

## Health Coverage Additional Information Form

Person who has been receiving Supplemental Security Income (SSI) benefits:

First name: \_\_\_\_\_ Last name: \_\_\_\_\_

Case ID: \_\_\_\_\_

This form asks for information about the person who has been receiving SSI benefits and members of their household. Include information for **all** these household members, even if they are not applying for Health First Colorado:

- The person who has been receiving SSI benefits.
- That person's spouse, even if they are not living with the person who has been receiving SSI benefits.
- All family members living with the person who has been receiving SSI benefits.
- Any family members who were living in the household and passed away this year.
- Anyone on the same federal tax return as the person who has been receiving SSI benefits.
- Anyone 18 or younger who lives with the person who has been receiving SSI benefits.
- You **DO NOT** have to include other unrelated roommates age 19 or older.

If you need more space to answer any questions, please attach a separate piece of paper.

### 1. Tell us about your household

<b>Name of person who has been receiving SSI benefits</b>	<b>Date of birth</b>
<b>Mailing address</b>	
<b>Street</b>	<b>Apartment #</b>

<b>City</b>	<b>State</b>	<b>ZIP</b>
<b>Phone number</b>		

**Other household members**

Tell us about everyone in your household.

You **must** give your Social Security number (SSN) if you are applying for health coverage.

- Providing your SSN and the SSN for everyone in your household will help us process your application faster. We use SSNs to check income and other information to see what type of health coverage you may qualify for.
- Sharing an SSN is optional for anyone who is not applying for health coverage.

<b>Name</b>	<b>Applying for health coverage?</b>	<b>Relationship to the person who has been receiving SSI benefits (parent, child, etc.)</b>	<b>Date of birth</b>	<b>SSN or date of application for SSN</b>	<b>U.S. citizen or U.S. national</b>
	<input type="checkbox"/> Yes <input type="checkbox"/> No	self	same as above		<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				<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				<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No

If a household member wants to apply for health coverage and is **not** a U.S. citizen or national, complete the table under 'Citizenship status' below.

**Is anyone in the household a full-time student?**  Yes  No

Name(s): \_\_\_\_\_

**Is anyone in the household pregnant?**  Yes  No

**If yes:** Pregnant person's name: \_\_\_\_\_

Number of babies expected: \_\_\_\_\_ Estimated due date: \_\_\_\_\_

## 2. Tax filing status

Complete this section for **all** household members. Start with the person who has been receiving SSI benefits.

**Does the person who has been receiving SSI benefits plan to file a federal income tax return next year?**

**Yes. If yes,** answer questions a-c.

**No. If no,** answer question c.

Will they file jointly with a spouse? .....  Y  N

**If yes,** write name of spouse: \_\_\_\_\_

Will they claim any dependents on their tax return?.....  Y  N

**If yes,** write name of dependents: \_\_\_\_\_

**Will they be claimed as a dependent on someone's tax return? .....  Y  N**

**If yes,** write the name of the tax filer: \_\_\_\_\_

How is the person who has been receiving SSI benefits related to the tax filer: \_\_\_\_\_

**Person 2.** Name: \_\_\_\_\_

**Do they plan to file a federal income tax return next year?**

**Yes. If yes,** answer questions a-c.

**No. If no,** answer question c.

Will they file jointly with a spouse? .....  Y  N

**If yes,** write name of spouse: \_\_\_\_\_

Will they claim any dependents on their tax return.....  Y  N

**If yes,** write name of dependents: \_\_\_\_\_

Will they be claimed as a dependent on someone's tax return? .....  Y  N

**If yes,**

Write the name of the tax filer: \_\_\_\_\_

Tell us how they are related to the tax filer: \_\_\_\_\_

**Person 3.** Name: \_\_\_\_\_

**Do they plan to file a federal income tax return next year?**

**Yes. If yes,** answer questions a-c.

**No. If no,** answer question c.

Will they file jointly with a spouse? .....  Y  N

**If yes,** write name of spouse: \_\_\_\_\_

Will they claim any dependents on their tax return.....  Y  N

**If yes,** write name of dependents: \_\_\_\_\_

Will they be claimed as a dependent on someone's tax return? .....  Y  N

**If yes,**

Write the name of the tax filer: \_\_\_\_\_

Tell us how they are related to the tax filer: \_\_\_\_\_

## Domestic violence

If you are a victim of domestic violence, you do **not** need to provide the perpetrator's information for the rest of the form. **Do** include information for anyone else in the household.

I am **not** providing the perpetrator's information below because of domestic violence.

Additional Information:

- Community-based domestic violence advocacy programs and other information is also available at [cdhs.colorado.gov/dvp](https://cdhs.colorado.gov/dvp).
- The Address Confidentiality Program (ACP) helps people experiencing domestic violence. Find out more at [acp.colorado.gov](https://acp.colorado.gov).

## Citizenship status

Complete the table below for anyone in the household who wants to apply for health coverage **and** is **not** a U.S. citizen or U.S. national. If the household member does **not** want health coverage, you do not have to list them.

**1. Name of household member** \_\_\_\_\_

In the U.S. since 1996?  Yes  No

This household member does **not** have a legal immigration status or is undocumented.

Non-citizen status	Alien or I-94 number	Card or passport number	Document expiration date	Country of issuance

**2. Name of household member** \_\_\_\_\_

In the U.S. since 1996?  Yes  No

This household member does **not** have a legal immigration status or is

undocumented.

Non-citizen status	Alien or I-94 number	Card or passport number	Document expiration date	Country of issuance

**3. Name of household member** \_\_\_\_\_

In the U.S. since 1996?  Yes  No

This household member does **not** have a legal immigration status or is undocumented.

Non-citizen status	Alien or I-94 number	Card or passport number	Document expiration date	Country of issuance

***Veteran or active-duty military***

Is the person who has been receiving SSI benefits, or their spouse or parent, an honorably discharged veteran or an active-duty member of the U.S. military?

Yes  N

**4.** Tell us about any **income** for everyone in your household, even if they are not applying for health coverage. Provide proof for each type of income household members have. Send copies. Do not send originals.

Or check  **No Income**

Examples of **types of income** include:

- Employment income (job)
- Railroad retirement
- Rental income
- Survivor benefit
- Retirement or pension
- Social Security benefit
- Self-employment
- Supplemental Security Income
- Social Security Disability Insurance
- Veterans benefit
- Veteran widow benefit
- Child support
- Dividends or interest
- Alimony (Note: Only include for divorces finalized before January 1, 2019)
- Unemployment
- Worker’s compensation
- Disability benefit
- Financial aid
- Other cash received each month

<b>Name of person receiving income</b>	<b>Type of income</b>	<b>How often do they get this income?</b>	<b>Amount before taxes and deductions (gross amount)</b>	<b>If income is from a job, check all that apply</b>
		<input type="checkbox"/> Daily <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	\$	<input type="checkbox"/> Seasonal job <input type="checkbox"/> Job with commission or tips <input type="checkbox"/> Neither
		<input type="checkbox"/> Daily <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	\$	<input type="checkbox"/> Seasonal job <input type="checkbox"/> Job with commission or tips <input type="checkbox"/> Neither



		<input type="checkbox"/> Daily <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	\$	<input type="checkbox"/> Seasonal job <input type="checkbox"/> Job with commission or tips <input type="checkbox"/> Neither
		<input type="checkbox"/> Daily <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	\$	<input type="checkbox"/> Seasonal job <input type="checkbox"/> Job with commission or tips <input type="checkbox"/> Neither
		<input type="checkbox"/> Daily <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	\$	<input type="checkbox"/> Seasonal job <input type="checkbox"/> Job with commission or tips <input type="checkbox"/> Neither

### 5. Other health insurance coverage

Is the person who has been receiving SSI benefits, or anyone in the household, enrolled in health coverage other than Health First Colorado or Child Health Plan *Plus* (CHP+)?

Yes  No

If **yes**, list each person's name and what health coverage they have:

Name	Health coverage

### 6. Help with activities of daily living

Answer these questions **only** for the person who has been receiving SSI benefits.

- Do you have a medical, physical, mental, or developmental condition that has lasted, or is expected to last, more than 12 months, including blindness?  Yes  No

- Do you have a medical, physical, mental, or developmental condition that causes you to regularly need help with some or all self-care activities (such as bathing, dressing, eating, using the bathroom)?  Yes  No
- Do you need to move to a nursing home, acute care, hospital, group home, mental health institution or long-term care facility within the next 30 days, or need in-home health care to be able to stay in your home?  Yes  No

**7.** Tell us about **resources** anyone in your household owns, even if they are not applying for health coverage. Provide proof for each type of resource household members have. Send copies. Do not send originals.

Or check  **No resources**

Examples of **resources** include:

- Cash
- Checking and savings accounts
- Certificates of Deposits (CDs)
- Annuities
- Mutual funds
- Inheritance
- PASS accounts
- Individual development accounts
- Retirement accounts
- Stocks
- Bonds
- Trusts
- Promissory notes
- College funds
- Education accounts
- Property (land, homes)
- Proceeds from sale of home(s)
- ABLE accounts

Owner's name	Jointly owned? (Owned with someone else)	Type of resource	Account number	Amount	Name of financial institution
	Yes <input type="checkbox"/> No			\$	
	Yes <input type="checkbox"/> No			\$	
	Yes <input type="checkbox"/> No			\$	
	Yes <input type="checkbox"/> No			\$	

**8.** Tell us about **property** anyone in your household owns or is buying, even if they are not applying for health coverage. Provide proof for each type of resource household members have. Send copies. Do not send originals.

Or check  **No property**

Examples of **property** include:

- House
- Timeshare
- Empty lot
- Rental property
- Warehouse
- Land

Owner's name	Jointly owned? (Owned with someone else)	Full address of property	Type of property	Value	Amount owed
	Yes <input type="checkbox"/> No			\$	\$
	Yes <input type="checkbox"/> No			\$	\$
	Yes <input type="checkbox"/> No			\$	\$

**9.** Tell us about **vehicles** anyone in your household owns or is buying, even if they are not applying for health coverage. Provide proof for each type of resource household members have. Send copies. Do not send originals.

Or check  **No vehicles**

Examples of **vehicles** include:

- Car
- Van
- Trailer
- Truck
- ATV
- RV
- SUV
- Boat

Owner's name	Jointly owned? (Owned with someone else)	Type of vehicle	Year	Make and model	Value	Amount owed
	Yes <input type="checkbox"/> No				\$	\$
	Yes <input type="checkbox"/> No				\$	\$
	Yes <input type="checkbox"/> No				\$	\$

**10.** Tell us about **life insurance policies** anyone in your household owns, even if they are not applying for health coverage. Provide proof for each type of resource household members have. Send copies. Do not send originals.

Or check  **No life insurance policies**

Owner's name	Policy number	People covered	Insurance company	Face value	Cash value
				\$	\$
				\$	\$
				\$	\$

				\$	\$
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**11.** Tell us about **burial policies** anyone in your household owns, even if they are not applying for health coverage. Provide proof for each type of resource household members have. Send copies. Do not send originals.

Or check  **No burial policies**

Owner's name	Amount	Is it irrevocable (can't be canceled)?	Name of institution or person holding the money
	\$	Yes <input type="checkbox"/> No	
	\$	Yes <input type="checkbox"/> No	
	\$	Yes <input type="checkbox"/> No	

**12.** Tell us if anyone in your household has **given away** anything of value within the last 5 years, even if they are not applying for health coverage.

Or check  **Nothing of value has been given away within the last 5 years.**

Examples include:

- Home
- Cash
- Vehicles
- Land

Person who gave item away	Item given away	Date given away	Value of item	Amount owed
			\$	\$
			\$	\$

			\$	\$
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**List of proof to send**

Provide proof for each type of income and resource household members have. **Send copies.** Do not send originals.

***Proof of income for this month's or last month's***

- Income from a job: A pay stub or letter from the employer.
- Income from self-employment: A profit and loss statement, business ledger, contract, or bank statement.
- Unearned income from unemployment, Social Security, alimony (Note: Only include for divorces finalized before January 1, 2019), or spousal support: An award letter or copy of your pension or retirement account statement that shows the monthly amount.

***Proof of resources for this month's or last month's***

- Bank accounts: A bank statement for all accounts.
- Trust accounts: The trust document and the account statement.
- Annuity: The whole contract and a statement that shows the monthly income it provides.
- Life insurance/burial policy: The policy that shows the type of policy and the cash value, if it has one.
- Real estate property: The deed or title for any properties you own that are not primary residence (where you live most of the time).
- Vehicle registration.

Signature and Certification:

By signing this form I am giving my permission to the State of Colorado and its designees to make contacts to verify the information given within this form. Under penalty of perjury I certify all information I have given is true and correct.

Print name: \_\_\_\_\_

Phone number: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Authorized representative, conservator, guardian or other contact if

you have one:

Print name: \_\_\_\_\_

Phone number: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_