NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Medicaid and Long-Term Care

Application for Medicaid and Insurance Affordability Programs (Financial Assistance)

Use this application to see which coverage options are available to you:	• Medicaid and/or Children's Health Insurance Program (CHIP). • New tax credits that can immediately help pay your premiums for health coverage. • Affordable private health insurance plans that offer comprehensive coverage to help you stay well.
Who can use this application?	• Nebraska residents
Is a Supplemental Application form required?	• If you are over age 65, or disabled, you will need to complete the Supplemental Application as well as this application. • If you fit into a Medically Needy population, you may need to complete a Supplemental Application.
Apply faster online:	• Apply through the Health Insurance Marketplace at **HealthCare.gov** or call **1-800-318-2596** for the **Customer Service Center.** • Apply online at **ACCESSNebraska.ne.gov/**
What information you may need to complete this application:	• Social Security Numbers (or document numbers for any legal immigrants who need insurance). • Employer and income information for everyone in your family (for example: paystubs, W-2 forms, or wage and tax statements). • Policy numbers for any current health insurance. • Information about any job-related health insurance available to your family.
Why do we ask for this information?	• We ask about income and other information to let you know what coverage you qualify for and if you can get help paying for it. • **We'll keep all the information you provide private and secure, as required by law.**
What happens next?	• Send completed application to: **Nebraska Department of Health and Human Services** **Medicaid Document Center** **PO Box 2992** **Omaha, NE 68103-2992** • Hand in a completed application at a DHHS local office. • **Fax** the application to: **(402) 742-2351.** • DHHS will notify you of the next steps to complete your health coverage. If you don't hear from us, **call 855-632-7633** or **(402) 473-7000** in Lincoln or **(402) 595-1178** in Omaha. For **TTY** call **(402) 471-7256.**
Get help with this application	• Online: **ACCESSNebraska.ne.gov/** • Phone: Call our Customer Service Center at **855-632-7633** or **(402) 473-7000** in Lincoln or **(402) 595-1178** in Omaha. • In person: Go to a DHHS local office or visit a Community Partner. To locate an office or a Community Partner visit our website. • En Espanol: Llame a nuestro cenro de ayuda gratis al **1-855-632-7633.**
For Economic Assistance Programs **Aid to Dependent Children (ADC) grant; Aid to Aged, Blind and Disabled (AABD) grant; Child Care, Low Income Home Energy Assistance Program (LIHEAP); Refugee Assistance, and/ or Supplemental Nutrition Assistance Program (SNAP)**	• Apply Online at: **ACCESSNebraska.ne.gov/** • Contact a local office. • Call and request an application be mailed to you, Toll Free: **800-383-4278**, Lincoln: **402-323-3900**, Omaha: **402-595-1258.** For **TTY** call **(402) 471-7256.**

Nebraska Medicaid Eligibilty
Toll Free: **855-632-7633**
Lincoln: **402-473-7000**
Omaha: **402-595-1178**

Go Online
ACCESSNebraska.ne.gov

Federal Health Insurance Marketplace
Go Online: **Healthcare.gov**
Customer Service Center: **800-318-2596**

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STEP 1: Tell Us About Yourself.

(We need one adult in the family to be the contact person for your application.)

1. First name, Middle name, Last name, & Suffix:

2. Home address (Leave blank if you don't have one):			3. Apartment or suite number:
4. City:	5. State:	6. ZIP code:	7. County:
8. Mailing address (If different from home address):			9. Apartment or suite number:
10. City:	11. State:	12. ZIP code:	13. County:
14. Phone number: ( )		15. Other phone number: ( )	

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: _____

17. Preferred spoken or written language (if not English): _____

☐ **Email:** By checking 'this box', I elect to receive notification of my written notices and other correspondence regarding my benefits from DHHS through the email address above. These benefits include; Medicaid, CHIP, SNAP, ADC, LIHEAP, CC Subsidy, AABD payment and SSAD. I will no longer receive information through the mail. I understand I will receive an email notification of the correspondence, which will provide a link to the DHHS ACCESSNebraska website where I can access the correspondence. I understand that I must create an authenticated account on the ACCESSNebraska website in order to view my correspondence in Benefit Inquiry.

☐ **Text Messaging:** By checking 'this box', I agree to receive text messages on the cell phone number above from DHHS regarding my benefits. These benefits include; Medicaid, CHIP, SNAP, ADC, LIHEAP, CC Subsidy, AABD payment and SSAD. I agree to contact DHHS if my cell phone number changes or if this number is no longer in my possession. I understand that I can opt out of this in the future by contacting DHHS. *NOTE: Text messaging is currently under development and is targeted to be available in the near future.*

STEP 2: Tell Us About Your Family.

Who do you need to include on this application?

Tell us about all the family members with whom you live. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage).

DO include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who lives with you

You DON'T have to include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their income.

Complete STEP 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than 2 people in your family, you'll need to make a copy of the pages and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to determine our eligibility for health coverage.

Now, tell us about your information on the back. ➡

? **NEED HELP WITH YOUR APPLICATION?** Visit **ACCESSNebraska.ne.gov** or call us at **1-855-632-7633** or **(402) 473-7000** in Lincoln or **(402) 595-1178** in Omaha. Para obtener una copia de este formulario en Español, llamé **1-855-632-7633**. If you need help in a language other than English, call **1-855-632-7633** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **(402) 471-7256**.

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Step 2 - PERSON 1: Start with yourself

Complete **STEP 2** for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix: | 2. Relationship to you? SELF

3. Date of birth: (mm/dd/yyyy) | 4. Sex: ☐ Male ☐ Female | 5. Social Security number (SSN) __ __ __ – __ __ – __ __ __ __

6. Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed | Effective date of marital status:

We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don't want health coverage too, because it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

7. **Do you plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)
☐ YES. **If yes**, please answer questions a-c. ☐ NO. **If no**, skip to question c.
a. Will you file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____
b. Will you claim any dependents on your tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____
c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How are you related to the tax filer? _____

8. Are you pregnant? ☐ Yes ☐ No a. **If yes**, how many babies are expected during this pregnancy? _____ Due date: _____

9. **Do you need health coverage?**
(Even if you have insurance, there might be a program with better coverage or lower costs.)
☐ YES. **If yes**, answer all the questions below: ⬇
☐ NO. **If no**, SKIP to the income questions on page 3. ➡ Leave the rest of this page blank.

10. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.)? ☐ Yes ☐ No Do you live in a medical facility or nursing home? ☐ Yes ☐ No
If yes, please give the name and address of the facility: _____

11. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

12. **If you aren't a U.S. citizen or U.S. national**, do you have an immigration status?
☐ Yes ☐ No Fill in your document type and ID number below:
a. Document type _____ b. Document ID number _____
c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No d. Are you, or your spouse or parent a veteran or an active duty member in the U.S. military? ☐ Yes ☐ No

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

14. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No

15. Are you a full-time student? ☐ Yes ☐ No | 16. Were you in foster care in Nebraska, at age 18 or older? ☐ Yes ☐ No

17. **If Hispanic/Latino, ethnicity (OPTIONAL— check all that apply):**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

18. **Race (OPTIONAL— check all that apply):**
☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other _____

Now tell us about any income from Person 1 on the back. ➡

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Application for Medicaid and Insurance Affordability Programs (Financial Assistance)

STEP 2 - PERSON 1: Current Job and Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 19.

☐ **Self-Employed**
Skip to question 28.

☐ **Not employed**
Skip to question 29.

CURRENT JOB 1:

19. Employer name and address:

20. Employer phone number: ( )

21. Wages/tips (before taxes): ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly

$_____

22. Average hours worked each WEEK: _____

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

23. Employer name and address:

24. Employer phone number: ( )

25. Wages/tips (before taxes): ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly

$_____

26. Average hours worked each WEEK: _____

27. **In the past year, did you?** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

28. **If self-employed, answer the following questions:**

a. Type of work

_____

b. How much net income (profits once business expenses are paid) will you receive from this self-employment this month?

$_____

29. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you receive it.

NOTE: You don't need to tell us about child support, veteran's payments, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $_____ How often?_____

☐ Pensions $_____ How often?_____

☐ Social Security $_____ How often?_____

☐ Retirement accounts $_____ How often?_____

☐ Alimony received $_____ How often?_____

☐ Net farming/fishing $_____ How often?_____

☐ Net rental/royalty $_____ How often?_____

☐ Other income Type: _____ $_____ How often?_____

30. **DEDUCTIONS:** Check all that apply, and give the amount and how often you pay it.

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 28b).

☐ Alimony paid $_____ How often?_____

☐ Other deductions $_____ How often?_____

☐ Student loan interest $_____ How often?_____

Type: _____ $_____ How often?_____

31. **YEARLY INCOME: Complete only if your income changes from month to month.**

If you do not expect changes to your monthly income, skip to the next person. ➡

Your total income **this year**:

$_____

Your total income **next year** (if you think it will be different):

$_____

THANKS! This is all we need to know about you.

? **NEED HELP WITH YOUR APPLICATION?** Visit **ACCESSNebraska.ne.gov** or call us at **1-855-632-7633** or **(402) 473-7000** in Lincoln or **(402) 595-1178** in Omaha. Para obtener una copia de este formulario en Español, llamé **1-855-632-7633**. If you need help in a language other than English, call **1-855-632-7633** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **(402) 471-7256**.

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STEP 2 - PERSON 2:

Complete **STEP 2** for your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix: | 2. Relationship to you?

3. Date of birth (mm/dd/yyyy): | 4. Sex: ☐ Male ☐ Female | 5. Social Security number (SSN) ___ ___ ___ – ___ ___ – ___ ___ ___ ___
We need this if PERSON 2 wants health coverage and has an SSN.

6. Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed | Effective date of marital status:

7. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No
If no, list address: _____

8. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?**
(PERSON 2 can still apply for health insurance even if PERSON 2 doesn't file a federal income tax return.)
☐ YES. **If yes**, please answer questions a - c. ☐ NO. **If no**, skip to question c.
a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____
b. Will PERSON 2 claim any dependents on his or her tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____
c. Will PERSON 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How is PERSON 2 related to the tax filer? _____

9. Is PERSON 2 pregnant? ☐ Yes ☐ No a. **If yes**, how many babies are expected during this pregnancy? _____Due date: _____

10. **Does PERSON 2 need health coverage?** (Even if they have insurance, there might be a program with better coverage or lower costs.)
☐ YES. **If yes**, answer all the questions below: ⬇ | ☐ NO. **If no**, SKIP to the income questions. ➡ Leave the rest of this page blank.

11. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ☐ Yes ☐ No

12. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No

13. **If PERSON 2 isn't a U.S. citizen or U.S. national**, do they have an immigration status?
☐ Yes ☐ No Fill in Person 2's document type and ID number below:
a. Document type _____ | b. Document ID number _____
c. Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No | d. Is PERSON 2, or their spouse or parent a veteran or an active-duty member in the U.S. military? ☐ Yes ☐ No

14. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

15. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

16. Was PERSON 2 in foster care at age 18 or older? ☐ Yes ☐ No

Please answer the following questions if PERSON 2 is 22 or younger:

17. Did PERSON 2 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No
a. If yes, end date: _____ b. Reason the insurance ended: _____

18. Is PERSON 2 a full-time student? ☐ Yes ☐ No

19. **Is PERSON 2 Hispanic/Latino, ethnicity? (OPTIONAL— check all that apply):**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

20. **Person 2's Race (OPTIONAL— check all that apply):**

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

Now, tell us about any income from PERSON 2 on the back. ➡

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STEP 2 - PERSON 2: Current Job and Income Information

☐ **PERSON 2 is Employed**
If PERSON 2 is currently employed, tell us about his or her income. Start with question 21.

☐ **PERSON 2 is Self-Employed**
Skip to question 30.

☐ **PERSON 2 is Not Employed**
Skip to question 31.

CURRENT JOB 1:

21. Employer name and address:

22. Employer phone number:
( )

23. Wages/tips (before taxes): ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly

$_____

24. Average hours worked each WEEK: _____

CURRENT JOB 2: (If PERSON 2 has more jobs, attach another sheet of paper.)

25. Employer name and address:

26. Employer phone number:
( )

27. Wages/tips (before taxes): ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly

$_____

28. Average hours worked each WEEK: _____

29. **In the past year, did PERSON 2?** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

30. **If self-employed, answer the following questions:**

a. Type of work

_____

b. How much net income (profits once business expenses are paid) will PERSON 2 get from self-employment this month?

$_____

31. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often Person 2 gets it.

NOTE: You don't need to tell us about child support, veteran's payments, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $_____ How often?_____

☐ Pensions $_____ How often?_____

☐ Social Security $_____ How often?_____

☐ Retirement accounts $_____ How often?_____

☐ Alimony received $_____ How often?_____

☐ Net farming/fishing $_____ How often?_____

☐ Net rental/royalty $_____ How often?_____

☐ Other income Type: _____ $_____ How often?_____

32. **DEDUCTIONS:** Check all that apply, and give the amount and how often PERSON 2 pays it.

If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: Do not include a cost already considered in question 30b, regarding PERSON 2's net self-employment income.

☐ Alimony paid $_____ How often?_____

☐ Student loan interest $_____ How often?_____

☐ Other deductions Type: _____ $_____ How often?_____

33. **YEARLY INCOME: Complete only if PERSON 2's income changes from month to month.**

PERSON 2's total income **this year**:

$_____

PERSON 2's total income **next year** (if you think it will be different):

$_____

THANKS! This is all we need to know about PERSON 2.

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STEP 3 - American Indian or Alaska Native (AI/AN) Family Member(s)

1. Are you or is anyone in your family American Indian or Alaska Native?

☐ **No.** If **No,** skip to **STEP 4**.

☐ **Yes. If yes,** complete **APPENDIX B (but still complete STEPS 4 through 6)**.

STEP 4 - Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. Is anyone enrolled in health coverage now?

☐ YES. **If yes,** check the type of coverage and write the name(s) next to the coverage they have. ☐ NO.

☐ Medicaid _____

☐ CHIP _____

☐ Medicare _____

☐ TRICARE (Don't check if you have direct care or Line of Duty)

_____

☐ VA Health Care programs _____

☐ Peace Corps _____

☐ Employer insurance _____

Name of health insurance _____

Policy number _____

Is this COBRA coverage? ☐ Yes ☐ No

Is this a retiree health plan? ☐ Yes ☐ No

☐ Other

Name of Insurance: _____

Policy number: _____

Is this a limited-benefit plan (like a school accident policy)? ☐ Yes ☐ No

2. Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone else's job, such as a parent or spouse.

☐ YES. **If yes,** you'll need to complete and include **APPENDIX A**. Is this a state employee benefit plan? ☐ Yes ☐ No

☐ NO. **If no, continue to STEP 5.**

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. The time required to complete this information collection is estimated to average one hour per response, 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.

STEP 5 - Read and Sign This Application

- I'm signing this application under penalty of perjury, which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false information.
- I know that I must tell Nebraska Medicaid if anything changes (or is different than) what I wrote on this application. I can visit **ACCESSNebraska.ne.gov** or call **1-855-632-7633** or **(402) 473-7000** in Lincoln or **(402) 595-1178** in Omaha to report any changes. I understand that a change in my information could affect the eligibility for any member of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file**.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, _____ is incarcerated.
  (name of person)

? **NEED HELP WITH YOUR APPLICATION?** Visit **ACCESSNebraska.ne.gov** or call us at **1-855-632-7633** or **(402) 473-7000** in Lincoln or **(402) 595-1178** in Omaha. Para obtener una copia de este formulario en Español, llamé **1-855-632-7633**. If you need help in a language other than English, call **1-855-632-7633** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **(402) 471-7256**.

Application for Medicaid and Insurance Affordability Programs (Financial Assistance)

- I hereby authorize the Nebraska Department of Health and Human Services and its agents to request from third parties any information or documents necessary for the administration of its programs. Such third parties shall include, but not be limited to: the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, a consumer reporting agency, and financial institutions. Any third party shall also be authorized to provide any information or documents requested by the Nebraska Department of Health and Human Services concerning myself or, when required by law, any other person. I further authorize the Nebraska Department of Health and Human Services
  to release such information or documents to cooperating State or Federal Agencies in accordance with any applicable law.

  This authorization is given only to the Nebraska Department of Health and Human Services to be used in the administration of its programs and for no other purposes. It shall continue in effect until the earliest of: the rendering of a final adverse decision on my application for medical assistance, the cessation of my eligibility for medical assistance, or such time as I state in writing that I rescind this authorization.

  I release any third party from any and all liability to me and, when applicable, any other person, for supplying the aforementioned information or documents.

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 Nebraska Medicaid to use income data, including information from tax returns. Nebraska Medicaid 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:

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don't use information from tax returns to renew my coverage in the future.

If anyone on this application is eligible for Medicaid

- Nebraska Medicaid has the right to pursue and get money from other health insurance, legal settlements, or other third parties. I am also giving Nebraska Medicaid the rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No

  If yes, I know I will 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 Nebraska Medicaid and I may not have to cooperate.

My right to appeal

If I think the Health Insurance Marketplace or Medicaid/Children's Health Insurance Program (CHIP) has made a mistake, I can appeal the decision. To appeal means to tell someone at the Health Insurance Marketplace or Medicaid/CHIP that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting Nebraska Medicaid at **1-855-632-7633** or **(402) 473-7000** in Lincoln or **(402) 595-1178** in Omaha. 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.

Sign this application. The person who filled out **STEP 1** should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in **APPENDIX C**.

Signature	Date: (mm/dd/yyyy)

I hereby authorize the Nebraska Department of Health and Human Services and its agents to request from third parties any information or documents necessary for the administration its programs, including financial information. I also authorize the release of my Social Security Number for this purpose.

Signature of Spouse of Applicant	Date: (mm/dd/yyyy)

STEP 6 - Mail Completed Application

Mail your signed application to:

Nebraska Department of Health and Human Services
Medicaid Eligibility Program
PO Box 2992
Omaha, NE 68103-2992

Voter Registration (Optional)

If you are not registered to vote where you live now, would you like to apply to register to vote today? ☐ Yes ☐ No

IF YOU DO NOT CHECK EITHER ANSWER ABOVE, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

Any citizen in the State of Nebraska who has met the voter registration requirements and applies for Medicaid must be provided the opportunity to register to vote. If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept helps is yours. You may fill out the application form in private. Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency. Please note that the information and office to which application was made will remain confidential and be used only for voter registration purposes.

If you believe someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the

Nebraska Secretary of State of Nebraska
State Capitol Building
P.O Box 94608
Lincoln, NE 68509-4608
Telephone (402) 471-2555

Need Help With Your Application?

? **NEED HELP WITH YOUR APPLICATION?** Visit **ACCESSNebraska.ne.gov** or call us at **1-855-632-7633** or **(402) 473-7000** in Lincoln or **(402) 595-1178** in Omaha. Para obtener una copia de este formulario en Español, llamé **1-855-632-7633**. If you need help in a language other than English, call **1-855-632-7633** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **(402) 471-7256**.

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Medicaid and Long-Term Care

Application for Medicaid and Insurance Affordability Programs (APPENDIX A)

Health Coverage From Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page from each job that offers coverage.

Tell us about the **job** that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

EMPLOYEE Information:

1. Employee name (First, Middle, Last):	2. Employee Social Security number: __ __ __ – __ __ – __ __ __ __

EMPLOYER Information:

3. Employer name:		4. Employer Identification number (EIN): __ __ – __ __ __ __ __ __ __
5. Employer address:		6. Employer phone number:
7. City:	8. State:	9. ZIP code:
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above): ( )	12. Email address:	

13. **Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the names of anyone else in your household who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

☐ **NO** (Stop here and go to **STEP 5** in the application)

Tell us about the **health plan** offered by this employer:

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? **$**_____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): _____

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage.

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? **$**_____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): _____

*An employer-sponsored health plan meets the minimum value standard if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs" (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

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Medicaid and Long-Term Care

Application for Medicaid and Insurance Affordability Programs (APPENDIX A)

Employer Coverage Tool

Use this tool to help answer questions in **APPENDIX A** about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below matches the boxes on **APPENDIX A**. For example, the answer to question 14 on this page should match question 14 on **APPENDIX A**.

Write your name and Social Security number in boxes 1 and 2 and **ask the employer to fill out the rest of the form**. Complete one tool for each employer that offers health coverage.

EMPLOYEE Information: The **employee** needs to fill out this section.

1. Employee name (First, Middle, Last):	2. Social Security number: __ __ __ - __ __ - __ __ __ __

EMPLOYER Information: Ask the **employer** for this information.

3. Employer name:		4. Employer Identification number (EIN): __ __ - __ __ __ __ __ __ __
5. Employer address (the Marketplace will send notices to this address):		6. Employer phone number:
7. City:	8. State:	9. ZIP code:
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above): ( )	12. Email address:	

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**
- ☐ **Yes** (Continue)
  - 13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy)
- ☐ **NO** (Stop here and go to **STEP 5** in the application)

Tell us about the **Health plan** offered by this employer:
Does the employer offer a health plan that covers an employee's spouse or dependent?

☐ Yes, Which people: ☐ Spouse ☐ Dependent(s)
☐ No

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes, (Go to question 15) ☐ No, (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? **$**_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year (if known)?
☐ Employer won't offer health coverage.
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? **$**_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): _____

*An employer-sponsored health plan meets the minimum value standard if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

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DEPT. OF HEALTH AND HUMAN SERVICES

Medicaid and Long-Term Care

Application for Medicaid and Insurance Affordability Programs (APPENDIX B)

American Indian or Alaska Native Family Member (AI/AN)

Complete this **APPENDIX B** if you or a family member are American Indian or Alaska Native. Submit this with your Application for Medicaid and Insurance Affordability Programs.

Tell us about your American Indian or Alaska Native Family member(s):
American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to participate in cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

1. Name (First name, Middle name, Last name)	First: Middle: Last:	First: Middle: Last:
2. Member of a federally recognized tribe?	☐ Yes **If yes**, tribe name: _____ ☐ No	☐ Yes **If yes**, tribe name: _____ ☐ No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often reported) on your application that includes money from these sources: • Per capita payments from a 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 trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	**$** _____ How often? _____	**$** _____ How often? _____

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Medicaid and Long-Term Care

Application for Medicaid and Insurance Affordability Programs (APPENDIX C)

Assistance With Completing This Application

You can choose an authorized representative:

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact the Marketplace and/or the Department of Health and Human Services. If you're a legally appointed representative for someone on this application submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name):

2. Address:		3. Apartment or suite number:
4. City:	5. State:	6. ZIP code:

7. Phone number:
( )

8. Organization name:	9. ID number (if applicable):

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

10. Your signature:	11. Date (mm/dd/yyyy

For certified application counselors, navigators, agents, and brokers only:

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy):

2. First name, Middle name, Last name, and suffix:

3. Organization name:	4. ID number (if applicable)

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