Appendix A: List of Questions in the Online Application to Support Eligibility Determinations for Enrollment through the Health Insurance Marketplace and for Medicaid and the Children's Health Insurance Program

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Background

This document represents a full draft of questions and systems logic that CMS is developing for the online application. This document (the "questionnaire") represents each possible item that may need to be asked for successful eligibility determinations. The questionnaire accounts for many different application scenarios: applicants may be applying for insurance affordability programs (e.g. Advanced Payment of the Premium Tax Credit, Medicaid, or CHIP) or just for eligibility to purchase a qualified health plan in the Health Insurance Marketplace.

 The questionnaire contains all potential items that can be displayed on the online application. Items will be displayed depending on applicants' household and income situations, so applicants won't be required to complete this entire list of items. Most applicants will need to complete less than one-third of these items.

The online application is a dynamic process that's tailored based on the application filer's responses to questions and the electronic verification of data available during the application process. You can follow conditional logic through the italicized directions in the questionnaire—these wouldn't appear on the screen.

For the purposes of this posting, we've provided headings for different sections and descriptions of the purpose of each section in "Notes to reviewers." We've also provided an annotated outline at the beginning of the questionnaire.

The questionnaire doesn't include help language, pop ups, or links to explanations, which we acknowledge will be critical to successful completion of the application for many people. We'll be developing that text over the next several weeks.

To view demonstrations of the online application, see Appendix B.

Individual Questionnaire Annotated Outline

I.   **My account**: Individuals must create an account to use the online application to apply for coverage through the Health Insurance Marketplace.

II.   **Privacy**: Users must indicate they understand how their information is going to be used to continue with the online application.

III.   **Getting started**: Gathers contact information for the application.

IV.   **Help paying for coverage**: Asks whether people want assistance paying for coverage.

V.   **Tell us how many people are applying for health insurance**: Creates a list of all people applying for coverage in the household.

VI.   **Family & household**: Determines household composition for APTC, Medicaid, and CHIP.

VII.   **Personal information**: Collects demographic information.

VIII. **Other addresses**: Collects addresses for other individuals on the application.

IX.   **Special circumstances**: Collects information about students, disabilities, and pregnancy, etc.

X.   **Expedited income**: Collects annual income for individuals who appear eligible for advance payments of the premium tax credit.

XI.   **Current/monthly income**: Collects current monthly income.

XII.   **Discrepancies**: Collects information on any discrepancies between what an individual reported and data sources.

XIII. **Health coverage (APTC eligible): access**: Collects information about access to employer health insurance.

XIV.   **Employer health coverage information**: Collects information about access to health insurance. This section also provides a link to the "Employer Coverage Form" for applicants to gather information from their employers so they can answer these items.

XV.   **Other insurance (APTC eligible)**: Collects information about access to other non-employer insurance (e.g., Medicaid, TRICARE, etc.).

XVI.   **American Indian/Alaska Native (APTC eligible)**

XVII. **Tax filer & other information:** Double checks some data points for those who appear otherwise APTC eligible.

XVIII. **Special Enrollment Periods**

XIX.   **Medicaid & CHIP specific questions**: Only displayed if someone appears Medicaid or CHIP eligible.

XX.   **Review & sign**: Printable review and summary of the application, requests required documents be uploaded (if needed), and signatures.

XXI.   **Plan enrollment (for APTC or QHP eligible applicants)**: Displays tobacco questions, compare and select plan(s), etc.

The following items are asked if the person checked that they didn't want financial assistance. These are required in order to enroll in a qualified health plan on the marketplace.

XXII.   **List applicants**: Collects all individuals applying for health insurance.

XXIII. **Tell us how many people are applying for health insurance**

XXIV.   **Personal information:** Collects demographic information.

XXV.   **Other addresses**: Collects addresses of all applicants on the application.

XXVI.   **American Indian/Alaska Native**: Collects information on applicants who are American Indian and Alaska Native.

XXVII. **Special Enrollment Periods**: Collects information to see if applicants qualify for a Special Enrollment Period.

XXVIII. **Review & sign:** Printable review and summary of the application, requests required documents be uploaded (if needed), and signatures.

XXIX. **Plan enrollment**: Displays tobacco questions, compare and select plan(s), etc.

I. My account

Note to reviewers: To access the Health Insurance Marketplace online application, the individual filling out the application must first set up "My account." This account will allow for individuals to access or update their contact information, communication preferences, notices, coverage status, and other information in a secure environment. Part of the account creation and application processes is for the individual to establish their identity via an authentication process. This entails entering some personal information and answering a set of "challenge" questions. We aren't providing the list of challenge questions in order to protect the security and integrity of the system. The individual is then able to initiate the application process from within "My account." It's possible some amount of additional authentication and consent steps may need to be taken during the application process depending on the individual's household makeup.

A. Create an account

(Display for users setting up an account. One account is required per application.)

1. Create account *(Display check box.)*
   a. First name: _____
   b. Middle name: _____ (optional)
   c. Last name: _____
   d. Suffix: *(Display dropdown menu of suffixes.)* (optional)
       i. Jr.
       ii. Sr.
       iii. III
       iv. IV
   e. Street address: _____
   f. Apartment or suite number: _____
   g. City: _____
   h. State: *(Display dropdown menu of states.)*
   i. ZIP code: _____
   j. County: *(Display dropdown selection of potential counties if ZIP code crosses more than one county.)*
   k. No home address? *(Display check box. If selected, prompt to enter a mailing address.)*
   l. Phone number: (___) ___-____ Ext. ___
   m. Email address: _____ (optional)
   n. Social Security number (SSN): ___-___-____ (optional)
   o. Date of birth: MM/DD/YYYY

2. Authentication process (includes challenge questions; *questions TBD.)*

Note to reviewers: Once a user has set up an account, he or she can click on "Apply now" to start the application. The first section they'll see is section II ["Privacy"]. It's followed by section III ["Getting started"]. As part of the Privacy step, an individual also provides agreement and consent for their information to be used and retrieved from data sources. They also agree that they have permission from all other persons they may list on the application for their information to be used and retrieved as part of the application process for verifying the household's information in order to make eligibility determinations. The specific components of the consent language are still under review across the federal agencies, but the essence of the language will address the basic agreement to the retrieval and

use of their household's data for verifying information and making eligibility determinations and will include language that agreement is provided under penalty of perjury and understanding of potential prosecution for false information (similar to when a person signs and submits the application).

II. Privacy

A. Privacy & use of your information
(Display privacy statement & consent language.)

1. I agree to allow my information to be used and retrieved from data sources for this application. I have consent for all people I will list on the application that allows their information to be retrieved and used from data sources for this application. *(Display check box. Provide links to: Learn more about your data and Privacy Act Statement.)*

III. Getting started

A. Contact information
(Pre-populate from section I ["My account"], and allow for editing.)
1. Name:
   a. First name : _____
   b. Middle name: _____
   c. Last name: _____
   d. Suffix: *(Display dropdown menu of suffixes.)*

2. Date of birth: MM/DD/YYYY *(Pre-populate from section I ["My account"], and allow for editing.)*

B. Contact home address
(Pre-populate from section I ["My account"], and allow for editing.)
1. Address:
   a. Street address: _____
   b. Apartment or suite number: _____
   c. City: _____
   d. State: *(Display dropdown menu of states.)*
   e. ZIP code: _____
   f. County: *(Display dropdown selection of potential counties, if ZIP code crosses more than one county.)*

2. No home address *(Display check box. If selected, prompt to enter a mailing address.)*

C. Contact mailing address
1. Is your mailing address the same as your home address?
   a. Yes *(If selected, skip to D ["Contact phone"].)*
   b. No *(If selected, continue to item 2.)*

2. Address:
    a. Street address: _____
    b. Apartment or suite number: _____
    c. City: _____
    d. State: *(Display dropdown menu of states.)*
    e. ZIP code: _____
    f. County: *(Display dropdown selection of potential counties, if ZIP code crosses more than one county.)*

D. Contact phone
(Pre-populate from section I ["My account"], and allow for editing.)
1. Phone number: (___) ___-____ Ext. ___

2. Phone type: (select one.)
    a. Cell
    b. Home
    c. Work

3. Second phone number: (___) ___-____ Ext. ___

4. Phone type: (select one.)
    a. Cell
    b. Home
    c. Work

E. Contact preferences
1. Preferred spoken language:
    a. *(Default to English and display dropdown menu of languages.)*

2. Preferred written language:
    a. *(Default to English and display dropdown menu of languages.)*

3. I can get information about this application by (select all that apply.):
    a. Text message *(Display check box. If selected, display "i.")*
        i. Phone number: ___-___-____ *(Pre-populate from cell phone above if one was entered, and allow for editing.)*
    b. Email *(Display check box. If selected, display "i.")*
        i. Email address: _____ *(Pre-populate from section I ["My account"] if available, and allow for editing.)*
    c. In the mail *(Display check box.)*

4. *(Display item if "a" or "b" was selected in item 3.)*
    We'll contact you by [text, email, or text and email] to let you know there's a message for you to read on "My account." Do you also want to get paper copies in the mail?
    a. Yes
    b. No

F. Authorized representative

Note to reviewers: The definition of an authorized representative and the procedures for identifying an authorized representative for purposes of filing an application are currently being discussed with federal agencies as part of pending policies on authentication and consent. Definitions of authorized representative are proposed in the Medicaid and Exchange sections of the ACA II proposed rule that CMS recently released. Thus, the definition is subject to change when this rule is finalized.

You can give a trusted friend or partner permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative."

1. Do you want to name someone as your authorized representative?
   a. Yes *(If selected, continue to item 2.)*
   b. No *(If selected, skip to section IV ["Help paying for coverage"].)*

2. Contact information:
   a. First name: _____
   b. Middle name: _____
   c. Last name: _____
   d. Suffix *(Display dropdown menu of suffixes.)*
   e. Street address: _____
   f. Apartment or suite number: _____
   g. City: _____
   h. State: *(Display dropdown menu of states.)*
   i. ZIP code: _____
   j. Phone number: (___) ___-____ Ext. ___
   k. Phone type: (select one.)
      i. Cell
      ii. Home
      iii. Work
   l. Email address: _____

3. Is this person part of an organization helping you apply for health insurance?
   a. Yes *(If selected, continue to item 4.)*
   b. No *(If selected, skip to item 5.)*

4. *(Display item if "a" was selected in item 3.)*
   a. Company name: _____
   b. Organization ID: _____

5. To make someone your authorized representative, [Household contact] needs to sign here or provide proof of a legal reason that [Name in item 2] can represent [Name of household contact]. Select an option below.
   a. Signature *(Collect signature of applicant.)*
   b. Submit document for proof

IV. Help paying for coverage

A. Who needs health insurance

1. Who are you applying for health insurance and health benefits for?
   a. [Household contact] only *(Display check box.)*
   b. [Household contact] & other family members *(Display check box.)*
   c. Other family members, not [Household contact] *(Display check box.)*

2. Do you want to find out if [you/your family] can get help paying for health insurance?
   a. Yes (*If selected, skip to section V ["Tell us how many people are applying for health insurance"].)*
   b. No (*If selected, continue to B ["Income screener"], and go the non-financial assistance question sequence.)*

B. Income screener (Get help with costs) (optional)

Note to reviewers: The next two questions are only asked if the person checks that they don't want to apply for financial assistance in the item above. The idea is to capture a couple of items to assess whether it may be worth their time to apply anyway. These items serve the purpose of trying to promote the use of the financial aid application for people who initially may not think they qualify. These questions aren't an actual determination of eligibility.

Even working families can pay less for health insurance right now. You may be eligible for a free or low cost plan, or a new kind of tax credit that lowers your monthly premiums right away. Answer 2 questions to see if you can get a break on costs.

1. How many people are on your federal income tax return this year? (If you didn't file taxes last year, tell us how many people live with you, including yourself.)
   a. ____

2. Based on your best guess, do you expect your total household income be less than [Equivalent to 400% of the federal poverty level in dollars for family size listed plus buffer] this year?
   a. Yes *(If selected, display text below.)*
      We encourage you to apply to see what help you can get paying for health insurance. Based on what you told us, you may be eligible to get health benefits or help paying for health insurance through the Health Insurance Marketplace. To begin the application, select "yes" on the next question.
   b. No *(If selected, display text below.)*
      Based on what you told us, your income may be too high to get help paying for health insurance. You can still get a good deal on insurance from the Health Insurance Marketplace, and you won't pay higher costs for pre-existing conditions.
   c. I don't know *(If selected, display text below.)*
      We encourage you to apply to see what help you can get paying for health insurance. We'll walk you through questions to find out what health benefits or help paying for health insurance you can get through the Health Insurance Marketplace. To begin the application, select "yes" on the next question.

3. Do you want to see what help [you/ you and your family] can get paying for health insurance?
   a. Yes
      We'll ask you questions about your income and personal situation to see how much you qualify for.
   b. No
      You'll answer fewer questions, but you won't get help paying for health coverage. *(If selected, go the non-financial assistance question sequence.)*

V. Tell us how many people are applying for health insurance
(Display section if household contact indicated that other family members want insurance/benefits.)

1. How many people in your family and household want health insurance? Include yourself.
   a. ___

2. Tell us about this person:
   a. First name: _____
   b. Middle name: _____
   c. Last name: _____
   d. Suffix: *(Display dropdown menu of suffixes.)*

3. Date of birth: MM/DD/YYYY
(Repeat items 2-3 for all applicants.)

VI. Family & household
Note to reviewers: The sequencing of items in this section is governed by complex logic in order to ask the fewest number of questions possible to determine both the tax household and Medicaid household of each applicant. In a conventional family living together where a tax filer parent is the household contact, there will be 6-8 questions total, depending on the ages of the children. Note the relevant year for questions about the tax household is the coverage year, so during initial open enrollment, questions would refer to 2014. For example, "Does [Household contact] plan to file a federal income tax return for 2014?" Please also note that during certain times of the year, particularly during annual open enrollment, application filers/applicants will be asked to provide certain application information for both the current year and for the coming coverage year, due to the availability of Special Enrollment Periods.

We start by creating the household composition for the household contact and only cycle through the questions again if someone listed on the applicant list above isn't in the household contact's tax household or Medicaid household. We also try to provide ways for people to continue with the application even if complete information on both Medicaid and tax household members isn't available, such as when a custodial or non-custodial parent applies and can't attest to the income of the other parent. "[FNLNS]" stands for "First name, Last name, Suffix" and indicates that the appropriate person's name would be pre-populated.

A. Tell us about your household
1. *(Display this item first to the household contact. After returning to this item for an additional applicant as necessary, display this item only if applicant is age 18 or older. If under age 18,*

ask whether the applicant is a dependent first [item 7], and return to this item if applicant isn't claimed as a dependent.)

Does [Household contact] plan to file a federal income tax return for [coverage year]?

a. Yes

b. No *(If selected, and applicant whose household is being completed has already selected "b" in item 7, skip to item 18.)*

(Continue to item 2.)

2. Is [Household contact] married?

   a. Yes (*If selected and a married tax filer, continue to item 3. If selected a married non-filer, skip to item 5.*)

   b. No *(If selected and a tax filer, skip to item 6. If selected and not a tax filer, skip to item 7.)*

3. *(Display this item only if a married tax filer.)*
   Does [Household contact] plan to file a joint federal income tax return with his or her spouse for [coverage year]?

   a. Yes *(If selected, continue to item 4.)*

   b. No *(If selected, skip to item 5.)*

4. Who is [Household contact]'s spouse?

   a. *(Display all applicants as options, and don't allow multi-select.)*

   b. Someone else not seeking health insurance *(If selected, display "i" and "ii.")*

      i. Name of spouse:
         First name: _____
         Middle name: _____
         Last name: _____
         Suffix: *(Display dropdown menu of suffixes.)*

      ii. Date of birth: MM/DD/YYYY

(If a tax filer, skip to item 6. If a non-filer, skip to item 22.)

5. *(Display this item if married but either a non-filer or a filer not filing a joint return.)*
   Does [Household contact] live with this spouse?

   a. Yes *(If selected, return to item 4.)*

   b. No *(If selected, continue to item 6.)*

6. *(Display this item for tax filers.)*
   Will [Household contact] [and spouse name (if "a" was selected in item 3)] claim any dependents on [his, her, or their] federal income tax return for [coverage year]?

   a. Yes (*If selected, display "i" and "ii," then skip to item 8.*)

      i. (*Display all household members who haven't already been identified as part of a tax household, and allow multi-select.*)

      ii. Someone else not seeking health insurance *(If selected, display "1" and "2.")*

         1. Name of dependent:
            First name: _____
            Middle name: _____
            Last name: _____

Suffix: *(Display dropdown menu of suffixes.)*
2. Date of birth: MM/DD/YYYY
   b. No *(If selected, continue to item 7.)*

7. *(Display this item if a non-filer or a filer not claiming a dependent, or start with this item if the applicant whose household is being completed is under age 18.)*
   Will [Household contact] be claimed as a dependent on someone else's federal income tax return for [coverage year]?
   a. Yes *(If selected, display "i," then skip to item 9.)*
       i. Who is the tax filer that will claim [Household contact] on their income tax return? If [Household contact] is claimed by a married couple filing a joint tax return, select either spouse below.
          1. *(Display all household members not already in completed tax households.)*
          2. Someone else not seeking health insurance *(If selected, display "a" and "b.")*
             a. Name of tax filer:
                First name: _____
                Middle name: _____
                Last name: _____
                Suffix: *(Display dropdown menu of suffixes.)*
             b. Date of birth: MM/DD/YYYY
   b. No
   • *(If selected and household contact is an applicant tax filer, the household contact's tax household is complete.*
   • *If selected and household contact is a non-filer applicant, skip to non-filer questions starting with item 18 [if under age 21] or item 22 [if age 21 or over].*
   • *If selected and the household contact isn't an applicant, return to item 1, beginning with the oldest applicant and substituting the name of the oldest applicant wherever it says "household contact."*
   • *If selected and the oldest applicant is under the age of 18, return to item 7 (about being claimed as a dependent). If "b" was selected in item 7, return to item 1.)*

8. *(Display this item if there's a tax household with dependents who are applicants for coverage.)*
   How is [Dependent FNLNS] related to [Tax filer FNLNS]? *(Repeat for joint tax filer, if there is one.)*
   (Display relationship dropdown menu.)
   a. Husband/wife
   b. Domestic partner
   c. Parent
   d. Stepparent
   e. Parent's domestic partner
   f. Son/daughter
   g. Stepson/stepdaughter
   h. Child of domestic partner
   i. Brother/sister

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j. Uncle/aunt
    k. Nephew/niece
    l. First cousin
    m. Grandparent
    n. Grandchild
    o. Other *(If selected, display subsequent list of relationships allowed for plan enrollment.)*
        i. Adopted son/daughter
        ii. Foster child
        iii. Son-in-law/daughter-in-law
        iv. Brother-in-law/sister-in-law
        v. Former spouse
        vi. Guardian
        vii. Father-in-law/mother-in-law
        viii. Sponsored dependent
        ix. Trustee
        x. Ward
        xi. Court-appointed guardian
        xii. Collateral dependent
        xiii. Other relative
        xiv. Other unrelated
    (Repeat for all dependents in tax household.)

- *(If the claiming tax filer's data hasn't yet been collected, continue to item 9.*
- *If the claiming tax filer's data has been collected:*
    - *If any applicant dependent's relationship is son/daughter or stepson/stepdaughter of tax filer and younger than age 21, skip to item 15.*
    - *If applicant dependent is a son/daughter or stepson/stepdaughter age 21 or over, dependent household is complete and can return to item 1 for additional applicants.*
    - *If applicant dependent is spouse of the tax filer, dependent's household is complete and can return to item 1 for additional applicants.*
    - *If applicant dependent selects a relationship other than son/daughter or stepson/stepdaughter, and is younger than age 21, skip to item 18 for non-filer questions.*
    - *If applicant dependent selects a relationship other than son/daughter or stepson/stepdaughter, and is age 21 or older, skip to item 23 for non-filer questions.)*

9. *(Display item if household contact is claimed as a dependent.)*
   Is [Claiming tax filer FNLNS] married?
   a. Yes *(If selected, display item "i," then continue to item 10.)*
       i. Who is [Claiming tax filer FNLNS]'s spouse?
           1. *(Display all household members, and don't allow multi-select.)*
           2. Someone else not seeking health insurance *(If selected, display "a" and "b.")*
               a. Name of spouse:
                  First name: _____

Middle name: _____

Last name: _____

Suffix: *(Display dropdown menu of suffixes.)*

  b.   b.   Date of birth: MM/DD/YYYY
  b.   No *(If selected, skip to item 14.)*

10. *Does [Applicant dependent FNLNS] live with [Tax filer] and/or [Spouse]?*
    a.   Yes
    b.   No

(Continue to item 11.)

11. Do [Tax filer] and [Spouse] plan to file a joint federal income tax return for [coverage year]?
    a.   Yes *(If selected, skip to item 13.)*
    b.   No *(If selected, continue to item 12.)*
    c.   I don't know *(Display this option only if tax filer(s) is/are not an applicant(s) and if either the relationship between household contact and tax filer isn't child-parent relationship or if applicant is under age 21 and doesn't live with claiming tax filer. If selected, display "i," then skip to non-filer household questions beginning at item 18.)*
        i.   In order for [Applicant dependent] to get a tax credit to help pay for health insurance, [Tax filer] [or Tax filer spouse] must fill out an application. However, [Household contact] can continue with this application to see if [Applicant] can get covered by [Names of state Medicaid and CHIP programs].

12. *(Display item if tax filer is married and not filing jointly and tax filer is an applicant.)*
    Does [Claiming tax filer FNLNS] live with this spouse?
    a.   Yes *(If selected, continue to item 13.)*
    b.   No *(If selected, skip to item 14.)*

13. *(Display item if household contact is claimed as a dependent and household contact or his/her claiming tax filer(s) are applicants. If none are applicants, return to item 1 beginning with the oldest applicant. Start with item 7 if the applicant is under age 18.)*
    Will [Tax filer (and spouse if "a" was selected in item 10)] claim any other dependents for [coverage year]?
    a.   Yes *(If selected, display "i" and "ii," then continue to item 14.)*
        i.   *(Display all household members not already in completed tax households, and allow multi-select.)*
        ii. Someone else not seeking health insurance *(If selected, display "1" and "2.")*
            1.   Name of dependent:
                First name: _____
                Middle name: _____
                Last name: _____
                Suffix: *(Display dropdown menu of suffixes.)*
            2.   Date of birth: MM/DD/YYYY
    b.   No *(If selected, continue to item 14.)*
    c.   I don't know *(Display this option only if tax filer(s) is/are not an applicant(s) and relationship between household contact and tax filer that was selected wasn't a child-parent relationship. If selected, skip to non-filer HH build beginning at item 18.)*

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14. *(Display item if household contact claims dependents and any dependent is an applicant.)*
How are these dependents related to [Claiming tax filer FNLNS]?
(Display relationship dropdown menu for each applicant dependent.)
- (*If relationship is son/daughter or stepson/stepdaughter of tax filer and less than age 21, continue to item 15.*
- *If applicant dependent is a son/daughter or stepson/stepdaughter over age 21, dependent household is complete. Return to item 1 for additional applicants.*
- *If applicant dependent selects a relationship other than son/daughter or stepson/stepdaughter, and is younger than age 21, skip to item 18 for non-filer questions.*
- *If applicant dependent selects a relationship other than son/daughter or stepson/stepdaughter, and is age 21 or older, skip to item 23 for non-filer questions.)*

15. *(Display item if applicant dependent has child-parent relationship with tax filer.)*
Does [Applicant dependent FNLNS] live with [Tax filer FNLNS] [or spouse FNLNS]?
    a. Yes
- *(If selected and tax filer <u>isn't</u> married, continue to item 16.*
- *If selected and tax filer <u>is</u> married, repeat questions for other applicant dependents in the household that have a child-parent relationship with tax filer, or return to item 1 for other applicants whose households haven't yet been identified.)*
    b. No *(If selected, continue to item 16.)*

16. Does [Dependent FNLNS] live with a parent or stepparent other than [Tax filer(s)]?
    a. Yes *(If selected, display item "i.")*
        i. Who is the parent or stepparent?
            1. *(Display all household members older than applicant dependent as options.)*
            2. Someone else not seeking health insurance *(If selected, display "a" and "b.")*
                a. First name: _____
                   Middle name: _____
                   Last name: _____
                   Suffix: (Display dropdown menu of suffixes.)
                b. Date of birth: MM/DD/YYYY
- *(If selected and household contact is a non-custodial parent tax filer, and custodial parent isn't seeking health insurance on the application, continue to item 17.*
- *If selected and applicant dependent lives with tax filer and another parent that doesn't claim him/her as a dependent, skip to item 20 for non-filer questions.)*
    b. No *(If selected, household for this applicant dependent is complete and repeat items 15 and 16 for other applicant dependents in the household that have a child-parent relationship with tax filer as needed or return to item 1 for other applicants whose households haven't yet been identified.)*

17. *(Display item if household contact is a non-custodial parent tax filer of an applicant child.)*

[Dependent FNLNS] may be eligible for Medicaid or the Children's Health Insurance Program (CHIP) through the parent they live with. That parent can file their own application. To do so, he or she can create their own account on this website, call 1-800-XXX-XXXX, or print a paper application at www.healthcare.gov/paperapp to mail in. You can also continue with this application now to see if [Tax filer(s) name(s)] can get a tax credit to pay for health insurance for [Dependent FNLNS] instead.

18. *(Display item if applicant is less than 21 years old <u>and</u> a non-filer not claimed as a dependent <u>or</u> if applicant is less than 21 years old <u>and</u> relationship between applicant and tax filer was selected as non child-parent.)*
    Does [Applicant FNLNS] live with their parent or stepparent?
    a. Yes *(If selected, continue to item 19.)*
    b. No *(If selected, skip to item 20.)*

19. *(Display item if applicant selects "a" in item 18.)*
    Who is [Applicant dependent FNLNS]'s parent or stepparent(s)?
    a. *(Display all household members older than applicant as options, and allow multi-select.)*
    b. Someone else not seeking health insurance *(If selected, display "i" and "ii.")*
         i. Name of parent or stepparent:
            First name: _____
            Middle name: _____
            Last name: _____
             Suffix: *(Display dropdown menu of suffixes.)*
        ii. Date of birth: MM/DD/YYYY
(Continue to item 20.)

20. *(Display item if non-filer household is being built.)*
    Does [Applicant FNLNS] live with brothers or sisters?
    a. Yes *(If selected, continue to item 21.)*
    b. No *(If selected, skip to item 22.)*

21. *(Display item if "a" was selected in item 20.)*
    Who is the brother or sister living with [Applicant dependent FNLNS]?
    a. *(Display all household members as options unless relationship to applicant is known, and allow multi-select.)*
    b. Someone else not seeking health insurance *(If selected, display "i" and "ii.")*
         i. Name of brother or sister:
            First name: _____
            Middle name: _____
            Last name: _____
            Suffix: *(Display dropdown menu of suffixes.)*
        ii. Date of birth: MM/DD/YYYY
(Continue to item 22.)

22. *(Display item if applicant is older than age 12 if non-filer household is being built.)*
    Does [Applicant FNLNS] live with their son, daughter, stepson, or stepdaughter?
    a. Yes *(If selected, display "i" and "ii," then proceed to next applicant.)*

i. *(Display all appropriate household members as options.)*
ii. Someone else not seeking health insurance *(If selected, display "1" and "2.")*
   1. Name of son, daughter, stepson, or stepdaughter:
      First name: _____
      Middle name: _____
      Last name: _____
      Suffix: *(Display dropdown menu of suffixes.)*
   2. Date of birth: MM/DD/YYYY
b. No *(If selected, household composition is complete.)*

23. *(Display item if applicant is older than age 15 and item 2 wasn't already displayed.)*
    Is [Selected name FNLNS] married?
    a. Yes *(If selected, continue to item 24.)*
    b. No *(If selected, proceed to next applicant.)*

24. *(Display item if "a" was selected in item 23.)*
    Does [Selected name FNLNS] live with a spouse?
    a. Yes *(If selected, display "i" and "ii," then continue to item 25 if other applicants' households haven't been built.)*
       i. *(Display all appropriate household members as options, and don't allow multi-select.)*
       ii. Someone else not seeking health insurance *(If selected, display "1" and "2.")*
          1. Name of spouse:
             First name: _____
             Middle name: _____
             Last name: _____
             Suffix: *(Display dropdown menu of suffixes.)*
          2. Date of birth: MM/DD/YYYY
    b. No (*If selected, household composition is complete.)*

25. *(Display item if applicant list includes a person that isn't listed as a tax filer or claimed as a tax dependent by anyone yet.)*
    How is [Next applicant FNLNS] related to [Household contact]?
    [Dependent FNLNS] is the *(Display relationship dropdown menu)* of [Claiming tax filer FNLNS].
    (Continue to item 26.)

26. *(Display item if item 25 was displayed.)*
    Does [Next applicant FNLNS] live with [Household contact]?
    a. Yes
    b. No
    (Repeat as necessary until all relationships are determined.)

27. *(Display item if applicant is over age 20 and isn't in the tax household nor Medicaid household of anyone in the household contact's tax or Medicaid household, and applicant isn't related to applicant members of the household contact's household in such a way that*

would allow the applicants to purchase a health insurance plan together based on state rules.)

[Applicant FNLNS] needs to file his or her own application in order to get help paying for health coverage. To do so, he or she can create their own account on this website, call 1-800-XXX-XXXX, or print a paper application at www.healthcare.gov/paperapp to mail in.

28. *(Display item if application is being completed during an open enrollment period beginning in October 2014 or later, when any applicant is part of a tax household, repeating as necessary for each tax household on the application.)*

    Does [Tax filer(s)] plan to change who they claim as a dependent on the tax return to be filed for [2nd possible coverage year]?

    a. Yes, [Tax filer(s)] plan to change who [Tax filer(s)] claim as a dependent on [his, her, or their] tax return *(If selected, display "i.")*

        i. Who will [Tax filer(s)] claim on [his, her, or their] tax return for [coverage year]?

            1. *(Display all household members as options, and allow multi-select.)*
            2. Someone else not seeking health insurance *(If selected, display "a" and "b.")*

                a. Name of dependent:
                   First name: _____
                   Middle name: _____
                   Last name: _____
                   Suffix: *(Display dropdown menu of suffixes.)*
                b. Date of birth: MM/DD/YYYY

    b. No, no plan to change

VII. Personal information

Note to reviewers: This section is for additional household members.
(Repeat for each household member, with the household member's name displayed at the top.)

A. [FNLNS] personal information

1. Sex:
   a. Male *(Display check box.)*
   b. Female *(Display check box.)*

2. *(Display item if a household member is listed on the applicant list.)*
   If [FNLNS] is applying for health insurance, you must provide a Social Security number (SSN) if available. If [FNLNS] doesn't have a SSN we can help [him/her] apply for one. Visit www.placeholder.gov. We only use SSNs to check income and other information to see if [FNLNS] can get help paying for health insurance. A SSN can also help with enrolling in a health plan if [FNLNS] is eligible for one.

   (Display item if a household member isn't listed on the applicant list.)
   Because [FNLNS] isn't applying for health insurance, you may provide a Social Security number (SSN) for [Name] if [he/she] has one. It's optional. We'll use this SSN to check [Name]'s income. This can speed up the decision about whether household members get help paying for insurance.

a. Social Security number: ___-___-____

3. *(Display item for everyone who enters a SSN.)*
Is [FNLNS] the same name that appears on [his/her] Social Security card?
   a. Yes *(If selected, skip to B ["Citizenship/immigration status"].)*
   b. No *(If selected, continue item 4.)*

4. *(Display item if "a" was selected in item 3.)*
Enter the same name as shown on [FNLNS]'s Social Security card:
   a. First name: _____
   b. Middle name: _____
   c. Last name: _____
   d. Suffix: *(Display dropdown menu of suffixes.)*

(At this point, non-applicants are done with this screen, unless an SSN has been entered and not verified by SSA, prompting retries of name, date of birth, and SSN as necessary. All applicants continue to B ["Citizenship/immigration status"].)

B. Citizenship/immigration status

1. Is [FNLNS] a U.S. citizen or U.S. national?
   a. Yes *(If selected and citizenship is verified with SSA, skip to C ["Parent/caretaker relatives"]. If selected and citizenship isn't verified with SSA, continue to item 2.)*
   b. No *(If selected, skip to item 4.)*

2. *(Display item if SSA doesn't verify U.S. citizenship or U.S. national status.)*
Is [FNLNS] a naturalized citizen?
   a. Yes *(If selected, continue to item 3.)*
   b. No *(If selected, inconsistency is found; skip to C ["Parent/caretaker relatives"], if applicable.)*

3. *(Display item if "a" was selected in item 2.)*
Document type: (select one.)
   a. Naturalization certificate *(If selected, display "i" and "ii.")*
      i. Alien number: _____ *(Display check box for "I don't have one.")*
      ii. Naturalization number: _____
   b. Certificate of citizenship *(If selected, display "i" and "ii.")*
      i. Alien number: _____ *(Display check box for "I don't have one.")*
      ii. Citizenship certificate number: _____

4. Check if [FNLNS] has eligible immigration status: *(Link to explanation of eligible immigration statuses.)*
   a. *(Display checkbox. If check box is selected, continue to item 5. If check box isn't selected, show message explaining that this person might be eligible for services if he/she has an*

emergency or is pregnant, and encourage applicant to review list of eligible statuses available through help text and select an option, if applicable.)

5. Document type: (select one.) *(If "a-m" is selected, display values shown in "5 i-vii" below. Link to explanation and images of document and status types.)*
   a. Reentry Permit (I-327)
   b. Permanent Resident Card ("Green Card," I-551)*
   c. Refugee Travel Document (I-571)
   d. Employment Authorization Card (I-766)*
   e. Machine Readable Immigrant Visa (with temporary I-551 language)*
   f. Temporary I-551 Stamp (on passport or I-94, I-94A)*
   g. Arrival/Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services*
   h. Arrival/Departure Record (I-94, I-94A) issued by U.S. Customs and Border Protection*
   i. Arrival/Departure Record in unexpired foreign passport (I-94)*
   j. Unexpired foreign passport
   k. Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)
   l. Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)
   m. Notice of Action (I-797)*
   n. Other documents or status types *(Link to "Other documents and status types.") (If selected, continue to item 6.)*

   (*For these document types, allow one selection from item "5 a-m" and one selection from item "6.a-i." Otherwise, display items "5 a-n." If "n" is selected, disable other selections in item 5 and enable list of "other document and status types" below in "6 a-i.")

   (Display appropriate option based on document type selected. The user will be prompted to provide one or more of the following based on the document type selection.)
       i. Alien number: _____
       ii. I-94 number: _____
       iii. Passport or document number: _____
       iv. Foreign passport country of issuance: *(Display dropdown list of countries.)*
       v. Passport expiration date: MM/DD/YYYY
       vi. SEVIS ID number: _____
       vii. Document description: _____

6. *(Display item if "n" was selected in item 5; show list of other document and statuses, as follows. For some status types that are unverifiable, the system may ask for the user to upload documents. For some document types, a user can select both a document type and status.)*
   a. Document indicating American Indian born in Canada (LPR – I-551)
   b. Document indicating member of a federally-recognized Indian tribe *(If selected, ask for documents at document upload.)*
   c. Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR)
   d. Office of Refugee Resettlement (ORR) eligibility letter (if under 18)
   e. Cuban/Haitian Entrant

f.   Document indicating withholding of removal

g.   Resident of American Samoa *(If selected, ask for documents at document upload.)*

h.   Resident of Commonwealth of the Northern Mariana Islands *(If selected, ask for documents at document upload.)*

i.   Other *(If selected, display these fields: Free text, Alien number, and I-94 number.)*

7.   *(Display item for everyone who selects a verifiable immigration document type.)*
Is [FNLNS] the same name that appears on [his/her] document?
a.   Yes *(If selected, skip to item 9.)*
b.   No *(If selected, continue to item 8.)*

8.   *(Display item if "b" was selected in item 7.)*
Enter the same name as shown on [FNLNS]'s document:
a.   First name: _____
b.   Middle name: _____
c.   Last name: _____
d.   Suffix: *(Display dropdown menu of suffixes.)*

9.   *(Display item for everyone who checked "eligible immigration status" and has a birth date prior to August 22, 1996.)*
Has [FNLNS] lived in the U.S. since 1996?
a.   Yes
b.   No

10. *(Display item if applicant checked "eligible immigration status" and the Department of Homeland Security indicates that the five-year bar applies.)*
Is [Person name– if over age 16; person name's spouse's name– if there is one; person name's parent name– if person is under age 19] an honorably discharged veteran or active duty member of the military?
a.   Yes
b.   No

(After clicking "Save & continue" on section VII ["Personal information"], retries of the SSN and DHS numbers may occur if any information was unable to be verified.)

C. Parent/caretaker relatives

Note to reviewers: The age of dependent children may be substituted as 18 instead of 19 in the logic of questions 1-5 for states that take up the option of counting full-time students as age 18.

(If the applicant is under age 19, skip to D ["Ethnicity & race"]. If the applicant has indicated that he/she lives with a child under 19 and claims him/her as a tax dependent, or the applicant has indicated that he/she is the parent of a child he/she lives with under age 19 and no one else claims that child as a tax dependent, then:

- *If the child's relationship to the applicant hasn't already been provided and the state has taken up an option to limit the allowable relationships of a caretaker relative to a dependent child, skip to item 4.*

- *If relationship is known or not needed, skip to D ["Ethnicity & race"].*

1. Does [FNLNS] live with at least one child under age [19] and is [he/she] the main person taking care of that child?
   a. Yes *(If selected, if there are any children under 19 listed on the application continue to item 2, and if not, skip to item 3.)*
   b. No *(If selected, skip to D ["Ethnicity & race"].)*

2. Who does [FNLNS] live with and take care of?
   a. *(Display check boxes with names of all applicants and non-applicants under age 19 on the application.)*
   b. Another child *(Display check box, and allow multi-select. If selected, continue to item 3.)*

3. *(Display item if "b" was selected in item 2, or "a" was selected in item 1 and item 2 was skipped.)*
   What's the name and date of birth of one child that [FNLNS] lives with and takes care of?
   a. First name: _____
   b. Middle name: _____
   c. Last name: _____
   d. Suffix: *(Display dropdown menu of suffixes.)*
   e. Date of birth: MM/DD/YYYY
   f. Add another child *(Display as a button. If selected, repeat item 3.)*

4. *(For each child for whom the applicant assumes primary responsibility [indicated in answer to item 1 or item 2 or via backend logic derived from section VI ["Family & household"] and who is under age 19, and the child's relationship to this applicant hasn't already been provided, and the state has taken up an option to limit the allowable relationships of a caretaker relative to a dependent child, ask this question. Repeat as needed for multiple such children.)*
   [Applicant name] is the *(Display relationship dropdown menu)* of [child name].
   a. Parent
   b. Stepparent
   c. Brother/sister
   d. Uncle/aunt
   e. Nephew/niece
   f. First cousin
   g. Grandparent
   h. Brother-in-law/sister-in-law
   i. Stepbrother/stepsister
   j. Other relative
   k. Other unrelated

5. *(Display item if the state hasn't eliminated the deprivation requirement for a child under 19 to be considered a "dependent child," for each child for whom the applicant assumes primary responsibility and who is under age 19 and who meets the state's relationship test, and if it's unknown whether the child lives with his or her parents.)*
   Does [Child name] live with 2 birth or adoptive parents?

a. Yes *(If selected, repeat item 5 as necessary for other potential dependent children.)*
b. No *(If selected, continue to* D [*"Ethnicity & race"].*)

D. Ethnicity & race

Optional information: This information will be used to help the U.S. Department of Health and Human Services (HHS) better understand and improve the health of and health care for all Americans. Providing this information won't impact your eligibility for health coverage, your health plan options, or your costs in any way.

1. Is [Person name] of Hispanic, Latino, or Spanish origin?
   a. Yes *(If selected, display "i.")*
      i. Ethnicity: (check all that apply.)
         (Display check boxes.)
         1. Cuban
         2. Mexican, Mexican American, or Chicano/a
         3. Puerto Rican
         4. Other: _____
         (Continue to item 2.)
   b. No *(If selected, skip to item 2.)*

2. Race: (check all that apply.)
   (Display check boxes.)
   a. American Indian or Alaska Native
   b. Asian Indian
   c. Black or African American
   d. Chinese
   e. Filipino
   f. Guamanian or Chamorro
   g. Japanese
   h. Korean
   i. Native Hawaiian
   j. Other Asian
   k. Other Pacific Islander
   l. Samoan
   m. Vietnamese
   n. White
   o. Other: _____

VIII. Other addresses

Note to reviewers: States have developed divergent definitions of "temporary absence" for Medicaid and CHIP residency. The Marketplace may tailor help text to state-specific rules to help people understand how to answer item 3 if adequate information is available to do so.

1. *(Display item if there are any applicants other than the household contact.)*
   Do any of the people below live at an address other than [Household contact address]?
   a. *(Display all applicant and non-applicant household members.)*

b. None of these people *(Disable list of names. If selected, skip to section IX ["Special circumstances."].)*

2. *(Display item if anyone is selected to have a different address in item 1, and repeat as necessary.)*
    Where does [FNLNS] live?
    a. Street address: _____
    b. Apartment or suite number: _____
    c. City: _____
    d. State: *(Display dropdown menu of states.)*
    e. ZIP code: _____
    f. County: *(Display dropdown selection of potential counties if ZIP code crosses more than one county.)*

3. *(Display item if applicant lists any address [in item 2] for an applicant outside state of Exchange.)*
    Is [FNLNS] living outside [State of Exchange] temporarily?
    a. Yes *(If selected, continue to item 4.)*
    b. No *(If selected, skip to section IX ["Special circumstances"].)*

4. *(Display item if "a" was selected in item 3).*
    Where will [FNLNS] be living in [State of Exchange]?
    a. City: _____
    b. ZIP code: _____
    c. County: *(Display dropdown selection of potential counties if ZIP code crosses more than one county.)*

IX. Special circumstances

Note to reviewers: The items on disability and long-term care need were developed under the guidance of the Center for Disability and Aging Policy in the Administration for Community Living and are used to screen whether any applicant could be potentially eligible for Medicaid on a basis other than MAGI. The items on full-time students will be asked in accordance with state Medicaid agency options taken up for students in relation to household composition, maximum age of dependent children for parent/caretaker relative status, and residency rules. The items on American Indian/Alaska Native status were developed with the office of Tribal Affairs following tribal consultation and focus groups. The items on foster care are subject to upcoming CMCS rulemaking.

The items in this section are formatted to work when there's more than one person to whom the question applies. If there's only one person to whom the question is relevant, we would maintain the substance, but alter the format for clarity and simplicity. For example, if there's only one applicant listed on the application, item 1 would read: "Does [FNLNS] have a disability?" with yes/no answer options.

1. Do any of the people below have a disability? (Click here for help answering this question.)
    a. *(Display each applicant name with a check box, and allow multi-select.)*
    b. None of these people *(Disable list of names.)*

2. Do any of the people below need help with activities of daily living through personal assistance services, a nursing home, or other medical facility?
   a. *(Display each applicant name with a check box, and allow multi-select.)*
   b. None of these people *(Disable list of names.)*

3. *(Display item if there's at least one person listed on the application who fits into categories "a-c" below.)*
   Are any of the people below full-time students?
   a. *(If state has adopted a restriction on residency for students going to school in their state, display each applicant aged 18-22 with a check box, and allow multi-select. If selected, continue to item 4.)*
   b. *(Display each potential parent/caretaker relative child who is age 18, even if non-applicant or not in HH with a check box, and allow multi-select. If selected, skip to item 5.)*
   c. *(Display each non-applicant aged 19 or 20 if state has elected to include such full-time students as children for purposes of household composition with a check box, and allow multi-select. If selected, skip to item 5.)*
   d. None of these people *(Disable list of names. If selected, skip to item 5.)*

4. *(Display item if applicant aged 18-22 was selected in item 3 and if state has adopted a restriction on residency for students going to school in their state.)*
   Does [Applicant name selected above] have a parent living in the same state where [Applicant name] goes to school?
   a. Yes *(If selected, skip to item 6.)*
   b. No *(If selected, continue to item 5.)*

5. *(Display item if "b" was selected in item 4 and there isn't already a parent on the application whose address is listed in the state of application.)*
   Do one or more of [Applicant]'s parents live in [State of application]?
   a. Yes
   b. No

6. Are any of the people below American Indian/Alaska Native?
   a. (*Display all applicants and non-applicants and pre-populate with checkmarks those who have already selected AI/AN on the race and ethnicity questions, and allow multi-select.)*
   b. None of these people *(Disable list of names.)*

7. Are any of the people below pregnant?
   a. *(Display names of each applicant and non-applicant female with a check box, and allow multi-select. For each person selected, display item 8.)*
   b. None of these people *(Disable list of names. If selected, skip to item 9.)*

8. *(Display item if an applicant was indicated in item 7 or a non-applicant was indicated in item 7 in a state that has taken up option to count more than one unborn baby in Medicaid household size in case of a pregnant non-applicant.)*
   How many babies is [Name selected above] expecting during this pregnancy?
   a. *(Display dropdown menu of 1-8.)*

9. Were any of the people below ever in foster care?
    a. *(Display names of applicants aged 18-25 with check boxes, and allow multi-select.)*
    b. None of these people *(Disable list of names.)*

10. *(Display item if an applicant name was selected in item 9.)*
    In what state was [Applicant name] in the foster care system?
    a. *(Display dropdown menu of states.)*

11. *(Display item if state selected in item 10 is the same as state of application, or state Medicaid agency has chosen to allow other states' foster care recipients into their former foster care eligibility group.)*
    Was [Applicant name] getting health care through [Name of state Medicaid program]?
    a. Yes *(If selected, continue to item 12.)*
    b. No *(If selected, skip to section X ["Expedited income"].)*

12. *(Display item if "a" was selected in item 11.)*
    How old was [Applicant name] when [he/she] left the foster care system?
    a. *(Display dropdown of ages less than and equal to current applicant age, up to age 21.)*

X. Expedited income

Note to reviewers: This process was developed so some people for whom tax data is available don't need to answer questions about their current/monthly income. If the results of this section place all household members in the APTC-income range, then those tax filers would skip to go to section XIII ["Health coverage (APTC eligible): access"]. This section is subject to change based on final guidance on authentication, consent and presence of an authorized representative. Some additional authentication "challenge" questions may be asked as a part of the Income step; however we aren't providing these questions to protect the integrity and security of our systems.

(If any of the following conditions don't apply, skip this section and go to section XI ["Current/monthly income"] for each household member:

- *Medicaid household and tax household are the same*
- *IRS tax data is available*
- *Tax filer(s) isn't an AI/AN*
- *Tax data shows income above the Medicaid/CHIP FPL limit relevant to each applicant for whom this tax filer's income will count.)*

1. *(Display item if single filer.)*
   According to federal income tax return data, [FNLNS]'s income was [amount from IRS] in [last available tax return year].

   What do you expect [FNLNS]'s yearly income will be in [coverage year]?

   (Display item if joint filers.)

According to federal income tax return data, [FNLNS] and [Spouse FNLNS]'s income was [amount] in [year].

What do you expect [FNLNS]'s and [Spouse FNLNS]'s yearly income will be in [coverage year]?

    a.   [FNLNS]: Amount: $_____
       (Display item if joint filers):
    b.   [Spouse FNLNS]: Amount: $_____
    c.   I don't know *(Display check box. If selected, skip to section XI ["Current/monthly income"].)*

(If amount entered is equal to or higher than amount for each applicant in this tax filer's household to be above the Medicaid/CHIP FPL limit in the relevant state, continue to item 2. If amount entered is lower, skip to section XI ["Current/monthly income"].)

2. Is [FNLNS]'s [if joint, display names of both filers] income (before taxes) for this month greater than [monthly FPL threshold amount]?
    a.   Yes *(If selected, skip to section XIII ["Health coverage (APTC eligible): access"] for this tax filer or joint filers and continue to next household member if applicable.)*
    b.   No *(If selected, continue to section XI ["Current/monthly income"].)*

XI. Current/monthly income

Note to reviewers: These income questions were developed in consultation with IRS experts, based on a balance of obtaining an accurate MAGI amount while maximizing simplicity and minimizing burden on both applicants and the determination entity. Some additional authentication "challenge" questions may be asked as a part of the Income step; however we aren't providing these questions to protect the integrity and security of our systems.

(Skip this section and go to section XIII ["Health coverage (APTC eligible): access"] for a tax filer if results of expedited income section indicate that all applicants for whom the tax filer's income is being considered are in the APTC income range.)

1. *(Display item for each person with available current income data.)*
    Review our records of [FNLNS]'s income and edit if necessary.

    (Display the type of current income, accompanied by the employer name, address, phone number, Employer Identification Number (if applicable), the amount [before taxes] and frequency, and allow deletion of an income source or edits to the amount or frequency. The frequency dropdown would mirror that provided for application filer-entered income, as below. This section subject to change based on outcome of identity proofing/authentication/consent/presence of an authorized representative.)
    Check this box if income is correct. *(Display check box.)*

2. *(Display item for each person with no available income data and repeat until "none" is selected.)*

Does [FNLNS] have any income?

a. Yes *(If selected, display each income type ["i-xii"] with a check box, and allow multi-select.)*
     i. None *(If selected, skip to item 16.)*
     ii. Job *(If selected, continue to item 4.)*
     iii. Self-employment *(If selected, skip to item 5.)*
     iv. Social Security benefits *(If selected, skip to item 6.)*
     v. Unemployment *(If selected, skip to item 7.)*
     vi. Retirement/pension *(If selected, skip to item 8.)*
     vii. Capital gains *(If selected, skip to item 9.)*
     viii. Investment income *(If selected, skip to item 10.)*
     ix. Rental or royalty income *(If selected, skip to item 11.)*
     x. Farming or fishing income *(If selected, skip to item 12.)*
     xi. Alimony received *(If selected, skip to item 13.)*
     xii. Other income *(If selected, skip to item 14.)*
b. No *(If selected, skip to the next household member's income screen or skip to section XII ["Discrepancies"] if no other household members are left.)*

3. *(Display item for each person with pre-populated income data.)*
   Does [FNLNS] have another income source? (Check all that apply.)
   (Display each income type ["a-l"] with a check box, and allow multi-select.)
   a. None *(If selected, skip to item 16.)*
   b. Job *(If selected, continue to item 4.)*
   c. Self-employment *(If selected, skip to item 5.)*
   d. Social Security benefits *(If selected, skip to item 6.)*
   e. Unemployment *(If selected, skip to item 7.)*
   f. Retirement/pension *(If selected, skip to item 8.)*
   g. Capital gains *(If selected, skip to item 9.)*
   h. Investment income *(If selected, skip to item 10.)*
   i. Rental or royalty income *(If selected, skip to item 11.)*
   j. Farming or fishing income *(If selected, skip to item 12.)*
   k. Alimony received *(If selected, skip to item 13.)*
   l. Other income *(If selected, skip to item 14.)*

4. *(Display item if "ii" [Job] was selected in item 2 or "b" [Job] was selected in item 3).*
   a. Name of employer: _____
   b. How much does [FNLNS] get paid (before taxes are taken out)? You should also tell us here about a one-time amount you got from a current or former employer this month.
        i. Amount: $_____
   c. How often does [FNLNS] get paid this amount?
      (Display dropdown menu.)
        i. Hourly *(If selected, continue to "d.")*
        ii. Daily *(If selected, continue to "d.")*
        iii. Weekly
        iv. Every 2 weeks
        v. Twice a month
        vi. Monthly

       vii.   Yearly
     viii.   One time only
  d.   *(Display item if "i" or "ii" is selected in "c.")*
     How much does [FNLNS] usually work per week at this job?
     (Display frequency based on selection in "c.")
       i.   Hours per week
      ii.   Days per week

5. *(Display item if "iii" [Self-employment] was selected in item 2 or "c" [Self-employment was selected in item 3.)*
   a. Type of work: _____
   b. How much net income (profits once expenses are paid) will [FNLNS] get from this self-employment this month? (Click here for hints about what to subtract to get the net amount.) If the costs for this self-employment are more than the amount [FNLNS] expects to earn, you can write a negative number.
      i. Amount: $_____

6. *(Display item if "iv" [Social Security benefits] was selected in item 2 or "d" [Social Security benefits was selected in item 3.)*
   a. How much does [FNLNS] get from Social Security retirement, disability, or survivors benefits?
      i. Amount: $_____
   b. How often does [FNLNS] get this amount?
      (Display dropdown menu.)
      i. One time only
      ii. Monthly
      iii. Yearly

7. *(Display item if "v" [Unemployment] was selected in item 2 or "e" [Unemployment] was selected in item 3.)*
   a. From what state government or former employer does [FNLNS] get unemployment benefits?
      i. _____
   b. How much does [FNLNS] get?
      i. Amount: $_____
   c. How often does [FNLNS] get this amount?
      (Display dropdown menu.)
      i. One time only
      ii. Monthly
      iii. Yearly
   d. Is there a date that the unemployment benefits are set to expire?
      i. Yes (If selected, display "1.")
         1. What's the date? MM/DD/YYYY
      ii. No

8. *(Display item if "vi" [Retirement/pension] was selected in item 2 or "f" was selected in item 3. We'll provide help text to indicate certain types of pensions that aren't taxable and don't need to be included).*
    a. How much does [FNLNS] get from this retirement account or pension? Include amounts received as a distribution from a retirement investment even if [FNLNS] isn't retired.
        i. Amount: $_____
    b. How often does [FNLNS] get this amount?
        (Display dropdown menu.)
        i. One time only
        ii. Weekly
        iii. Every 2 weeks
        iv. Twice a month
        v. Monthly
        vi. Yearly

9. *(Display item if "vii" [Capital gains] was selected in item 2 or "g" [Capital gains] was selected in item 3. We'll provide help text to indicate examples of capital gains that should and shouldn't be reported.)*
    a. How much does [FNLNS] expect to get from net capital gains (the profit after subtracting capital losses) this month?
        i. Amount: $_____
    b. How much does [FNLNS] expect to get from net capital gains (the profit after subtracting capital losses) this year?
        i. Amount: $_____

10. *(Display item if "viii" [Investment income] was selected in item 2 or "h" [Investment income] was selected in item 3. We'll provide help text to indicate examples of investment income that should and shouldn't be reported.)*
    a. How much does [FNLNS] get from investment income, like interest and dividends?
        i. Amount: $_____
    b. How often does [FNLNS] get this amount?
        (Display dropdown menu.)
        i. One time only
        ii. Weekly
        iii. Monthly
        iv. Quarterly
        v. Yearly

11. *(Display item if "ix" [Rental or royalty income] was selected in item 2 or "i" [Rental or royalty income] was selected in item 3. We'll provide help text to indicate examples of rental/royalty income that should and shouldn't be reported.)*
    a. How much does [FNLNS] get from net rental income (the profit after subtracting costs)? (Click here to learn about the costs that can be subtracted to get the net amount.)
        i. Amount: $_____
    b. How often does [FNLNS] get this amount?
        (Display dropdown menu.)
        i. One time only
        ii. Weekly

iii. Every 2 weeks
iv. Twice a month
v. Monthly
vi. Yearly

12. *(Display item if "x" [Farming or fishing income] was selected in item 2 or "j" [Farming or fishing income] was selected in item 3. We'll provide help text to indicate examples of farming/fishing income that should and shouldn't be reported.)*
    a. How much does [FNLNS] get from net farming or fishing income (the profit after subtracting costs)? (Click here to learn about the costs that can be subtracted to get the net amount.)
    b. Amount: $_____
    c. How often does [FNLNS] get this amount?
       (Display dropdown menu.)
          i. One time only
          ii. Weekly
          iii. Every 2 weeks
          iv. Twice a month
          v. Monthly
          vi. Yearly

13. *(Display item if "xi" [Alimony received] was selected in item 2 or "k" [Alimony received] was selected in item 3.)*
    a. How much does [FNLNS] get from alimony?
          i. Amount: $_____
    b. How often does [FNLNS] get this amount?
       (Display dropdown menu.)
          i. One time only
          ii. Weekly
          iii. Every 2 weeks
          iv. Twice a month
          v. Monthly
          vi. Yearly

14. *(Display item if "xii" [Other income] was selected in item 2 or "l" [Other income] was selected in item 3, and allow multi-select.)*
    Which other type of income does [FNLNS] get?
    a. Canceled debts *(If selected, skip to "15 b.")*
    b. Court awards *(If selected, skip to "15 b.")*
    c. Jury duty pay *(If selected, skip to "15 b.")*
    d. Other *(If selected, continue to "15 a.")*

15. *(Display item for income types indicated in item 14.)*
    a. You don't need to tell us about child support, veteran's payments, or Supplemental Security Income (SSI). (Click here to learn about more about what not to list.)
       What other type of income does [FNLNS] have? _____
    b. How much?
          i. Amount: $_____

c. How often?
(Display dropdown menu.)
   i. One time only
   ii. Weekly
   iii. Every 2 weeks
   iv. Twice a month
   v. Monthly
   vi. Yearly

16. *(Display item for all applicants and allow multi-select.)*
   If [FNLNS] pays for certain things that can be deducted on an income tax return, telling us about them could make the cost of health insurance a little lower. What does [FNLNS] pay for? (check all that apply.)
   a. Alimony paid *(If selected, skip to "17 b.")*
   b. Student loan interest paid *(If selected, skip to "17 b.")*
   c. (*Display item if tax filer.*)
   Other deduction [FNLNS] could take on [his/her] [coverage year] tax return *(If selected, continue to "17 a.")*
   d. None

17. *(Display for applicants with responses to item 16.)*
   a. You shouldn't include a cost that you already considered in your answer to net self-employment or rental income. What other deductions do you have?

   _____
   b. How much?
      i. Amount: $_____
   c. How often?
   (Display dropdown menu.)
      i. One time only
      ii. Weekly
      iii. Every 2 weeks
      iv. Twice a month
      v. Monthly
      vi. Yearly

18. *(Display item if any income was reported: [FNLNS]'s income summary table with calculated monthly income amounts.)*

19. *(Display item if [FNLNS] is American Indian or Alaska Native, and has reported income above.)*
   Of the income in the summary table, is any money from any of these sources? *(Display check boxes for "a-c.")*
   a. Per capita payments from the tribe that come from natural resources, usage rights, leases or royalties *(If selected, skip to "19 d.")*
   b. Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) *(If selected, skip to "19 d.")*

    c.   Money from selling things that have cultural significance *(If selected, skip to "19 d.")*
    d.   Select income type: *(Display table of income this household member has entered.)*

20. Based on what you told us, if [FNLNS]'s income is steady month-to-month, then it's about [amount] per year. Is this how much you think [FNLNS] will get in [coverage year]?
    a.   Yes *(If selected, continue to section XII ["Discrepancies"].)*
    b.   No *(If selected, continue to item 21 or 22, based on availability of IRS data.)*

21. *(Display item if "b" was selected in item 20 and individual IRS data is available for this person.)*
According to federal income tax return data, [FNLNS]'s income was [amount] in [year]. Based on what you know today, how much do you think [FNLNS] will make in [coverage year]?
    a.   Amount: $_____
    b.   I don't know *(If selected, continue to item 23.)*
    (This section is subject to change based on outcome of identity proofing/authentication/consent/presence of an authorized representative.)

22. *(Display item if "b" was selected in item 20 and individual IRS data isn't available for this person).*
Based on what you know today, how much do you think [FNLNS] will make in [coverage year]?
    a.   Amount: $_____
    b.   I don't know *(If selected, continue to item 23.)*

23. *(Display item if "b" was selected on item 21 or 22).*
Do you expect your income in [coverage year] to be higher or lower than [amount in item 20], which is based on your monthly income?
    a.   Higher
    b.   Lower

XII. Discrepancies

(Display section after income information is complete for each household member, if the household in total has attested to income that puts any applicant in Medicaid or CHIP range, while the available electronic income data indicate that such applicant is above Medicaid or CHIP range as applicable.)

1. *(Display item if the household member has deleted a job when it was pre-populated in the wage data.)*
Did [FNLNS] stop working at [Employer] within the last [#] months?
    a.   Yes
    b.   No *(if selected, continue to item 2.)*

2. *(Display item if "b" was selected in item 1.)*
Did [FNLNS] ever work at [Employer]?
    a.   Yes *(If selected, skip to item 5.)*

b. No *(If selected, skip to section XIII ["Health coverage (APTC eligible): access"] or section XIX ["Medicaid & CHIP specific questions"] depending on preliminary eligibility determination.)*

3. *(Display item if the household member has reduced the amount of monthly income from a job when it was pre-populated in the wage data.)*
   Have [FNLNS]'s hours decreased at [Employer] during the last [#] months?
   a. Yes
   b. No *(If selected, continue to item 4.)*

4. *(Display item if "b" was selected in item 3.)*
   Has [FNLNS]'s wage or salary been cut at [Employer] during the last [#] months?
   a. Yes
   b. No (*If selected, display message in "i."*)
      i. The paycheck amount might be lower than the gross amount we're asking for here because taxes or other deductions are taken out of most paychecks. Double check the amount you listed for [Employer] is the gross amount.

5. *(Display item if "a" was selected in item 2 or "b" was selected in item 4.)*
   Is there another explanation for why the amount reported for [FNLNS]'s job income is lower than what our electronic records show? *(Help text will explain our data source.)*
   a. _____

6. *(Display item if applicant has attested to an annual income that is in the Medicaid/CHIP range and monthly income is not in the Medicaid/CHIP range, and the state has taken up the option to consider reasonably predictable increases in income.)*
   Is [FNLNS] a seasonal worker?
   a. Yes
   b. No

7. *(Display item if applicant's tax household is more than 3 people larger than the tax household size reported by the IRS from the most recent available return data.)*
   Explain why you told us that [FNLNS] will claim more dependents on [FNLNS]'s tax return than there were on [FNLNS]'s federal income tax return in [IRS reported tax year].
   a. _____

8. *(Display one high-level "Income summary page" for all household members.)*
   Is there any other income the people above get, including joint income?
   a. Add another income *(If selected, display message in "i.")*
      i. Click on the person's name on the left side of the screen to add more income for that person.

Note to reviewers: The following sections appear after the user has completed the income section. Based on income, the individuals are determined potentially eligible for a particular program, such as Advanced Premium Tax Credits, Medicaid, or CHIP. Depending on the program for which the person is potentially eligible, the system will display appropriate questions. This is to minimize the burden to applicants by only asking questions that apply to a particular person.

Please note that sections XIII ("Health coverage (APTC eligible): access"), XIV ("Employer health coverage information"), and XV ("Other insurance (APTC eligible)") reflect our most current questions for employer-sponsored and other health coverage. These aren't reflected in Appendix B.

XIII. Health coverage (APTC eligible): access

(Display for each applicant potentially eligible for APTC based on income attestation. Please note that during certain times of the year, particularly during annual open enrollment, questions will be asked about both the current year and the coming coverage year due to the availability of Special Enrollment Periods.)

Health coverage information for [FNLNS]
(Display items 1 and/or 2 based on date of application.)

1. Is [FNLNS] offered health coverage through a job (even if it's from another person's job, like a spouse)? *(Display "or parent/guardian" if person is under age 26)*
   a. Yes (*If selected, continue to item 2 based on the date of application, then continue to item 3.*)
   b. No *(If selected, continue to item 2 if it's an open enrollment period, and skip to item 4 or item 5 depending on the date of the application.)*

2. Will [FNLNS] be offered health coverage from a job (even if it's from another person's job, like a spouse) (*Display "or parent/guardian" if person is under age 26*) in [coverage year]?
   a. Yes *(If selected, display "i" and "ii", then continue to item 3. After completing this section, skip to item 2 in section XIV ["Employer health coverage information"].)*
      i. Date [FNLNS] could start coverage: MM/DD/YYYY
      ii. I don't know
   b. No *(If selected, skip to item 4 or 5 depending on the date of application.)*

3. *(Display item if "a" was selected in item 1.)*
   Tell us which employers offer health coverage:
   a. *(Where possible, pre-populate check box list of the following information obtained from income section. Provide ability to add another employer that offers health coverage, if needed.)*
      i. Employer: _____
      ii. Employer's street address: _____
      iii. City: _____
      iv. State: (*Display dropdown menu of states*.)
      v. ZIP code: _____
      vi. Employer's phone number: (___) ___-____ Ext. ___
      vii. Employer Identification Number (EIN): _____
      viii. Who can we contact about this employer's health coverage? If you're not sure, ask your employer. (optional) (*Display employer phone with "Same as above" check box or display "1, 2, and 3" if user-prepopulated employer information isn't available.)*
         1. Name:_____

<div align="center">

2. Phone number (___) ___-____ Ext. ___
3. Email address: _____
</div>

    a. Another employer *(Repeat values from above.)*

(Display items 4 and/or 5 depending on the date of application.)

4. Is [FNLNS] currently enrolled in health coverage from any of the following?
   a. COBRA *(If selected, continue to item 5 based on the date of application, then continue to item 6.)*
   b. Retiree health plan *(If selected, continue to item 5 based on the date of application, then continue to item 6.)*
   c. Veterans health program (*If selected, continue to item 5 based on date of application, then skip to section XV ["Other insurance"].*)
   d. None of the above (*If selected, continue to item 5 based on date of application, then skip to section XV ["Other insurance"].*)

5. Will [FNLNS] be enrolled in health coverage from any of the following in [coverage year]?
   a. COBRA *(If selected, continue to item 6.)*
   b. Retiree health plan *(If selected, continue to item 6.)*
   c. Veterans health program (*If selected, skip to section XV ["Other insurance"].*)
   d. None of the above (*If selected and selected "1 b" and "2 b," skip to section XV ["Other insurance"]. Otherwise, skip to section XIV ["Employer health coverage information."]*)

6. *(Where possible pre-populate check box list of the following information obtained from income section. Provide ability to add another employer that offers health coverage or select "Same as above," if needed.)*
   Tell us about your former employer:
   a. Former employer: _____
   b. Former employer's street address: _____
   c. City: _____
   d. State: *(Display dropdown menu of states.)*
   e. ZIP code: _____
   f. Former employer's phone number: (___) ___-____ Ext. ___
   g. Employer Identification Number (EIN): _____
   h. Who can we contact about this employer's coverage? If you're not sure, ask your former employer (optional): *(Display employer phone with "Same as above" check box or display "i, ii, iii" if user prepopulated employer information is not available.)*
      i. Name: _____
      ii. Phone number: (___) ___-____ Ext._____
      iii. Email address: _____

XIV. Employer health coverage information

(Display section for each health coverage offer selected in section XIII ["Health coverage (APTC eligible): access"]. To avoid repetition, the dynamic system logic will record that individuals have access to coverage from a particular employer and not require them to enter the information again, if they've already provided the information. Please note that during certain times of the year, particularly during

annual open enrollment, application filers/applicants will be asked to provide certain application information for both the current year and for the coming coverage year, due to the availability of Special Enrollment Periods.)

(Display a link to a printable "Employer Coverage Form." This is a blank form that can be provided by the employee to his/her employer to collect the necessary information to complete this portion of the application.)

(Display items 1 and/or 2 based on date of application.)

1. Is [FNLNS] currently enrolled in a health plan offered by [Employer name]?
    a. Yes
    b. No

2. Will [FNLNS] be enrolled in a health plan offered by [Employer name] in [coverage year]?
    a. Yes
        i. Date [FNLNS] will be covered by [Employer name]'s plan: MM/DD/YYYY
        ii. I don't know
    b. No

3. Does [FNLNS] expect any changes to [Employer Name's] health coverage in [coverage year]?
    a. Yes *(If selected, continue to item 4.)*
    b. No *(If selected and selected "1 b" and "2 b" in section XIII, ["Health coverage (APTC eligible): access"], skip to section XV ["Other insurance"]. All others skip to item 5.)*

4. *(Display item if "a" was selected in item 3.)*
   What does [FNLNS] expect to change in [coverage year]?
    a. [Employer name] will no longer offer health coverage *(If selected, display "i," then skip to section XV ["Other insurance."])*
        i. What's the last day [Employer Name's] coverage will be available to [FNLNS]?
            1. Date: MM/DD/YYYY
            2. I don't know *(Display check box.)*
    b. *(Display item if selected "a" was selected in items 1 or 2.)*
       [FNLNS] plans to drop [Employer Name]'s health coverage *(If selected, display "i," then continue to item 5.)*
        i. What will be [FNLNS]'s last day of coverage through [Employer Name]'s health plan?
            1. Date: MM/DD/YYYY
            2. I don't know *(Display check box.)*
    c. *(Display item if "b" was selected in item 1.)*
       [Employer Name] will offer [FNLNS] coverage in [coverage year].
        i. What's the first date [FNLNS] would be covered by [Employer Name]'s health plan?
           (If selected, skip to item 6 with message that reads "Give the information for [Employer name]'s plan [in date entered in "a" or if no date entered, [coverage year]].)
            1. Date: MM/DD/YYYY

2. I don't know *(Display check box.)*

    d. *(Display item if "b" was selected in item 1.)*
[FNLNS] is planning to enroll in [Employer Name's] health coverage in [coverage year].
(If selected, display "i." and skip to item 6 with message that appears: "Give the information for this plan offered by [Employer name] in [date entered in "a" or if no date entered, [coverage year]].)
        i. What's the first day [FNLNS] will be covered by [Employer Name]'s health plan?
            1. Date: MM/DD/YYYY
            2. I don't know *(Display check box.)*
    e. *(Display if "a" was selected in item 1.)*
        i. [Employer Name]'s health plan options are going to change in [coverage year], including changes in the cost and minimum value. *(If selected, display "i," then continue to item 6.)*
        When will the change happen?
            1. Date: MM/DD/YYYY
            2. I don't know *(Display check box.)*

5. What's the name of the lowest cost self-only health plan offered to [FNLNS]? (Only include plans that meet the "minimum value standard" set by the Affordable Care Act.) (Link to Employer Coverage Form.")
    a. _____ (Display free text field.)
    b. I don't know *(Display check box.)*
    c. No plans meet the minimum value standard *(Display check box.)*
    (Skip to item 7.)

6. *(Display if "c," "d," or "e" was selected in item 4.)*
What's the name of the lowest cost self-only health plan that will be offered to [FNLNS] in [coverage year]? (Only include plans that meet the "minimum value standard" set by the Affordable Care Act.) *(Link to "Employer Coverage Form.")*
    a. _____ *(Display free text field.)*
    b. I don't know *(Display check box.)*
    c. No plans meet the minimum value standard *(Display check box.)*
    (Continue to item 7.)

7. How much would [FNLNS] pay in premiums to enroll in this plan?
    a. Amount: $_____
    b. I don't know *(Display check box.)*

8. How often would [FNLNS] pay this amount?
    a. *(Display dropdown menu.)*
        ii. Weekly
        iii. Every 2 weeks
        iv. Twice per month
        v. Monthly
        vi. Yearly
        vii. Other: _____

viii. I don't know *(Display check box.)*

9. *(Display item if premium information isn't available or the attested plan cost is determined to be affordable based on household income for purposes of initiating an inconsistency period.)*
Does [FNLNS] think this coverage is affordable?
   a. Yes
   b. No

XV. Other insurance (APTC eligible)
(Display items below for all potentially APTC eligible applicants. Display items 1 and/or 2 based on date of application.)

1. Is [FNLNS] eligible for health coverage from any of the following? Select even if [FNLNS] isn't currently enrolled.
   a. Medicare
   b. TRICARE
   c. Peace Corps
   d. Other state or federal health benefit program *(If selected, display "i" and "ii.")*
      i. Type:_____
      ii. Name of program:_____
   e. None of the above

2. Will [FNLNS] be eligible for health coverage from any of the following in [coverage year]? Select even if [FNLNS] isn't currently enrolled.
   a. Medicare
   b. TRICARE
   c. Peace Corps
   d. Other state or federal health benefit program *(If selected, display "i" and "ii.")*
      i. Type:_____
      ii. Name of program:_____
   e. None of the above

XVI. American Indian/Alaska Native (APTC eligible)
(Display items in this section if someone has been identified as AI/AN in section IX ["Special circumstances"] and is potentially eligible for APTC or QHP based on income attestation.)

1. Are any of these individuals a member of a federally recognized tribe?
   a. *(Display APTC eligible applicants who indicated they were AI/AN in section IX ["Special circumstances"] with check boxes, and allow multi-select.)*
   b. None of the above.

2. *(Display item for each selected applicant in "1 a.")*
   a. State: *(Display dropdown menu of states.)*
   b. Tribe name: *(Display dropdown menu of tribes.)*

XVII. Tax filer & other information

1. *(Display item if the claiming tax filer hasn't entered a Social Security number on his/her personal page and one or more members of their tax household are eligible for APTC.)*
   [Tax filer name] indicated [he/she] is the claiming tax filer for [Applicant(s) names]; however a Social Security number (SSN) hasn't been entered for [Tax filer name]. Providing a SSN may help get a better idea of how much help you can get in paying for health insurance coverage. The SSN you provide won't be used to verify citizenship or immigration status. Does [Tax filer name] want to provide one now?
   a. Yes *(If selected, display "i.")*
      i. SSN: ___-___-____
   b. No

2. *(Display item if applicants are otherwise APTC eligible, but haven't identified that they expect to file taxes or be claimed as a dependent on someone else's tax return for the coverage year.)*
   In order for [Applicant(s) names] to get help paying for health insurance, each person must file a tax return or be claimed as a dependent on someone else's tax return. Do you want to change your answers about how [Applicant(s) names] will file taxes for [coverage year]?
   a. Yes *(If selected, return to section VI ["Family & household"] and allow users to make changes to their responses.)*
   b. No *(If selected, will be determined ineligible for APTC in eligibility results.)*

3. *(Display item if applicants are otherwise APTC eligible, but are married and haven't identified that they expect to file a joint tax return.)*
   In order for [Applicant(s) names] to get help paying for health insurance, [he/she] must file a joint federal income tax return with (his or her) spouse. Do you want to change your answers about how [Applicant(s) names] will file taxes for [coverage year]?
   a. Yes *(If selected, return to section VI ["Family & household"] and allow users to make changes to their responses.)*
   b. No *(If selected, will be determined ineligible for APTC in eligibility results.)*

4. *(Display item if applicant is APTC or QHP eligible and indicated they're living outside the [State of Exchange] and didn't provide a city, ZIP code, and county in section VIII ["Other addresses"].)*
   Where will [FNLNS] be living in [State of Exchange]?
   a. City: _____
   b. ZIP code: _____
   c. County: *(Display dropdown selection of potential counties if ZIP code crosses more than one county.)*

XVIII. Special Enrollment Periods

(Display section for all APTC and QHP eligible individuals beginning on November 1, 2013, to see if they may qualify for a Special Enrollment Period.)

1. Did any of these people lose health insurance in the last 60 days?
   a. *(Display check box list of all APTC and QHP eligible individuals, and allow multi-select.)*

2. *(Display item for each individual selected in item 1.)*
   When did [FNLNS] lose health insurance?
   a. MM/DD/YYYY
(Continue to item 3.)

3. *(Display item for each individual selected in item 1.)*
   Did [FNLNS] lose health insurance because of not paying premiums?
   a. Yes
   b. No

4. Did any of the following people get married in the last 60 days?
   a. *(Display check box for all married APTC and QHP eligible individuals, and allow multi-select. If anyone is selected, continue to item 5.)*

5. *(Display item for each individual selected in item 4.)*
   When did [FNLNS] get married?
   a. MM/DD/YYYY

6. Have any of the following people been adopted or placed for adoption in the last 60 days?
   a. *(Display check box list of all APTC and QHP eligible individuals, and allow multi-select. If anyone is selected, continue to item 7.)*

7. *(Display item for each individual selected in item 6.)*
   When was [FNLNS] adopted or placed for adoption?
   a. MM/DD/YYYY

8. Did any of the following people gain eligible immigration status in the last 60 days?
   a. *(Display check box list of all APTC and QHP eligible individuals who selected that they had eligible immigration status, and allow multi-select. If anyone is selected, continue to item 9.)*

9. *(Display item for each individual selected in item 8.)*
   When did [FNLNS] gain eligible immigration status?
   a. MM/DD/YYYY

10. Did any of the following people move in the last 60 days?
    a. *(Display check box list of all APTC and QHP eligible individuals, and allow multi-select.)*

11. *(Display item for each individual selected in item 10.)*
    Provide the following information from [FNLNS]'s previous address:
    a. ZIP code: _____
    b. County *(Display if system verifies address and finds that ZIP code covers more than one county, the system will provide an option for the user to select the correct county.)*

12. *(Display item for each individual selected in item 10.)*
    What was the date of the move?
    a. MM/DD/YYYY

13. Did any of the following people get released from incarceration (jail or prison) in the last 60 days?
    a. *(Display check box list of all APTC and QHP eligible individuals, and allow multi-select. If anyone is selected, continue to item 14.)*

14. *(Display item for each individual selected in item 13.)*
    When was [FNLNS] released from incarceration (jail or prison)?
    a. MM/DD/YYYY

XIX. Medicaid & CHIP specific questions

Note to reviewers: The questions on past coverage for potentially-CHIP eligible applicants may be removed pending regulation. States may also choose to collect some of the information below, such as enrollment in other health insurance for potential Medicaid beneficiaries, post-eligibility for coordination of benefits, but as some states find it useful to have this information included with the application, these questions have been included here. The AI/AN questions were written by the Tribal Affairs group following an all-tribes consultation.

(Display this section for each applicant that's potentially eligible for Medicaid or CHIP based on attestations and system logic.)

1. Does [FNLNS] have health insurance now?
   a. Yes *(If selected, continue to item 2.)*
   b. No

2. *(Display if "a" was selected in item 1.)*
   What health insurance does [FNLNS] have now?
   a. *(Display plan already identified on APTC page, if any.)*
   b. *(Display name of Medicaid program in state of Exchange.)*
   c. *(Display name of CHIP program in state of Exchange.)*
   d. Medicare
   e. Insurance through an employer *(If selected, continue to item 3.)*
   f. Veterans or TRICARE
   g. Other *(If selected, continue to item 3.)*

3. *(Display if "e" or "g" was selected in item 2.)*
   What's the health plan called? _____

4. *(Display if "d-g" was selected in item 2, wording to vary based on type of insurance.)*
   What's the [policy number/member ID]? _____

5. *(Display if applicant is American Indian or Alaska Native (AI/AN) and potentially eligible for Medicaid or CHIP.)*
   Has [FNLNS] ever gotten a health service from the Indian Health Service, a tribal health program, or urban Indian health program or through a referral from one of these programs?
   a. Yes
   b. No *(If selected, continue to item 6.)*

6. *(Display if item "b" was selected in item 5.)*
   Is [FNLNS] eligible to get health services from Indian Health Services or a Tribal Health Organization?
   a. Yes
   b. No

A. Medicaid specific questions
(Display the items in this section if one or more applicants are potentially eligible for Medicaid based on income attestation.)

1. Do you want help paying for medical bills from the last 3 months for [FNLNS]?
   a. Yes
   b. No

2. *(Display item if applicant is potentially eligible for Medicaid through the VIII group category, and is the parent or caretaker relative of a dependent child who isn't applying for coverage.)*
   Do any of the following people have health insurance now?
   a. *(Display each non-applying dependent child name with a checkbox, and allow multi-select.)*
   b. None of these people

3. *(Display item if the potentially Medicaid-eligible individual is a non-citizen in a state which requires 40 work quarters and applicant's own SSN hasn't provided enough quarters to meet the requirement).*

   (Display item if FNLNS is married.)
   [FNLNS] could get free or low-cost health coverage if [he/she] has enough of a work history in the U.S. on [his/her] own or through a family member. We checked [FNLNS]'s work history already because you gave us [his/her] Social Security number (SSN). We can also check the work history for [FNLNS]'s family members if you give us the SSN of [FNLNS]'s parent or spouse. Would you like to give a SSN now?

   (Display if FNLNS isn't married.)
   [FNLNS] could get free or low-cost health coverage if [he/she] has enough of a work history in the U.S. on [his/her] own or through a family member. We checked [FNLNS]'s work history already because you gave us [his/her] Social Security number (SSN). We can also check the work history for [FNLNS]'s family members if you give us the SSN of [FNLNS]'s father or mother. Would you like to give a SSN now?
   a. Yes *(If selected, display "i.")*
      i. Name *(Choose from list if there's a known or potential parent or spouse on application.)*
      ii. *(Display only if not chosen from the list in "i.")*
         1. First name: _____
         2. Middle name: _____
         3. Last name: _____
         4. Suffix: *(Display dropdown menu of suffixes.)*

5. Date of birth: MM/DD/YYYY
6. SSN: ___-__-____
7. Relationship *(Display if FNLNS is married, dropdown with "parent" or "spouse.")*

  b. No

4. *(Display item if any parent or caretaker relative is potentially eligible for Medicaid and his or her dependent child is also potentially eligible for Medicaid and that child lives with 0 or 1 parent.)*
   Does [Child name] have a parent living outside the home?
   a. Yes
   b. No

5. *(Display item if applicant is potentially eligible for the parent/caretaker relative category and the dependent child lives with 2 parents and the state has a deprivation requirement and no parent has been identified as underemployed or unemployed via the income section.)*
   How many hours per week do [Child's name]'s parents work?
   a. Parent 1: __
   b. Parent 2: __

B. CHIP specific questions
(Display section for each applicant potentially eligible for CHIP based on attestations and system logic.)

1. *(Display item if state has a waiting period for CHIP and applicant potentially eligible for CHIP is not a pregnant woman.)*
   Did [FNLNS] have health insurance from a job that ended in the last [number of months of waiting period]?
   a. Yes *(If selected, continue to item 2.)*
   b. No *(If selected, skip to item 3.)*

2. *(Display if "a" was selected in item 1.)*
   Why did that insurance end?
   a. The parent no longer works for the employer that offered the insurance
   b. The employer stopped offering insurance
   c. The employer stopped offering insurance to dependents (kids)
   d. The insurance was too expensive
   e. [FNLNS] had medical needs not covered by the other insurance
   f. Other: _____

3. *(Display item if state of Exchange hasn't taken up option to cover all otherwise eligible CHIP applicants with access to state employee benefits.)*
   Is [FNLNS] offered the [state of Exchange] state employee health benefit plan through a job, or a family member's job?
   a. Yes
   b. No

XX. Review & sign

Note to reviewers: This section describes the summary, signature, and results pages of the application, and is more focused on displaying information rather than asking questions. These sections attempt to acknowledge differences in what information the Marketplace will provide regarding Medicaid and CHIP in both assessment and determination models, and the options individuals may have, such as the ability to raise one's hand for a full determination by the Medicaid agency on bases other than MAGI. The signature requirements are subject to outstanding policies on authentication and consent. The eligibility results are subject to forthcoming rulemaking on coordinated notices. In addition, we're continuing to create a user-friendly interface, which could result in changes to the flow and format below.

A. Review application
(Display section once per application.)

1. Contact information
   [FNLNS1]   (Edit)
   [Address]
   [Email address]
   [Preferred phone number]

2. Family & household
   [FNLNS1]   (Edit)
   [Address]
   [Relationship to [FNLNS1]]
   [Date of birth]
   [Citizenship/immigration status]
   (Display if person has identified to have an immigrant status.)
   [Satisfactory immigration status: [Y/N] and [date entered the U.S.]

   [FNLNS2]   (Edit)
   [Address]
   [Relationship to [FNLNS1]]
   [Date of birth]
   [Citizen/immigration status]
   (Display if person has identified to have an eligible immigration status.)
   [Satisfactory immigration status: [Y/N] and [date entered the U.S.]]

3. Tax filing status   (Edit)
   [FNLNS1] [Tax filing status]
   [FNLNS2] [Tax filing status]

4. Income information   (Edit)

   [FNLNS1]
   (Display for each employer. Display unemployment benefits if applicable.)
   [Employer 1]
   [Employer 1 address]
   [Employer Identification Number]

[Wages per month, pre-taxes]

[Employer 2]
[Employer 2 address]
[Employer Identification Number]
[Wages per month, pre-taxes]
[Other income types and amount and frequency]

[FNLNS2]
(Display for each employer. Display unemployment benefits if applicable.)
[Employer 1]
[Employer 1 address]
[Employer Identification Number]
[Wages per month, pre-taxes]

[Employer 2]
[Employer 2 address]
[Employer Identification Number]
[Wages per month, pre-taxes]
[Other income types and amount and frequency]

5. Additional information   (Edit)
[FNLNS1]
[Additional information]
[FNLNS2]
[Additional information]

B. Sign & submit
Read and check the box next to each statement if you agree.
(Display check boxes for user to indicate agreement and sign page.)

1. *(Display item if applicants are eligible for Medicaid.)*
   I know that if Medicaid pays for a medical expense, any money I get from other health insurance or legal settlements will go to Medicaid in an amount equal to what Medicaid pays for the expense. *(Display check box.)*

2. *(Display item if a parent and his or her child are eligible for Medicaid and an absent parent was indicated for the child.)*
   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 won't have to cooperate. *(Display check box.)*

3. No one applying for health insurance on this application is incarcerated (in prison or jail). *(Display check box.)*
   a. *(If box is unchecked when submitted, display the following question.)*
      Who is incarcerated (in prison or jail)?

i. *(Display check box list of applicants.)*
Is this person pending disposition?

1. Yes
2. No

4. I understand that if I'm eligible for help paying for health insurance, I may also be able to renew the coverage. During the renewal process, the Marketplace will use income data including information the tax returns of household members. This will determine yearly eligibility for help paying for health insurance for the next 5 years. The Marketplace will send me a notice and let me make changes. If I don't respond, the Marketplace will continue my eligibility at the level indicated by the data. I understand this renewal process will occur each year for the next 5 years unless I tell the Marketplace that I don't want to renew, or if I leave the Marketplace. I also understand that I can change my answer later. If I don't check the box, I can select less than 5 years. *(Display check box.)*

   a. *(If box is unchecked when submitted, display the following.)*
   I give permission for my eligibility for help paying for health insurance to be renewed for a period of:
   1 year
      i. 1 year
      ii. 2 years
      iii. 3 years
      iv. 4 years
      v. Don't renew my eligibility for help paying for health insurance.

5. I know that I must tell the program I'm enrolled in if information I listed on this application changes. *(Display check box.)*

6. I'm signing this application under penalty of perjury. This means I've provided true answers to all the questions on this form to the best of my knowledge. I know that if I'm not truthful, there may be a penalty. *(Display check box.)*

7. *(Display for household contact and for each tax filer if APTC eligible. Subject to discussions on authentication, consent and authorized representatives.)*
   [FNLNS]'s electronic signature

C. Required documents
(Display if any factor of eligibility hasn't yet been verified in accordance with Marketplace rules. If an applicant is potentially Medicaid or CHIP eligible, and the Marketplace is making assessments rather than determinations for the relevant program, then the request to the applicant might be different so that documents go directly to state agencies.)

The members of the household below need to provide additional documentation so we can verify the information entered on the application. If you plan to submit the required documents at a later time, you can access the "Required documents" checklist on your "My account" page.

(Display applicable items.)

1. Proof of income
   [FNLNS1] *(upload button)* [Due date]
   [FNLNS2] *(upload button)* [Due date]

2. Proof of tribal membership
   [FNLNS1] *(upload button)* [Due date]
   [FNLNS2] *(upload button)* [Due date]

3. Proof of eligible immigration status
   [FNLNS1] *(upload button)* [Due date]
   [FNLNS2] *(upload button)* [Due date]

4. Proof of citizenship
   [FNLNS1] *(upload button)* [Due date]
   [FNLNS2] *(upload button)* [Due date]

5. Proof of [other]
   [FNLNS1] *(upload button)* [Due date]
   [FNLNS2] *(upload button)* [Due date]

6. If you don't have an electronic copy of the required documents, you can mail them to this address:
   [Exchange]
   [Address]

D. Eligibility results
(Display summary table which includes all individuals on the application – applicants and non-applicants.)

1. Eligibility results

   [FNLNS1]
   [Program name & eligibility status 1]
   [Program name & eligibility status 2]
   [Link to more information]

   [FNLNS2]
   [Program name & eligibility status 1]
   [Program name & eligibility status 2]
   [Link to more information]

- *(Values for "Program name.")*
    a. Up to [$XXXX] in advance payments of the premium tax credit for [FNLNS] [and FNLNS *(if filing joint return)*]
    b. Cost sharing reductions

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  c. Medicaid

  d. Medicaid based on disability or age

  e. CHIP

  f. Emergency Medicaid

  g. Selecting plans through this Marketplace *(for individuals eligible to enroll in a Qualified Health Plan)*

- *(Values for "Eligibility status.")*
  - a. Eligible
  - b. Pending

2. Not eligible for

   [FNLNS1]
   [Not eligible for program name 1]
   [Not eligible for program name 2]
   [Link to more information & appeals]

   [FNLNS2]
   [Not eligible for program name 1]
   [Not eligible for program name 2]
   [Link to more information & appeals]

   Link to more information & appeals
   a. If you think the Health Insurance Marketplace has made a mistake, you can appeal the decision within 90 days. To appeal means to tell someone at the Marketplace that you think the decision is wrong and you want a fair review of the decision. Find out more about how to appeal *(hyperlinked sentence).*
   b. Following federal law, there's no discrimination on the basis of care, color, national origin, sex, or disability. If you feel you've been discriminated against, you can file a complaint of discrimination *(hyperlinked sentence).*

3. *(Display only in a state where the Exchange is making an assessment of Medicaid eligibility and the person hasn't been assessed potentially eligible for Medicaid.)*
   Do you want to withdraw the Medicaid application for [FNLNS1] and just get a tax credit?
   a. Yes
   b. No

4. *(Don't display if applicant has answered "yes" to being disabled, blind, or in need of long term care or the State Medicaid agency is the entity processing this application.)*
   Do you want to request a full determination for Medicaid for [FNLNS] [and FNLNS (*if joint filers*)] as conducted by [name of the State Medicaid Agency] on the basis of age, disability or blindness?
   a. Yes
   b. No

5. Would you like to register to vote?

     a.   Yes *(Link to blank voter registration form)*

     b.   No

(The user continues from the Eligibility Results to a "to-do" list page that includes tasks tailored to each individual to complete their application and enrollment process. No additional questions are asked on the "to-do" list page. For APTC or QHP eligible individuals, this page includes tasks to enroll in a health plan and links to section XXI ["Plan enrollment"] and additional information. For Medicaid or CHIP eligible individuals, this page includes the state specific process for next steps from the State Medicaid or CHIP agency and links for additional information. If applicable, this "to-do" list also includes the status of required documents and due date(s) for document submission.)

XXI. Plan enrollment (for APTC or QHP eligible applicants)

1. Have you used tobacco products in the last 12 months? *(Note: This is placeholder language. The language and number of questions is to be determined.)*

2. *(User reviews and selects plan(s) (health and/or dental only) and identifies which applicants will be on each plan, if more than one plan is selected.)*

3. *(Display if item APTC eligible. User selects amount of advance payments of premium tax credit they want paid each month to their insurer and applied to plan premiums.)*

    (Display item if APTC eligible. Primary Tax Filer must review and sign the APTC Attestation. Placeholder language below.)
    I understand that because advance payments of the premium tax credit will be paid on my behalf to reduce the cost of my health insurance and/or health insurance for one or more of my dependents:
    - I must file a federal income tax return in 2015 for the tax year 2014.
    - If I'm married at the end of 2014, I must file a joint income tax return with my spouse.
    - I expect that no one else will be able to claim me as a dependent on their 2014 federal income tax return.
    - I expect that I'll claim a personal exemption deduction on my 2014 federal income tax return for any individual listed on this application as a dependent who is enrolled in coverage through this Marketplace and whose premium for coverage is paid in whole or in part by advance payments.

    I also understand that when I file my 2014 federal income tax return, I must reconcile the amount of advance payments actually made with the amount of any premium tax credit I'm entitled to get. I understand that if the amount of the advance payments made on my behalf is less than the amount of any premium tax credit I'm entitled to get, I may be entitled to an additional credit amount. Alternatively, if the amount of advance payments made on my behalf exceeds the amount of any credit I'm entitled to get, I may owe additional federal income tax.

    Tax filer signature(s)

Note to reviewers: This section displays the questions that appear for users who have indicated that they don't want help paying for health insurance or health benefits, and are applying to enroll in a qualified health plan through the Health Insurance Marketplace.

XXII. Non-financial assistance

(Display if "b" ["no"] was selected in item 2 ["Do you want to find out if [you/your family] can get help paying for health insurance or health benefits?"] in section IV ["Help paying for coverage"].)

XXIII. Tell us how many people are applying for health insurance

(Display if household contact indicated that other family members want insurance/benefits.)

1. Tell us about this person:
   a. First name: _____
   b. Middle name: _____
   c. Last name: _____
   d. Suffix: *(Display dropdown menu of suffixes.)*

2. Date of birth: MM/DD/YYYY
   (Repeat items 1-2 for all applicants.)

3. [Applicant Name] is the *(Display relationship dropdown menu)* of [Household contact]
   a. Husband/wife
   b. Domestic partner
   c. Parent
   d. Stepparent
   e. Parent's domestic partner
   f. Son/daughter
   g. Stepson/stepdaughter
   h. Child of domestic partner
   i. Brother/sister
   j. Uncle/aunt
   k. Nephew/niece
   l. First cousin
   m. Grandparent
   n. Grandchild
   o. Other (*If selected, display subsequent list of relationships that are allowed for plan enrollment.*)
      i. Adopted son/daughter
      ii. Foster child
      iii. Son-in-law/daughter-in-law
      iv. Brother-in-law/sister-in-law
      v. Former spouse
      vi. Guardian
      vii. Father-in-law/mother-in-law
      viii. Sponsored dependent
      ix. Trustee
      x. Ward

  xi. Court-appointed guardian
  xii. Collateral dependent
  xiii. Other relative
  xiv. Other unrelated

XXIV. Personal information

A. Tell us more about [Household contact, FNLNS]

1. Sex:
   a. Male *(Display check box.)*
   b. Female *(Display check box.)*

2. *(Display item if a household member is listed on the applicant list.)*
   If [FNLNS] is applying for health insurance, you must provide a Social Security number (SSN) if available. If [FNLNS] doesn't have a SSN we can help [him/her] apply for one. Visit www.placeholder.gov.
   a. Social Security number: ___-___-____

3. *(Display for everyone who enters a SSN.)*
   Is this [FNLNS] the same name that appears on [his/her] Social Security card?
   a. Yes *(If selected, skip to C ["Ethnicity & race.])*
   b. No *(If selected, continue to item 4.)*

4. *(Display item if "b" was selected in item 3.)*
   Enter the same name as shown on [FNLNS]'s Social Security card.
   a. First name: _____
   b. Middle name: _____
   c. Last name: _____
   d. Suffix: (*Display dropdown menu of suffixes*.)

   (If a SSN has been entered and not verified by the Social Security Administration, the system will provide two more opportunities for the user to review and make changes to name, birthdate, and SSN. All applicants continue to B ["Immigration status"].)

B. Immigration status

1. Is [FNLNS] a U.S. citizen or U.S. national?
   a. Yes *(If selected and citizenship verified with SSA, continue to C ["Ethnicity & race"]. If selected and not verified with SSA, continue to item 2.)*
   b. No *(If selected, skip to item 4.)*

2. *(Display if SSA does not verify U.S. citizenship or U.S. national status.)*
   Is [FNLNS] a naturalized citizen?
   a. Yes *(If selected, continue to 3.)*
   b. No *(If selected, inconsistency is found.)*

3. *(Display if "a" was selected in item 2).*

Document type: (select one.)
a. Naturalization certificate *(If selected, display "i" and "ii.")*
    i. Alien number: _____ *(Display check box for "I don't have one.")*
    ii. Naturalization number: _____
b. Certificate of citizenship *(If selected, display "i" and "ii.")*
    i. Alien number: _____ *(Display check box for "I don't have one.")*
    ii. Citizenship certificate number: _____

4. Check if [FNLNS] has eligible immigration status: *(Link to explanation of eligible immigration statuses.)*
   a. *(Display check box. If check box is selected, continue to item 5. If check box isn't selected, prompt user to review list of eligible statuses available through help text and select an option, if applicable.)*

5. Document type: (select one.) *(If "a-m" is selected, display values shown in "5 i-vii" below. Link to explanation and images of document and status types.)*
   a. Reentry Permit (I-327)
   b. Permanent Resident Card ("Green Card", I-551)*
   c. Refugee Travel Document (I-571)
   d. Employment Authorization Card (I-766)*
   e. Machine Readable Immigrant Visa (with temporary I-551 language)*
   f. Temporary I-551 Stamp (on passport or I-94, I-94A)*
   g. Arrival/Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services*
   h. Arrival/Departure Record (I-94, I-94A) issued by U.S. Customs and Border Protection*
   i. Arrival/Departure Record in unexpired foreign passport (I-94)*
   j. Unexpired foreign passport
   k. Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)
   l. Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)
   m. Notice of Action (I-797)*
   n. Other documents or status types (*Link to "Other documents and status types."*) *(If selected, continue to item 6.)*

   (*For these document types allow one selection from item "5 a-n" and one selection from item "6 a-i." Otherwise, display items "5 a-n." If "n" is selected, disable other selections in item 5 and enable list of "other document and status types" below in "6 a.-i.")

   (Display appropriate option based on document type selected. The user will be prompted to provide one or more of the following based on the document type selection.)
       i. Alien number: _____
       ii. I-94 number: _____
       iii. Passport or document number: _____
       iv. Foreign passport country of issuance: *(Display dropdown list of countries.)*
       v. Passport expiration date: MM/DD/YYYY

vi.   SEVIS ID number: _____

vii.   Document description: _____

6. *(Display if "n" was selected in item 5, show list of other document and statuses, as follows. For some status types that are unverifiable, the system may ask for the user to upload documents. For some document types, a user can select both a document type and status.)*
   a. Document indicating American Indian born in Canada (LPR – I-551)
   b. Document indicating member of a Federally-recognized Indian tribe**
   c. Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR)
   d. Office of Refugee Resettlement (ORR) eligibility letter (if under 18)
   e. Cuban/Haitian Entrant
   f. Document indicating withholding of removal
   g. Resident of American Samoa**
   h. Resident of Commonwealth of the Northern Mariana Islands**
   i. Other *(If selected, display these fields: Free text, Alien number, and I-94 number.)*

   (**For these document/status types ask for documents at section XXVIII ["Review & sign"].)

7. *(Display item for everyone who selects a verifiable immigration document type.)*
   Is [FNLNS] the same name that appears on [his/her] document?
   a. Yes *(If selected, skip to C ["Ethnicity & race"].)*
   b. No *(If selected, continue to item 8.)*

8. *(Display item if "b" was selected in item 7.)*
   Enter the same name as shown on [FNLNS]'s document.
   a. First name: _____
   b. Middle name: _____
   c. Last name: _____
   d. Suffix: *(Display dropdown menu of suffixes.)*

   (After clicking "Save & continue" on section XXIV ["Personal information"], retries of the SSN and DHS numbers may occur based on responses from the Hub.)

C. Ethnicity & race

This information will be used to help the U.S. Department of Health and Human Services (HHS) better understand and improve the health of and health care for all Americans. Providing this information won't impact your eligibility for health coverage, your health plan options, or your costs in any way.

1. Is [Person Name] of Hispanic, Latino, or Spanish origin? (optional)
   a. Yes *(If selected, display "i.")*
      i. Ethnicity: (check all that apply.)
         1. Cuban
         2. Mexican, Mexican American, or Chicano/a
         3. Puerto Rican

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4. Other: _____
    (Continue to item 2.)
    b. No *(If selected, skip to item 2.)*

2. Race: (check all that apply) (optional)
    (Display check boxes.)
    a. American Indian or Alaska Native
    b. Asian Indian
    c. Black or African American
    d. Chinese
    e. Filipino
    f. Guamanian or Chamorro
    g. Japanese
    h. Korean
    i. Native Hawaiian
    j. Other Asian
    k. Other Pacific Islander
    l. Samoan
    m. Vietnamese
    n. White
    o. Other: _____

XXV. Other addresses

Note to reviewers: For individuals living outside the state of the Exchange in which they're applying, the system needs a city, ZIP code, and county (if ZIP code covers more than one county) in order to identify qualified health plans for that applicant.

1. *(Display item if there are any applicants other than the household contact.)*
    Do any of the people below live at an address other than [Household contact address]?
    a. *(Display all applicants, and allow multi-select.)*
    b. None of these people *(Disable list of names. Skip to section XXVI ["American Indian/Alaska Native"].)*

2. *(Display item if anyone is selected to have a different address in item 1, and repeat as necessary.)*
    Where does [FNLNS] live?
    a. Street address: _____
    b. Apartment or suite number: _____
    c. City: _____
    d. State: *(Display dropdown menu of states.)*
    e. ZIP code: _____
    f. County: *(Display dropdown selection of potential counties if ZIP code crosses more than one county.)*

3. *(Display item if applicant lists any address [in item 2] for an applicant outside state of Exchange.)*
    Is [FNLNS] living outside [State of Exchange] temporarily?

a. Yes *(If selected, continue to item 4.)*
b. No *(If selected, skip to section XXVI ["American Indian/Alaska Native"].)*

4. Where will [FNLNS] be living in [State of Exchange]?
   a. City: _____
   b. ZIP code: _____
   c. County: *(Display dropdown selection of potential counties if ZIP code crosses more than one county.)*

XXVI. American Indian/Alaska Native

1. Are any of these people a member of a federally recognized tribe?
   a. *(Display checkbox list of applicants' names. Pre-check names that had selected American Indian/Alaska Native from C ["Ethnicity & race"].)*
   b. None of the above.

2. *(Display for each selected applicant.)*
   a. State: *(Display drop down menu of states.)*
   b. Tribe name: *(Display drop down menu of tribes.)*

XXVII. Special Enrollment Periods

(Display section for all applicants in the non-financial assistance section beginning on November 1, 2013, to see if they may qualify for a Special Enrollment Period.)

1. Did any of these people lose health insurance in the last 60 days?
   a. *(Display checkbox list of all QHP eligible individuals, and allow multi-select.)*

2. *(Display for each individual selected in item 1.)*
   When did [Person's name] lose health insurance?
   a. MM/DD/YYYY
   (Continue to item 3.)

3. *(Display for each individual selected in item 1.)*
   Did [Person's name] lose health insurance because of not paying premiums?
   a. Yes
   b. No

4. Did any of the following people get married in the last 60 days?
   a. *(Display check box for all QHP eligible individuals, and allow multi-select. If anyone is selected, continue to item 5.)*

5. *(Display item for each individual selected in item 4.)*
   When did [Person's name] get married?
   a. MM/DD/YYYY

6. Have any of the following people been adopted or placed for adoption in the last 60 days?
   a. *(Display checkbox list of all QHP eligible individuals, and allow multi-select. If anyone is selected, continue to item 7.)*

7. *(Display item for each individual selected in item 6.)*
   When was [Person's name] adopted or placed for adoption?
   a. MM/DD/YYYY

8. Did any of the following people gain eligible immigration status in the last 60 days?
   a. *(Display checkbox list of all QHP eligible individuals who selected that they had eligible immigration status, and allow multi-select. If anyone is selected, continue to item 9.)*

9. *(Display item for each individual selected in item 8.)*
   When did [Person's name] gain eligible immigration status?
   a. MM/DD/YYYY

10. Did any of the following people move in the last 60 days?
    a. *(Display checkbox list of all QHP eligible individuals, and allow multi-select).*

11. *(Display item for each individual selected in item 10.)*
    Provide the following information from [Person's name]'s previous address:
    a. ZIP code: _____
    b. County: *(Display dropdown selection of potential counties if ZIP code crosses more than one county.)*

12. *(Display item for each individual selected in item 10.)*
    What was the date of the move?
    a. MM/DD/YYYY

13. Did any of the following people get released from incarceration (jail or prison) in the last 60 days?
    a. *(Display check box list of all QHP eligible individuals, and allow multi-select. If anyone is selected, continue to item 14.)*

14. *(Display for each individual selected in item 13.)*
    When was [Person's name] released from incarceration (jail or prison)?
    a. MM/DD/YYYY

XXVIII. Review & sign

Note to reviewers: This section describes the summary, signature, and results pages of the application, and is more focused on displaying information rather than asking questions. The signature requirements are subject to outstanding policies on identity proofing and consent. In addition, we are continuing to create a user-friendly interface, which could result in changes to the flow and format described below.

A. Review application
(Display once per application.)

1. Contact information
   [FNLNS1]   (Edit)
   [Address]

[Email address]
[Preferred phone number]

2. Family & household
    [FNLNS1]   (Edit)
    [Address]
    [Relationship to [FNLNS1]]
    [Date of birth]
    [Citizenship/immigration status]
    (Display if person has identified to have an immigrant status.)
    [Satisfactory immigration status: [Y/N] and [date entered the U.S.]]

    [FNLNS2]   (Edit)
    [Address]
    [Relationship to [FNLNS1]]
    [Date of birth]
    [Citizen/immigration status]
    (Display if person has identified to have an eligible immigration status.
    [Satisfactory immigration status: [Y/N] and [date entered the U.S.]]

3. Additional information   (Edit)
    [FNLNS1] [Additional information]
    [FNLNS2] [Additional information]

B. Sign & submit

Read and check the box next to each statement if you agree.
(Display check boxes for user to indicate agreement and sign page.)

1. No one applying for health insurance on this application is incarcerated (in prison or jail). *(If the box isn't checked, display "a.")*
    a. Who is incarcerated (in prison or jail)?
        (Display list of all applicants, and allow multi-select. If anyone is selected, display "i" for each selected individual.)
        i.   Is this person pending disposition?
            1. Yes
            2. No

2. I know that I must tell the Health Insurance Marketplace if information I listed on this application changes.

3. I'm signing this application under penalty of perjury. This means that I've provided true answers to all the questions on this form to the best of my knowledge. I know that if I'm not truthful, there may be a penalty.

4. *(Display for household contact.)*

[FNLNS]'s electronic signature

C. Required documents
(Display if any factor of eligibility hasn't yet been verified in accordance with Marketplace rules.)

1. Proof of tribal membership
   [FNLNS1] *(upload button)* [Due date]
   [FNLNS2] *(upload button)* [Due date]

2. Proof of eligible immigration status
   [FNLNS1] *(upload button)* [Due date]
   [FNLNS2] *(upload button)* [Due date]

3. Proof of citizenship
   [FNLNS1] *(upload button)* [Due date]
   [FNLNS2] *(upload button)* [Due date]

4. Proof of [other]
   [FNLNS1] *(upload button)* [Due date]
   [FNLNS2] *(upload button)* [Due date]

5. If you don't have an electronic copy of the required documents, you can mail them to this address:
   [Exchange]
   [Address]

D. Eligibility results
(Display summary table which includes all applicants on the application.)

1. Eligibility results

   [FNLNS1]
   [Program name & eligibility status 1]
   [Program name & eligibility status 2]
   [Link to more information]

   [FNLNS2]
   [Program name & eligibility status 1]
   [Program name & eligibility status 2]
   [Link to more information]

- *Values for "Program name & eligibility status"*
   a. Cost sharing reductions *(for American Indian/Alaska Natives)*
   b. Selecting a plan through this Marketplace *(for individuals eligible to enroll in a Qualified Health Plan)*

2. Not eligible for

[FNLNS1]
[Not eligible for program name 1]
[Not eligible for program name 2]
[Link to more information & appeals]

[FNLNS2]
[Not eligible for program name 1]
[Not eligible for program name 2]
[Link to more information & appeals]

Link to more information & appeals

    a. If you think the Health Insurance Marketplace has made a mistake, you can appeal the decision within 90 days. To appeal means to tell someone at the Marketplace that you think the decision is wrong and you want a fair review of the decision. Find out more about how to appeal *(hyperlinked sentence).*

    b. Following federal law, there's no discrimination on the basis of care, color, national origin, sex, or disability. If you feel you've been discriminated against, you can file a complaint of discrimination *(hyperlinked sentence).*

3. Would you like to register to vote?
    a. Yes *(Link to blank voter registration form)*
    b. No

(The user continues from the Eligibility Results to a "to-do" list page that includes tasks tailored to each individual to complete their application and enrollment process. No additional questions are asked on the "to-do" list page. For QHP eligible individuals, this page includes tasks to enroll in a health plan and links to section XXI ["Plan enrollment"] and additional information. If applicable, this "to-do" list also includes the status of required documents and due date(s) for document submission.)

XXIX. Plan enrollment

1. Have you used tobacco products in the last 12 months? *(Note: This is placeholder language. The language and number of questions is to be determined.)*

2. User reviews and selects plan(s) (health and/or dental only) and identifies which applicants will be on each plan, if more than one plan is selected.

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-XXXX. 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.

Single Streamlined Application for the Health Insurance Marketplace: Items in Online Application for Comment – Paperwork Reduction Act (PRA) Appendix A
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