

TN

Application for Health Coverage & Help Paying Costs

➔ Apply faster online at www.tennconnect.tn.gov



Use this Application to see what coverage you qualify for

- Free or low-cost insurance from TennCare or CoverKids.
- Help with paying for Medicare costs.



Who can use this Application?

- Use this Application to apply for anyone in your family.
- Other people in your household who want to apply for TennCare or CoverKids.
- 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.
- **This application can't be used for Katie Beckett coverage.** You must apply online for Katie Beckett. Go to tenncareconnect.tn.gov. Log into your account or create an account to apply.



Things you may need to complete this Application

- 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, bank statements or wage and tax statements). Policy numbers for any health insurance you have now (other than TennCare or CoverKids).
- Information about any job-related health insurance available to your family.



Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.** To view the Privacy Act Statement, go to <https://www.tn.gov/web-policies/privacy-statement.html>.



What happens next?

Send your complete, **signed** Application to:
TennCare Connect
P.O. Box 305240
Nashville, TN 37230-5240

You may also **fax** your Application to TennCare Connect at **1-855-315-0669**.

What if you don't have all the information we ask for when it's time to send us your Application? Sign and send us your Application anyway. After we get your Application, we'll look to see what facts we still need from you. Then we'll send you a letter that asks you to send us the facts we still need. That letter will include a cover page that you'll send back with your facts. The cover page helps us easily link the facts you send to your Application.

After we get your Application and facts, we'll review your information. We'll send you a letter that tells you our decision. If you have questions, call us for free at **1-855-259-0701**.



Do you want to know other ways you can apply?

Online: www.tennconnect.tn.gov

Phone: Call TennCare Connect to apply or get help at **1-855-259-0701**.
En español: Llame a nuestro centro de ayuda gratis al **1-855-259-0701**.

In person: You can apply in person at your local Department of Human Services (DHS) office. To find your local office, go to: www.tn.gov/humanservices and click "Office Locations" at the bottom of the page.



Need help with your Application? Call us at **1-855-259-0701**. Do you need help in a language other than English? When you call, tell us the language you need. We'll get you help at no cost to you. Do you have a hearing or speech problem and use a TTY? Call 1-800-848-0298, then dial 1-855-259-0701.

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Help with completing this Application

Do you need help with your Application? You can call TennCare Connect at **1-855-259-0701**.

What if you need help in person with your Application? You can get help from TennCare Connect by calling **1-855-259-0701**.

Your local Department of Human Services (DHS) office can help you. To find your local office, go to: <https://www.tn.gov/humanservices> and click "Office Locations" at the bottom of the page or call **1-866-311-4287**. If you are calling from Nashville, call **1-615-313-4700**.

If you're getting care at a local community mental health center, they can also help you. Their offices are listed at: www.tamho.org/#services.

Do you have an intellectual and/or other developmental disability and need help with your Application?

You can get help from the Department of Developmental and Intellectual Disabilities in the area where you live.

West TN: **1-866-372-5709**

Middle TN: **1-800-654-4839**

East TN: **1-888-531-9876**

Do you want to apply for Home and Community Based Services (HCBS) or nursing home care and need help with your Application?

You can get help from the Area Agency on Aging and Disability. Call: **1-866-836-6678**.

Is someone helping you fill out this application? If yes, tell us who. Name: _____

Do you have an Assisting Person who can talk to us about your Application on your behalf? This person can be the same or different than the person you named above. An Assisting Person is a trusted person who, with your consent (your OK), can act on behalf of you and all members in your household.

Your Assisting Person can be an individual or an organization. Information shared by and with your Assisting Person may be shared with others. Not everyone has to follow the same privacy rules.

Your Assisting Person will continue to have these rights until you tell us you want to change. If you ever need to change your Assisting Person, or end their rights as your representative, call TennCare Connect at **1-855-259-0701**. This will not change facts we have already shared with your Assisting Person, but we won't share any more facts.

If you or someone in this Application already has a legally Assisting Person (a guardian, custodian or power of attorney), send us proof with the Application. It's helpful to send it even if you've already given us this proof before.

Tell us about your Assisting Person by filling out their information below.

1. Name of Assisting Person (First name, Middle name, Last name, Suffix)		
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number		

Please tell us the responsibilities and permission granted to this Assisting Person:

- Sign an Application for all members in my household
- Complete and submit a Renewal Packet for the members in my household
- Receive all notices, insurance cards, and other communications about the application, appointments, renewals or eligibility for all members of my household
- Act as the Authorized Representative for all members in my household. This means this person can help with all eligibility issues including:
- Signing applications, complete and submitting Renewal Packets, and receiving notices as listed above;
 - Going to interviews, hearings or appeals;
 - The appeal process, including legal proceedings.

How long do you want your Assisting Person to help you? 3 Months 5 Months 1 Year Ongoing

If you ever need to change your Assisting Person, or end their rights as your representative, call TennCare Connect at **1-855-259-0701**.

If your Assisting Person is part of an organization helping you apply, such as a hospital, a doctor, or a nursing home, the employee representative must complete the information and sign below. They must also agree that:

As an employee, staff member or volunteer with the named organization or provider below, they affirm that they will adhere to 42 CFR 431 (f), 42 CFR 155.260(f) and 45 CFR 447.10, as well as other relevant State and Federal laws concerning conflicts of interest and confidentiality of information. The organization or provider shall notify the Agency of any change in name or contact information for the representative with in ten (10) days of the change.

1. Organization name (if applicable)	2. ID number (if applicable)
3. Signature of authorized representative (if applicable)	4. Date (if applicable)



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Please print in capital letters using black or dark blue ink only. Check the boxes () like this .

Before you get started:

Use this Application to apply for TennCare, CoverKids, or a Medicare Savings Program, like QMB/SLMB.

STEP 1: Person 1 Tell us about yourself

You'll be **Person 1** starting on the next page. Person 1 is the Head of Household.

1. First name		Middle name		Last name		Suffix (Jr., Sr., III)	
2. Home address (Leave blank if you don't have one)						3. Apartment or suite number	
4. City			5. State <input type="text"/>	6. ZIP code <input type="text"/>	7. County		
8. Mailing address (if different from home address)						9. Apartment or suite number	
10. City			11. State <input type="text"/>	12. ZIP code <input type="text"/>	13. County		
14. Phone number Type: <input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Work (<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> Ext: <input type="text"/>				15. Other phone number Type: <input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Work (<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> Ext: <input type="text"/>			
16. What's your preferred spoken language?				What's your preferred written language?			

STEP 2: Tell us about your family.

We'll use your facts to see if you qualify for health care coverage with us. We'll check first to see if you qualify for TennCare. If your income is too high but you're under the age of 19 or pregnant and meet other rules, we'll see if you qualify for CoverKids. The kind of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure you can get coverage with us.

Do Include:

- Yourself
- Your spouse
- Your children (or stepchildren) under 21 who live with you
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 19 who you take care of and lives with you

Children Under 21 also include:

- Parent (or stepparent) who live with you
- Sibling (or stepsibling) who live with you
- Your children (or stepchildren) under 21 who live with you
- Anyone you include on your tax return, even if they don't live with you

You DON'T have to include:

- 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

Complete Step 2 for each person in your family.

Start with yourself, then add other people who live with you. If you have more than 2 people in your family, you'll need to make a copy of the pages and attach them. Or, you can print them from our website at www.tn.gov/tenncare.

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.



Need help with your Application? Call us at **1-855-259-0701**. Do you need help in a language other than English? When you call, tell us the language you need. We'll get you help at no cost to you. Do you have a hearing or speech problem and use a TTY? Call 1-800-848-0298, then dial 1-855-259-0701.

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STEP 2: PERSON 1**Start with yourself. Remember, Person 1 is the Head of Household**

Complete Step 2 for yourself and other family members who live with you. This includes anyone on your same federal tax return (if you file one). 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. Date of birth (mm/dd/yyyy) _____ 3. Sex Male Female 4. Relationship to Person 1
SELF

5. **Social Security Number (SSN)** ____ - ____ - ____ If not, what date did you apply for one? _____

 **We need a Social Security number (SSN) if you want health coverage and have an SSN or can get one.** We use SSNs to check income and other information to see who's eligible for help paying for health coverage. If you need help getting an SSN, visit socialsecurity.gov, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. Or call TennCare Connect for free at 1-855-259-0710.

6. Are you applying for health coverage with us? Yes No If no, please answer questions 13, 22, 38-49, and 52-54.

7. **If Hispanic/Latino, ethnicity (Optional – Check all that apply.)**

Mexican Mexican American Chicano/a Puerto Rican Cuban Other _____

8. **Race (Optional – Check all that apply.)**

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

9. Have you ever been known by any other name? **If yes:**

First name _____ Middle initial _____ Last name _____ Suffix _____

10. If you are approved for TennCare Medicaid or CoverKids, there are three health plans to choose from. We'll try to enroll you in the health plan you choose. If you don't pick now, we can pick one for you. Usually, family members are enrolled in the same health plan. Please choose the same health plan for each person on this application.

I want my health plan to be: AMERIGROUP BlueCare UnitedHealth Care Community Plan

11. Are you a Tennessee resident? Yes No

12. Are you temporarily living out of state? Yes No

If Yes, do you plan to return to Tennessee? Yes No Date you plan to return to Tennessee: _____ (mm/dd/yyyy)

13. If you are younger than 22 years old, what is your school enrollment status? Skip this question if you are age 22 or older.

None Less than 6 hours a week 6 or 7 hours a week 8 to 11 hours a week 12 or more hours a week (full time)

14. Are you a **U.S. citizen** or **U.S. national**? Yes No If yes, skip 15-16

15. Are you a naturalized or derived citizen? Yes No If yes, provide a. and b.

a. Alien Number: _____ b. Certificate Number: _____

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

a. What is your immigration status? _____

What date did you gain that status? _____

Fill in your document type and ID number below. Document Type:

Alien Number I-94 Number Card Number Passport Number
 SEVIS ID Certificate of Citizenship Number Naturalization Certificate Number Visa Number

ID Number: _____ Expiration date: _____ (mm/dd/yyyy)

b. Did you have a different immigration status before? Yes No

c. Have you lived in the U.S. since 1996? Yes No

17. Are you or your spouse or parent, a veteran or an active-duty member of the U.S. military? Yes No

18. If you are an American Indian or Alaska Native answer 19-21. If not, skip 19-21.

19. Are you a member of a federally recognized tribe? Yes No **If yes**, what is the name of the tribe? _____

20. Have you ever gotten a service from the Indian Health Service, a tribal health program or urban Indian health program, or through referral of one of these? Yes No

21. Are you eligible to get services from the Indian Health Service, a tribal health program or urban Indian health program, or through referral of one of these? Yes No



Need help with your Application? Call us at **1-855-259-0701**. Do you need help in a language other than English? When you call, tell us the language you need. We'll get you help at no cost to you. Do you have a hearing or speech problem and use a TTY? Call 1-800-848-0298, then dial 1-855-259-0701.

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STEP 2: PERSON 1

Continue with yourself

22. Will you file a federal income tax return the next time taxes are due? You can still apply for coverage even if you don't file a federal income tax return.

Yes. If yes, please answer questions a–d. No. If no, skip to question d.

a. Will you file jointly with a spouse? Yes No

If yes, write name of spouse: _____

b. Will you claim any dependents on your tax return? Yes No

If yes, list name(s) of dependents: _____

c. Do any of your dependents live outside of your household? Yes No

If yes, list the names of dependent(s): _____

d. 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? _____

23. Are you a primary caregiver to a child under age 19? Yes No

If yes, to who? _____ What is your relationship to them? _____

24. Are you pregnant or were pregnant in the last 5 months? Yes No

If yes, how many babies are/were you expecting from this pregnancy? _____

Are you still pregnant? Yes No

If yes, what is your due date? _____ (mm/dd/yyyy)

If no, when did you have the baby? _____ (mm/dd/yyyy)

Do you have any other pregnancies in the last 5 months that you want to report? Yes No

If yes, how many babies are/were you expecting from this pregnancy? _____

When is/was your pregnancy due date or end date? _____

25. Are you enrolled in, or entitled to enroll in, Medicare Part A or B? Yes No

26. Have you experienced an emergency health problem and need help paying for those emergency services? Yes No

27. Are you younger than 26 and were in foster care at age 18 or older and lived in Tennessee at that time? Yes No

28. Are you under age 65 and getting treatment now or do you need treatment for breast or cervical cancer? Yes No

29. Are you in a medical facility (like a hospital) and have been there for at least 30 days? OR, are you a medical facility (like a hospital) and will be there for at least 30 days? Yes No

If yes, when did you go into the medical facility? _____ (mm/dd/yyyy)

Please tell us the name of the medical facility you are in: _____

Please tell us your doctor's name and phone number: _____

30. Do you live in a nursing home? Yes No

If yes, what is the name of the facility? _____

31. Do you need hospice care? Yes No

32. Are you over age 65 or are you an adult with physical disabilities and do you want to receive Home and Community Based Services (HCBS)?

Yes No

What if you think you need care at home to keep from going into a nursing facility? Call your Area Agency on Aging and Disability at 1-866-836-6678. You still need to finish this application but they can help you.

33. Do you have intellectual or development disabilities and want care at an intermediate care facility for individuals with Intellectual Disabilities (ICF/IID)?

Yes No

34. Do you have intellectual and/or other developmental disabilities and want to receive Home and Community Based Services (HCBS) and participate in Employment and Community First CHOICES? Yes No

What if you think you need care at home to keep from going into a nursing facility? Then you must also complete an online referral at: <https://tpaes.tennare.tn.gov/tmtrack/ecf/index.htm>

Remember, you can't use this paper application to apply for Katie Beckett. You must apply online at www.tennareconnect.tn.gov

35. Do you have Medicare and want to get or keep help paying Medicare cost sharing like QMB or SLMB? Yes No

36. Did you receive Supplemental Security Income, or SSI benefits, in the past but don't now? Yes No

If yes, when did it end? _____

37. Do you have expenses for things to help you work because you are blind or disabled? Yes No



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STEP 2: PERSON 1**Current Job & Income Information****Current job & income information**

Employed: If you are currently employed, tell us about your income. Start with question 38.

Not employed: Skip to question 48.

Self-employed: Skip to question 49.

Current job 1:

38. Employer name

a. Employer address

b. City

c. State

d. ZIP code

39. Employer phone number

40. Wages/tips per pay period (before taxes)

\$

41. How often do you get paid?

- Hourly Daily Weekly
 Every 2 weeks Twice a month Monthly
 Yearly Quarterly Irregularly
 Semi-annually One Time only

42. Average hours worked each pay period (answer only if you checked the box for Hourly in question 41)

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

43. Employer name

a. Employer address

b. City

c. State

d. ZIP code

44. Employer phone number

45. Wages/tips per pay period (before taxes)

\$

46. How often do you get paid?

- Hourly Daily Weekly
 Every 2 weeks Twice a month Monthly
 Yearly Quarterly Irregularly
 Semi-annually One Time only

47. Average hours worked each pay period (answer only if you checked the box for Hourly in question 46)

48. **Other income you get this month:** Check all that apply and give the amount and how often you get it.

- | | | | | |
|---|----------|--|--|------------------|
| <input type="checkbox"/> None | | <input type="checkbox"/> Census Worker | \$ _____ | How often? _____ |
| <input type="checkbox"/> Unemployment | \$ _____ | How often? _____ | <input type="checkbox"/> Alimony received | \$ _____ |
| | | | Alimony Order Date | _____ |
| <input type="checkbox"/> Pensions | \$ _____ | How often? _____ | <input type="checkbox"/> Net farming/fishing | \$ _____ |
| <input type="checkbox"/> Net rental/royalty | \$ _____ | How often? _____ | <input type="checkbox"/> Retirement Accounts | \$ _____ |
| <input type="checkbox"/> Tribal Income | \$ _____ | How often? _____ | <input type="checkbox"/> Veteran Benefits | \$ _____ |
| <input type="checkbox"/> Social Security | \$ _____ | How often? _____ | Type | _____ |
| | | | <input type="checkbox"/> Lottery income | \$ _____ |
| | | | How often? _____ | |
| | | | <input type="checkbox"/> Other income | \$ _____ |
| | | | Type | _____ |
| | | | How often? _____ | |

If you checked the Social Security box, you must answer question 50 below.

49. If you are self-employed answer questions a-c.

a. What do you do? _____

b. What type of self-employment do you have? _____

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



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STEP 2: PERSON 1

Continue to tell us about yourself.

(Answer question 50 only if you checked the Social Security box in question 48 above.)

50. Does someone other than a parent (if you are under 18) or spouse help pay for your food OR housing each month? (Housing includes expenses such as rent, mortgage, property insurance, gas, electric, heating fuel, water, sewer, garbage collection service or property taxes.)

 Yes No **If yes** answer questions a-g.a. Does the person who helps you pay for this live with you? Yes No

b. What do they help you pay for? _____

c. How much is this expense or bill? \$ _____

d. How much do you pay? \$ _____

e. How much do they pay? \$ _____

f. Number of people in the home? _____

g. Does everyone living with you get any kind of public assistance? (Public assistance includes Families First, SSI, Disaster Relief and Emergency Assistance, VA Pension, VA Aid and Attendance, the Refugee Act of 1980. It also includes help you may get from state or local governments to pay for things like housing, utility bills, or phones.)

 Yes No51. Do you have medical or dental bills for care you've received or paid in the last 3 months? Yes No

a. How much is this expense or bill? \$ _____

b. What was the date of service? \$ _____

c. Who do you send payments to? \$ _____

d. Are you younger than 22 years old, do you work full time? Yes No52. Do you have shelter or utility expenses, dependent care expenses, or child support expenses? Yes No53. Do you have before tax deductions? Yes No **If yes**, check all that apply. Give the amount you pay each month. If no, skip to question 54. Medical Insurance \$ _____ Per Month Deferred Compensation \$ _____ Per Month Dental Insurance \$ _____ Per Month Pre-Tax life insurance premiums \$ _____ Per Month Vision Care Insurance \$ _____ Per Month Other Deduction Type _____ Flexible Spending Account (Health and dependent plans) \$ _____ Per Month54. Do you have expenses that can be deducted on an income tax return? Yes No **If yes**, check all at apply. Give the amount that you pay each month. If no, skip this question. Alimony Paid Alimony Order Date \$ _____ Per Month Health Savings Account Deduction \$ _____ Per Month Student Loan Interest Paid \$ _____ Per Month Military Moving Expense \$ _____ Total Tuition and Fees \$ _____ Per Month Other Deduction Type \$ _____ Per Month Educator Expenses \$ _____ Per Month Business Expenses \$ _____ Per Month Deductible part of self-employment \$ _____ Per Month**Thanks! This is all we need to know about you****Need help with your Application?** Call us at 1-855-259-0701. Do you need help in a language other than English? When you call, tell us the language you need. We'll get you help at no cost to you. Do you have a hearing or speech problem and use a TTY? Call 1-800-848-0298, then dial 1-855-259-0701.


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STEP 2: PERSON 2**Tell us about another family member.**

Complete Step 2 for other family members who live with you. This includes anyone on your same federal tax return (if you file one). 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. Date of birth (mm/dd/yyyy)		3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	4. Relationship to Person 1

5. **Social Security Number (SSN)** ____ - ____ - ____ If not, what date did Person 2 apply for one? _____

 We need a Social Security number (SSN) if Person 2 wants health coverage and has an SSN or can get one. We use SSNs to check income and other information to see who's eligible for help paying for health coverage. If Person 2 needs help getting an SSN, visit socialsecurity.gov, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. Or call TennCare Connect for free at 1-855-259-0710.

6. Is PERSON 2 applying for health coverage with us? Yes No If no, please answer questions 13, 22, 38-49, and 52-54.

7. **If Hispanic/Latino, ethnicity (Optional – Check all that apply.)**

Mexican Mexican American Chicano/a Puerto Rican Cuban Other _____

8. **Race (OPTIONAL – Check all that apply.)**

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

9. Has PERSON 2 ever been known by any other name? **If yes:**

First name	Middle initial	Last name	Suffix
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10. If you are approved for TennCare Medicaid or CoverKids, there are three health plans to choose from. We'll try to enroll you in the health plan you choose. If you don't pick now, we can pick one for you. Usually, family members are enrolled in the same health plan. Please choose the same health plan for each person on this application.

I want my health plan to be: AMERIGROUP BlueCare UnitedHealth Care Community Plan

11. Is PERSON 2 a Tennessee resident? Yes No

12. Is PERSON 2 temporarily living out of state?

If **Yes**, does PERSON 2 plan to return to Tennessee? Yes No Date PERSON 2 plans to return to Tennessee: _____ (mm/dd/yyyy)

13. If PERSON 2 is younger than 22 years old, what is their school enrollment status? Skip this question if PERSON 2 is age 22 or older.

Less than 6 hours a week 6 or 7 hours a week 8 to 11 hours a week 12 or more hours a week (full time)

14. Is PERSON 2 a **U.S. citizen** or **U.S. national**? Yes No If yes, skip 15-16.

15. Is PERSON 2 a naturalized or derived citizen? Yes No If yes, provide answers to a. and b.

a. Alien Number: _____ b. Certificate Number: _____

16. **If PERSON 2 isn't a U.S. citizen or U.S. national**, do they have eligible immigration status? **YES**.

a. What is their immigration status? _____

What date did they gain that status? _____

Fill in Person 2's document type and ID number below. Document Type:

Alien Number I-94 Number Card Number Passport Number
 SEVIS ID Certificate of Citizenship Number Naturalization Certificate Number Visa Number

ID Number: _____ Expiration date: _____ (mm/dd/yyyy)

b. Did they have a different immigration status before? Yes No

c. Have they lived in the U.S. since 1996? Yes No

17. Is PERSON 2, or PERSON 2's spouse or parent, a veteran or an active-duty member of the U.S. military? Yes No

18. If PERSON 2 is American Indian or Alaska Native answer 19-21. If not, skip 19-21.

19. Is PERSON 2 a member of a federally recognized tribe? Yes No **If Yes** what is the name of the tribe? _____

20. Has PERSON 2 ever gotten a service from the Indian Health Service, a tribal health program or urban Indian health program, or through referral of one of these? Yes No

21. Is PERSON 2 eligible to get services from the Indian Health Service, a tribal health program or urban Indian health program, or through referral of one of these? Yes No



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STEP 2: PERSON 2

Continue with PERSON 2.

22. Will PERSON 2 file a federal income tax return the next time taxes are due? Person 2 can still apply for coverage even if he/she doesn't file a federal income tax return.

YES. If yes, please answer questions a–d. NO. If no, skip to question d.

a. Will PERSON 2 file jointly with a spouse? Yes No

If yes, write name of spouse: _____

b. Will PERSON 2 claim any dependents on your tax return? Yes No

If yes, list name(s) of dependents: _____

c. Do any of these dependents live outside of Person 2's household? Yes No

If yes, list the names of dependent(s): _____

d. Will PERSON 2 be claimed as a dependent on someone's tax return? Yes No

If yes, please list the name of the tax filer: _____ How is Person 2 related to the tax filer? _____

23. Is PERSON 2 a primary caregiver to a child under age 19? Yes No

If yes, to who? _____ What is their relationship to PERSON 2? _____

24. Is PERSON 2 pregnant or were they pregnant in the last 5 months? Yes No

If yes, how many babies are/were they expecting from this pregnancy? _____

Are they still pregnant? Yes No

If yes, what is their due date? _____ (mm/dd/yyyy)

If no, when did they have the baby? _____ (mm/dd/yyyy)

Do they have any other pregnancies in the last 5 months that they want to report? Yes No

If yes, how many babies are/were they expecting from this pregnancy? _____

When is/was their pregnancy due date or end date? _____

25. Is PERSON 2 enrolled in, or entitled to enroll in Medicare Part A or B? Yes No

26. Has PERSON 2 experienced an emergency health problem and needs help paying for those emergency services? Yes No

27. Is PERSON 2 younger than 26 and was in foster care at age 18 or older and lived in Tennessee at that time? Yes No

28. Is PERSON 2 under age 65 and getting treatment now or do they need treatment for breast or cervical cancer? Yes No

29. Is Person 2 in a medical facility like a hospital and have been there for at least 30 days? OR, are they in a medical facility like a hospital and will be there for at least 30 days? Yes No

If yes, When did they go into the medical facility? _____ (mm/dd/yyyy)

Please tell us the name of the medical facility they are in: _____

Please tell us their doctor's name and phone number: _____

30. Does Person 2 live in a nursing home? Yes No

If yes, what is the name of the facility? _____

31. Does Person 2 need hospice care? Yes No

32. Is Person 2 over age 65 or are you an adult with physical disabilities and wants to receive Home and Community Based Services (HCBS)?

Yes No

What if Person 2 thinks they need care at home to keep from going into a nursing facility? Call their Area Agency on Aging and Disability at 1-866-836-6678. Person 2 still needs to finish this application but they can help you.

33. Does Person 2 have intellectual or development disabilities and want care at an intermediate care facility for individuals with Intellectual Disabilities (ICF/IID)? Yes No

34. Does Person 2 have intellectual and/or other developmental disabilities and want to receive Home and Community Based Services (HCBS) and participate in Employment and Community First CHOICES? Yes No

What if Person 2 thinks they need care at home to keep from going into a nursing facility? Then they must also complete an online referral at: <https://tpaes.tennnecare.tn.gov/tmtrack/ecf/index.htm>

Remember, you can't use this paper application to apply for Katie Beckett. You must apply online at www.tennnecareconnect.tn.gov

35. Does Person 2 have Medicare and want to get or keep help paying Medicare cost sharing like QMB or SLMB? Yes No

36. Did Person 2 receive Supplemental Security Income, or SSI benefits, in the past but don't now? Yes No

If yes, when did it end? _____

37. Does Person 2 have expenses for things to help you work because you are blind or disabled? Yes No

Need help with your Application? Call us at 1-855-259-0701. Do you need help in a language other than English? When you call, tell us the language you need. We'll get you help at no cost to you. Do you have a hearing or speech problem and use a TTY? Call 1-800-848-0298, then dial 1-855-259-0701.

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STEP 2: PERSON 2**Current Job & Income Information****Current job & income information**

Employed: If PERSON 2 is currently employed, tell us about their income. Start with question 38.

Not employed: Skip to question 48.

Self-employed: Skip to question 49.

Current job 1:

38. Employer name

a. Employer address

b. City

c. State

d. ZIP code

39. Employer phone number

40. Wages/tips per pay period (before taxes)

\$

41. How often does Person 2 get paid?

- Hourly Daily Weekly
 Every 2 weeks Twice a month Monthly
 Yearly Quarterly Irregularly
 Semi-annually One Time only

42. Average hours worked each pay period. (answer only if you checked the box for Hourly in question 41)

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

43. Employer name

a. Employer address

b. City

c. State

d. ZIP code

44. Employer phone number

45. Wages/tips per pay period (before taxes)

\$

46. How often does Person 2 get paid?

- Hourly Daily Weekly
 Every 2 weeks Twice a month Monthly
 Yearly Quarterly Irregularly
 Semi-annually One Time only

47. Average hours worked each pay period. (answer only if you checked the box for Hourly in question 46)

48. **Other income Person 2 gets this month:** Check all that apply and give the amount and how often PERSON 2 gets it.

- | | | | |
|--|---------------------------|--|---------------------------|
| <input type="checkbox"/> None | | <input type="checkbox"/> Census worker | \$ _____ How often? _____ |
| <input type="checkbox"/> Unemployment | \$ _____ How often? _____ | <input type="checkbox"/> Alimony received | \$ _____ How often? _____ |
| <input type="checkbox"/> Pensions | \$ _____ How often? _____ | <input type="checkbox"/> Alimony Order Date | _____ |
| <input type="checkbox"/> Tribal Income | \$ _____ How often? _____ | <input type="checkbox"/> Net farming/fishing | \$ _____ How often? _____ |
| <input type="checkbox"/> Social Security | \$ _____ How often? _____ | <input type="checkbox"/> Veteran Benefits | \$ _____ How often? _____ |
| | | Type | _____ |
| | | <input type="checkbox"/> Lottery income | \$ _____ How often? _____ |
| | | <input type="checkbox"/> Other income | \$ _____ How often? _____ |
| | | Type | _____ |

If you checked the Social Security box, you must answer question 50 below.

49. If PERSON 2 is self-employed answer questions a-c.

a. What does PERSON 2 do? _____

b. What type of self-employment does PERSON 2 have? _____

c. How much net income (profits once business expenses are paid) will PERSON 2 get from this self-employment this month? \$ _____



STEP 2: PERSON 2

Continue to tell us about PERSON 2

(Answer question 50 only if you checked the Social Security box in question 49 above.)

50. Does someone other than a parent (if Person 2 is under 18) or spouse help pay for Person 2's food OR housing each month? (Housing includes expenses such as rent, mortgage, property insurance, gas, electric, heating fuel, water, sewer, garbage collection service or property taxes.)

 Yes No **If yes** answer questions a-g.a. Does that someone who helps pay for this live with Person 2? Yes No

b. What do they help Person 2 pay for? _____

c. How much is this expense or bill? \$ _____

d. How much does Person 2 pay? \$ _____

e. How much does that someone pay? \$ _____

f. Number of people in the home? _____

g. Does everyone living with Person 2 get any kind of public assistance? (Public assistance includes Families First, SSI, Disaster Relief and Emergency Assistance, VA Pension, VA Aid and Attendance, the Refugee Act of 1980. It also includes help Person 2 may get from state or local governments to pay for things like housing, utility bills, or phones.)

 Yes No51. Does PERSON 2 have medical or dental bills for care they've received or paid in the last 3 months? Yes No

a. How much is this expense or bill? \$ _____

b. What was the date of service? \$ _____

c. Who does Person 2 send payments to? \$ _____

d. Is Person 2 younger than 22 years old, and work full time? Yes No52. Does PERSON 2 have shelter or utility expenses, dependent care expenses, or child support expenses? Yes No53. Does Person 2 have before tax deductions? Yes No **If yes**, check all that apply. Give the amount Person 2 pays each month. If no, skip to question 54. Medical Insurance \$ _____ Per Month Dental Insurance \$ _____ Per Month Vision Care Insurance \$ _____ Per Month Flexible Spending Account (Health and dependent plans) \$ _____ Per Month Deferred Compensation \$ _____ Per Month Pre-Tax life insurance premiums \$ _____ Per Month Other Deduction Type \$ _____ Per Month54. Does PERSON 2 have expenses that can be deducted on an income tax return? Yes No **If yes**, check all at apply. Give the amount that PERSON 2 pays each month. If no, skip this question. Alimony Paid Alimony Order Date \$ _____ Per Month Student Loan Interest Paid \$ _____ Per Month Tuition and Fees \$ _____ Per Month Educator Expenses \$ _____ Per Month Business Expenses \$ _____ Per Month Deductible part of self-employment \$ _____ Per Month Health Savings Account Deduction \$ _____ Per Month Military Moving Expense \$ _____ Total Other Deduction Type \$ _____ Per Month**Thanks! This is all we need to know about PERSON 2!****What if you have more than 2 people living with you that need to apply?
Make a copy of Step 2 Person 2 for each additional person who wants to apply.
Or, print them from our website at www.tn.gov/tenncares.****Need help with your Application?** Call us at 1-855-259-0701. Do you need help in a language other than English? When you call, tell us the language you need. We'll get you help at no cost to you. Do you have a hearing or speech problem and use a TTY? Call 1-800-848-0298, then dial 1-855-259-0701.

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STEP 3**Tell us about your family's health coverage**

1. Is anyone on your Application enrolled in health coverage now? Yes No

If yes, tell us more about that health coverage. Answer a-i.

If no, skip to question 2.

a. Name of Health Insurance Company		b. What type of Health Insurance coverage is this?	
c. Who all is covered on this policy?			
d. Policy Number:	e. Group Number:	f. Date coverage started (mm/dd/yyyy)	
g. Is this a state employee benefit plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			
h. Is this a limited benefit plan (like a school accident policy)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
i. Does this plan cover maternity benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No			

2. Does anyone on your Application have access to other health insurance coverage but is not enrolled? Yes No

If yes, who: _____

STOP and READ: The next set of questions below ask about your family's resources. Do you think you might qualify as a pregnant woman, a child, or a caretaker of a minor child? Then you don't have to answer these questions. But answering these questions now will help us review your application for more eligibility categories where resources count. If you skip these questions, go to Step 4 to finish this application.

1. Does anyone have any financial resources? This includes things like checking accounts, savings accounts, stocks or mutual funds, pension funds, bonds, trust funds, annuities, and qualified tuition savings plans. Yes No

If yes, check all that apply. **If no**, skip to question 6.

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Annuity | <input type="checkbox"/> Keogh Account | <input type="checkbox"/> Cash | <input type="checkbox"/> Pension fund |
| <input type="checkbox"/> Bonds | <input type="checkbox"/> Patient/Resident Trust Account | <input type="checkbox"/> Checking Account | <input type="checkbox"/> Child Support |
| <input type="checkbox"/> Certificate of Deposit | <input type="checkbox"/> Promissory Note | <input type="checkbox"/> Health Reimbursement Account | <input type="checkbox"/> Qualified tuition Savings Plan (529 Plans) |
| <input type="checkbox"/> Dividends | <input type="checkbox"/> Retirement Account | <input type="checkbox"/> Individual Retirement Account | <input type="checkbox"/> Savings Account |
| <input type="checkbox"/> Individual Development Account | <input type="checkbox"/> Stocks, Mutual funds | <input type="checkbox"/> Loan | <input type="checkbox"/> Trust Fund |
| | <input type="checkbox"/> ABLE Account | | <input type="checkbox"/> Other _____ |

Tell us more about the financial resources that your family owns. If you've checked more than one kind of resource above, tell us about the other resource(s) on a separate sheet of paper.

2. Resource Type:	Resource Value: \$
-------------------	--------------------

List everyone who owns this resource:

3. Tell us about the bank or company where you have this financial resource

Name of Bank or Company

a. Address

b. City	c. State	d. ZIP code	4. Bank or Company phone number
---------	----------	-------------	---------------------------------

5. If anyone owns a Trust, tell us about the trust that they own.

a. Trust type:	b. Trustee:	c. Value: \$
----------------	-------------	--------------



Family Resources cont'd

6. Does anyone own any property? Yes No

If yes, check all that apply. **If no**, skip to question 9.

- | | |
|---|--|
| <input type="checkbox"/> Apartment Building | <input type="checkbox"/> Farm |
| <input type="checkbox"/> Duplex | <input type="checkbox"/> Land |
| <input type="checkbox"/> House | <input type="checkbox"/> Mobile Home |
| <input type="checkbox"/> Life Estate | <input type="checkbox"/> Vacation home |
| <input type="checkbox"/> Rental Property | <input type="checkbox"/> Other |
| <input type="checkbox"/> Condo | |

7. Tell us more about the property that your family owns.

- a. List anyone who owns this property: _____
- b. Property Use: _____
- c. Does anyone live here? Yes No **If yes**, tell us who? _____ **If no**, Did they intend to return to this home? Yes No
- d. Does a spouse or child (under age 21 or is blind or permanently disabled) live in this home? Yes No
- e. Does anyone get rent money from this property? Yes No **If yes**, tell us who: _____
- If yes**, what is the monthly income from this property? \$ _____ Per month
- f. How much is owed on this property? \$ _____
- g. What is the value of this property? \$ _____

8. Tell us the address of the property that you own, answer questions a-f.

a. Property address (Leave blank if you don't have one.)			b. Apartment or suite number	
c. City	d. State	e. ZIP code	f. County	

9. Does anyone own a life insurance policy? Yes No **If no**, skip to question 11.

- a. List anyone who owns a life insurance policy: _____
- b. What type of life insurance do you have? Term/Group Whole/Universal
- c. What is the face value of this Life Insurance Policy? \$ _____
- d. What is the cash surrender of this Life Insurance policy? \$ _____
- e. Policy Number: _____

10. Tell us about the insurance company that issued the Life Insurance policy.

Name of Company

a. Address

b. City	c. State	d. ZIP code	e. Company phone number
---------	----------	-------------	-------------------------

11. Does anyone own burial resources (like contracts or lots)? Yes No **If no**, skip to question 12.

If yes, list anyone who owns burial resources: _____

a. Value of Burial Resource: \$	b. How much do you owe on this burial resource? \$
c. Burial resource type:	d. Who is the burial resource designated for?



Family's Resources Cont'd

12. Does anyone own a vehicle? Yes No **If yes**, check all that apply. **If no**, skip to question 16.

- | | |
|--|---|
| <input type="checkbox"/> ATV/Golf Carts | <input type="checkbox"/> Farm Equipment |
| <input type="checkbox"/> Cars/Trucks | <input type="checkbox"/> RV |
| <input type="checkbox"/> Motorcycle | <input type="checkbox"/> Aircraft |
| <input type="checkbox"/> Trailer | <input type="checkbox"/> Other |
| <input type="checkbox"/> Snowmobile | |
| <input type="checkbox"/> Boats/Personal Watercraft | |

13. Tell us more about the vehicle in question 12. If you've checked more than one vehicle above, tell us about other the vehicle(s) on a separate sheet of paper.

a. Who owns this vehicle? _____

b. Year: _____

c. Make: _____

d. Model: _____

e. How much is owed on the vehicle? _____

f. How much is the vehicle worth? \$ _____

14. Does the owner receive income from use of this vehicle? Yes No

15. How does the owner use this vehicle?

- | | | |
|---|--|---|
| <input type="checkbox"/> Household Transportation | <input type="checkbox"/> Self-Employment | <input type="checkbox"/> Homestead |
| <input type="checkbox"/> Income Producing | <input type="checkbox"/> Recreational | <input type="checkbox"/> Tools of the Trade |

16. Does anyone have any other resources? Yes No If yes, list all of them below.

a. Type of resource(s): _____

b. How much is each resource worth? \$ _____

c. How much is owed on each resource? \$ _____

17. Who owns these resources: _____

18. Has anyone sold, traded, or given away resources in the last five years? Yes No **If no**, skip this question.

a. Resource type: _____

b. Who owned this resource: _____

c. Who did you sell, trade, or give away this resource too? _____

d. Why did you sell, trade, or give away this resource? _____

e. What date with you sell, trade, or give away this resource? _____

f. What was the value of the resource? \$ _____

g. How much money was received when the resource was sold, traded, or given away? \$ _____

Thanks! This is all we need to know about what your family owns.

You are not finished with this Application. Read the next pages and then sign this Application!



STEP 4: Read & Sign this Application

- I know that I must tell TennCare if anything changes (and is different than) what I wrote on the Application within 10 days of that change. I can report changes online at www.tennconnect.tn.gov. I can call 1-855-259-0701 to report any changes. I can mail changes to TennCare Connect at P.O. Box 305240, Nashville, TN 37230-5240. I can fax changes to 1-855-315-0669. Someone at a county DHS office can help me report a change.
- 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. If you think you have been treated unfairly, call 1-855-259-0701 to report it. It's a free call.
- I know that if I am approved, I can't keep any health insurance or medical payments I get from insurance or other companies. Those payments belong to the State. I understand that I must sign them over to the State.
- I know that TennCare may use the email address (or mobile phone number) that I provided to send emails or Short Message Service (SMS) messages related to my coverage, depending on my communication preference selections. TennCare and their partners may also use the phone number I provided to call me about my coverage.
- I understand if I'm eligible for other kinds of benefits like disability, unemployment income, or retirement income, I must apply for those programs if I want to keep coverage with TennCare.
- I know that if the Tennessee Bureau of Investigation, TennCare, Office of Inspector General or another agency asks for my help catching health care fraud and abuse, I must help.
- I know that if the State pays for medical bills or for nursing home care for me, the State may get that money back. I know that after my death, the State may be paid back with money from my estate.
- I know no one else can use my health care card. I know if I let someone else use my card I may have to pay the State back for that other person's medical bills. And I could go to jail.
- If I have a Social Security Number (SSN) and I'm applying for coverage, I know I am required to provide a valid SSN. Federal law lets us ask for an SSN. [42 CFR 435.910] State law also lets us ask for your SSN. [Tenn. Code Ann § 71-5-106]
- If anyone on the Application is eligible for health care coverage with TennCare, I am giving TennCare rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving TennCare rights to pursue and get medical support from a spouse or parent.
- I know I'll 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 the agency and I may not have to cooperate.
- Does any child on this Application have a parent living outside of the home? 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 TennCare and I may not have to cooperate.
- If I think TennCare or CoverKids (CHIP) has made a mistake, I can appeal its decision. To appeal means to tell someone that I think the action is wrong, and ask for a fair review of the action. 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. I know that I can find out how to appeal by contacting TennCare Connect at **1-855-259-0701**.
- If I think TennCare is taking more than 45 days (or more than 90 days if I applied for long-term care), I can ask for a "delay hearing". I know I can ask for a delay hearing by contacting TennCare Connect at 1-855-259-0701.

Your Right to Privacy

We know you value the privacy of your personal information. Federal laws states we must follow privacy rules to keep your facts private. You can read all about the rules on our website. For more information about our privacy rules, go to our privacy page. If you want us to mail you a copy, call TennCare Connect for free at 1-855-259-0701.

Non-Discrimination

We do not allow unfair treatment in our program.

No one is treated in a different way because of race, color, birthplace, religion, language, sex, age, or disability. Do you think you've been treated unfairly? Do you have more questions? Do you need more help? You can make a **free call** to **TennCare Connect** at **1-855-259-0701**. Or go to <http://www.tn.gov/tenncare/topic/non-discrimination-compliance> to learn more.

Voter Registration

Are you registered to vote where you live now?

Yes No

TennCare is a voter registration agency. You can choose to apply today to register to vote. Deciding not to register will not change our decision about the kind of help we provide to you.

To register to vote:

- You must be a U.S. Citizen
- You must be a Tennessee Resident
- You must be at least 18 years old on or before the next election **and**
- You must not have been convicted of a felony or if you have, your voting rights have been restored.

If you are not registered to vote where you live now, you can complete a voter registration form at www.tn.gov/sos/election/registration.



Need help with your Application? Call us at **1-855-259-0701**. Do you need help in a language other than English? When you call, tell us the language you need. We'll get you help at no cost to you. Do you have a hearing or speech problem and use a TTY? Call 1-800-848-0298, then dial 1-855-259-0701.

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Or you can choose for us to mail you a voter registration application.

Would you like us to mail you a voter registration application?

- Yes No

If you do not make a choice, we will consider your answer to be "No." If you would want help registering to vote, we will help you.

If you think someone has interfered with your right, you can file complaint. You can mail your complaint to:

Division of Elections

312 Rosa L. Parks Avenue
7th Floor, Snodgrass Tower
Nashville, TN 37243-1102

Or call: 1-877-850-4959
1-(615)741-7956

Individuals with hearing or speech impairments can use Tennessee Relay Center: 1-800-848-0299

STEP 4: Read & Sign this Application

Renewal for Coverage in Future Years

Usually, we must renew your eligibility each year to see if you still qualify. To make it easier to renew your coverage, we can use federal sources, like information from your tax returns. We need your OK to check this information automatically. If you don't give us permission, that's ok. We'll reach out to you when it's time to renew each year. Please choose an option below.

Yes, you have permission to try to renew my eligibility automatically for the next:

- 5 Years (the maximum number of years allowed)
- 4 Years
- 3 Years
- 2 Years
- 1 Year
- Don't use information from tax returns to renew my coverage.

Sign this Application in the space below. The person who filled out Step 1 should **sign below**. If you're an Assisting Person you may sign below, if you have provided the information required on page 2.

<div style="display: flex; align-items: center;"> → <div style="border-bottom: 1px solid black; flex-grow: 1; min-height: 20px;"></div> </div>	<p style="font-size: 0.8em; margin: 0;">Date signed (mm/dd/yyyy)</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <td style="width: 25%; height: 20px;"> </td> <td style="width: 25%; height: 20px;"> </td> <td style="width: 25%; height: 20px;"> </td> <td style="width: 25%; height: 20px;"> </td> </tr> </table>				

STEP 5: Mail completed Application



Mail your signed Application to the address below.

TennCare Connect
P.O. Box 305240
Nashville, TN 37230-5240

You may also fax your Application to **1-855-315-0669**. Remember to send in the proof we need to decide if you can get health care coverage with us.



Need help with your Application? Call us at **1-855-259-0701**. Do you need help in a language other than English? When you call, tell us the language you need. We'll get you help at no cost to you. Do you have a hearing or speech problem and use a TTY? Call 1-800-848-0298, then dial 1-855-259-0701.