



# Application for Health Coverage & Help Paying Costs

THINGS TO



## Use this application to see what coverage choices you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost insurance from **Medical Assistance**.  
**You may qualify for a free or low-cost program even if you earn as much as \$94,000 a year (for a family of 4).**



## Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- If you're single, you may be able to use a short form. Visit [HealthCare.gov](http://HealthCare.gov).
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Attachment C.



## Apply faster online

Apply faster online at [gateway.ga.gov](http://gateway.ga.gov).



## What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from 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

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.**



## What happens next?

Send your complete, signed application to the address on page 8. **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. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, visit [gateway.ga.gov](http://gateway.ga.gov) or call **1-877-423-4746**. Filling out this application doesn't mean you have to buy health coverage.



## Get help with this application

- **Online:** [gateway.ga.gov](http://gateway.ga.gov)
- **Phone:** Call our Help Center at **1-877-423-4746**.
- **In person:** There may be counselors in your area who can help. Visit our website or call **1-877-423-4746** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-877-423-4746**.

**NEED HELP WITH YOUR APPLICATION?** Visit [gateway.ga.gov](http://gateway.ga.gov) or call us at **1-877-423-4746**. Para obtener una copia de este formulario en Español, llame **1-877-423-4746**. If you need help in a language other than English, call **1-877-423-4746** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-255-0135**.  
Form 94a (Rev. 9/17)

## 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Email address: _____			
17. What is your preferred spoken or written language (if not English)?			

## STEP 2 Tell us about your family.

### Who do you need to include on this application?

Tell us about all the family members who live with you. 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 you take care of and 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 incomes. This information helps us make sure everyone gets the best coverage they can.

**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 check if you're eligible for health coverage.



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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? <b>SELF</b>
3. Date of birth (mm/dd/yyyy)	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	

5. Social Security number (SSN) \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**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 since 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](https://www.socialsecurity.gov). TTY users should call 1-800-255-0135.

### 6. 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? \_\_\_\_\_

7. Are you pregnant?  Yes  No If yes, what is the expected due date \_\_/\_\_/\_\_; and how many babies are expected? \_\_\_\_\_

### 8. 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.

9. Do you 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

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

11. **If you aren't a U.S. citizen or U.S. national**, do you have eligible immigration status?

Yes. Fill in your document type and ID number below.

a. Immigration 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 of the U.S. military?  Yes  No

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

13. 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

14. Are you a full-time student?  Yes  No

15. Were you in foster care at age 18 or older?  Yes  No

### 16. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)

Mexican  Mexican American  Chicano/a  Puerto Rican  Cuban  Other \_\_\_\_\_

### 17. 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 \_\_\_\_



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## STEP 2: PERSON 1 (Continue with yourself)

### Current Job & Income Information

**Employed**

If you're currently employed, tell us about your income. Start with question 18.

**Not employed**

Skip to question 28.

**Self-employed**

Skip to question 27.

#### CURRENT JOB 1:

18. Employer name and address	19. Employer phone number (    )    -
20. Wages/tips (before taxes) <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly \$ _____	
21. Average hours worked each WEEK	

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

22. Employer name and address	23. Employer phone number (    )    -
24. Wages/tips (before taxes) <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly \$ _____	
25. Average hours worked each WEEK	

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

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

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

28. **OTHER INCOME:** Check all that apply, and give the amount and how often you get it.

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

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> None                                    | <input type="checkbox"/> Unemployment    \$    How often?     | <input type="checkbox"/> Net farming/fishing    \$    How often? |
| <input type="checkbox"/> Pensions    \$    How often?            | <input type="checkbox"/> Social Security    \$    How often?  | <input type="checkbox"/> Net rental/royalty    \$    How often?  |
| <input type="checkbox"/> Retirement accounts    \$    How often? | <input type="checkbox"/> Alimony received    \$    How often? | <input type="checkbox"/> Other income    \$    How often?        |
|  |   | Type: _____  |

29. **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 27b).

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



30. **YEARLY INCOME:** Complete only if your income changes from month to month. If you don't expect changes to your monthly income, skip to the next person. ➔

Your total income <b>this year</b> \$ _____	Your total income <b>next year</b> (if you think it will be different) \$ _____
--	--

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

## STEP 2: PERSON 2

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?
3. Date of birth (mm/dd/yyyy)	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
5. Social Security number (SSN) _____ - _____ - _____ <b>We need this if you want health coverage and have an SSN.</b>		
6. Does PERSON 2 live at the same address as you? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If no</b> , list address: _____		
7. <b>Does PERSON 2 plan to file a federal income tax return NEXT YEAR?</b> (You can still apply for health insurance even if you don't file a federal income tax return.) <input type="checkbox"/> <b>YES. If yes</b> , please answer questions a–c. <input type="checkbox"/> <b>NO. If no</b> , skip to question c. a. Will PERSON 2 file jointly with a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes</b> , name of spouse: _____ b. Will PERSON 2 claim any dependents on his or her tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes</b> , list name(s) of dependents: _____ c. Will PERSON 2 be claimed as a dependent on someone's tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes</b> , please list the name of the tax filer: _____ How is PERSON 2 related to the tax filer? _____		
8. Is PERSON 2 pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the expected due date ___/___/___ ; and how many babies are expected? _____		
9. <b>Does PERSON 2 need health coverage?</b> (Even if they have insurance, there might be a program with better coverage or lower costs.) <input type="checkbox"/> <b>YES. If yes</b> , answer all the questions below.  <input type="checkbox"/> <b>NO. If no</b> , SKIP to the income questions on page 5.  Leave the rest of this page blank.		
10. 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
11. Is PERSON 2 a U.S. citizen or U.S. national? <input type="checkbox"/> Yes <input type="checkbox"/> No		
12. <b>If PERSON 2 isn't a U.S. citizen or U.S. national</b> , do they have eligible immigration status? <input type="checkbox"/> Yes. Fill in their document type and ID number below. a. Document type _____ b. Document ID number _____ c. Has PERSON 2 lived in the U.S. since 1996? <input type="checkbox"/> Yes <input type="checkbox"/> No d. Is PERSON 2, or their spouse or parent a veteran or an active-duty member in the U.S. military? <input type="checkbox"/> Yes <input type="checkbox"/> No		
13. Does PERSON 2 want help paying for medical bills from the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	14. 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	15. Was PERSON 2 in foster care at age 18 or older? <input type="checkbox"/> Yes <input type="checkbox"/> No

### Please answer the following questions if PERSON 2 is under the age of 19.

16. Did PERSON 2 have health insurance and lose it within the past 2 months?  Yes  No  
a. **If yes**, end date: \_\_\_\_\_ b. Reason the insurance ended: \_\_\_\_\_

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

### 18. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)

Mexican  Mexican American  Chicano/a  Puerto Rican  Cuban  Other \_\_\_\_\_

### 19. 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 & Income Information

**Employed**

If you're currently employed, tell us about your income. Start with question 20.

**Not employed**

Skip to question 30.

**Self-employed**

Skip to question 29.

#### CURRENT JOB 1:

20. Employer name and address

21. Employer phone number

( ) -

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

\$ \_\_\_\_\_

23. Average hours worked each WEEK

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

24. Employer name and address

25. Employer phone number

( ) -

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

\$ \_\_\_\_\_

27. Average hours worked each WEEK

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

#### 29. If self-employed, answer the following questions:

a. Type of work

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

\$ \_\_\_\_\_

30. **OTHER INCOME:** Check all that apply, and give the amount and how often you get it.

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

None

Unemployment \$ \_\_\_\_\_ How often? \_\_\_\_\_

Net farming/fishing \$ \_\_\_\_\_ How often? \_\_\_\_\_

Pensions \$ \_\_\_\_\_ How often? \_\_\_\_\_

Net rental/royalty \$ \_\_\_\_\_ How often? \_\_\_\_\_

Social Security \$ \_\_\_\_\_ How often? \_\_\_\_\_

Other income \$ \_\_\_\_\_ How often? \_\_\_\_\_

Retirement accounts \$ \_\_\_\_\_ How often? \_\_\_\_\_

Type: \_\_\_\_\_

Alimony received \$ \_\_\_\_\_ How often? \_\_\_\_\_

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often you pay 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:** You shouldn't include a cost that you already considered in your answer to net self-employment (question 29b).

Alimony paid \$ \_\_\_\_\_ How often? \_\_\_\_\_

Other deductions \$ \_\_\_\_\_ How often? \_\_\_\_\_

Student loan interest \$ \_\_\_\_\_ How often? \_\_\_\_\_

Type: \_\_\_\_\_

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

If you don't expect changes to PERSON 2's monthly income, add another person or skip to the next section.

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.**

**If you have more than two people to include, make a copy of Step 2: Person 2 (pages 4 and 5) and complete.**



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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?

- If **No**, skip to Step 4.  
 **Yes. If yes**, go to Attachment B.

## STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

### 1. Is anyone enrolled in health coverage now from the following?

- YES. If yes**, check the type of coverage and write the person(s)' name(s) next to the coverage they have.  **NO.**
- |  |   |
|--|---|
| <input type="checkbox"/> Medical Assistance _____                                      | <input type="checkbox"/> Employer insurance _____                                       |
| <input type="checkbox"/> Medicare _____  | <input type="checkbox"/> Name of health insurance: _____                                |
| <input type="checkbox"/> TRICARE (Don't check if you have direct care or Line of Duty) | Policy number: _____  |
| <input type="checkbox"/> VA Health Care Programs _____                                 | Is this COBRA coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No        |
| <input type="checkbox"/> Peace Corps _____   | Is this a retiree health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|  | <input type="checkbox"/> Other  |
|  | Name of health insurance: _____   |
|  | Policy number: _____  |
|  | Is this a limited-benefit plan (like a school accident policy)?                         |
|  | <input type="checkbox"/> Yes <input type="checkbox"/> 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 Attachment A.  
 **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 [Insert Time (hours or 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.

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**Form 94a (Rev. 9/17)**

## STEP 5 Read & 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 and or untrue information.
- I know that I must report any changes within 10 calendar days of the date of which the change occurs. I can visit [gateway.ga.gov](http://gateway.ga.gov) or call **1-877-423-4746** to report any changes. I understand that a change in my information could affect the 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 calling the Georgia Department of Community Health, Office of Inspector General (OIG), Program Integrity Section at 404-463-7590 or toll free at 1-800-533-0686.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, \_\_\_\_\_ is incarcerated.  
(name of person)

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, Department of Labor (DOL), TALX (work number), the Department of Homeland Security and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

### 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 the Health Insurance Agencies, DFCS and the FFM to use income data, including information from tax returns. The Health Insurance Agencies, DFCS and the FFM 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.

### If anyone on this application is eligible for Medical Assistance

- I am giving to the Medical Assistance agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medical Assistance agency 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 Medicaid and I may not have to cooperate.

### My right to appeal

If I think the Health Insurance Agencies, DFCS and the FFM has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Agencies, DFCS or the FFM 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 the Division of Family & Children Services (DFCS) at **1-877-423-4746**. 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 Attachment C.

Signature	Date (mm/dd/yyyy)
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## **STEP 6** Mail completed application.

Mail your signed application to the address below:

**Division of Family and Children Services**  
**Customer Contact Center**  
**P.O. Box 4190**  
**Albany, GA 31706**

If you want to register to vote, you can complete a voter registration form at [www.sos.ga.gov](http://www.sos.ga.gov).



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