Application for the Government Health Plan

Apply faster online at Medicaid.PR.gov.

Who can use this application?

- Use this application to apply for anyone in your household.
- Apply even if you, your spouse, or your child already has health coverage.
- Households that include eligible immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying will not affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this form, you may need to complete Attachment B.

What you may need to apply

- Social Security Numbers (or document numbers for any eligible immigrant who needs coverage).
- Employer and income information for each member of your household with income (like pay stubs or wage and tax statements).
- Policy numbers for any current health insurance plan.
- Attachment F lists documents you may need.

Why do we ask for this information?

We ask about income and other information to let you know for what coverage you qualify. **We'll keep all the information you provide private and secure, as required by law**. To view the Privacy Act Statement, go to medicaid.PR.gov.

What happens next?

Send your complete, signed application to the address on page 11. **If you do not have all the information we ask for, sign, and submit your application anyway**. We'll follow up with you within 1–2 weeks with instructions on the next steps to complete your application. You'll get an eligibility decision notice in the mail after your application is processed. If you do not hear from us, visit medicaid.PR.gov or call Call Center. Filling out this application doesn't mean you committed to anything.

Get help with this application

- **Online**: medicaid.PR.gov
- **Phone**: Call our Help Center at **(787) 641-4224** / (787) 625-6955 TTY/TDD. (Impaired hearing person)
- **In person**: At any Puerto Rico Medicaid local office.
- **En español**: Llamé a nuestro Centro de Llamadas al **(787) 641-4224** / (787) 625-6955 TTY/TDD (persona audio impedida)
- **Other languages**: If you need help in a language other than English or Spanish, call our call center and tell the customer service representative what language you need. We'll provide you help at no cost to you.

Use blue or black ink to fill out this application.

STEP 1: Tell us about yourself.

One adult in the family must be the contact person for this application and their information should be in this section.

First name	Middle name	Last name	Second last name

Home address (Leave blank if you do not have a home address)

Address line 1		Address line 2	
City	**State**	**ZIP code**	**Barrio**

Mailing address (required) — **Same as Home address:** ☐

Address line 1		Address line 2	
City	**State**	**ZIP code**	

Phone number ◯ Home ◯ Cell ◯ Work — ( ) -

Other phone number ◯ Home ◯ Cell ◯ Work — ( ) -

Do you want to receive communications electronically? Yes ◯ No ◯

Email address:

Preferred spoken language:	English ◯	Spanish ◯	Other ◯ _____
Preferred written language:	English ◯	Spanish ◯	Other ◯ _____

STEP 2: Tell us about your family.

Who do you need to include on this application?

Complete STEP 2 for each person living in your household, even if the person has health coverage already. The information in this application helps us make sure everyone gets the best coverage they can. The type of program for which each person qualifies is based on the number of people in their household and their household income. If you do not include someone, because they already have health coverage, eligibility results could be affected.

For adults who need health coverage:

*Include the people below **even if they are not applying for health coverage for themselves**, if they live in the same home -*

- Any spouse.
- Any son or daughter under age 19, including stepchildren.

For children, birth through age 18, who need coverage:

*Include the people below **even if they are not applying for health coverage for themselves**, if they live in the same home -*

- Any parent (or stepparent).
- Any sibling under age 19.
- Any son or daughter under age 19, including stepchildren.
- Any spouse.

Complete STEP 2 for each person in your household.

Start with yourself, then add other adults and children. If you have more than 2 people in your family, you'll need to copy the pages to add more family members and attach them to this application. You do not need to provide immigration status or a Social Security Number (SSN) for anyone who is not applying for health coverage.

Check all Attachments. You must fill out the application for all members of your household. Fill out Attachments A (for American Indians or Alaska Natives (AI/AN) and/or B (Help Completing this Application) if applicable. Attachment C is optional. If any household members are 65 or over, are blind, have a disability, or receive medical services for special health needs, completing Attachment C (for that household member only) increases the ways they might be found eligible. Fill out Attachment D to choose insurance companies for each person. Include all completed Attachments with the application.

STEP 2: PERSON 1 (Start with yourself)

Complete STEP 2 for yourself, your spouse/partner and children who live with you. See page 2 for more information about who to include.

1. First name	Middle name	Last name	Second last name

2. Relationship to Person 1	3. Date of birth (dd/mm/yyyy)	4. Sex	5. Gender
SELF	/ /	M ◯ F ◯	M ◯ F ◯

6. Social Security Number (SSN)	7. Is PERSON 1 Married?
- -	Yes ◯ No ◯

★ **We need this if you want health coverage and have an SSN or can get one.** We use SSNs to check income and other information to see who's eligible for health coverage. For more information on getting an SSN, visit socialsecurity.gov or call 1-800-772-1213. TTY users should call 1-800-325-0778 or visit your local PR Medicaid office, and they can assist you in applying for one.

8. Are you pregnant?	If yes, how many babies are expected with this pregnancy?	Estimated delivery date (dd/mm/yyyy) – Optional
Yes ◯ No ◯		/ /

9. Does PERSON 1 need health coverage?	If yes, answer all the questions below. If no, skip to income questions starting with question 20.
Yes ◯ No ◯	

10a. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility / nursing home?	Yes ◯ No ◯
10b. Are you blind?	Yes ◯ No ◯
10c. Do you have a disability?	Yes ◯ No ◯

★ **If you answered yes to question 10a, 10b, and/or 10c, you may want to complete Attachment C for PERSON 1**. Attachment C is required to be considered for another type of coverage for adults 65 or over, individuals with blindness or disabilities, and special health care needs. If you do not complete Attachment C, your coverage determination will not be delayed based on the information in this application. You can complete Attachment C at a later time, if you are denied coverage and someone in your household has special health care needs.

11a. Is PERSON 1 a **U.S. citizen** or **U.S. national?** (See Attachment F)	Yes ◯ No ◯ **If no,** skip to question 12.

11b. Is PERSON 1 a **naturalized or derived citizen**?

Yes ◯ No ◯ **If Yes**, please provide the information below (if available). **If no**, skip to question 13.

Alien number:	Certificate number:

12. If PERSON 1 is not a U.S. citizen or U.S. national, does PERSON 1 have eligible immigration status?

Yes ◯ No ◯ **If Yes**, enter document type and appropriate ID number and answer other questions below (see Attachment E)

Immigration document type	Write PERSON 1's name as it appears on their immigration document.
Alien or I-94 number	**Card number or passport number**
SEVIS ID or expiration date (as applicable)	**Other (category code or country of issuance)**

Has PERSON 1 lived in the U.S. since 1996?	Yes ◯ No ◯	Is PERSON 1 or PERSON 1's spouse or parent, a veteran or an active-duty member of the U.S. military?	Yes ◯ No ◯

13. Is PERSON 1 a **Puerto Rico government employee?**

Yes ◯ No ◯ **If Yes**, answer the questions below.

PERSON 1 is employed by:	◯ Agency of central government ◯ Municipality ◯ Public corporation		
Agency / Municipality / Public Corporation		Monthly Health Plan Contribution	$

STEP 2: PERSON 1 (Continue with yourself)

14. Is PERSON 1 a **member of the Puerto Rico Police,** or does PERSON 1 have a **relationship with a member of the Puerto Rico Police?**

Yes ◯ No ◯ **If Yes**, answer the questions below.

Name of the member of the Police	
Relationship that PERSON 1 has with the member of the Police	◯ Police ◯ Spouse ◯ Son/Daughter

15. Does PERSON 1 want help paying for medical bills from the last 3 months? Yes ◯ No ◯

16. Does PERSON 1 live with at least one child under the **age of 19**, and is PERSON 1 the main person taking care of this child? (Select "Yes" if either PERSON 1 or PERSON 1's spouse takes care of the child.)
If yes, please complete Step 3 of this application. Yes ◯ No ◯

17. Was PERSON 1 in foster care at age 18 or older? Yes ◯ No ◯ **If yes**, in which state?

Optional:
(Fill in all that apply.)

18. If Hispanic/Latino, Ethnicity:
☐ Mexican ☐ Mexican American ☐ Chicano ☐ Puerto Rican ☐ Cuban ☐ Other _____

19. Race:
☐ White/Caucasian ☐ Black/African American ☐ American Indian or Alaskan Native
☐ Filipino ☐ Japanese ☐ Korean ☐ Asian Indian
☐ Chinese ☐ Vietnamese ☐ Other Asians
☐ Native Hawaiian ☐ Guamanian or Charmorro ☐ Samoan ☐ Other Pacific Islander
☐ Other _____

Current job & income information

◯	**Employed:** If **PERSON 1** is currently employed tell us about his/her income. Start with question 20.	◯	**Not employed:** Skip to question 30.	◯	**Self-employed:** Skip to question 29.

Current Job 1:

20. Employer Name

21. Employer Address: Line 1 | Line 2

City | State | ZIP code | Employer phone number ( ) -

22. Wages/tips (before taxes) $

◯ Hourly ◯ Weekly ◯ Every 2 weeks
◯ Twice a month ◯ Monthly ◯ Yearly

23. Average hours worked/WEEK

Current Job 2: (If PERSON 1 has more than 2 jobs, attach additional sheets of paper with the information)

24. Employer Name

25. Employer Address: Line 1 | Line 2

City | State | ZIP code | Employer phone number ( ) -

26. Wages/tips (before taxes) $

◯ Hourly ◯ Weekly ◯ Every 2 weeks
◯ Twice a month ◯ Monthly ◯ Yearly

27. Average hours worked/WEEK

28. In the past year, did PERSON 1: ◯ Change Jobs ◯ Stop working ◯ Start working fewer hours ◯ None of these

29. If PERSON 1 is self-employed: Type of work:

How much net income (profits once business expenses are paid) will PERSON 1 get from this self-employment this month? $

STEP 2: PERSON 1 (Continue with yourself)

30. Other incomes PERSON 1 gets this month: Fill in all that apply, giving the amount and how often PERSON 1 gets it. **Do not** tell us about PERSON 1's income from child support, veteran's payments or SSI.

Fill here if none ◯

☐ **Unemployment** $ ____ How Often? ____	☐ **Alimony received** $ ____ How Often? ____
☐ **Pension** $ ____ How Often? ____	☐ **Net farming/fishing** $ ____ How Often? ____
☐ **Social Security** $ ____ How Often? ____	☐ **Net rental/royalty** $ ____ How Often? ____
☐ **Retirement accounts** $ ____ How Often? ____	☐ **Other income, type:** _____ $ ____ How Often? ____

31. Deductions: Fill in all that apply, giving the amount and how often PERSON 1 pays it. **NOTE:** Do not include any child support PERSON 1 pays, or costs already considered in answer to net self-employment income.

◯ **Alimony paid** $ ____ How Often? ____	☐ **Student loan interest** $ ____ How Often? ____

NOTE: In questions 30 & 31, answer "How Often?" with – Weekly / Every 2 weeks / Monthly / Twice Monthly / Yearly / or write other value.

STEP 2: PERSON 2

Make copies of pages 6, 7, & 8 if there are more than 2 people in your household.

Complete this page for your spouse/partner and children who live with you. See page 2 for more information about who to include.

1. First name	Middle name	Last name	Second last name

2. Relationship to Person 1*	3. Date of birth (dd/mm/yyyy)	4. Sex	5. Gender
	/ /	M ◯ F ◯	M ◯ F ◯

6. Social Security Number (SSN)	7. Is PERSON 2 Married?
- -	Yes ◯ No ◯

★ **We need this if you want health coverage and have an SSN or can get one.** We use SSNs to check income and other information to see who's eligible for health coverage. For more information on getting an SSN, visit socialsecurity.gov or call 1-800-772-1213. TTY users should call 1-800-325-0778 or visit your local PR Medicaid office, and they can assist you in applying for one.

Does PERSON 2 live at the same address as PERSON 1? Yes ◯ No ◯

If No, enter address

8. Is PERSON 2 pregnant?	If yes, how many babies are expected with this pregnancy?	Estimated delivery date (dd/mm/yyyy) – Optional
Yes ◯ No ◯		/ /

9. Does PERSON 2 need health coverage? Yes ◯ No ◯

If yes, answer all the questions below.
If no, skip to income questions starting with question 20.

10a. Does PERSON 2 have a physical, mental, or emotional health condition causing limitations in activities (bathing, dressing, daily chores, etc.) or live in a medical facility / nursing home?	Yes ◯ No ◯
10b. Is PERSON 2 blind?	Yes ◯ No ◯
10c. Does PERSON 2 have a disability?	Yes ◯ No ◯

★ **If you answered yes to question 10a, 10b, and/or 10c, you may want to complete Attachment C for PERSON 2**. Attachment C is required to be considered for another type of coverage for adults 65 or over, individuals with blindness or disabilities, and special health care needs. If you do not complete Attachment C, PERSON 2's coverage determination will not be delayed based on the information in this application. You can complete Attachment C at a later time, if PERSON 2 is denied coverage and has special health care needs.

11a. Is PERSON 2 a **U.S. citizen** or **U.S. national?** (See Attachment F) Yes ◯ No ◯ **If no**, skip to question 12.

11b. Is PERSON 2 a **naturalized or derived citizen**?

Yes ◯ No ◯ **If Yes**, please provide the information below (if available). **If no,** skip to question 13.

Alien number:	Certificate number:

12. If PERSON 2 is not a U.S. citizen or U.S. national, does PERSON 2 have eligible immigration status?

Yes ◯ No ◯ **If Yes**, enter document type and appropriate ID number and answer other questions below (see Attachment E)

Immigration document type	Write PERSON 2's name as it appears on their immigration document.
Alien or I-94 number	**Card number or passport number**
SEVIS ID or expiration date (as applicable)	**Other (category code or country of issuance)**

Has PERSON 2 lived in the U.S. since 1996?	Yes ◯ No ◯	Is PERSON 2 or PERSON 2's spouse or parent, a veteran, or an active-duty member of the U.S. military?	Yes ◯ No ◯

13. Is PERSON 2 a **Puerto Rico government employee?**

Yes ◯ No ◯ **If Yes**, answer the questions below.

PERSON 2 is employed by:	◯ Agency of central government ◯ Municipality ◯ Public corporation		
Agency / Municipality / Public Corporation		Monthly Health Plan Contribution	$

STEP 2: PERSON 2 (Continue with PERSON 2)

14. Is PERSON 2 **a member of the Puerto Rico Police,** or does PERSON 2 have **a relationship with a member of the Puerto Rico Police?**

Yes ◯ No ◯ **If Yes**, answer the questions below.

Name of the member of the Police	
Relationship that PERSON 2 has with the member of the Police	◯ Police ◯ Spouse ◯ Son/Daughter

15. Does PERSON 2 want help paying for medical bills from the last 3 months? Yes ◯ No ◯

16. Does PERSON 2 live with at least one child under the **age of 19**, and is PERSON 2 the main person taking care of this child? (Select "Yes" if either PERSON 2 or PERSON 2's spouse takes care of the child.) If yes, please complete Step 3 of this application. Yes ◯ No ◯

17. Was PERSON 2 in foster care at age 18 or older? Yes ◯ No ◯ **If yes**, in which state?

Optional: (Fill in all that apply.)

18. If Hispanic/Latino, Ethnicity:
☐ Mexican ☐ Mexican American ☐ Chicano ☐ Puerto Rican ☐ Cuban ☐ Other _____

19. Race:
☐ White/Caucasian ☐ Black/African American ☐ American Indian or Alaskan Native
☐ Filipino ☐ Japanese ☐ Korean ☐ Asian Indian
☐ Chinese ☐ Vietnamese ☐ Other Asians
☐ Native Hawaiian ☐ Guamanian or Charmorro ☐ Samoan ☐ Other Pacific Islander
☐ Other _____

Current job & income information

◯	**Employed:** If **PERSON 2** is currently employed tell us about his/her income. Start with question 20.	◯	**Not employed:** Skip to question 30.	◯	**Self-employed:** Skip to question 29.

Current Job 1:

20. Employer Name

21. Employer Address: Line 1 | Line 2

City | State | ZIP code | Employer phone number ( ) -

22. Wages/tips (before taxes) $

◯ Hourly ◯ Weekly ◯ Every 2 weeks
◯ Twice a month ◯ Monthly ◯ Yearly

23. Average hours worked/WEEK

Current Job 2: (If PERSON 2 has more than 2 jobs, attach additional sheets of paper with the information)

24. Employer Name

25. Employer Address: Line 1 | Line 2

City | State | ZIP code | Employer phone number ( ) -

26. Wages/tips (before taxes) $

◯ Hourly ◯ Weekly ◯ Every 2 weeks
◯ Twice a month ◯ Monthly ◯ Yearly

27. Average hours worked/WEEK

28. In the past year, did PERSON 2: ◯ Change Jobs ◯ Stop working ◯ Start working fewer hours ◯ None of these

29. If PERSON 2 is self-employed: Type of work:

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

STEP 2: PERSON 2 (Continue with yourself)

30. Other incomes PERSON 2 gets this month: Fill in all that apply, giving the amount and how often PERSON 2 gets it. **Do not** tell us about PERSON 2's income from child support, veteran's payments or SSI.

Fill here if none ◯

☐ **Unemployment** $ ____ How Often? ____	☐ **Alimony received** $ ____ How Often? ____
☐ **Pension** $ ____ How Often? ____	☐ **Net farming/fishing** $ ____ How Often? ____
☐ **Social Security** $ ____ How Often? ____	☐ **Net rental/royalty** $ ____ How Often? ____
☐ **Retirement accounts** $ ____ How Often? ____	☐ **Other income, type:** _____ $ ____ How Often? ____

31. Deductions: Fill in all that apply, giving the amount and how often PERSON 2 pays it. **NOTE:** Do not include any child support PERSON 2 pays, or costs already considered in answer to net self-employment income.

◯ **Alimony paid** $ ____ How Often? ____	☐ **Student loan interest** $ ____ How Often? ____

* See the list at the bottom of page 10 for the choices that can be entered for "Relationship" in question 2.

NOTE: In questions 30 & 31, answer "How Often?" with – Weekly / Every 2 weeks / Monthly / Twice Monthly / Yearly / or write other value.

STEP 3: Relationships between household members

You need to tell us the relationships which exist between all household members. The relationship for each person to PERSON 1 has already been collected in STEP 2, but we still need to establish the relationship between other people on this application. If the application is for only one or two persons, skip this section and go to STEP 4.

In the section below for the 2nd PERSON, enter the name of the 2nd PERSON at the top of the section. Then, for each person after the 2nd, enter the person's name on the appropriate row and his/her relationship to the 2nd PERSON. In the following section, repeat similarly for the 3rd PERSON and the relationship of other members to the 3rd PERSON. Then successively for each additional member, as necessary, in the remaining sections until the last for the relationship between the 10th PERSON and 9th PERSON.

At each additional person's section there will be one fewer row than the previous section as fewer relationships need to be established. If the application contains more than 10 people, please contact us at a local office or by calling our CALL CENTER.

Make sure the name of any person entered below matches with a person entered in STEP 2.

2nd PERSON – Name:

#	Name	Relationship to the 2nd PERSON
3		
4		
5		
6		
7		
8		
9		
10		

3rd PERSON – Name:

#	Name	Relationship to the 3rd PERSON
4		
5		
6		
7		
8		
9		
10		

4th PERSON – Name:

#	Name	Relationship to the 4th PERSON
5		
6		
7		
8		
9		
10		

STEP 3: Relationships between household members (Continued)

5th PERSON – Name:		
#	Name	Relationship to the 5th PERSON
6		
7		
8		
9		
10		

6th PERSON – Name:		
#	Name	Relationship to the 6th PERSON
7		
8		
9		
10		

7th PERSON – Name:		
#	Name	Relationship to the 7th PERSON
8		
9		
10		

8th PERSON – Name:		
#	Name	Relationship to the 8th PERSON
9		
10		

9th PERSON – Name:		
#	Name	Relationship to the 9th PERSON
10		

Use one of the following values to indicate relationships between people:

- Husband
- Wife
- Father
- Mother
- Stepfather
- Stepmother
- Son
- Daughter
- Stepson
- Stepdaughter
- Brother
- Sister
- Stepbrother
- Stepsister
- Grandfather
- Grandmother
- Grandson
- Granddaughter
- Uncle
- Aunt
- Nephew
- Niece
- First Cousin
- Other family
- Not related

* The relationships above also apply when the relationship is the result of an adoption.

STEP 3: Caretaker relationships between household members

Complete this section **for each person with an answer YES to question 16 in STEP 2**, to indicate he / she is the main person taking care of a child under 19 years of age. Under the name of each PERSON who takes care of one or more children under 19 years of age, list the names of the children under 19 years old that the person looks after.

Make sure the name of any person entered below matches with a person entered in STEP 2.

PERSON Name:	
Household Member Name (a child under 19) for whom this PERSON is the main person taking care of the child	

PERSON Name:	
Household Member Name (a child under 19) for whom this PERSON is the main person taking care of the child	

PERSON Name:	
Household Member Name (a child under 19) for whom this PERSON is the main person taking care of the child	

If more space is needed, copy this page and attach it to the application.

STEP 4: American Indian or Alaska Native (AI/AN) household member(s)

1. Are you, or anyone on your household, American Indian or Alaska Native?	
◯ No **If no**, continue to STEP 5.	◯ Yes **If yes**, complete Attachment A and include it with this application, and then continue with STEP 5.

STEP 5: Your household's existing health coverage

1. You and members of your household may still be eligible for Government Health Plan coverage, even if currently covered by another health plan. If anyone has health coverage already, fill out the information in question 2, otherwise skip to STEP 6.

2. Fill out one section below for each person with health insurance for each plan they have. If needed, makes copies of this page. Make sure the name of the person entered below matches with a person entered in STEP 2.

Person/Insurance 1

Name of person enrolled in health coverage

Type of coverage:

◯ Employer insurance ◯ COBRA ◯ Medicare ◯ TRICARE ◯ VA ◯ Peace Corps ◯ Government Health Plan ◯ Other

Name of health insurance company	**Policy / ID number**

Is this a limited-benefit plan, like a school accident policy? Yes ◯ No ◯

Person/Insurance 2

Name of person enrolled in health coverage

Type of coverage:

◯ Employer insurance ◯ COBRA ◯ Medicare ◯ TRICARE ◯ VA ◯ Peace Corps ◯ Government Health Plan ◯ Other

Name of health insurance company	**Policy / ID number**

Is this a limited-benefit plan, like a school accident policy? Yes ◯ No ◯

Person/Insurance 3

Name of person enrolled in health coverage

Type of coverage:

◯ Employer insurance ◯ COBRA ◯ Medicare ◯ TRICARE ◯ VA ◯ Peace Corps ◯ Government Health Plan ◯ Other

Name of health insurance company	**Policy / ID number**

Is this a limited-benefit plan, like a school accident policy? Yes ◯ No ◯

Person/Insurance 4

Name of person enrolled in health coverage

Type of coverage:

◯ Employer insurance ◯ COBRA ◯ Medicare ◯ TRICARE ◯ VA ◯ Peace Corps ◯ Government Health Plan ◯ Other

Name of health insurance company	**Policy / ID number**

Is this a limited-benefit plan, like a school accident policy? Yes ◯ No ◯

STEP 6: Your agreement & signature

1. Is anyone who is applying for health coverage on this application incarcerated (detained or jailed)?	Yes ◯	No ◯
If yes, tell us the name of the person incarcerated.		
	Fill here if this person is facing disposition of charges. ◯	

If anyone on this application is eligible for Medicaid:

- I'm giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I'm also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home? Yes ◯ No ◯
- If yes, I know I'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 Puerto Rico Medicaid Program and I may not have to cooperate.
- I am signing this application under penalty of perjury, which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.
- I know that I must tell the Puerto Rico Medicaid Program within 30 days if anything changes (and is different than) what I wrote on this application. I understand that a change in my information could affect my eligibility as well as eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted based on race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting hhs.gov/ocr/office/file.
- I know that information on this form will be used only to determine eligibility for health coverage, help paying for coverage (if requested), and for lawful purposes of the Puerto Rico Medicaid Program that help pay for coverage.

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us documentation to confirm the information.

What should I do if I disagree with the decisions in my eligibility notice?

If you do not agree with what you qualify for, in many cases, you can ask for an appeal. Please review your eligibility notice to find appeals instructions specific to each person in your household who applies for coverage, including how many days you have in which to request an appeal. Here's important information to consider when requesting an appeal:

- You can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer, or other individual. Or, you can request and participate in your appeal on your own.
- If you request an appeal, you may be able to keep your eligibility for coverage while your appeal is pending.
- The outcome of an appeal could change the eligibility of other members of your household.

To appeal your eligibility results, visit **Medicaid.PR.gov** or appeal in person at one of our local offices. You can also mail an appeal request form or your own letter requesting an appeal to: Puerto Rico Medicaid Program, Puerto Rico Department of Health, PO BOX 70184, SAN JUAN, PR 00936-8184. You can appeal eligibility decisions, eligibility and enrollment periods, and cost-sharing levels among the results of this application.

Signature

PERSON 1 should sign this application.

If you are an authorized representative, you may sign here so long as PERSON 1 signed Attachment B.

Signature	**Date signed** (dd/mm/yyyy)
	☐☐ / ☐☐ / ☐☐☐☐

STEP 7: Return completed application

Mail your completed and signed application to:
Puerto Rico Medicaid Program
Department of Health of Puerto Rico
PO BOX 70184
SAN JUAN, PR 00936-8184

OR

Deliver your completed and signed application to any Puerto Rico Medicaid Program local office.

Attachment A For American Indians or Alaska Natives (AI/AN)

Complete this Attachment and include it with your application, **if you or a household member is American Indian or Alaska Native and is applying for health coverage**.

Tell us about your American Indian or Alaska Native household member(s)

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They may also not have to pay cost sharing and may get special monthly enrollment periods. Answer the questions below to make sure your household gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach it to this application.

AI/AN PERSON 1

1. First name	Middle name	Last name	Second last name

2. Member of a federally recognized tribe? Yes ◯ No ◯

If yes, name of tribe: _____ The State in which the tribe is located: ☐☐

3. Has this person every gotten a service from the Indian Health Services, a tribal health program, or an urban Indian health program, or through a referral from one of these programs? ..... Yes ◯ No ◯

If no, is this person eligible to get services from the Indian Health Services, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ..... Yes ◯ No ◯

4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often received) which is included as income in STEP 2 for this person, that comes from these sources:

- Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties
- 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)
- Money from selling things that have cultural significance.

$ _____ How often? _____

AI/AN PERSON 2

1. First name	Middle name	Last name	Second last name

2. Member of a federally recognized tribe? Yes ◯ No ◯

If yes, name of tribe: _____ The State in which the tribe is located: ☐☐

3. Has this person every gotten a service from the Indian Health Services, a tribal health program, or an urban Indian health program, or through a referral from one of these programs? ..... Yes ◯ No ◯

If no, is this person eligible to get services from the Indian Health Services, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ..... Yes ◯ No ◯

4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often received) which is included as income in STEP 2 for this person, that comes from these sources:

- Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties
- 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)
- Money from selling things that have cultural significance.

$ _____ How often? _____

NOTE: In questions 4, answer "How Often?" with – Weekly / Every 2 weeks / Monthly / Twice Monthly / Yearly / or write other value.

Attachment B Help completing this application

For certified application counselors, navigators, agents, and brokers ONLY

Complete this section if you are a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)	/ /		
2. First name	Middle name	Last name	Second last name
3. Organization name			
4. ID Number (if applicable)		**5.** Agents/Brokers only: NPN number	

You can choose an authorized representative

You can give a trusted person permission to talk with us about this application, 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. You can grant this person permission to act on your behalf during the application process, or to continue acting on your behalf in all related matters which continue after the application is approved, in dealing with the Puerto Rico Medicaid Program. This person is called an "authorized representative". If you ever need to change or remove your authorized representative, contact the Puerto Rico Medicaid Program. The person you designate as your authorized representative must fill the information requested below in SECTION 1, then sign and date in the space provided. You must complete SECTION 2 indicating which activities you authorize this person to perform on your behalf and sign and date at the end of this SECTION 2.

SECTION 1 - To be completed by the person being designated as authorized representative

1. First name	Middle name	Last name	Second last name
2. Address line 1		Line 2	
4. City	**5.** State	**6.** ZIP Code	**7.** Phone number ( ) -
8. Organization Name			
9. ID Number (if applicable)			

10. Relationship to applicant (PERSON 1)

○ Attorney ○ Dept. of the Family ○ Relative

○ Institutional ○ Friend ○ Other (explain) _____

SIGNATURE of authorized representative	**Date signed** (dd/mm/yyyy) / /

SECTION 2 - To be completed by PERSON 1 as entered on this application

Authorized Activity	Description of activities allowed	
○ Application	• Sign application & participate in interviews if required • Provide all necessary information and documentation requested for eligibility determination	• Receive the notice of eligibility decision • Speak on applicant's behalf in any hearing because of an appeal related to this application
○ Continuity	• Report changes to information provided in the application • Act on applicant/beneficiary's behalf in redeterminations	• Coordinate appointments with the PR Medicaid Program • Receive all notices related to the applicant/beneficiary

I the undersigned, authorize the person named above in SECTION 1 to act on my behalf for those activities I have checked above in this SECTION 2. I understand that I am responsible for any information provided to the PR Medicaid Program by anyone acting as my authorized representative. I also understand that it is my responsibility to contact the PR Medicaid Program if at any time I wish to change or remove the person I have designated as my authorized representative.

SIGNATURE of PERSON 1 on this application	**Date signed** (dd/mm/yyyy) / /

Attachment C Supplementary application

Coverage for Aged, Blind, Disabled, other Medically Needy and State Program

The initial application information entered in STEP 2 is used to evaluate you and other household members for Medicaid or CHIP coverage using what are known as MAGI rules. If you do not qualify for coverage under MAGI rules, it is still possible that you may be eligible for coverage under other rules for what is known as Medically Needy, which is still a part of the federal Medicaid program. Additionally, the Puerto Rico Medicaid Program can evaluate you for coverage under our State Program. These additional rules are collectively known as "non-MAGI". This section is optional. You do not have to be evaluated for these other options, but if you choose to be evaluated you must supply the additional information requested below. Adding this information will not delay a decision about whether you are eligible under "MAGI". If you do not qualify under MAGI rules and do not elect to proceed with this supplemental application, you may do so later without starting a new application.

NOTE: For Aged individuals (persons 65 years and older), qualifying under MAGI rules is only possible if the individual is a close relative of a child under 18 years of age and is the main person taking care of this child.

Copy Attachment C for each person in your household who is 65 or over, is blind, has a disability, and/or has special health care needs if this person wishes to be evaluated for non-MAGI coverage. If the applicant who is 65 or over, is blind, has a disability, and/or has special health care needs lives with a spouse, also fill out Attachment C for the spouse.

1. First name	Middle name	Last name	Second last name

◯ **YES,** individual wants an evaluation for non-MAGI.	◯ **NO,** individual does not want a non-MAGI evaluation.

If the answer to question 1 is "Yes," please complete the remainder of this supplementary application for that person.

4. Additional types of income to be considered. If this person has any of the income types shown from "a" to "d", enter the amount and the frequency with which the income is received.

Type of income	Amount	How Often?
a. Veteran's benefits	$	
b. Help received from family	$	
c. In kind	$	

5. Additional expenses to be considered. If this person has any of the expense types shown from "a" to "e", enter the amount and the frequency with which the expense is incurred.

Type of expense	Amount	How Often?
a. Help given to family	$	
b. Child support paid	$	
c. Childcare expenses required so this person can go to work.	$	
Enter the name of the child: …… (This child must be a person on this application in STEP 2.)		
d. Childcare expenses required so this person can go to work.	$	
Enter the name of the child: …… (This child must be a person on this application in STEP 2.)		
e. Expense for the care of a disabled individual 21 years or older required so this person can go to work.	$	
Enter the name of the disabled individual: ……		

NOTE: In questions above, answer "How Often?" with – Weekly / Every 2 weeks / Monthly / Twice Monthly / Yearly / or write other value.

If more space is required for care expenses for this person, copy this page and attach it to the application.

NOTE: Make sure to report each "care" expense in the household under a single person and do not duplicate them. If more than one person is jointly responsible for these expenses, choose to whom each one should be assigned.

Attachment C Supplementary application (Continued)

First name	Middle name	Last name	Second last name

Copy name from question 1 on the previous page and continue answering questions for this person.

6. Assets to be considered. If this person has any of the asset types shown from "a" to "l", enter the value of the asset.

Type of Asset	Value	Type of Asset	Value
a. Cash	$	b. Bank accounts	$
c. Savings certificates / CDs	$	d. Bonds / Stocks	$
e. Life insurance	$	f. Trust Funds	$
g. IRA / 401k / Retirement funds	$	h. Other financial assets	$
i. Equipment / Machines / Tools	$	j. Merchandise / Livestock	$
k. Real estate*	* Enter the details under question 7.	l. Vehicles *	* Enter the details under question 8.

7. Real Estate to be considered. Houses, buildings, land that this individual owns. Mark no more than one as primary home.

Description including location	Primary home	Value	Owed (mortgage etc.)
	☐	$	$
	☐	$	$
	☐	$	$

8. Vehicles to be considered. Cars, trucks, vans, motorcycles, motor homes, boats, and any other vehicle.

Description (Model/Make)	Year	License / ID #	State	Value	Amount Owed
				$	$
				$	$
				$	$

NOTE: Do not copy the information about assets (including real estate and vehicles) under more than one person. If assets are jointly owned, chose one person under whom to record that asset.

Signature

PERSON 1 should sign this supplemental application.

If multiple copies are made of the pages for Attachment C, only the last page of all Attachment C pages must be signed.

If you are an authorized representative, you may sign here so long as PERSON 1 signed Attachment B.

Signature	Date signed (dd/mm/yyyy)
	/ /

Attachment D Selection of MCO (Insurance Company)

If, as a result of the evaluation of this application, you are found eligible for health coverage then you will need to be assigned to one of the MCOs contracted by the Puerto Rico Health Insurance Administration (ASES) to administer the Government Health Plan. You have the choice of indicating your preferred MCO now. If you do not indicate a preference, one will be assigned to you if you are found eligible for coverage.

Each person on this application may choose an MCO from the list of those currently contracted by ASES. Fill out the preference for each person in the table below. IF no preference is indicated for any person on this application, he/she will be assigned an MCO randomly. If there are more persons on this application than the space allows, make a copy of this page, and attach it to the application.

A list of the contracted MCOs is provided below the table. This list may change over time and this Attachment will be updated as needed. If you have doubts as to whether this copy of the application form is up-to-date, you can check by going to the ASES web Site at www.ases.pr.gov, or by calling our CALL CENTER.

First name	Middle name	Last name	Second last name
Preferred MCO:			

First name	Middle name	Last name	Second last name
Preferred MCO:			

First name	Middle name	Last name	Second last name
Preferred MCO:			

First name	Middle name	Last name	Second last name
Preferred MCO:			

First name	Middle name	Last name	Second last name
Preferred MCO:			

First name	Middle name	Last name	Second last name
Preferred MCO:			

MCOs (Insurance Companies) contracted by ASES to provide services under the Government Health Plan

- First Medical Health Plan
- Plan de Salud Menonita
- MMM Multi Health
- Triple-S Salud

Note: MCO stands for Managed Care Organization.

Attachment E Immigration status and documents Use with STEP 2, Question 12

Eligible immigration status list

If you see a person's status in the list below, go back to STEP 2 and answer the question on eligible immigration status as "Yes".

- Lawful Permanent Resident (LPR/Green Card holder)
- Asylees
- Refugees
- Cuban/Haitian entrants
- Paroled into the U.S. for at least one year
- Conditional entrant granted before 1980
- Battered non-citizens, spouses, children, or parents
- Victims of trafficking and his or her spouse, child, sibling, or parent or individuals with a pending application for a victim of trafficking visa
- Lawful Temporary Resident
- Resident of American Samoa
- Granted withholding of deportation
- Member of a federally recognized Indian tribe or American Indian born in Canada
- Citizens of the Marshall Islands, Micronesia, and Palau who are living in one of the U.S. states or territories (referred to as Compact of Free Association or COFA migrants)

Immigration documents

People who are not citizens, but who are eligible to apply for health insurance coverage, must put their immigration documents, ID numbers, and card numbers in STEP 2. A list of documents, ID numbers, and card numbers is below. If your document is not listed it may still be acceptable. If you need help getting documents you need, you should still submit your application. If you need help you can contact the CALL CENTER at (787) 641-4224 / (787) 625-6955 TTY/TDD. (Impaired hearing person)

- Permanent Resident Card (I-551, also known as Green Card)
  - Alien registration number
  - Card number
- Temporary I-551 Stamp (on passport or I-94, I-94A)
  - Alien registration number
- Machine Readable Immigrant Visa (with temporary I-551 language)
  - Alien registration number
  - Passport number
- Employment Authorization Document (EAD or I-766)
  - Alien registration number
  - Card number
  - Expiration date
  - Category code
- Arrival/Departure Record (I-94 or I-94A)
  - I-94 number
- Arrival/Departure Record in foreign passport (I-94)
  - I-94 number
  - Passport number
  - Expiration date
  - Country of issuance
- Foreign passport
  - Passport number
  - Expiration date
- Country of issuance Reentry Permit (I-327)
  - Alien registration number
- Refugee travel document (I-571)
  - Alien registration number
- Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)
  - Alien registration number or an I-94 number
  - Description of the type or name of the document
- Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)
  - SEVIS ID
- Notice of Action (I-797)
  - Alien registration number or an I-94 number
- Other
  - Alien number (also called alien registration number or USCIS number) or I-94 number
  - Description of the type or name of the document

You can also list these documents or statuses:

- Document indicating a member of a federally recognized Indian tribe or American Indian born in Canada
- Office of Refugee Resettlement (ORR) eligibility letter (if under 18)
- Document indicating withholding of removal
- Administrative order staying removal issued by the Department of Homeland Security (DHS)
- Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR)
- Cuban or Haitian entrant
- Resident of American Samoa card

Attachment F Documentation you may need to provide

Much of the information you supplied for yourself and members of your household in this application will need to be verified. If we cannot complete the verification through electronic means you may need to supply documents that can prove the information you supplied is correct.

If you are completing this application to send by mail, you can include documents with this application, and this may save time if we need to use them to verify your information. If you choose to make your application at a local office of the Puerto Rico Medicaid Program, you should bring the documents with you. When using other ways to submit your application, follow the appropriate instructions. In general, copies of documents are acceptable.

Below you will find various sections for different types of information and guidance on what types of documents can be used to verify your information. Read carefully as you do NOT need to have ALL these documents. In many cases there is a choice as to which documents can be used, and in others the documents are only relevant in certain circumstances. If you need help getting documents you need, you should still submit your application. For a full list of documents that can be used to verify citizenship, see federal requirements at 42 CFR 435.407: https://www.govinfo.gov/content/pkg/CFR-2011-title42-vol4/pdf/CFR-2011-title42-vol4-sec435-407.pdf. If you need help, you can contact the Call Center at (787) 641-4224 / (787) 625-6955 TTY/TDD (Impaired hearing person).

Citizenship

1. If you are a U.S. citizen, you can provide ONE document to verify citizenship. Below is a list of the most commonly-used documents. These can also be used to confirm your date of birth.

- U.S. Passport or U.S. passport card, even if expired.
- Certificate of Naturalization issued by the Department of Homeland Security (DHS forms N-550 or N-570).
- Certificate of U.S. Citizenship issued by the Department of Homeland Security (DHS forms N-560 or N-561).
- A Driver's License or Identification Card issued by a U.S. State or Territory if the State requires proof of citizenship or an SSN before issuance. (A Puerto Rico Driver's License meets this requirement. You may submit a Driver's License or Identification Card from another state or territory if it meets the requirement.)
- Documentary evidence issued by a federally recognized tribe, with photo. The document should identify the federally recognized tribe that issued the document, identify the individual by name, and confirm the individual's membership, enrollment, or affiliation with the tribe. Such documents include, but are not limited to, a certificate of degree of Indian blood, tribal enrollment card, tribal census document, and documents on tribal letterhead.
- A social security number, which we will match with the Social Security Administration records.

2. If you are a U.S. citizen but cannot provide one of the above documents, you can establish U.S. citizenship by providing ONE of the documents in column (A) below provided it is also accompanied by ONE of the documents from column (B). (Any of these documents may be used to also confirm date of birth if that information is contained in the document.)

(A)

- U.S. Birth Certificate (see Notes 1 & 2).
- Certification of Report of Birth (Form DS-1350 or prior version FS-545).
- Report of Birth Abroad (Form FS-240).
- United States Citizenship Identification Card (I-197 or prior version I-179).
- Final adoption decree (see Note 3).
- Northern Mariana Islands Identification Card (I-873).
- Evidence of U.S. Civil Service employment before June 1, 1976.
- Documentation that a child meets the requirements of the Child Citizenship Act of 2000.
- Medical, school, insurance, or religious records (see Note 4).
- U.S. Military Records, showing a U.S. place of birth.

(B)

- State (or territory) Driver's license with photo.
- ID Card with photo, issued by federal, State, or local government with the same identifying information as a driver's license.
- U.S. Military card or draft record.
- U.S. Coast Guard Merchant Mariner card.
- School identification card with photo with identifying information.
- Military dependent's identification card.
- For children under 19, a clinic, doctor, hospital, or school record (including preschool or daycare).
- A finding of identity from an express lane agency

- Federal or state census record showing a US citizenship or US place of birth

Notes:

1. U.S. Birth Certificate means a public birth certificate from one of:
   - the 50 States, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam (on or after April 20, 1899), the U.S. Virgin Islands (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (after November 4, 1986).
2. For an individual born in Puerto Rico before January 13, 1941 – Evidence of birth in Puerto Rico plus a statement from the individual that he or she was residing in Puerto Rico, the U.S., or a U.S. possession on January 13, 1941.
3. A final adoption decree must show the child's name and place of birth in the U.S.
4. Medical records, Life, health or other insurance records, Official religious records, or School records (including preschool, Head-Start and daycare) that show the individual's name and U.S. place of birth.

Immigration Status and Identity

1. For an individual who is not a U.S. citizen, full coverage under the Government Health Plan is only available if the individual can prove an eligible immigrant status (see Attachment E for more details on the various statuses and documents). For those individuals who can provide one of the documents listed below, these documents can be used to prove both Immigration Status and Identity.

- Permanent Resident Card ("Green Card") (Form I-551).
- Employment Authorization Document (Form I-766).

2. For an individual who is not a U.S. citizen and who does not have one of the documents listed above in section 1, Immigration Status must be proved by supplying one of the documents listed in Attachment E plus one of the documents for proof of Identity shown above in the section for Citizenship and Identity under 2(B).

Home Address

1. The Home address entered in STEP 1 of this application must be confirmed. Any of the document types listed below can be used to prove the address is valid, but the document provided must be dated within the previous 6 months of when you sign this application.

- Lease, or a letter / rent receipt from landlord with the address.
- A Utility Bill (gas, electric, phone, cable TV, water, etc.). Must include address and be for a utility delivered to the home (not cell phone).
- Property tax records.
- Mortgage statement.
- State (or territory) Driver's license.
- ID Card, issued by Federal, State of Local government with address.
- Postmarked (with legible date) envelope or postcard. (only valid if sent to a physical address and not a PO Box.)

Income

1. You must be able to provide documents that proves any income you or members of your household received or expect to receive in the current month. You do NOT need to provide all the documents shown below. Only provide those which can prove the income if any, that you and members of your household receive. The lists contain various alternative documents that may be supplied. For any given type of income for any member of your household you only need to supply one of the possible documents.

Wages and Salary

- Paycheck stubs.
- Direct Deposit Statements.
- Letter from employer on company letterhead, signed and dated by an official of the employer.
- Business / payroll records.
- Official copy of most recent income tax return including all schedules.

Self-Employment

- Official copy of most recent income tax return including all schedules.
- Records of earning and expenses / business records.

Unemployment Benefits

- Award letter or certificate.
- Monthly benefit statement for the Department of Labor and Human Resources.
- Printout of individual's account from the Department of Labor and Human Resources.
- Copy of Direct Payment Card with printout.
- Official correspondence from the Department of Labor and Human Resources.

Child Support Received

- Letter from person paying the support.
- Document from Court.
- Copy of child support account information (ASUME).
- Copy of bank statement that clearly identifies deposit of support payments.

Income (Continued)

Alimony Received

- Letter from person paying the alimony.
- Document from Court.
- Bank statement that clearly identifies deposit payments.

Private Pension / Annuities

- Statement from pension / annuity.

Social Security

- Award letter / certificate.
- Annual Benefit Statement.
- Official correspondence from Social Security. Administration.

Worker's Compensation

- Award letter.
- Check Stub.
- Direct Deposit Statement.
- Bank statement that clearly identifies deposit of payments.

Military Pay

- Award letter.
- Check Stub.
- Direct Deposit Statement.
- Bank statement that clearly identifies deposit of payments.

Income from Rent or Room and Board

- Check Stub.
- Bank statement that clearly identifies deposit of payments.
- Letter from tenant / boarder.

Interest / Dividends / Royalties

- Recent statement from bank, credit union or other financial institution.
- Letter / Statement from broker.
- Letter / Statement from agent.
- 1099 or tax return (only if no other documentation is available).

Deductions

1. You must be able to provide documents that proves any deductions from income that you or members of your household have reported on this application. Deductions may have been entered in STEP 2 under question 29, or you may have entered them in Attachment C under question 5. You do NOT need to provide all the documents shown below. Only provide those which can prove the deductions if any, that you and members of your household paid. The lists contain various alternative documents that may be supplied. For any given type of deduction for any member of your household you only need to supply one of the possible documents.

Alimony Paid

- Letter from person receiving the alimony.
- Document from Court.
- Bank statement that clearly identifies payments.

Student Loan Interest

- Statement bank or other financial entity which provided the loan.
- Cancelled checks.

Child Support Paid

- Letter from person receiving the support.
- Document from Court.
- Copy of child support account information (ASUME).
- Copy of bank statement that clearly identifies support payments.

Help Given to Family

- Cancelled checks.
- Letter from person receiving the help.

Deductions (Continued)

Expenses for childcare or for the care of a disabled individual 21 years or older

- Written statement from day care center, or other child / adult care provider.
- Cancelled checks or receipts that show the payments made.

Note: the documents must identify who made the payments.

Others

1. You may need to supply documentation to support other information you supplied on this application. Below are several other categories on application information which may require documentation. Only gather these documents if you entered the corresponding type of information in the application.

Health Insurance (If entered in STEP 5)

- Document which proved current health insurance (Insurance policy, Certificate of Insurance, Insurance ID Card).
- Health Insurance Termination letter.
- Medicare Card.

Resources (If entered as Assets in Attachment C under question 4, 5 and 6)

- Bank account statements: checking, savings, retirement (such as IRA, Keogh).
- Stocks, Bonds: certificates or statements.
- Copy of life insurance policy.
- Copy of trust fund, burial plot deed, funeral agreement.
- Deed for real estate other than primary residence.
- Any similar documents for other assets.

Medical Expenses for the 3 months prior to application date (If question 15 in STEP 2 was answered YES for a PERSON)

- If any of the documentation provided so far, for the current month, is different in any of the prior 3 months, provide that same documentation as it applies for the prior 3 months. For instance, if the income or expenses for you or members of your household were different you will need to those for the months in which they were different.
- Documentation of unpaid medical expense incurred during the prior 3 months. This can be bills, letters, or other written documents from the provider of the medical service you want help in paying.