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Covered California Enrollment Worksheet

For CEE/CEC use only:
A checked box indicates the CEC has reviewed or completed that selection with the consumer.

☐ Authorization for Enrollment Assistance Form ☐ Voter Registration Assistance Information

☐ Consumer Delegated Under Correct Program (indicate which program with an 'x') ___ IPA ___ NAV

UNDERSTANDING THE COVERED CALIFORNIA ENROLLMENT WORKSHEET:
This worksheet contains key terms related to completing specific questions on the application.

Key terms to look out for:

- **TIP**:
  - A TIP is designed to assist the consumer answer questions that affect eligibility
  - Indicated next to certain questions within parentheses ()
  - Full description of TIP located below designated question
  - Consumer should use the TIP as a guide to answer the designated question

- **Application Index**:
  - The Application Index is located on page five (5) of the Enrollment Worksheet
  - Some worksheet questions will refer to a specific section of the Application Index
  - The Application Index contains the online application drop-down menu selections for the specific question
  - Only drop-down menu selection should be used to answer questions

GETTING STARTED

Would you like to receive premium assistance? (see TIP 1 below) (All consumers are recommended to select 'YES'.)	☐ Yes ☐ No

TIP 1: Selecting 'NO' will affect the cost of coverage for all members in your household, including children and all dependents.

Today's Date (MMDDYYYY)	# in Household	How did you hear about Covered California? (refer to Application Index 1)

Permission to let Covered California Verify your Information	☐ I agree to Consent for Verification

HOUSEHOLD

Do you give permission to Covered California to confirm your identity? (see TIP 2 & 3 below)	☐ Yes ☐ No

TIP 2: Primary Contact must enter legal name (name as it appears on a state ID, driver's license, birth certificate, etc.), current home address, main phone number, date of birth, and email address correctly of all consumers listed on this application. Experian will use information from other agencies to help check the Primary Contact's identity. Only the Primary Contact will see the information from the report. This information will never be presented to outside parties. This information will not affect your credit score. The report will be called "CMS Proofing Services" and will be taken off the consumer's Experian report after 25 months.
Tip 3: Selecting 'NO' to confirming the Primary Contact's identity, means the application cannot be completed.

Primary Contact Name (First, Middle, Last, and suffix, ex: Jr, Sr, I, II, III, IV, V, VI, VII, VIII, IX, X) (see TIP 4 below)

TIP 4: Primary Contact must be the same as household member one. This person will receive notifications of changes in coverage. Be sure that you enter your legal name, current home address, main phone number, date of birth, and email address correctly.

Primary Contact Home Address (see TIP 5 below)

Street		Apartment #
City	State	Zip Code

TIP 5: If you do not have a permanent home address, please enter a temporary address with the City and Zip Code or a mailing address with the City and Zip Code where you live. An address is needed to find available plans in your area.

Home Phone Number ( )	Secondary Phone Number ( )	Email Address

HOUSEHOLD – MEMBERS

FAMILY RELATIONSHIP	PERSON 1 (PRIMARY)	PERSON 2	PERSON 3	PERSON 4
NAME (first, middle, last, and suffix, ex: Jr, Sr, I, II, III, IV, V, VI, VII, VIII, IX, X)				
Are you applying for coverage? (see TIP 6 below)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

TIP 6: Always select 'YES' for children even if already covered by Medi-Cal, as this may affect the coverage of others in the household.

Gender	☐ Female ☐ Male	☐ Female ☐ Male	☐ Female ☐ Male	☐ Female ☐ Male
Date of birth (MMDDYYYY)				
Has Social Security # (refer to Application Index 2)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Social Security # (if 'NO' selected, provide an option from Application Index 2)				
U.S. Citizen or U.S. National (see TIP 7 below)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

TIP 7: If 'YES', provide a Nationalization or Citizen Certificate Number below, and provide an Alien Number. If **'NO'** is selected, **skip** to the Eligible Immigration Status question.

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HOUSEHOLD – MEMBERS (CONTINUED)

FAMILY RELATIONSHIP	PERSON 1 (PRIMARY)	PERSON 2	PERSON 3	PERSON 4
Naturalization/Citizen Certificate #				
Eligible Immigration Status (see TIP 8 below & refer to Application Index 3)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
TIP 8: If 'YES', provide an option from Application Index 4 in the Document Type box along with relevant corresponding document information for each relevant household member. Please note, passports alone are not an acceptable form of proof of residency.				
Document Type				
Alien # or I-94 #				
Green Card #				
SEVIS ID				
Expiration Date (MMDDYYYY)				
Name on the document (first, middle, last, and suffix, ex: Jr, Sr, I, II, III, IV, V, VI, VII, VIII, IX, X)				
Has lived in the US since 1996?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Honorably discharged veteran or active duty military member?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
How are household members related to PERSON 1? (refer Application Index 4)	Self			

PERSONAL DATA – DEMOGRAPHIC INFORMATION

Marital Status CIRCLE ONE	Married / Never Married Single/ Divorced/ Widowed Registered Domestic Partner	Married / Never Married Single/ Divorced/ Widowed Registered Domestic Partner	Married / Never Married Single/ Divorced/ Widowed Registered Domestic Partner	Married / Never Married Single/ Divorced/ Widowed Registered Domestic Partner
Physical, emotional, developmental, or mental disability?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Any medical expense in the last 3 months you need help paying?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Are you pregnant?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If YES, due date: (MMDDYYYY)				
# of babies expected				
Member of a Federally-recognized Indian Tribe?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If a child, who is the primary caretaker?				

PERSONAL DATA – TAX INFORMATION

Are you the primary tax filer? (see TIP 9 below)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
TIP 9: Only one primary tax filer per household.				
Did this person file taxes **last year**?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If YES, Tax Filing Status CIRCLE ONE	Single Married filing jointly Married filing separately Head of household	Single Married filing jointly Married filing separately Head of household	Single Married filing jointly Married filing separately Head of household	Single Married filing jointly Married filing separately Head of household
If NO, were you claimed as a dependent on a tax return last year?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Filing taxes for the benefit/coverage year? (see TIP 10 below)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
TIP 10: To receive the Advanced Premium Tax Credit (APTC), taxes must be filed for 2014.				
If YES, Tax Filing Status (see TIP 11 below) CIRCLE ONE	Single Married filing jointly Married filing separately Head of household	Single Married filing jointly Married filing separately Head of household	Single Married filing jointly Married filing separately Head of household	Single Married filing jointly Married filing separately Head of household
TIP 11: If married, both the husband and wife must select 'Married Filing Jointly'.				

PERSONAL DATA – TAX INFORMATION (CONTINUED)

FAMILY RELATIONSHIP	PERSON 1 (PRIMARY)	PERSON 2	PERSON 3	PERSON 4
Are you expecting to be claimed as a dependent? (see TIP 12 below)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

TIP 12: Never select 'YES' for a spouse as a dependent.

PERSONAL DATA – HEALTH CARE INFORMATION

Offered affordable health insurance for 2015? (refer to Application Index 5)				
If **Employer Sponsored Insurance outside Exchange** is chosen, answer all questions in this section, if not **skip** to 'Need help with long term care/home & community based services' question.				
Name of Employer				
What is the Enrollment Status?	☐ Currently enrolled ☐ Not currently enrolled/ doesn't plan on enrolling ☐ In waiting period to enroll	☐ Currently enrolled ☐ Not currently enrolled/ doesn't plan on enrolling ☐ In waiting period to enroll	☐ Currently enrolled ☐ Not currently enrolled/ doesn't plan on enrolling ☐ In waiting period to enroll	☐ Currently enrolled ☐ Not currently enrolled/ doesn't plan on enrolling ☐ In waiting period to enroll
How much is the monthly premium?				
Does the health plan meet the minimum standard value?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Need help with long term care/home & community based services?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Do you have Medicare benefits? (see TIP 13 below)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

TIP 13: If consumer is over 65 or has Medicare they will fail this application but can apply at the county.

PERSONAL DATA – OPTIONAL DATA

Note: Covered California uses this important information to improve outreach efforts and the level of service to make sure enrollment efforts succeed. This information will help Covered California provide equal access to assistance services for all Californians.

Written language preferred? (refer to Application Index 6)				
Spoken language preferred? (refer to Application Index 6)				
Hispanic, Latino or Spanish Origin?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If YES, to the above, what is this person's origin? (refer to Application Index 7)				
What race is this person? (refer to Application Index 8)				
Member of a Federally-recognized Indian Tribe?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If YES, in which state is tribe recognized?				
If YES, what is the tribe name?				

INCOME

EMPLOYMENT INCOME (w-2)

FAMILY RELATIONSHIP	PERSON 1 (PRIMARY)	PERSON 2	PERSON 3	PERSON 4
Employer (1) Name				
Amount paid before taxes ($)				
At what pay rate? CIRCLE ONE	Hourly Daily Weekly Monthly Every 2 weeks Twice a month Annual	Hourly Daily Weekly Monthly Every 2 weeks Twice a month Annual	Hourly Daily Weekly Monthly Every 2 weeks Twice a month Annual	Hourly Daily Weekly Monthly Every 2 weeks Twice a month Annual
If Hourly or Daily, indicate the quantity worked per week.				
First Date Paid (MMDDYYYY)				
Last Date Paid (MMDDYYYY)				

INCOME (CONTINUED)

EMPLOYMENT INCOME (w-2)

FAMILY RELATIONSHIP	PERSON 1 (PRIMARY)	PERSON 2	PERSON 3	PERSON 4
Employer (2) Name				
Amount paid before taxes ($)				
At what pay rate? CIRCLE ONE	Hourly Daily Weekly Monthly Every 2 weeks Twice a month Annual	Hourly Daily Weekly Monthly Every 2 weeks Twice a month Annual	Hourly Daily Weekly Monthly Every 2 weeks Twice a month Annual	Hourly Daily Weekly Monthly Every 2 weeks Twice a month Annual
If Hourly or Daily, indicate the quantity worker per week.				
First Date Paid (MMDDYYYY)				
Last Date Paid (MMDDYYYY)				

SELF-EMPLOYMENT INCOME (w-9)

Type of work (1)				
Net income this month				
Type of work (2)				
Net income this month				

OTHER INCOME

Type of Income (refer to Application Index 9)				
Source of Income (refer to Application Index 10)				
How often are you paid? CIRCLE ONE	Hourly Daily Weekly Monthly Every 2 weeks Twice a month Annual	Hourly Daily Weekly Monthly Every 2 weeks Twice a month Annual	Hourly Daily Weekly Monthly Every 2 weeks Twice a month Annual	Hourly Daily Weekly Monthly Every 2 weeks Twice a month Annual
If Hourly or Daily, indicate the quantity per week.				
First Date Paid (MMDDYYYY)				
Last Date Paid (MMDDYYYY)				
One-Time Lump Sum (see TIP 12 below)				

TIP 12: "One-Time" payments are those that you do not expect to get again. They can include lottery winnings, prizes, awards, and retroactive Social Security payments. It does not include income you get more than one time, or for more than one month. Getting a "One-Time" payment may affect your eligibility for health insurance. Make sure you choose the right option from the drop down choices "One-Time" payments.

INCOME DEDUCTIONS (see TIP 13 below)

TIP 13: If you have already included an expense when you calculated your net self-employment or rental property income, do not include it here.

Type of Deduction CIRCLE ONE	Alimony Paid Student Loan Interest Paid Other	Alimony Paid Student Loan Interest Paid Other	Alimony Paid Student Loan Interest Paid Other	Alimony Paid Student Loan Interest Paid Other
Paid to?				
How much do you pay for this deduction?				
How often are you paid? CIRCLE ONE	Hourly Daily Weekly Monthly Every 2 weeks Twice a month Annual One-time Lump Sum	Hourly Daily Weekly Monthly Every 2 weeks Twice a month Annual One-time Lump Sum	Hourly Daily Weekly Monthly Every 2 weeks Twice a month Annual One-time Lump Sum	Hourly Daily Weekly Monthly Every 2 weeks Twice a month Annual One-time Lump Sum
If Hourly or Daily, indicate the quantity per week.				
First Date Paid (MMDDYYYY)				
Last Date Paid (MMDDYYYY)				
If One-time Lump Sum, when? (MMDDYYYY)				

Application Index

Household Members

1) How did you hear about Covered California?
(Provide answer in designated space on worksheet)

Provide answer in designated space on worksheet

- Billboard
- Brochure
- Certified Enrollment Counselor (CEC)
- Certified Insurance Agent
- Church
- Community Organization or Community Event
- CoveredCA.com website
- Email
- Employer
- Family/Friend
- Government Office
- Internet Search
- Mailer
- Mobile Ad
- News program or story
- Newspaper/Magazine
- Other
- Outreach and Education Program
- Pharmacy
- Provider/Hospital
- Radio
- Sign in Retail Store
- Social Media (Facebook/Twitter/Google+)
- Transit
- TV
- Web
- Word of Mouth
- Other

2) Has Social Security Number (SSN)?
(options available in online application)

If no SSN, why?

- Religious Exemption
- Child Under 1
- ITIN/ATIN
  - Provide ITIN/ATIN
- This person does not quality for an SSN
- SHOP Application

3) Has Eligible Immigration Status?
(options available in online application)

'YES', household member has eligible immigration status, please indicate which document demonstrates the eligible immigration status and provide the relevant document information:

Provide: ALIEN NUMBER, and EXPIRATION DATE if any of the following documents are provided as proof of eligible immigration status

- Reentry Permit (I-327)
- Refugee Travel Document (I-571)
- Employment Authorization Card (I-766)
- Notice of Action (I-797)
- Document Indicating American Indian born in Canada. LPR. I-551
- Document Indicating member of a federally-recognized Indian tribe
- Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR)
- Office of Refugee Resettlement (ORR) eligibility letter
- Cuban/Haitian Entrant, Document indicating withholding or removal

Provide: ALIEN NUMBER, PASSPORT NUMBER, and EXPIRATION DATE if the following documents are provided as proof of eligible immigration status

- Temporary I-551 Stamp (on passport or I-94, I-94A)

Provide: I-94 NUMBER, SEVIS ID, and EXPIRATION DATE if the following documents are provided as proof of eligible immigration status

- Arrival/Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services
- Arrival/Departure Record (I-94, I-94A) issued by U.S. Customs and Border Protection
- Certification of Eligibility for Nonimmigrant (F-1) Student Status (I-20)
- Certification of Eligibility for Exchange Visitor (J-1) Status (DS2019)

Provide: ALIEN NUMBER, CARD NUMBER, and EXPIRATION DATE if the following documents are provided as proof of eligible immigration status

- Permanent Resident Card (Green Card, I-551)

Personal Data – Tax Information

4)Household Relationships
(Provide answer in designated space on worksheet)

Provide answer in designated space on worksheet (continued on next page)

- Adopted Son/Daughter
- Brother/Sister
- Brother-in-law/Sister-in-law
- Child of domestic partner
- Collateral dependent
- Court-appointed guardian
- Domestic partner
- Father-in-law/Mother-in-law
- First cousin
- Former spouse
- Foster child
- Foster parent
- Grandchild
- Grandparent
- Guardian
- Husband/Wife
- Nephew/Niece
- Other relative
- Parent
- Parent's domestic partner
- Son/Daughter
- Son-in-law/Daughter-in-law
- Sponsored dependent
- Stepbrother/Stepsister
- Stepparent
- Stepson/Stepdaughter
- Trustee
- Uncle/Aunt
- Unrelated
- Ward

Application Index (CONTINUED)

Personal Data – Health Care Information

5) Offered affordable Health Insurance for 2014?
(Provide answer in designated space on worksheet)

Provide answer in designated space on worksheet

- COBRA
- Employer Sponsored Insurance outside Exchange
- Peace Corps
- Retiree health plan
- TRICARE/CHAMPUS
- Veterans health plan
- Indian Health Services
- Tribal Health Program
- Urban Indian Health Program
- None of the Above

Personal Data – Optional Data

6) Written and Spoken language preferred
(Provide answer in designated space on worksheet)

Provide answer in designated space on worksheet

- English
- Arabic
- Armenian
- Farsi
- Cambodian (Khmer)
- Traditional Chinese
- Hmong
- Korean
- Russian
- Spanish
- Tagalog
- Vietnamese
- Cantonese (spoken only)
- Mandarin (spoken only)

7) What is this person's origin?
(Provide answer in designated space on worksheet)

Provide answer in designated space on worksheet only if 'Yes' is selected for previous question (include all that apply)

- Cuban
- Mexican/Mexican American/Chicano
- Puerto Rican
- Other

8) What is this person's race?
(Provide answer in designated space on worksheet)

Provide answer in designated space on worksheet (include all that apply)

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

Income – Other Income

9) Other Types of Income
(Provide answer in designated space on worksheet)

Provide answer in designated space on worksheet

- Unemployment Benefits
- Social Security Benefits
- Retirement/Pension Income
- Rental or Royalty Income
- Alimony received
- Investment income
- Capital Gains
- Farming or Fishing Income
- Cancelled Debts
- Court Awards
- Jury Duty Pay
- Miscellaneous

10) Source of Income
(Provide answer in designated space on worksheet)

Dependent on the Type of Income selected above, provide the answer to Source of Income using the following questions.

- Unemployment Benefits: **From what state or former employer?**
- Social Security Benefits: **Retirement, Disability or Survivors?**
- Retirement/Pension Income: **Provide your own source of income**
- Rental or Royalty Income: **How much net income (profits after expenses) will this person get from this source this month ($)?**
- Alimony received: **Provide your own source of income**
- Investment income: **How much net income (profits after expenses) will this person get from this source this month ($)?**
- Capital Gains: **How much net income (profits after expenses) will this person get from this source this month ($)?**
- Farming or Fishing Income: **How much net income (profits after expenses) will this person get from this source this month ($)?**
- Cancelled Debts: **Provide your own source of income**
- Court Awards: **From what court?**
- Jury Duty Pay: **From what court?**
- Miscellaneous: **From what sources?**

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IMPORTANT INFORMATION FOR CONSUMER RECORDS

Health Insurance Plan			
Phone: ( )	Website:		
Provider Name			
Estimated household monthly premium BEFORE deductions			$
Estimated Covered California Benefits:	Cost Sharing $	Tax Credit $	Total $
Estimated household monthly premium AFTER deductions			$
Consumer Username:	Consumer Password:		
Case ID:	Consumer PIN:		
Name of Certified Enrollment Entity:	Phone:		
Name of Certified Enrollment Counselor:	Certificate Number: 100000		
Address:	Phone: Email:		

PROOF OF DOCUMENTS REQUIRED

DOCUMENT REQUIRED	UPLOADED	PENDING
☐ PROOF OF INCOME		
☐ PROOF OF CALIFORNIA RESIDENCY		
☐ PROOF OF CITIZENSHIP/LEGAL RESIDENCY		
☐ OTHER PROOF		

COVERED CALIFORNIA MAY REQUEST ADDITIONAL DOCUMENTATION WITH A 90-DAY TURNAROUND. COVERED CALIFORNIA CONDUCTS SEMI-ANNUAL "DATA MATCHING" TO VERIFY YOUR HOUSEHOLD'S ELIGIBILITY AND INCOME CHANGES WITH A 30-DAY TURNAROUND.

CONSUMER RESPONSIBILITIES

CONTACT YOUR HEALTH PLAN TO SCHEDULE OR MAKE YOUR FIRST PREMIUM PAYMENT WITHIN **SEVEN (7)** DAYS OF ENROLLING WITH COVERED CALIFORNIA IF YOU HAVE NOT RECEIVED A BILL.

Paying Your Premium	• You can make your payments directly through the insurance company you selected.
	• You must pay your first premium and receive your insurance card to have access to the health services offered by your Health Plan.
	• Payments must be received by your Health Plan 4 days before the first (1st) of your activation month
	  ○ If you enroll and pay the premium by the 15th of the month, your benefits will be active on the 1st of the next month.
	  • Example: Enroll and pay by February 15 - benefits will be active on March 1
	  • Example: Enroll and pay on or after February 16 - benefits will be active on April 1

Report Changes Within 30 Days	• Addition of a household member (birth, adoption, marriage, etc.) • Remove a household member • Change in incarceration status • Change in health coverage • Change in citizenship/immigration status • Change in household contact information or address change • Change in name • Change in income • Change in tax information

ADDITIONAL INFORMATION

Stay Informed

- Make sure you review your health insurance documents and stay inform about the services you will have access to, including the free preventive care services available through your insurance.
- www.heatlhcare.gov has many detailed educational materials available for patient education.

Complaints or Concerns

- The Office of Patient Advocate – This state agency provides a great overview of the health care industry with a glossary of terms, patient rights, and a step-by-step guide that shows consumers how to deal with a problem or file a complaint against their health care insurance company.
- For more information, visit www.opa.ca.gov or call 1(800) 466-8900.

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