Complete a new copy of this form for each additional person applying for Medicaid.

STEP 1: ADDITIONAL PERSON

Complete a new copy of this form for each additional person who lives with you and/or anyone on your same federal income tax return if you file one. See DHHS Form 3400 (Application for Medicaid and Affordable Health Coverage) for more information about whom 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 (Please provide Full Legal Name)

2. Relationship to you?

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

4. Sex: ☐ Male ☐ Female

5. Social Security number (SSN)

We need this if this person wants health coverage and has an SSN.

a. If you don't have a SSN, have you applied for one?
☐ Yes ☐ No
If no, indicate the reason at question 16.

6. Does this person live at the same address as you? ☐ Yes ☐ No

If no, list address:

7. **Does this person 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 this person file jointly with a spouse? ☐ Yes ☐ No If yes, name of spouse:

b. Will this person claim any dependents on your tax return? ☐ Yes ☐ No

If yes, list dependents:

c. Will this person be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the tax filer: How is person related to the tax filer?

8. Is this person pregnant or recently pregnant? ☐ Yes ☐ No If yes, a. How many babies are expected? b. Due date?

c. If recently pregnant, enter the date the pregnancy ended:

d. Was this person enrolled in Medicaid on the last day of pregnancy? ☐ Yes ☐ No

9. **Does this person need health coverage (Medicaid)?** *(Even if you have insurance, there might be a program with better coverage or lower costs)*
☐ YES. If yes, answer the questions below. ☐ NO. If no, SKIP to the income questions on page 2. Leave the rest of this page blank.

10. Does this person have a disabling physical, mental, or emotional health condition that causes limitations in activities? ☐ Yes ☐ No

11. Does this person need to live in a medical facility or nursing home or need nursing services at home? ☐ Yes ☐ No

12. Has this person been diagnosed with and are receiving treatment for any of the following? ☐ Yes ☐ No
• Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia • Precancerous Cervical Lesion (CIN 2/3)

13. Does this person want to apply for Family Planning benefits? ☐ Yes ☐ No
Family Planning is a limited benefit program, which provides family planning services, family planning-related services and certain limited preventative screenings. Family Planning is not full Medicaid coverage. If you leave this question blank, we will not assess you for Family Planning.

14. a. Is this person a U.S. citizen? (Born in U.S.; child of U.S. citizen; or former alien now naturalized as a U.S. citizen) ☐ Yes ☐ No

b. Is this person a U.S. national? (Born in unincorporated U.S. Territory who elects to be a national, not a U.S. citizen) ☐ Yes ☐ No

15. **If this person isn't a U.S. citizen or U.S. national, does this person have eligible immigration status?** ☐ Yes ☐ No
If YES, fill in this person's document type and ID number below.

a. Immigration document type: b. Document ID number:

c. Has this person lived in the U.S. since 1996? ☐ Yes ☐ No d. Date of Entry:

e. Is this person, their spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

16. If this person has not applied for a Social Security Number, list the reasons
☐ Issued for non-work reasons only ☐ No SSN due to religious reasons ☐ Not eligible for SSN
☐ Newborn, mother currently receiving Medicaid ☐ Newborn, mother NOT receiving Medicaid

17. Does this person want help paying for medical bills from the last 3 months? ☐ Yes ☐ No
a. If YES, was this person's household size the same during these 3 months as it is now? ☐ Yes ☐ No
b. Was this person's household income the same during these 3 months as it is now? ☐ Yes ☐ No
If NO, enter the total monthly income for: Last Month: $ 2 Months Ago: $ 3 Months Ago: $

18. Does this person live with at least one child under 19, and is This person the main person taking care of this child? ☐ Yes ☐ No

19. Is this person a full-time student? ☐ Yes ☐ No

20. a. Was this person in foster care and enrolled in Medicaid on their 18th birthday? ☐ Yes ☐ No

b. If yes, what state did they reside in when they aged out of foster care?

21. Is this person currently living in a foster home? ☐ Yes ☐ No

22. Is this person currently living in a DJJ group home? ☐ Yes ☐ No

Now, tell us about any income from this person on the next page.

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STEP 1: ADDITIONAL PERSON

Ethnicity and Race: You do not have to answer these questions to get health care. This data helps us to identify groups of people who have health concerns so we can find ways to improve their access to quality care.

23. **If Hispanic/Latino, ethnicity**
☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Puerto Rican
☐ Cuban ☐ Other: _____

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

Current job & income information

☐ **Employed**
If currently employed, tell us about income.
Start with question 25.

☐ **Not Employed**
SKIP to question 37.

☐ **Self-Employed**
SKIP to question 36.

CURRENT JOB 1:

25. Employer name and address _____

26. Employer phone number _____

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

$ _____ 28. Average hours worked each week _____ 29. Start date _____

CURRENT JOB 2: (If this person has more jobs and needs more space, attach another sheet of paper)

30. Employer name and address _____

31. Employer phone number _____

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

$ _____ 33. Average hours worked each week _____ 34. Start date _____

35. **In the past year, did this person:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

36. **If self-employed, answer the following questions:**
a. Type of work _____
b. How much net income (profits once business expenses are paid will this person get from this self-employment this month?)
$ _____

37. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often this person 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 acc'ts $ _____ How often? _____
☐ Alimony received $ _____ How often? _____
☐ Net farming/fishing: $ _____ How often? _____
☐ Net rental/royalty: $ _____ How often? _____
☐ Other income:
☐ Type: _____ $ _____ How often? _____
☐ Type: _____ $ _____ How often? _____

38. **DEDUCTIONS:** Check all that apply, and give the amount and how often this person gets it.
If this person 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: You shouldn't include a cost that you already considered in your answer to net self-employment (question 36b).

☐ Alimony paid $ _____ How often? _____
☐ Student loan interest $ _____ How often? _____
☐ Other deductions: $ _____ How often? _____
Type: _____

39. **YEARLY INCOME:** **Complete only if this person's income changes from month to month.**

This person's total income this year
$ _____

This person's total income next year (if you think it will be different)
$ _____

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