



STEP 2: ADDITIONAL PERSON

Name from STEP 1 _____

Complete Step 2 for your spouse and children who live with you and/or anyone on your same federal income tax return if you file one. Include both parents living in the home (for a child under 21). See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name _____ Middle name _____ Last name _____ Suffix _____

3. Date of birth (mm/dd/yyyy) / /
 4. Sex Male Female
 2. Relationship to you? _____

5. Social Security number (SSN) - -
We need this if you want health coverage for this PERSON and they have an SSN.

6. Does this PERSON live at the same address as you? Yes No
If no, list address: _____

7. **Does this PERSON plan to file a federal income tax return NEXT YEAR?**
 (You can still apply for health insurance even if this PERSON doesn't file a federal income tax return.)

YES. If yes, please answer questions a-c. **NO. If no**, skip to question c.

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

If yes, name of spouse: _____

b. Will this PERSON claim any dependents on his or her tax return? Yes No

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

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

If yes, please list the name of the tax filer: _____

How is this PERSON related to the tax filer? _____

8. Is this PERSON pregnant? Or were they pregnant in the last 60 days? Yes No

a. **If yes**, how many babies are expected during this pregnancy? Expected due date: _____

9. **Does this PERSON need health coverage?** (Even if this PERSON has Medicare or other insurance, there might be a program with better coverage or lower costs.) **If NO, skip to the income questions on the next page and leave the rest of this page blank.**

YES. If yes, answer all the questions below.

9a. **YES.** If under 19 or over 64 and not eligible for full coverage, does this PERSON wish to be evaluated for Plan First (family planning coverage only)? **or** **NO.** If this PERSON is age 19 to 64 and is not eligible for full coverage, this PERSON will be evaluated for Plan First (family planning coverage only) unless you check NO.

10. Does this PERSON 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 or nursing home? If Yes, please complete Appendix D. Yes No

11. Is this PERSON a U.S. citizen or U.S. national? Yes No

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

Yes. Fill in their document type and ID number below.

a. Document type _____

b. Document ID number _____

c. Has this PERSON lived in the U.S. since 1996? Yes No

d. Is this PERSON, or their spouse or parent a veteran or an active-duty member in the U.S. military? Yes No

13. Is this PERSON living with at least one child under age 19 and the main person taking care of this child?

14. Was this PERSON in foster care at age 18 or older? Yes No
If yes, in which state _____

15. Is this PERSON incarcerated (detained or jailed)? Yes No
 Check here if pending disposition of charges

If Yes Federal State (DOC or DJJ) Local/Regional
 Expected release date / /

16. Is this PERSON a full-time student? Yes No

17. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply)**

Mexican Mexican American Chicano/a Puerto Rican Cuban Other _____

18. **Race (OPTIONAL—check all that apply.)**

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



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STEP 2: ADDITIONAL PERSON

Current Job & Income Information

Employed

If this PERSON is currently employed, tell us about their income. Start with question 19.

Not employed

Skip to question 29.

Self-employed

Skip to question 28.

CURRENT JOB 1:

19. Employer name		a. Employer address	
b. City	c. State [][]	d. Zip code [][][][][]	20. Employer phone number ([][][]) [][][] - [][][][]
21. Wages/tips (before taxes) <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks \$ [][][][][][] <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly		22. Average hours worked each WEEK [][][]	

CURRENT JOB 2: (If this PERSON has more jobs and needs more space, attach another sheet of paper.)

23. Employer name		a. Employer Address	
b. City	c. State [][]	d. Zip code [][][][][]	24. Employer phone number ([][][]) [][][] - [][][][]
25. Wages/tips (before taxes) <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks \$ [][][][][][] <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly		26. Average hours worked each WEEK [][][]	

27. In the past year, did PERSON 2: Change jobs Stop working Start working fewer hours None of these

28. If this PERSON is self-employed, answer the following questions:

- a. Type of work _____
- b. How much net income (profits once business expenses are paid) will this PERSON get from this self-employment this month? \$ [][][][][][]

29. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often this PERSON gets it. Check here if none

NOTE: You don't need to tell us about this PERSON's child support, veteran's payment, or Supplemental Security Income (SSI).

<input type="checkbox"/> Unemployment \$ [][][][] How often? _____	<input type="checkbox"/> Alimony received \$ [][][][] How often? _____
<input type="checkbox"/> Pensions \$ [][][][] How often? _____	<input type="checkbox"/> Net farming/fishing \$ [][][][] How often? _____
<input type="checkbox"/> Social Security \$ [][][][] How often? _____	<input type="checkbox"/> Net rental/royalty \$ [][][][] How often? _____
<input type="checkbox"/> Retirement accounts \$ [][][][] How often? _____	<input type="checkbox"/> Other income \$ [][][][] How often? _____
Type _____	

30. Does this PERSON want help paying for medical bills from the last 3 months? Yes No If yes, provide monthly income for last 3 months.

Month 1: \$ [][][][][] Month 2: \$ [][][][][] Month 3: \$ [][][][][]

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often this PERSON gets it.

If this PERSON pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 28b).

<input type="checkbox"/> Alimony paid \$ [][][][] How often? _____	<input type="checkbox"/> Other deductions \$ [][][][] How often? _____
<input type="checkbox"/> Student loan interest \$ [][][][] How often? _____	Type: _____

32. **YEARLY INCOME:** Complete only if this PERSON's income changes from month to month.

If you don't expect changes to this PERSON's monthly income, skip to the next person. 

This PERSON's total income this year \$ [][][][][][]	This PERSON's total income next year (if you think it will be different) \$ [][][][][][]
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THANKS! This is all we need to know about this PERSON.

If you have more people to include, complete another Additional Person single page supplement form.



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