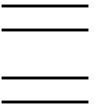


Person ID: 1886526
 Client ID: 002076406
 Application ID: 8580498



Maria Mate
 4 Short St
 Westport, CT 06880

Mailed: June 02, 2021

It's Time to Renew Your HUSKY Health Coverage

Dear **Maria Mate**,

Every year, Access Health CT (AHCT) and the Department of Social Services (DSS) must determine if you are qualified to get another year of HUSKY Health coverage. We start this renewal process about two months before your coverage is scheduled to end.

Enrolled in other programs?

If anyone is enrolled in an AHCT health insurance plan or in a DSS program such as SNAP or TFA, they will get separate letters when it is time to renew those programs.

Your Current HUSKY Health Coverage

Person	HUSKY Health	Coverage Start	Coverage End
Maria Mate	HUSKY D - Adult	August 01, 2020	July 31, 2021

We tried to renew your HUSKY Health coverage without asking you for more information. We looked at your last application as well as information available to us from other government computer systems. We could not renew your coverage without some updates to your application. Please contact Access Health CT to renew your HUSKY Health coverage and update your information such as your household size, income, and tax information.

You have until July 16, 2021 to renew your coverage. If you do not contact Access Health CT by this deadline, you will lose your HUSKY Health coverage on July 31, 2021.

Please see the attachment *How to Renew* for the different ways of renewing your health coverage.



The fastest ways of renewing are by going Online or by Phone

We have included a pre-filled paper application form that you can review, edit and return to us. But paper is not always the fastest way.

If you have an online account with Access Health CT then that is the best way of updating your details. You can call the call center to get help setting up an online account or you can renew over the phone.

Sincerely,

Access Health CT



Renewing your Health Care

How to Renew

Online and Phone are the fastest and easiest ways of renewing!

You can renew your coverage in any one of these ways:

- ▶ **By Going Online:** Renewing online is the fastest way! Follow the directions below in *How to Renew Online*.
- ▶ **By Phone:** Call the Access Health CT contact center at 1-855-805-4325. If you are deaf or hard of hearing, the TTY number is 1-855-789-2428.
- ▶ **By Mail:** Complete and then mail the pre-filled Husky Health Renewal Form which was included with this notice.
- ▶ **In Person:** Visit www.ct.gov/dss for a listing of all Department of Social Service (DSS) offices. Or call 1-866-6 CONNECT (1-866-626-6632) for the location that's best for you. Office hours are 8:00 am – 4:30 pm, Monday through Friday.

How to Renew Online

Please follow the steps listed below to renew your coverage online:

- ▶ Log in to your Access Health CT account at: www.accesshealthct.com
- ▶ Click the "Report a Change/Renew Coverage" quick link from your account home screen.
- ▶ Review and confirm that each applicant's information is accurate.
- ▶ Report any changes necessary.
- ▶ Provide your electronic signature and submit.
- ▶ Select a program and complete the enrollment process.

How to Contact Access Health CT

Contact Access Health CT if you need to report changes, apply for coverage, select a plan or program, or have any questions about this notice. Let us know if you need help applying for health care coverage or accessing your account. You can contact Access Health CT:

- ▶ **By Going Online** at www.accesshealthct.com, or
- ▶ **By calling** the Access Health CT Contact Center 1-855-805-4325 or, for those individuals who are deaf or hard of hearing, the TTY number 1-855-789-2428.

If you have a disability you may ask for and get a reasonable accommodation or special help from Access Health CT.



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Renewal Form



Do not use this form if you are not Maria Mate

Maria Mate
4 Short St
Westport, CT 06880

06/02/2021

Respond by: July 16, 2021

Person ID: 1886526

Client ID: 002076406

It is time to renew your HUSKY Health (HUSKY A, B or D) coverage.

You can renew your HUSKY Health (Medicaid & CHIP) in any one of these ways

Renewing online is faster! Go to www.accesshealthct.com, sign-in and then click on the *Report a Change/Renew Coverage link*.

- **By phone:** Just call **1-855-805-4325** (TTY: 1-855-789-2428). The call is free.
- **By mail:** Complete this form and mail it to:
Access Health CT / DSS
PO Box #670
Manchester, CT 06045-0670
- **In person:** Visit www.ct.gov/dss for a listing of all DSS Regional Office locations and directions. Or call 1-855-6 CONNECT (1-855-626-6632) for the location that's best for you. Office hours are 8:00 am – 4:30 pm, Monday through Friday.

How to complete this renewal form

1. Review all of the questions on the form.
2. Read the information about you and each member of your household. Add any missing information. If any information has changed, write in the correct information.
3. Sign the form in Section 9.
4. **Return this form by July 16, 2021.** If you do not return the form by this deadline, you will lose your HUSKY Health coverage.

What we need

We need information about each person living in your household or listed on your tax return, including:

- those who get HUSKY Health now,
- those who do not get HUSKY Health now but would like to apply, and
- others who live in the household and do not get HUSKY Health but do not want to apply.

We will check your answers using information from computer data sources, including the Internal Revenue Service (IRS), the Social Security Administration, the Department of Homeland Security and others. If the information does not match, we may ask you to send more information.

If you do not qualify for HUSKY Health (Medicaid & CHIP)

If you do not qualify for HUSKY Health, Access Health CT will check to see if you qualify for other kinds of health coverage.

If you have questions about your renewal

Call Access Health CT at 1-855-805-4325. The call is free. TTY: 1-855-789-2428. Or visit www.accesshealthct.com.



1 Your contact information

▼ Review your contact information here

Maria Mate

Home address:

4 Short St
Westport, CT 06880

Mailing address:

4 Short St
Westport, CT 06880

Phone:

Home: 2032271610

Other:

Email:

mrszilagyi695@gmail.com

Communication preference:

Email

▼ Correct any wrong or missing information here

Name *(first middle last suffix)*

Check here if you are homeless.

Home address

Apartment #

City (home)

State

Zip Code

Mailing address

Apartment #

City (mailing)

State

Zip Code

Best phone to reach you:

Number:

Home Work Cell

Preferred email address:

Preferred communication:

Paper/ US Mail

Email

2 We need information about who files tax returns

You can still renew if you do not file tax returns.

► Review your tax information below and correct any wrong or missing information for everyone in your household who plans to file a **federal tax** return for the year **2021**.

Tax Filer 1

Name *(first middle last suffix)*:

Is this person planning to file taxes? Yes No

If yes, Is this person married? Yes No

If yes, are they filing jointly? Yes No

Name of spouse: _____

Names of dependents:

(a) _____ (c) _____

(b) _____ (d) _____

Will this Tax Filer be claimed as a dependent on someone's tax return? Yes No

If yes, name of the tax filer: _____

Section 2 continued on next page ►►►





2 We need information about who files tax returns *(continued)*

You can still renew if you do not file tax returns.

Tax Filer 2

Name *(first middle last suffix)*:

Is this person planning to file taxes?

Yes No

If yes, Is this person married?

Yes No

If yes, are they filing jointly?

Yes No

Name of spouse: _____

Names of dependents:

(a) _____ (c) _____

(b) _____ (d) _____

Will this Tax Filer be claimed as a dependent on someone's tax return?

Yes No

If yes, name of the tax filer: _____

- ▶ If anyone will be claimed as a dependent on someone else's tax return, write the name of the tax filer and the dependents below. Review any existing information that we have and correct as needed.

Answer only if different than what you reported above or if you did not fill in any information above.

Tax Dependent 1

Name of dependent *(first middle last suffix)*:

Name of tax filer *(first middle last suffix)*:

Does the dependent reside at a different address than the tax filer?

Yes No

If yes, provide the address: _____

Tax Dependent 2

Name of dependent *(first middle last suffix)*:

Name of tax filer *(first middle last suffix)*:

Does the dependent reside at a different address than the tax filer?

Yes No

If yes, provide the address: _____

3 These are the people in your household who get HUSKY Health and who now need to renew

Person 1: Maria Mate

HUSKY D

- Check here if this person is no longer living in the household.
- Check here if this person no longer wants HUSKY Health.
- Check here if this person is a full-time student in high school or vocational/technical school.

4 We need more information about people NOT listed in Section 3

- ▶ Tell us about anybody else in your household or on your tax return.
- ▶ Review the details below and correct any wrong or missing information.

Section 4 continued on next page ▶▶▶





4 We need more information about people NOT listed in Section 3 *(continued)*

- ▶ Tell us about anybody else in your household or on your tax return.
- ▶ Review the details below and correct any wrong or missing information.

Other Person 1: Name *(first middle last suffix)*:

Access Health CT **does not** have this person's Social Security number. **Write it in the space below**

____ - ____ - _____

This person may choose not to give the Social Security Number if he or she is not applying but it helps us to have it.

If this person does not have an SSN please check any of the following that are applicable:

- Has applied for an SSN
- Not eligible to receive an SSN
- Has non-work type visa and so an SSN is not required
- Person's religion prohibits the use of such identification numbers

Date of birth *(mm/dd/yyyy)*:

This person is a: Male Female

Is this person a full-time student in high school or vocational/technical school? Yes No

How is this person related to you?

Check here if the person wants health care coverage and fill out **Attachment A**.

Other Person 2: Name *(first middle last suffix)*:

Access Health CT **does not** have this person's Social Security number. **Write it in the space below**

____ - ____ - _____

This person may choose not to give the Social Security Number if he or she is not applying but it helps us to have it.

If this person does not have an SSN please check any of the following that are applicable:

- Has applied for an SSN
- Not eligible to receive an SSN
- Has non-work type visa and so an SSN is not required
- Person's religion prohibits the use of such identification numbers

Date of birth *(mm/dd/yyyy)*:

This person is a: Male Female

Is this person a full-time student in high school or vocational/technical school? Yes No

How is this person related to you?

Check here if the person wants health care coverage and fill out **Attachment A**.

Section 4 continued on next page ▶▶▶



4 We need more information about people NOT listed in Section 3 *(continued)*

- ▶ Tell us about anybody else in your household or on your tax return.
- ▶ Review the details below and correct any wrong or missing information.

Other Person 3: Name *(first middle last suffix)*:

Access Health CT **does not** have this person's Social Security number. **Write it in the space below**

____ - ____ - _____

This person may choose not to give the Social Security Number if he or she is not applying but it helps us to have it.

If this person does not have an SSN please check any of the following that are applicable:

- Has applied for an SSN
- Not eligible to receive an SSN
- Has non-work type visa and so an SSN is not required
- Person's religion prohibits the use of such identification numbers

Date of birth *(mm/dd/yyyy)*:

This person is a: Male Female

Is this person a full-time student in high school or vocational/technical school? Yes No

How is this person related to you?

Check here if the person wants health care coverage and fill out **Attachment A**.

5 Tell us about any employer health insurance coverage

- ▶ Include anyone in Sections 3 and 4 who is applying for healthcare and who has health insurance through a job.
- ▶ Review the details below and correct any wrong or missing information.

Name of insurance company:

Policy number:

Is this COBRA coverage? Yes No

Is this a retiree health plan? Yes No

List everyone who is on this policy:

Name of insurance company:

Policy number:

Is this COBRA coverage? Yes No

Is this a retiree health plan? Yes No

List everyone who is on this policy:

- ▶ We need to know about any other possible health insurance through a job

Check here if anyone else on this form is offered health insurance through a job or through the job of a spouse or parent, even if they are not enrolled in it.

List their names:

6 Tell us about any other health insurance coverage

- ▶ Include anyone in Sections 3 and 4 who is applying for healthcare and has non-Access Health CT health insurance.
- ▶ Review the details below and correct any wrong or missing information.

Section 6 continued on next page ▶▶▶





6 Tell us about any other health insurance coverage *(continued)*

- ▶ Include anyone in Sections 3 and 4 who is applying for healthcare and has non-Access Health CT health insurance.
- ▶ Review the details below and correct any wrong or missing information.

Name of insurance company:		Policy number:	
Type of insurance:	<input type="checkbox"/> Medicare	<input type="checkbox"/> Tricare	<input type="checkbox"/> Veteran's health coverage
	<input type="checkbox"/> Other insurance _____	If other , is this a limited benefit plan? <input type="checkbox"/> <i>(like a school accident policy or dental only)</i>	
List everyone who is on this policy:			

Name of insurance company:		Policy number:	
Type of insurance:	<input type="checkbox"/> Medicare	<input type="checkbox"/> Tricare	<input type="checkbox"/> Veteran's health coverage
	<input type="checkbox"/> Other insurance _____	If other , is this a limited benefit plan? <input type="checkbox"/> <i>(like a school accident policy or dental only)</i>	
List everyone who is on this policy:			

7a Tell us about work

- ▶ Fill in the information below for everyone in your household or on your tax return who has income from a job (**not self-employed**) whether or not they are renewing or applying for coverage. If someone has more than one job, tell us about **all jobs**. You can tell us about **self-employment** in Section 7c.
- ▶ Make a copy of this page if you need space for more jobs or people. Cross out any information that is **not correct** about members of your household. Write in any new information.

Job 1: Name of the person who is working *(first, middle, last & suffix)*:

Employer name:		Employer phone number:	
Employer address:	City:	State:	Zip Code:
How often are wages or tips paid? <input type="checkbox"/> Hourly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Yearly			
How much does this person get paid? \$ _____			
<i>This is the gross pay before taxes but after deducting pre-tax contributions such as those for child care, commuting, employer-sponsored health insurance, flexible spending accounts and retirement plans such as 401(k) and 403(b).</i>			
Average hours worked each week:			

Job 2: Name of the person who is working *(first, middle, last & suffix)*:

Employer name:		Employer phone number:	
Employer address:	City:	State:	Zip Code:
How often are wages or tips paid? <input type="checkbox"/> Hourly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Yearly			
How much does this person get paid? \$ _____			
<i>This is the gross pay before taxes but after deducting pre-tax contributions such as those for child care, commuting, employer-sponsored health insurance, flexible spending accounts and retirement plans such as 401(k) and 403(b).</i>			
Average hours worked each week:			

Section 7 continued on next page ▶▶▶





7a Tell us about work *(continued)*

- ▶ Fill in the information below for everyone in your household or on your tax return who has income from a job (**not self-employed**) whether or not they are renewing or applying for coverage. If someone has more than one job, tell us about **all jobs**. You can tell us about **self-employment** in Section 7c.
- ▶ Make a copy of this page if you need space for more jobs or people. Cross out any information that is **not correct** about members of your household. Write in any new information.

Job 3: Name of the person who is working (*first, middle, last & suffix*):

Employer name:

Employer phone number:

Employer address:

City:

State:

Zip Code:

How often are wages or tips paid? Hourly Every two weeks Monthly Weekly Twice a month Yearly

How much does this person get paid? \$ _____

This is the gross pay before taxes but after deducting pre-tax contributions such as those for child care, commuting, employer-sponsored health insurance, flexible spending accounts and retirement plans such as 401(k) and 403(b).

Average hours worked each week:

7b Tell us about recent changes in work

- ▶ List anyone in your household who has **changed jobs** or has **worked fewer hours** in the past **four** months.

Changes 1: Name of the person (*first, middle, last & suffix*):

This person stopped working

This person is now working fewer hours

This person changed jobs

Changes 2: Name of the person (*first, middle, last & suffix*):

This person stopped working

This person is now working fewer hours

This person changed jobs

7c Tell us about self-employment

- ▶ If anyone in your household is **self-employed**, we need to know about their work. See the **expense instructions** below for more information about net income and expenses.

Self-employment 1: Name of the person (*first, middle, last & suffix*):

Type of Work:

How much *net income* (income after expenses but before tax and deductions) will this person typically get from self employment?

Monthly amount: \$

Self-employment 2: Name of the person (*first, middle, last & suffix*):

Type of Work:

How much *net income* (income after expenses but before tax and deductions) will this person typically get from self employment?

Monthly amount: \$

- ▶ **Expense Instructions:** Subtract the expenses below from gross income to get self-employment net income.

- Car and truck expenses (for traveling during the workday, not commuting)
- Depreciation
- Employee wages and fringe benefits
- Property, liability, or business interruption insurance
- Interest (including mortgage interest paid to banks, etc.)
- Legal and professional services
- Rent or lease of business property and utilities
- Commissions, taxes, licenses and fees

- Advertising
- Contract labor
- Repairs and maintenance
- Certain business travel and meals
- Deductible self-employment taxes
- Cost of self-employed health insurance
- Contributions to a self-employed SEP, SIMPLE, or qualified retirement plan





8a Tell us about other income

► Cross out any information that is **not correct** about members of your household. Write in any new information.
NOTE: You don't need to tell us about child support, veteran's payments or Supplemental Security Income (SSI).

Name 1 (first middle last & suffix):

<input type="checkbox"/> Unemployment	\$ _____	How often? _____	<input type="checkbox"/> Retirement accounts	\$ _____	How often? _____
<input type="checkbox"/> Pensions	\$ _____	How often? _____	<input type="checkbox"/> Alimony received	\$ _____	How often? _____
<input type="checkbox"/> Social Security	\$ _____	How often? _____	<input type="checkbox"/> Net farming or fishing	\$ _____	How often? _____
<input type="checkbox"/> Capital gains	\$ _____	How often? _____	<input type="checkbox"/> Net rental or royalty	\$ _____	How often? _____
<input type="checkbox"/> Investment income	\$ _____	How often? _____	<input type="checkbox"/> Other income	\$ _____	How often? _____
			Type: _____		

Name 2 (first middle last & suffix):

<input type="checkbox"/> Unemployment	\$ _____	How often? _____	<input type="checkbox"/> Retirement accounts	\$ _____	How often? _____
<input type="checkbox"/> Pensions	\$ _____	How often? _____	<input type="checkbox"/> Alimony received	\$ _____	How often? _____
<input type="checkbox"/> Social Security	\$ _____	How often? _____	<input type="checkbox"/> Net farming or fishing	\$ _____	How often? _____
<input type="checkbox"/> Capital gains	\$ _____	How often? _____	<input type="checkbox"/> Net rental or royalty	\$ _____	How often? _____
<input type="checkbox"/> Investment income	\$ _____	How often? _____	<input type="checkbox"/> Other income	\$ _____	How often? _____
			Type: _____		

8b Tell us about deductions

► If anyone in your household has deductions, tell us what kind.
Cross out any information that is **not correct** about members of your household. Write in any new information.

Name 1 (first middle last & suffix):

<input type="checkbox"/> Alimony paid	\$ _____	How often? _____	<input type="checkbox"/> Student loan interest	\$ _____	How often? _____
			<input type="checkbox"/> Other deductions	\$ _____	How often? _____
			Type: _____		

Name 2 (first middle last & suffix):

<input type="checkbox"/> Alimony paid	\$ _____	How often? _____	<input type="checkbox"/> Student loan interest	\$ _____	How often? _____
			<input type="checkbox"/> Other deductions	\$ _____	How often? _____
			Type: _____		

► **Deduction Information:** These are the types of deductions that can be reported on the front page of a federal income tax return form 1040. Here are some examples.

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Alimony paid | <input type="checkbox"/> Tuition and fees | <input type="checkbox"/> IRA deduction | <input type="checkbox"/> Penalty on early withdrawal of savings |
| <input type="checkbox"/> Student loan interest | <input type="checkbox"/> Educator expenses | <input type="checkbox"/> Moving expenses | <input type="checkbox"/> Health savings account deduction |





8c Tell us about yearly income

► List the names of anyone whose income **changes** from month to month. Also tell us how much you think their income will be for the year. Make a copy of this page if you need space for more people.

Name 1 (first middle last & suffix):

What do you expect his or her yearly income (before taxes) to be in **2021**?

Amount \$ _____

Name 2 (first middle last & suffix):

What do you expect his or her yearly income (before taxes) to be in **2021**?

Amount \$ _____

Name 3 (first middle last & suffix):

What do you expect his or her yearly income (before taxes) to be in **2021**?

Amount \$ _____

Name 4 (first middle last & suffix):

What do you expect his or her yearly income (before taxes) to be in **2021**?

Amount \$ _____





9 Read and sign this application

Fast track your future renewals

► Read the statement below and check **one** box

I give permission to Access Health CT to use information from my tax returns for the number of years I checked below. I understand that Access Health CT may be able to use this information to automatically renew my HUSKY Health (Medicaid and CHIP) without needing to send me a renewal form. I can also change my mind and not allow Access Health CT to check this information.

Yes, I give permission to check my income on tax returns for (check one box):

- 5 years (the longest time) 4 Years 3 Years 2 Years 1 Year
 No, I do not give permission to use my tax returns

Help because of a disability or impairment

Do you need a reasonable accommodation or help to complete this renewal because of a disability or impairment?

- Yes No

If yes, what kind do you need? _____

Your rights and responsibilities

I am signing this renewal form under penalty of perjury. This means that I have been truthful in confirming the information on this form and providing corrections to and additional information for all the questions on this form. I have provided this information to the best of my knowledge. I know that I may be subject to civil and criminal penalties under state and federal law if I provide false or misleading information.

I know that I must tell Access Health CT (AHCT) or the Connecticut Department of Social Services (DSS) if anything changes or is different from what appeared on this form or if there are any changes to anything that I corrected or added to this form. I can call 1-800-805-4325 (TTY: 1-855-789-2428) or visit www.connect.ct.gov to report any changes. I understand that a change in our information might affect whether I or someone in my household qualifies for coverage.

I know that under state and federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, disability, or because of genetic information. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file or the Connecticut Commission on Human Rights and Opportunities (CHRO) www.ct.gov/chro/site/default.asp.

By signing below, I confirm that no one applying for healthcare coverage on this application is incarcerated (detained or jailed). If someone is incarcerated, what is their name: _____

I understand that Access Health CT and the Department of Social Services need the information on this form to check our ongoing eligibility for help paying for health coverage. I understand that Access Health CT and the Department of Social Services will check our answers using information from federal data sources, including the Social Security Administration, the Department of Homeland Security, and/or a consumer reporting agency. If the information does not match, Access Health CT or the Department of Social Services may ask us to send us proof.

I understand that Access Health CT and the Department of Social Services are authorized to collect information on this form, and other supporting information, including Social Security numbers, under the Patient Protection and Affordable Care Act (Public Law No. 111-148), as amended by the Health Care Education Reconciliation Act of 2010 (PL 111-148, as amended by the Health Care Education Reconciliation Act of 2010 (PL 111-152), 42 USC §§ 1320(b)-7(a)(1) and (b) (5), 42 CFR 435.920 and Conn. Gen. Stat. § 17b-77.

I understand that when I send in this form, it means I have permission from everyone whose information is on the form to submit their information to Access Health CT and the Department of Social Services and to receive any communications about their eligibility and enrollment.

Section 9 continued on next page ►►►





If anyone on this application is eligible or found eligible for HUSKY Health (Medicaid or CHIP)

I am giving to the Department of Social Services (the Medicaid agency) the rights to pursue and get medical support from a spouse or parent.

List the names of any children in the household who have a parent living outside the home:

I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating with the agency that collects of medical support will harm me or my children, I can tell the Department of Social Services and I may not have to cooperate.

I give permission to Access Health CT and the Department of Social Services to release information about me and others in my household who are receiving benefits for purposes directly connected with the administration of the HUSKY Health Program. Purposes directly connected with the administration of the program include, but are not limited to, establishing eligibility, determining the amount of assistance, providing services, and the investigation, prosecution, or civil proceedings related to the administration of the HUSKY Health program.

I understand that all information on this form, including Social Security numbers, is confidential, except as permitted or required by court order, state or federal law. I understand that if the Department of Social Services believes that there is imminent danger to a child's or family's health, safety or welfare, they will provide the child's address and telephone number to the Department of Children and Families.

I understand that after my death, the Department of Social Services can file a claim against my estate to recover money that the agency paid for coverage provided to me. If I am qualified for HUSKY A and 55 years or older, the state can recover for all types of medical care. If I am qualified for HUSKY D and 55 years or older, the state can recover only for my nursing facility services, home and community based services or related hospital and prescription drug services. The amount recovered will not be more than the amount the HUSKY Health paid for my care. The State may bill my legally liable relative to repay it for the costs of my medical care.

I understand that information on this form is subject to verification by federal and state officials. I will cooperate with these officials by providing authorizations, documents, and other proof to prove what I have said. I will cooperate with state and federal personnel in Quality Control Reviews.

I understand that money from a pending or future lawsuit will go (be assigned) to the State of Connecticut to recovery any medical expenses paid by HUSKY Health related to the lawsuit. By receiving medical assistance, I allow the State to recover the cost of my medical bills that are covered by a third party, such as other insurance, directly from that third party.

By applying for medical assistance, I give (assign) my right of support from third parties to the Department of Social Services.

Your right to appeal

If I think Access Health CT or the Department of Social Services has made a mistake on my eligibility, I can appeal the decision. I may ask for a hearing, in writing, by telephone, or by email if I disagree with an action taken. I can find out how to appeal by contacting Access Health CT at 1-855-805-4325.

- ▶ *Sign this application. The person who filled out step 1 should sign this application. If you are an authorized representative, you may sign here as long as you have provided the information required in Appendix C.*

Signature of household contact or authorized representative:	Date (mm/dd/yyyy):
---	---------------------------



Attachment A

New person applying for HUSKY Health

For people now applying for health coverage in Section 4

► Tell us about anyone in your household who wants to apply for HUSKY Health (Medicaid & CHIP). **Do not answer** these questions for people who already have HUSKY Health (Medicaid & CHIP). If more than one person is applying, make a copy of this page.

Name (first middle last suffix): _____

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

If no, list this person's address: _____

► Tell us about citizenship

Is this person a U.S. citizen or U.S. national? Yes **If yes**, go to "Tell us more about this person"
 No **If no**, answer all of the questions below.

Check here, if this person has eligible immigration status and fill in the document type: _____
and document ID Number: _____

See **Attachment ID** for more information about eligible immigration status and document types.

Check here, if this person has lived in the U.S. since 1996.

Check here, if this person has had their current immigration status for 5 years or more.

Check here, if this person, his or her spouse, or a parent is a veteran or an active duty member in the U.S. military.

► Tell us more about this person

Is this person Pregnant? Yes No **If yes**, with how many babies? _____ Due date (mm/dd/yyyy): _____

Check here, if this person lives with at least one child under the age of 19, and is the main person taking care of this child. **If yes**, list the names of the children: _____

Check here, if this person is 18 years or younger and has a parent living outside of the household.

Check here, if this person wants help paying for medical bills from the last three months.

Check here if this person was in Connecticut foster care at age 18 or older.

Check here if anyone who is renewing or applying for health insurance coverage is an American Indian or Alaska Native, and **fill out Attachment B**.

Check here if this person has a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or lives in a medical facility or nursing home.

► Tell us about this person's race and ethnicity. You may choose not to answer these questions.

If this person is Hispanic/Latino, check all that apply:

Mexican Mexican American Chicano/a Puerto Rican Cuban Other _____

What is this person's race? Check all that apply:

<input type="checkbox"/> Caucasian	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Korean	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Chinese	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Samoan
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Filipino	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Other Pacific Islander
	<input type="checkbox"/> Japanese	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other: _____

Check here, if this person is a full-time high school or vocational/technical school.



Attachment B New American Indian and Alaskan Native family members (AI/AN) To help you fill out Attachment A

► Tell us about your American Indian or Alaska Native (AI/AN) family member(s) from Attachment(s) A.

American Indians and Alaska Natives (AI/AN) can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They may not have to pay co-pays and may get special monthly enrollment periods. NOTE: If you have more people to include, make a copy of this page and attach.

1. Names

AI/AN Person 1	AI/AN Person 2	AI/AN Person 3	AI/AN Person 4
First	First	First	First
Middle	Middle	Middle	Middle
Last	Last	Last	Last
Suffix	Suffix	Suffix	Suffix

2. Member of federally recognized tribe?

AI/AN Person 1	AI/AN Person 2	AI/AN Person 3	AI/AN Person 4
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tribe name	Tribe name	Tribe name	Tribe name
State	State	State	State

3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, an urban Indian health program, or through a referral from one of these programs?

AI/AN Person 1	AI/AN Person 2	AI/AN Person 3	AI/AN Person 4
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If no</i> , has this person ever gotten a service from the Indian Health Service, a tribal health program, an urban Indian health program, or through a referral from one of these programs?	<i>If no</i> , has this person ever gotten a service from the Indian Health Service, a tribal health program, an urban Indian health program, or through a referral from one of these programs?	<i>If no</i> , has this person ever gotten a service from the Indian Health Service, a tribal health program, an urban Indian health program, or through a referral from one of these programs?	<i>If no</i> , has this person ever gotten a service from the Indian Health Service, a tribal health program, an urban Indian health program, or through a referral from one of these programs?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

4. List any income that includes money from these sources:

- Per capita payments from a tribe for 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

AI/AN Person 1	AI/AN Person 2	AI/AN Person 3	AI/AN Person 4
How much?	How much?	How much?	How much?
How often?	How often?	How often?	How often?



Attachment C Assistance with completing this application

- ▶ You can choose an authorized representative to assist in completing the application (Certified application counselors, in-person assisters, navigators and brokers please see below).

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 Access Health CT at 1-855-805-4325. If you are a legally appointed representative for someone on this application, submit proof with the application.

- ▶ If you have an authorized representative now, or would like to add one, please answer these questions.

Select the type of representative:

- Court Appointed Representative and Power of Attorney
- Responsible Adult

1. Name of authorized representative (first middle last suffix):		
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 assisters, counselors, navigators, and brokers only.

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

1. Application start date (mm/dd/yyyy)	
2. Name (first middle last suffix)	
3. Organization name	4. ID number (if applicable)





Attachment D Helpful information about immigration status and document types *To help you fill out Attachment A*

Eligible immigration status list

► If you see the person's status below, go back to **Attachment A** and check the Yes box.

- | | |
|--|--|
| <ul style="list-style-type: none"> ■ Lawful Permanent Resident (LPR or Greencard holder) ■ Asylee ■ Refugee ■ Cuban or Haitian entrant ■ Paroled into the U.S. ■ Conditional entrant granted before 1980 ■ Battered spouse, child and parent ■ Victim of Trafficking and his/her spouse, child, sibling or parent ■ Granted Withholding of Deportation or Withholding of Removal, under the immigration laws and under the Convention against Torture (CAT) ■ Individual with Non-immigrant Status (includes worker visas, student visas, and citizens of Micronesia, the Marshall Islands, and Palau) ■ Temporary Protected Status (TPS) and Applicant for Temporary Protected Status (TPS) ■ Deferred Enforced Departure (DED) ■ Family Unity beneficiary ■ Deferred Action Status (Deferred Action for Childhood Arrivals - DACA) is not an eligible immigration status for applying for health insurance | <ul style="list-style-type: none"> ■ Applicant for Special Immigrant Juvenile Status ■ Applicant for Adjustment to LPR Status ■ Applicant for Asylum ■ Applicant for Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT) ■ Registry Applicants (with Employment Authorization) ■ Order of Supervision (with Employment Authorization) ■ Applicant for Cancellation of Removal or Suspension of Deportation (with EAD Employment Authorization) ■ Applicant for Legalization under IRCA (with Employment Authorization) ■ Legalization under the LIFE Act (with Employment Authorization) ■ Lawful Temporary Resident ■ Member of a federally-recognized Indian tribe or American Indian Born in Canada ■ Resident of American Samoa ■ Administrative order staying removal issued by the Department of Homeland Security |
|--|--|

Immigration document types

► People who are not citizens, but who are eligible to apply for health insurance coverage, must put their immigration documents and ID numbers on **Attachment A**. A list of documents and ID numbers is below. If your document type is not listed, you can write its name. If you have questions, or are eligible but have no document, call 1-855-805-4325.

<p>Permanent Resident Card (I-551, also known as Green Card)</p> <ul style="list-style-type: none"> ■ Alien registration number ■ Card number <p>Temporary I-551 Stamp (on passport or I-94, I-94A)</p> <ul style="list-style-type: none"> ■ Alien registration number <p>Immigrant Visa (with temporary I-551 language)</p> <ul style="list-style-type: none"> ■ Alien registration number ■ Passport number <p>Employment Authorization Card (EAD or I-766)</p> <ul style="list-style-type: none"> ■ Alien registration number ■ Card number ■ Expiration date ■ Category code <p>Arrival/Departure Record (I-94 or I-94A)</p> <ul style="list-style-type: none"> ■ I-94 number <p>Arrival/Departure Record in foreign passport (I-94)</p> <ul style="list-style-type: none"> ■ I-94 number ■ Passport number ■ Expiration date ■ Country of issuance <p>Foreign passport</p> <ul style="list-style-type: none"> ■ Passport number ■ Expiration date <p>Country of issuance Reentry Permit (I-327)</p> <ul style="list-style-type: none"> ■ Alien registration number 	<p>Refugee travel document (I-571)</p> <ul style="list-style-type: none"> ■ Alien registration number <p>Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)</p> <ul style="list-style-type: none"> ■ Alien registration number or an I-94 number ■ Description of the type or name of the document <p>Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)</p> <ul style="list-style-type: none"> ■ SEVIS ID <p>Notice of Action (I-797)</p> <ul style="list-style-type: none"> ■ Alien registration number or an I-94 number <p>Other</p> <ul style="list-style-type: none"> ■ Alien registration number or an I-94 number ■ Description of the type or name of the document <p>You can also list these documents or statuses:</p> <ul style="list-style-type: none"> ■ Document indicating a member of a federally recognized Indian tribe or American Indian born in Canada This is considered an eligible immigration status for Medicaid, but not for a Qualified Health Plan [QHP] ■ Office of Refugee Resettlement (ORR) eligibility letter (if under 18) ■ Document indicating withholding of removal ■ Administrative order staying removal issued by the Department of Homeland Security (DHS) ■ Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR) ■ Cuban/Haitian entrant ■ Resident of American Samoa
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