan administrator to get information needed to determine whether my company's benefit plan may be subsidized.

Signature of FHIAP applicant: _____ Date: _____

Employer name: _____

You may return this form and plan information directly to FHIAP. Or, you may give it to an employee to include as part of an application.

FHIAP

Attn: Benchmarking

P.O. Box 5880

Salem, Oregon 97304-0880

Do not use this form if you submitted your most recent (current) federal tax return. Use this form **ONLY** if you have filed an extension on your federal tax return or your income has changed **drastically in the last year**. Your income must be reported on an IRS Schedule C. Please complete and send the following:

- Send monthly business ledgers or detailed profit and loss transaction statements for the six months before the month you sign the application.
- Send a copy of your federal tax return extension.
- Fill out Sections A, B, and C. Sign and date this form.
- If your business is a **corporation or partnership** (you complete IRS Schedule E) **fill out the Corporation/Partnership Income Worksheet included in the Other Forms Packet**.
- If your business is a **LLC**, call FHIAP at 888-564-9669. Be sure to ask for a self-employment specialist. We will tell you what parts of the worksheet to fill out.
- If your income is from **fishing** (you complete IRS Schedule C) **fill out the Farming, Ranching, and Fishing Income Worksheet included in the Other Forms Packet**.

A — Business Information

Name	Business name
Business address	Type of business


B — Gross Receipts Received

Please list all business income/gross receipts received in the six months **before** the month you sign your application for FHIAP. List gross receipts before any expenses are subtracted.

Name months

Name month you sign application _____						
Income Source (please list):						
Income Source (please list):						
Total Income/Gross Receipts:						

C — Business Expenses

You may choose one of two ways to figure your income. You can either have FHIAP reduce your gross business receipts by 50 percent, or reduce your gross business receipts using actual allowable expenses. Use the method that will help you the most. We will not go back and re-figure your eligibility using the other method. If you are not sure which way to figure your income, call 888-564-9669 and ask for a self-employment eligibility specialist. 

To have FHIAP take a 50% deduction for your expenses from your total gross receipts, check this box:

If you checked the box above, all you need to do is sign on the next page!

If you want FHIAP to deduct your actual allowable expenses, do not check the box. Turn the page and complete Section C.

C — Business Expenses, *continued*

Name months

Name month you sign application _____						
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Expenses

1) Wholesale cost of inventory purchased						
2) *Employee wages/benefits/payroll taxes						
3) Business property: rent paid (<i>see #11** below</i>)						
4) Business property: utilities (<i>see #11** below</i>)						
5) Business insurance, taxes, and assessments						
6) Licenses, permits, legal, and professional fees						
7) Operating supplies (<i>office supplies, postage</i>)						
8) Equipment rental/service/repair/maintenance						
9) Equipment purchase/machinery/durable goods						
10) Business telephone expense						
11) Advertising						
12) Interest on business loans						
13) Mileage/transportation costs <i>(see Self-Employment Instructions)</i>						
14) Bad debt (<i>write offs</i>)						
15) Other expenses (<i>use separate sheet</i>)						
Total Expenses:						

***Do not include wages, benefits, taxes, etc. for family members**

The following costs are NOT allowable business expenses:

- | | |
|--|--|
| <ol style="list-style-type: none"> 1. Meals for the applicant, spouse, or dependents 2. Payments on the principal of the purchase price of income-producing real estate 3. Federal, state, and local income taxes 4. Draws or salaries paid to any family member and related payroll expenses 5. Money allocated for personal retirement 6. Work-related personal expenses (personal business, entertainment, etc.) 7. Depreciation | <ol style="list-style-type: none"> 8. Costs related to traveling to another area when there is no reasonable possibility of deriving income from the trip 9. Interest or fees on credit cards 10. Personal telephone charges 11. **The costs of real property used as both a home and a business, unless the real property (including utilities) used for a business is separate from the dwelling. <i>For more information see the Sample Self-Employment Worksheet and Instructions in the Other Forms Packet.</i> |
|--|--|

By signing this worksheet, I declare that the information submitted on this form is true, and if my file is chosen for a quality assurance audit, I agree to cooperate and furnish documentation verifying this information. I also understand by giving false, incomplete, or misleading information could cause an overpayment of benefits that I must repay for subsidy I was not eligible to receive.

Sign here Applicant's signature: _____ Date: _____
 Spouse's signature: _____ Date: _____

Please submit your most recent federal tax return (including all schedules), both personal **AND** corporation or partnership. Also submit three months of both personal **AND** business bank statements. In addition, complete Section A and B below. If your business pays any of your family’s living or personal expenses, those payments are counted as income to your family the same as any funds paid to you as wages or salary. Please call FHIAP and ask to speak to an Eligibility Specialist for additional questions or instructions.

A — Business Information

Name	Business name
Business address	Type of business
Is this a corporation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this a partnership? <input type="checkbox"/> Yes <input type="checkbox"/> No

B — Personal Expenses Paid By Corporation/Partnership

Please list all personal expenses paid by the corporation or partnership for the **three months prior to the date you signed the application.**

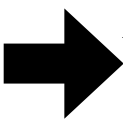
Month (<i>Name months</i>)			
Mortgage/Rent			
Auto, Health, Life Insurance			
Food/Groceries			
Entertainment			
Personal Credit Card Payments			
Other Payments			
Total Expenses:			

Do you receive wages/draws or income in addition to the above expenses paid by the business. Yes No

If yes, list below. If you receive only wages/income (business does not pay personal expense) enter the amount below.

Wages/Draws/Income	\$	\$	\$
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By signing this worksheet, I declare that the information submitted on this form is true, and if my file is chosen for a quality assurance audit, I agree to cooperate and furnish documentation verifying this information. I also understand by giving false, incomplete, or misleading information could cause an overpayment of benefits that I must repay for subsidy I was not eligible to receive.

Sign here  Applicant’s signature: _____ Date: _____
 Spouse’s signature: _____ Date: _____

Use this form only if:

- you **DID NOT** file a federal tax return last year, or
- you filed an extension, or
- your taxes filed last year **DO NOT** reflect your current income.

Also remember to:

- Include your monthly business ledgers or detailed profit and loss transaction statements for the 12 months before the month you sign the application.
- Include a copy of your federal tax return extension.
- Fill out sections A, B, and C. Sign and date the form.
- If your business is a **corporation or partnership** (you complete IRS Schedule E) **fill out the Corporation/Partnership Income Worksheet included in the Other Forms Packet.**
- If your business is a **LLC**, call FHIAP at 888-564-9669. Be sure to ask for a self-employment specialist. We will tell you what parts of the worksheet to fill out.
- **Be sure to choose (either #1 or #2) which method you would like FHIAP to use for business expenses in Section C.** FHIAP will use this information to determine your average monthly income.

A — Business Information

Name:	Business name:
Business address:	Type of business:

B — Gross Receipts Received

Please list all business gross receipts received in the **12 months** prior to the month you are signing your application for FHIAP. Please write in the month in the space provided. Do not include current month's income.

	Last Month	2 Mths Ago	3 Mths Ago	4 Mths Ago	5 Mths Ago	6 Mths Ago	7 Mths Ago	8 Mths Ago	9 Mths Ago	10 Mths Ago	11 Mths Ago	12 Mths Ago
Month you sign application: _____												
Income Source (please list): _____												
Income Source (please list): _____												
Income Source (please list): _____												
Total Income/Gross Receipts:												

C — Business Expenses

Choose which method to use:

1 To have FHIAP take a 50% deduction for your expenses from your total gross income receipts, check this box (don't fill out the table below):

If you would like FHIAP to deduct your actual allowable expenses, please complete the table below.

OR

2 Expenses

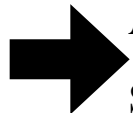
Last Month 2 Mths Ago 3 Mths Ago 4 Mths Ago 5 Mths Ago 6 Mths Ago 7 Mths Ago 8 Mths Ago 9 Mths Ago 10 Mths Ago 11 Mths Ago 12 Mths Ago

Month you sign application:	Last Month	2 Mths Ago	3 Mths Ago	4 Mths Ago	5 Mths Ago	6 Mths Ago	7 Mths Ago	8 Mths Ago	9 Mths Ago	10 Mths Ago	11 Mths Ago	12 Mths Ago
1) Wholesale cost of inventory purchased												
2) Wages to employees <i>(excluding family members)</i>												
3) Business Property: Rent paid*												
4) Business Property: Utilities*												
5) Business insurance												
6) Licenses, permits, legal and professional fees												
7) Operating supplies <i>(office supplies, postage)</i>												
8) Equipment Rental												
9) Advertising												
10) Interest on business loans <i>(do not include credit cards)</i>												
11) Mileage/transportation costs* <i>(choose one)</i>												
12) Other* <i>(list on a separate sheet of paper and put totals here)</i>												
Total Expenses:												

* Please see Sample Self-Employment Income Worksheet and Instructions for directions on how to fill out this item.

By signing this worksheet, I declare that the information submitted on this form is true, and if my file is chosen for a quality assurance audit, I agree to cooperate and furnish documentation verifying this information. I also understand by giving false, incomplete, or misleading information could cause an overpayment of benefits that I must repay for subsidy I was not eligible to receive.

Sign here



Applicant's signature: _____ Date: _____

Spouse's signature: _____ Date: _____

Instructions also apply to Farming, Ranching, and Fishing Income Worksheet

This is an example of a worksheet that is properly completed. **Use this as an example of how to report your income if you have not filed a federal tax return for last year.** This form is the same for those who are self-employed and those who are involved in farming, ranching, and fishing. Even though the Farming, Ranching, and Fishing Income Worksheet looks different, the only difference for applicants is that these occupations must list gross income received and business expenses for **12 months** instead of six.

If your business is a corporation or partnership, see the example on the back side of this form for the Corporation/Partnership Income Worksheet. If your business is a LLC, call FHIAP at 888-564-9669. Be sure to ask for a self-employment specialist. We will tell you what parts of the worksheet to fill out.

Instructions:

1 Business Ledgers:

Include your monthly business ledgers or detailed profit and loss transaction statements.

Also, send a copy of your federal tax return extension.

Do not use this form if you submitted your most recent (current) federal tax return. Use this form **ONLY** if you have filed an extension on your federal tax return or your income has changed **drastically in the last year**. Your income must be reported on an IRS Schedule C. Please complete and send the following:

- Send monthly business ledgers or detailed profit and loss transaction statements for the six months before the month you sign the application. 1
- Send a copy of your federal tax return extension.
- Fill out Sections A, B, and C. Sign and date this form.
- If your business is a **corporation or partnership** (you complete IRS Schedule E) **fill out the Corporation/Partnership Income Worksheet included in the Other Forms Packet.**
- If your business is a **LLC**, call FHIAP at 888-564-9669. Be sure to ask for a self-employment specialist. We will tell you what parts of the worksheet to fill out.
- If your income is from **fishing** (you complete IRS Schedule C) **fill out the Farming, Ranching, and Fishing Income Worksheet included in the Other Forms Packet.**

A – Business Information

Name John Johnson	Business name ABC Construction
Business address 123 Main St., Salem, OR 97301	Type of business Construction

B – Gross Receipts Received

Please list all business income/gross receipts received in the six months **before** the month you sign your application for FHIAP. List gross receipts before any expenses are subtracted.

Name month you sign application	Name months						
	March	Sep.	Oct.	Nov.	Dec.	Jan.	Feb.
Income Source (please list): Const. Jobs		3,100	21,900	4,000	3,000	4,100	20,150
Income Source (please list):		0	0	0	0	0	0
Total Income/Gross Receipts:		3,100	21,900	4,000	3,000	4,100	20,150

C – Business Expenses

You may choose one of two ways to figure your income. You can either have FHIAP reduce your gross business receipts by 50 percent, or reduce your gross business receipts using actual allowable expenses. Use the method that will help you the most. We will not go back and re-figure your eligibility using the other method. If you are not sure which way to figure your income, call 888-564-9669 and ask for a self-employment eligibility specialist.

To have FHIAP take a 50% deduction for your expenses from your total gross receipts, check this box: 2

If you checked the box above, all you need to do is sign on the next page!

If you want FHIAP to deduct your actual allowable expenses, do not check the box. Turn the page and complete Section C.

3 Business Property — Rent Paid:
You may not count rent as an expense if the property is used as both a residence and business.

4 Business Property — Utilities:
List only one-third of utilities if you work out of your home. List 100 percent of utilities if the business is separate. Cell phones used exclusively for business may be counted here.

5 Mileage/transportation costs:
You may list work-related mileage or actual expenses for fuel and maintenance on business vehicles. If using mileage, calculate at a rate of 20 cents per mile. FHIAP does not allow commuting as an expense. If submitting transportation costs, include proof of actual expenses with your application.

6 Bad debt: Example includes NSF checks that are written off.

7 Other: Examples include business-related bank and credit card fees such as credit card merchant fees, but not overdraft fees.

8 Corporation/Partnership Income Worksheet: Example of a corporation/partnership.

9 Signature: *Don't forget to read and sign at the bottom of this page!* If you have a spouse they must sign.

C — Business Expenses, continued

Name month you sign application	Name months						
	March	Sep.	Oct.	Nov.	Dec.	Jan.	Feb.
Expenses							
1) Wholesale cost of inventory purchased	2,135	5,000	0	500	1,250	7,000	
2) *Employee wages/benefits/payroll taxes	0	3,000	500	500	725	3,000	
3) Business property: rent paid (see #11** below) 3	0	0	0	0	0	0	
4) Business property: utilities (see #11** below) 4	33	33	33	33	33	33	
5) Business insurance, taxes, and assessments	62	62	62	62	62	62	
6) Licenses, permits, legal, and professional fees	50	50	50	50	50	250	
7) Operating supplies (office supplies, postage)	135.29	135.29	135.29	135.29	0	0	
8) Equipment rental/service/repair/maintenance	350	350	350	350	700	700	
9) Equipment purchase/machinery/durable goods	250	0	500	0	500	0	
10) Business telephone expense	120	120	120	120	120	120	
11) Advertising	100	0	100	0	0	120	
12) Interest on business loans	24	24	24	24	24	24	
13) Mileage/transportation costs (see Self-Employment Instructions) 5	90	180	80	60	75	100	
14) Bad debt (write offs) 6	0	450	30	0	0	50	
15) Other expenses (use separate sheet) 7	0	0	150	0	0	300	
Total Expenses:	3,349.29	9,404.29	2,134.29	1,834.29	3,539.00	11,759.00	

***Do not include wages, benefits, taxes, etc. for family members**

The following costs are NOT allowable business expenses:

- Meals for the applicant, spouse, or dependents
- Payments on the principal of the purchase price of income-producing real estate
- Federal, state, and local income taxes
- Draws or salaries paid to any family member and related payroll expenses
- Money allocated for personal retirement
- Work-related personal expenses (personal business, entertainment, etc.)
- Depreciation
- Costs related to traveling to another area when there is no reasonable possibility of deriving income from the trip
- Interest or fees on credit cards
- Personal telephone charges
- **The costs of real property used as both a home and a business, unless the real property (including utilities) used for a business is separate from the dwelling. For more information see the Sample Self-Employment Worksheet and Instructions in the Other Forms Packet.



Corporation/Partnership Income Worksheet **8**



Please submit your most recent federal tax return (including all schedules), both personal **AND** corporation or partnership. Also submit three months of both personal **AND** business bank statements. In addition, complete Section A and B below. If your business pays any of your family's living or personal expenses, those payments are counted as income to your family the same as any funds paid to you as wages or salary. Please call FHIAP and ask to speak to an Eligibility Specialist for additional questions or instructions.

A — Business Information

Name John Johnson	Business name ABC Construction
Business address 123 Main St., Salem, OR 97301	Type of business Construction
Is this a corporation? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Is this a partnership? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

B — Personal Expenses Paid By Corporation/Partnership

Please list all personal expenses paid by the corporation or partnership for the **three months prior to the date you signed the application.**

Month (Name months)	Dec.	Jan.	Feb.
Mortgage/Rent	\$1,000	\$1,000	\$1,000
Auto, Health, Life Insurance	\$500	\$500	\$500
Food/Groceries	\$400	\$400	\$400
Entertainment	\$50	\$50	\$25
Personal Credit Card Payments	\$100	\$100	\$50
Other Payments	\$75	\$125	\$0
Total Expenses:	\$2,125	\$2,175	\$1,975

Do you receive wages/draws or income in addition to the above expenses paid by the business. Yes No
If yes, list below. If you receive only wages/income (business does not pay personal expense) enter the amount below.

Wages/Draws/Income	\$500	\$250	\$0
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Warning:
FHIAP deductions are not the same as IRS deductions.

Sign here → Applicant's signature: John Johnson **9** Date: 3/11/2011
Spouse's signature: N/A Date: _____

B — Family Information

Self	Name (Last, first, middle initial)		U.S. Citizen? 2 <input type="checkbox"/> Yes <input type="checkbox"/> No
	Date of birth	Social Security Number	State born in: _____ Birth name: _____
	<input type="checkbox"/> Male <input type="checkbox"/> Female	Pregnant? <input type="checkbox"/> Yes 1 <input type="checkbox"/> No	Insured in the past 2 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Ethnicity: <input type="checkbox"/> Hispanic or Latino OR <input type="checkbox"/> Not Hispanic or Latino 5		If yes, name of company: _____
Race: <input type="checkbox"/> American Indian/Alaskan Native 6		Start and end dates: _____	
<input type="checkbox"/> Asian <input type="checkbox"/> Black or African American		On or eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	On OHP? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White		Applying for FHIAP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Spouse (legally married)	Name (Last, first, middle initial)		U.S. Citizen? 2 <input type="checkbox"/> Yes <input type="checkbox"/> No
	Date of birth	Social Security Number	State born in: _____ Birth name: _____
	<input type="checkbox"/> Male <input type="checkbox"/> Female	Pregnant? <input type="checkbox"/> Yes 1 <input type="checkbox"/> No	Insured in the past 2 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Ethnicity: <input type="checkbox"/> Hispanic or Latino OR <input type="checkbox"/> Not Hispanic or Latino 5		If yes, name of company: _____
Race: <input type="checkbox"/> American Indian/Alaskan Native 6		Start and end dates: _____	
<input type="checkbox"/> Asian <input type="checkbox"/> Black or African American		On or eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	On OHP? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White		Applying for FHIAP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Relationship to Applicant 4 Other 3 My child	Name (Last, first, middle initial)		U.S. Citizen? 2 <input type="checkbox"/> Yes <input type="checkbox"/> No
	Date of birth	Social Security Number	State born in: _____ Birth name: _____
	<input type="checkbox"/> Male <input type="checkbox"/> Female	Pregnant? <input type="checkbox"/> Yes 1 <input type="checkbox"/> No	Insured in the past 2 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Ethnicity: <input type="checkbox"/> Hispanic or Latino OR <input type="checkbox"/> Not Hispanic or Latino 5		If yes, name of company: _____
Race: <input type="checkbox"/> American Indian/Alaskan Native 6		Start and end dates: _____	
<input type="checkbox"/> Asian <input type="checkbox"/> Black or African American		On or eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	On OHP? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White		Applying for FHIAP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Relationship to Applicant 4 Other 3 My child	Name (Last, first, middle initial)		U.S. Citizen? 2 <input type="checkbox"/> Yes <input type="checkbox"/> No
	Date of birth	Social Security Number	State born in: _____ Birth name: _____
	<input type="checkbox"/> Male <input type="checkbox"/> Female	Pregnant? <input type="checkbox"/> Yes 1 <input type="checkbox"/> No	Insured in the past 2 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Ethnicity: <input type="checkbox"/> Hispanic or Latino OR <input type="checkbox"/> Not Hispanic or Latino 5		If yes, name of company: _____
Race: <input type="checkbox"/> American Indian/Alaskan Native 6		Start and end dates: _____	
<input type="checkbox"/> Asian <input type="checkbox"/> Black or African American		On or eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	On OHP? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White		Applying for FHIAP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Relationship to Applicant 4 Other 3 My child	Name (Last, first, middle initial)		U.S. Citizen? 2 <input type="checkbox"/> Yes <input type="checkbox"/> No
	Date of birth	Social Security Number	State born in: _____ Birth name: _____
	<input type="checkbox"/> Male <input type="checkbox"/> Female	Pregnant? <input type="checkbox"/> Yes 1 <input type="checkbox"/> No	Insured in the past 2 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Ethnicity: <input type="checkbox"/> Hispanic or Latino OR <input type="checkbox"/> Not Hispanic or Latino 5		If yes, name of company: _____
Race: <input type="checkbox"/> American Indian/Alaskan Native 6		Start and end dates: _____	
<input type="checkbox"/> Asian <input type="checkbox"/> Black or African American		On or eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	On OHP? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White		Applying for FHIAP? <input type="checkbox"/> Yes <input type="checkbox"/> No	

- 1** Attach a note from your health care provider with due date.
- 2** If “yes,” send proof of citizenship (see flyer). If “no,” attach a copy of both sides of your INS card.
- 3** “Child” may include unmarried children under the age of 23 who either live with you or who are in school; step children, legally adopted children and children placed under your guardianship; and an adult child who is disabled and living in your home, but you must also include income of this child.
- 4** “Other” may include a foster child, grandchild, non-relative, or an adult age 55 and older living in your home.
- 5 6** Race/ethnic heritage: You don’t have to fill this out. If you do, check one box for each person. Answering this helps us follow federal Civil Rights laws.

B — Family Information

Self	Name (Last, first, middle initial)		U.S. Citizen? 2 <input type="checkbox"/> Yes <input type="checkbox"/> No
	Date of birth	Social Security Number	State born in: _____ Birth name: _____
	<input type="checkbox"/> Male <input type="checkbox"/> Female	Pregnant? <input type="checkbox"/> Yes 1 <input type="checkbox"/> No	Insured in the past 2 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Ethnicity: <input type="checkbox"/> Hispanic or Latino OR <input type="checkbox"/> Not Hispanic or Latino 5		If yes, name of company: _____
Race: <input type="checkbox"/> American Indian/Alaskan Native 6		Start and end dates: _____	
<input type="checkbox"/> Asian <input type="checkbox"/> Black or African American		On or eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	On OHP? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White		Applying for FHIAP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Spouse (legally married)	Name (Last, first, middle initial)		U.S. Citizen? 2 <input type="checkbox"/> Yes <input type="checkbox"/> No
	Date of birth	Social Security Number	State born in: _____ Birth name: _____
	<input type="checkbox"/> Male <input type="checkbox"/> Female	Pregnant? <input type="checkbox"/> Yes 1 <input type="checkbox"/> No	Insured in the past 2 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Ethnicity: <input type="checkbox"/> Hispanic or Latino OR <input type="checkbox"/> Not Hispanic or Latino 5		If yes, name of company: _____
Race: <input type="checkbox"/> American Indian/Alaskan Native 6		Start and end dates: _____	
<input type="checkbox"/> Asian <input type="checkbox"/> Black or African American		On or eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	On OHP? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White		Applying for FHIAP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Relationship to Applicant 4 Other 3 My child	Name (Last, first, middle initial)		U.S. Citizen? 2 <input type="checkbox"/> Yes <input type="checkbox"/> No
	Date of birth	Social Security Number	State born in: _____ Birth name: _____
	<input type="checkbox"/> Male <input type="checkbox"/> Female	Pregnant? <input type="checkbox"/> Yes 1 <input type="checkbox"/> No	Insured in the past 2 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Ethnicity: <input type="checkbox"/> Hispanic or Latino OR <input type="checkbox"/> Not Hispanic or Latino 5		If yes, name of company: _____
Race: <input type="checkbox"/> American Indian/Alaskan Native 6		Start and end dates: _____	
<input type="checkbox"/> Asian <input type="checkbox"/> Black or African American		On or eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	On OHP? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White		Applying for FHIAP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Relationship to Applicant 4 Other 3 My child	Name (Last, first, middle initial)		U.S. Citizen? 2 <input type="checkbox"/> Yes <input type="checkbox"/> No
	Date of birth	Social Security Number	State born in: _____ Birth name: _____
	<input type="checkbox"/> Male <input type="checkbox"/> Female	Pregnant? <input type="checkbox"/> Yes 1 <input type="checkbox"/> No	Insured in the past 2 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Ethnicity: <input type="checkbox"/> Hispanic or Latino OR <input type="checkbox"/> Not Hispanic or Latino 5		If yes, name of company: _____
Race: <input type="checkbox"/> American Indian/Alaskan Native 6		Start and end dates: _____	
<input type="checkbox"/> Asian <input type="checkbox"/> Black or African American		On or eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	On OHP? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White		Applying for FHIAP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Relationship to Applicant 4 Other 3 My child	Name (Last, first, middle initial)		U.S. Citizen? 2 <input type="checkbox"/> Yes <input type="checkbox"/> No
	Date of birth	Social Security Number	State born in: _____ Birth name: _____
	<input type="checkbox"/> Male <input type="checkbox"/> Female	Pregnant? <input type="checkbox"/> Yes 1 <input type="checkbox"/> No	Insured in the past 2 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Ethnicity: <input type="checkbox"/> Hispanic or Latino OR <input type="checkbox"/> Not Hispanic or Latino 5		If yes, name of company: _____
Race: <input type="checkbox"/> American Indian/Alaskan Native 6		Start and end dates: _____	
<input type="checkbox"/> Asian <input type="checkbox"/> Black or African American		On or eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	On OHP? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White		Applying for FHIAP? <input type="checkbox"/> Yes <input type="checkbox"/> No	

- 1** Attach a note from your health care provider with due date.
- 2** If “yes,” send proof of citizenship (see flyer). If “no,” attach a copy of both sides of your INS card.
- 3** “Child” may include unmarried children under the age of 23 who either live with you or who are in school; step children, legally adopted children and children placed under your guardianship; and an adult child who is disabled and living in your home, but you must also include income of this child.
- 4** “Other” may include a foster child, grandchild, non-relative, or an adult age 55 and older living in your home.
- 5 6** Race/ethnic heritage: You don’t have to fill this out. If you do, check one box for each person. Answering this helps us follow federal Civil Rights laws.