Health Insurance Marketplace

Application for Health Coverage & Help Paying Costs (Short Form)

Form Approved
OMB No. 0938-1191
Expires: 10/31/2025

Apply faster online at HealthCare.gov

Use this application to see what coverage you qualify for

- Marketplace plans that offer comprehensive coverage to help you stay well.
- A tax credit that can immediately help lower your premiums for health coverage.
- Free or low-cost coverage through Medicaid or the Children's Health Insurance Program (CHIP).

Who can use this application?

Single adults who:

- Aren't offered health coverage from their employer.
- Plan to file a tax return, don't have any dependents and can't be claimed as a dependent on someone else's tax return.

NOTE: If any of these apply, you need to fill out a different form to make sure you get the most savings possible:

- You're married or take care of children.
- You were in the foster care system, and you're under age 26.
- You have items that can be deducted from your income. If your only deduction is student loan interest, you can use this form.
- You're not a U.S. citizen or U.S. national, and you haven't been living in the U.S. since at least 1996.
- You're American Indian or Alaska Native.
- You're incarcerated (detained or jailed), but pending disposition.

What you may need to apply

- Your Social Security Number (SSN) (or document number if you're an eligible immigrant).
- Employer and income information (like paystubs, W-2 forms, or wage and tax statements).

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 any help paying for it.

We'll keep all the information you provide private and secure, as required by law. To view the Privacy Act Statement, visit **HealthCare.gov**.

What happens next?

Send your complete, signed application to the address on page 4. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow up with you within 1–2 weeks and you may get a call from the Marketplace if we need more information. You'll get an Eligibility Notice in the mail after we process your application. Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

- **Online:** **HealthCare.gov**.
- **Phone:** Call the Marketplace Call Center at **1-800-318-2596**. TTY users can call **1-855-889-4325**.
- **In-person:** There may be counselors in your area who can help. Visit **HealthCare.gov**, or call the Marketplace Call Center at **1-800-318-2596** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-800-318-2596.**
- **Other languages:** If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you.

You have the right to get Marketplace information in an accessible format, like large print, braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit **CMS.gov/about-cms/agency-Information/aboutwebsite/cmsnondiscriminationnotice**, or call the Marketplace Call Center at **1-800-318-2596** for more information. TTY users can call **1-855-889-4325**.

HealthCare.gov

Print in capital letters using black or dark blue ink only.
Fill in the circles (◯) like this → ●.

Step 1: Tell us about yourself.

(You must be 18 or older to submit this application. If you have an Authorized Representative, that person may submit the application for you as long as you sign Appendix C.)

1. First name | Middle name | Last name | Suffix

2. Home address (Leave blank if you don't have one.) | 3. Home address 2

4. City | 5. State | 6. ZIP code | 7. County

8. Mailing address (if different from home address) | 9. Home address 2

10. City | 11. State | 12. ZIP code | 13. County

14. Phone number ( ) -

15. Second phone number ( ) -

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

Email address:

17. Preferred language: Written | Spoken

18. Date of birth (mm/dd/yyyy) / /

19. Sex ◯ Female ◯ Male

20. Social Security Number (SSN) - -

We need an 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's eligible for help paying for health coverage. For more information on getting an SSN, visit **socialsecurity.gov**, or call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.

21. Are you a **U.S. citizen** or **U.S. national**? ◯ Yes ◯ No

22. Are you a **naturalized** or **derived citizen**? *(This usually means you were born outside the U.S.)*
◯ **YES. If yes,** complete a and b. ◯ **NO. If no,** continue to question 23.
a. Alien number: b. Certificate number:
After you complete a and b, SKIP to question 24.

23. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status? ◯ **YES.** Enter document type and ID number. *See instructions.*
Immigration document type | Status type (optional) | Write your name as it appears on your immigration document.

Alien or I-94 number | Card number or passport number

SEVIS ID or expiration date (optional) | Other (category code or country of issuance)

24. Are you pregnant? ◯ Yes ◯ No a. **If yes,** how many babies are expected during this pregnancy? ☐

25. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.), a special health care need, or live in a medical facility or nursing home? ◯ Yes ◯ No

Optional: *(Fill in all that apply.)*

26. If Hispanic/Latino, ethnicity: ◯ Mexican ◯ Mexican American ◯ Chicano/a ◯ Puerto Rican ◯ Cuban ◯ Other _____

27. Race: ◯ White ◯ Black or African American ◯ American Indian or Alaska Native ◯ Filipino ◯ Japanese ◯ Korean ◯ Asian Indian ◯ Chinese ◯ Vietnamese ◯ Other Asian ◯ Native Hawaiian ◯ Guamanian or Chamorro ◯ Samoan ◯ Other Pacific Islander ◯ Other _____

Step 2: Current job & income information

◯ **Employed:** If you're currently employed, tell us about your income. Start with item 1.

◯ **Not employed:** Skip to item 11.

◯ **Self-employed:** Skip to item 10.

Current job 1:

1. Employer name

a. Employer address (optional)

b. City | c. State | d. ZIP code | 2. Employer phone number ( ) -

3. Wages/tips (before taxes) $ ◯ Hourly ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Monthly ◯ Yearly

4. Average hours worked each WEEK

Current job 2: (If you have additional jobs and need more space, attach another sheet of paper.)

5. Employer name

a. Employer address (optional)

b. City | c. State | d. ZIP code | 6. Employer phone number ( ) -

7. Wages/tips (before taxes) $ ◯ Hourly ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Monthly ◯ Yearly

8. Average hours worked each WEEK

9. **In the past year, did you:** ◯ Change jobs ◯ Stop working ◯ Start working fewer hours ◯ None of these

10. **If self-employed, answer a and b:**

a. Type of work:

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

11. **Other sources of income you get this month:** Fill in all that apply, and give the amount and how often you get it. Fill in here if none ◯
NOTE: You **don't** need to tell us about income from child support, veteran's payments, or Supplemental Security Income (SSI).

◯ Unemployment $ How often?

◯ Alimony received $ How often?

◯ Pension $ How often?

◯ Net farming/fishing $ How often?

◯ Social Security $ How often?

◯ Net rental/royalty $ How often?

◯ Retirement accounts $ How often?

◯ Other income, type: _____ $ How often?

12. Do you pay student loan interest (not the amount of the loan) that can be deducted on a federal income tax return?
◯ **YES. If yes,** how much $ How often? ◯ **NO.**

13. **Complete this question if your income changes during the year**, like if you only work at a job for part of the year or receive a benefit for certain months. If you don't expect changes to your monthly income, skip to Step 3.

Your total income **this year** $

Your total income **next** year (if you think it'll be different) $ ◯ Fill in if you think your income will be hard to predict.

Step 3: Your health coverage

Are you enrolled in health coverage now from the following? ◯ Yes ◯ No

(If you have access to health coverage through a job, complete the Family Application and fill out Appendix A.)

If yes, check which coverage you have.

◯ Medicaid ◯ CHIP ◯ Medicare ◯ TRICARE ◯ VA health care program ◯ Peace Corps ◯ Other: _____

Name of health insurance company ◯ Fill in if this is Marketplace health coverage.

Policy/ID number

Were you found not eligible for Medicaid or the Children's Health Insurance Program (CHIP) in the past 90 days?

(Fill in yes only if you were found not eligible for this coverage by your state, not by the Marketplace) ◯ Yes ◯ No

Date:

Or, were you found not eligible for Medicaid or CHIP due to your immigration status in the last 5 years? ◯ Yes ◯ No

Did you apply for coverage during the Marketplace Open Enrollment Period or after a qualifying life event? ◯ Yes ◯ No

Step 4: Your agreement & signature

Do you agree to allow the Marketplace to use income data, including information from tax returns, for the next 5 years? ..... ◯ Yes ◯ No

To make it easier to determine your eligibility for help paying for coverage in future years, you can agree to allow the Marketplace to use updated income data, including information from tax returns. The Marketplace will send a notice and let you make any changes. The Marketplace will check to make sure you're still eligible, and may have to ask you to confirm that your income still qualifies. You can opt out at any time.

If no, automatically update my information for the next: ◯ 5 years ◯ 4 years ◯ 3 years ◯ 2 years ◯ 1 year

◯ Don't use my tax data to renew my eligibility for help paying for health coverage (selecting this option may impact your ability to get help paying for coverage at renewal.)

If I'm eligible for Medicaid: I'm giving to the Medicaid agency my 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.

- 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 intentionally provide false or untrue information.
- I know that I must tell the Health Insurance Marketplace® within 30 days if anything changes (and is different than) what I wrote on this application. I can visit **HealthCare.gov** or call **1-800-318-2596** to report any changes. I understand that a change in my information could affect my eligibility as well as eligibility for member(s) 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 **hhs.gov/ocr/office/file**.
- I know that information on this form will be used only to determine eligibility for health coverage, help paying for coverage (if requested), and for lawful purposes of the Marketplace and programs that help pay for coverage.

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us confirmation.

What should I do if I think my Eligibility Notice is wrong?

If you don't agree with what you qualify for, in many cases, you can ask for an appeal. Review your Eligibility Notice to find appeals instructions specific to each person in your household who applies for coverage, including how many days you have to request an appeal. Here's important information to consider when requesting an appeal:

- You can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer, or other individual. Or, you can request and participate in your appeal on your own.
- If you request 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.

To appeal your Marketplace eligibility results, visit **HealthCare.gov/marketplace-appeals**. Or, call the Marketplace Call Center at **1-800-318-2596**. TTY users can call **1-855-889-4325**. You can also mail an appeal request form or your own letter requesting an appeal to **Health Insurance Marketplace**, Dept. of Health and Human Services, Attn: Appeals, 465 Industrial Blvd., London, KY 40750-0001. You can appeal eligibility for purchasing health coverage through the Marketplace, enrollment periods, tax credits, cost-sharing reductions, Medicaid, and CHIP, if you were denied these. If you qualify for tax credits or cost-sharing reductions, you can appeal the amount we determined you're eligible for. Depending on your state, you may be able to appeal through the Marketplace or you may have to request an appeal with the state Medicaid or CHIP agency.

PERSON who filled out Step 1 should sign this application. If you're an authorized representative, you may sign here as long as you've provided the information required in Appendix C.

Signature	Date signed (mm/dd/yyyy)
	___ / ___ / ____

If you're signing this application outside of Open Enrollment (between November 1 and January 15), make sure you review Appendix D ("Questions about life changes").

Step 5: Mail completed application

Mail your signed application to:

Health Insurance Marketplace
Dept. of Health and Human Services
465 Industrial Blvd.
London, KY 40750-0001

If you want to register to vote, you can complete a voter registration form at **eac.gov**.

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 15 minutes 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.

NEED HELP WITH YOUR APPLICATION? Visit **HealthCare.gov**, or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users can call **1-855-889-4325**.

Appendix C: Help with Completing this Application

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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, & Suffix

3. Organization name

4. ID number (if applicable)

5. Agents/Brokers only: NPN number

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 or remove your authorized representative, contact the Marketplace. 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. Home address 2

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 related to this application.

10. Signature of PERSON 1 listed on this application

11. Date signed (mm/dd/yyyy)

/ /

Appendix D: Questions about life changes

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(You must complete the rest of this application along with this page. Don't submit this page by itself.)

If anyone on this application experienced certain life changes—like losing health coverage, getting married, or having a baby—in the past 60 days (OR expects to in the next 60 days), fill out this page and include it with your completed, signed application. Certain life changes allow your coverage through the Marketplace to start right away. We also recommend you answer these questions if you're applying outside Open Enrollment.

These questions are optional. If your life circumstances haven't changed, you can leave the answers blank. You can enroll in Medicaid and the Children's Health Insurance Program (CHIP) any time of the year, even if you didn't experience life changes. Members of federally recognized tribes and Alaska Native shareholders can enroll in coverage through the Marketplace any time of the year.

Tell us about changes in your household.

1. Did anyone lose qualifying health coverage in the last 60 days, or expect to lose qualifying health coverage in the next 60 days?

Name(s)	Date coverage ended or will end (mm/dd/yyyy)
	/ /

2. Did anyone get married in the last 60 days?

Name(s)	Date (mm/dd/yyyy)
	/ /

a. Did any of these people have qualifying health coverage at any time in the last 60 days? ◯ Yes ◯ No

If yes, enter their name(s) below:

Name(s)

3. Did anyone get released from incarceration (detention or jail) in the last 60 days?

Name(s)	Date (mm/dd/yyyy)
	/ /

4. Did anyone gain eligible immigration status in the last 60 days?

Name(s)	Date (mm/dd/yyyy)
	/ /

5. Was anyone adopted, placed for adoption, or placed for foster care in the last 60 days?

Name(s)	Date (mm/dd/yyyy)
	/ /

6. Did anyone become a dependent due to a child support or other court order in the last 60 days?

Name(s)	Date (mm/dd/yyyy)
	/ /

7. Did anyone move in the last 60 days?

Name(s)	Date of move (mm/dd/yyyy)
	/ /

a. What is the ZIP code of your previous address? ◯ Fill in here if you moved from a foreign country or U.S. territory

b. Did any of these people have qualifying health coverage at any time in the last 60 days? ◯ Yes ◯ No

If yes, enter their name(s) below:

Name(s)