

Uninsured? Interested in finding out what free or low-cost health insurance options are available for you? Easy ways to find out:



In Person. Group enrollment sessions are available daily by calling Lynn Swartwood at the Family Health Centers-Portland at 774-8631.

One-on-one appointments are also available for those who need extra help or prefer a personal touch. You can set an appointment by calling a Family Health Center kynector at the health center site of your choice – *see the chart below.*

Site	FHC kynector	Telephone
Americana <i>(main# 772-8860)</i>	Megan Russell	396-3017
East Broadway <i>(main# 583-1981)</i>	Zach Barlett	415-8490
Fairdale <i>(main# 361-2381)</i>	Ask for Lynn Swartwood, FHC kynector scheduler	774-8631
Iroquois <i>(main# 366-4747)</i>	Megan Russell	396-3017
	Ask for Lynn Swartwood, FHC kynector scheduler	774-8631
Phoenix <i>(main# 568-6972)</i>	Jameson Bailey	415-8328
	Ashley Shoemaker	415-8256
Portland <i>(main# 774-8631)</i>	Ask for Lynn Swartwood, FHC kynector scheduler	774-8631
Southwest <i>(main# 995-5051)</i>	Ask for Lynn Swartwood, FHC kynector scheduler	774-8631



On-Line. You can complete an application on your own by visiting www.kynect.ky.gov and apply on line!



Paper Application. Complete a paper application and return by mail or by fax. The address and fax numbers are on the application.



Telephone. Call 1-855-4kynect (1-855-459-6328) and enroll over the phone. Help is available in over 20 languages.



December 15th is the deadline to enroll in health insurance, or December 31st to sign up for Medicaid, to begin benefits on January 1st 2014. kynect Open Enrollment for health insurance ends March 31st 2014.

Helpful items sometimes needed for an application are listed on the back of this page.

Helpful Things for an Application

Not all of these may be needed, but they may speed up enrollment process. You may not have everything on this list, which is okay, so please gather what you have. It is important to also allow 1-3 hours for an enrollment as each one varies based on individual circumstances.

□ Your Contact Information

- Email Address and Password (*if you don't have an account, a relative/friend might be able to create one for you or instructions are also provided with this flyer*)
- Address
- Proof of residence (a utility bill, lease, etc.)
- Phone Number (*that you can always be reached at*)
- Birthdate

□ ID (pick one)

- Social Security Card or Immigration Documents (I-9, Green Card, or I-94 if available)
- Government Issued ID like a Driver's License
- Birth Certificate

□ Household Information

- Names, dates of birth and Social Security Numbers (SSN) of all persons living in your house
- Proof of Marriage

□ Proof of Income (pick at least one)

- W-2 Form(s)
- Last year's Tax Return(s)
- Pay Stubs from the last month
- Proof of unearned income (SSI or Disability check stub)
- Other proof of income

□ Expenses Information

- Alimony (if you pay alimony)
- Student loan interest payment
- Teacher expenses (if you are a school teacher only)
- School tuition and fees

□ Health Insurance/Card for Current Insurance (if you have insurance through a job)

- Cost of Insurance (premium bill or check stub showing premium deductions)
- If interested in Medicaid insurance coverage, does your medical provider(s) accept Medicaid (Passport, Coventry Cares, Humana Care Source, Wellcare)? Researching which insurance plans your medical providers accept can help save you time when selecting a plan.

□ Work information

- Employer Identification Number (EIN) if you know this number. This number is on your W-2 form.
- Work Name
- Work Address
- Work Phone Number or Work Number for your Human Resources Office/Contact
- If your job offers health insurance, bring a copy of your Work's health plan

□ Follow up visit?

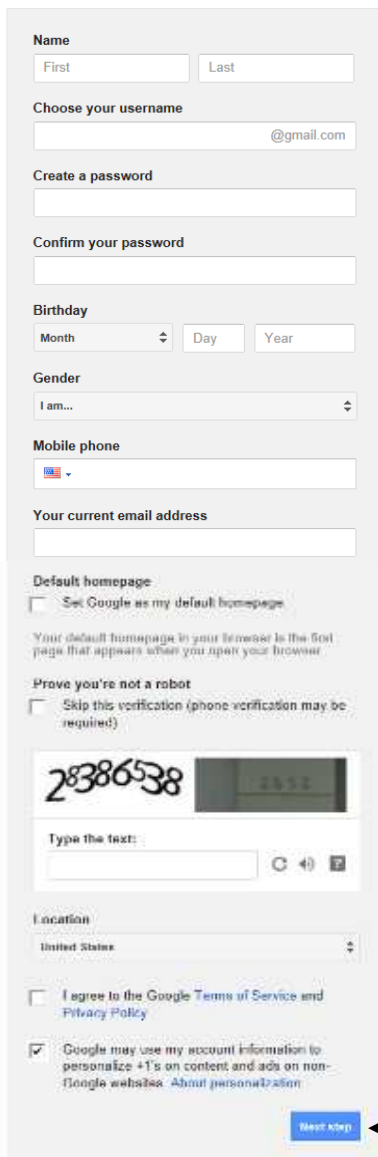
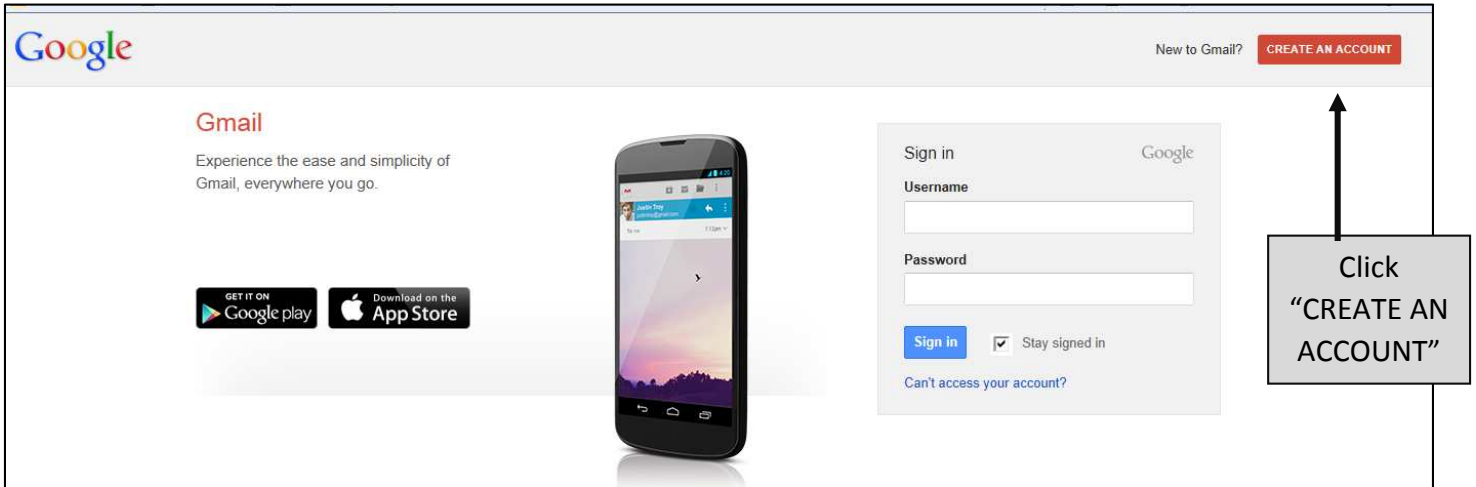
- Written Application (if you started one)
- If you haven't gotten notice from DCBS/kynect that any verification/pending status has been approved, please call your FHC kynector before you visit to make sure your application can be processed.

□ Questions? FHC kynectors can be reached at the following locations – just ask for a 'kynector'.

Portland 774-8631 (*ask for Lynn*) · Phoenix 568-6972 · Iroquois & Fairdale 366-4747 · E. Broadway & Southwest 583-1981

Create An Email Account & Password in 5 quick and easy steps:

STEP 1: Go to www.gmail.com

A screenshot of the Gmail account creation form. It contains several sections: "Name" with "First" and "Last" input fields; "Choose your username" with a text input field and "@gmail.com" suffix; "Create a password" and "Confirm your password" with text input fields; "Birthday" with "Month", "Day", and "Year" dropdowns; "Gender" with a dropdown menu; "Mobile phone" with a country code dropdown and a text input field; "Your current email address" with a text input field; "Default homepage" with a checkbox "Set Google as my default homepage" and explanatory text; "Prove you're not a robot" with a checkbox "Skip this verification (phone verification may be required)" and a CAPTCHA image showing the number "28386538"; "Location" with a dropdown menu set to "United States"; and two checkboxes at the bottom: "I agree to the Google Terms of Service and Privacy Policy" and "Google may use my account information to personalize +1's on content and ads on non-Google websites. About personalization". A blue "Next step" button is at the bottom right.

STEP 2: Fill out the online form. An easy user name to remember is your name plus your date of birth.

Example: susansmith010180. Your password must be at least 8 characters long.

You do not need to provide your mobile phone number or your current email address.

← **Step 3:** Click "Next Step".

Step 4: You do not have to add a profile photo. Click “Next Step”.

Your profile

Now that you have a Google Account, create your Google profile. It's how you represent yourself publicly on the web, and helps friends and family find each other easily. Your profile also lets you publicly "+1" things you love on the web, so you and your friends benefit from each other's impeccable taste – in search results, on sites across the web, even on ads. Your profile is public, and can include as little as your name, or as much as you feel like adding – it's up to you. [About profiles.](#)

Put a face to your name

Your profile is public, and can include as little as your name, or as much as you feel like adding. Upload a photo to better express yourself. Want some ideas? Check out this video.

How you'll appear

Melissa Noyes

Your public profile will help your friends recognize you.

[Add Profile Photo](#) [Next step](#)

Click
“Next Step”

Step 5: Sign in to your new Gmail account! Go to www.gmail.com. Type in your username and password from Step 2 and begin using your Gmail account.

Gmail

Experience the ease and simplicity of Gmail, everywhere you go.

GET IT ON Google play | Download on the App Store

Sign in

Username

Password

[Sign in](#) Stay signed in

[Can't access your account?](#)

Sign In
here.

Write down your username and password below and keep this form.

USERNAME: _____

PASSWORD: _____



Health Coverage & Help Paying Costs

Application for One Person

THINGS TO KNOW

<p>Use this application to see what insurance choices you qualify for</p>	<p>Free or low-cost insurance from Medicaid or the Kentucky Children’s Health Insurance Program (KCHIP) Payment Assistance that can help you pay for your health coverage Affordable health insurance plans that offer comprehensive coverage to help you stay well</p>
<p>Who is this application for?</p>	<p>Single individuals who: Live in Kentucky and plan to stay in Kentucky Do not have any dependents and cannot be claimed as a dependent on someone else’s tax return</p>
<p>Apply faster online</p>	<p>Apply faster online at www.kynect.ky.gov.</p>
<p>What you may need to apply</p>	<p>Your social security number (or document number if you are a legal immigrant) Employer and income information (for example, paystubs, W-2 forms, or wage and tax statements)</p>
<p>Why do we ask for this information?</p>	<p>We ask about your Social Security Number (SSN), your income and other information to see if you qualify for and if you can get any help paying for your health coverage costs.</p> <p>If you need help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.</p> <p>We’ll keep all the information you give us private, as required by law.</p>
<p>What happens next?</p>	<p>Mail or fax your completed, signed application to:</p> <p>Office of the Kentucky Health Benefit Exchange 12 Mill Creek Park Frankfort, KY 40601</p> <p>Fax: 1-502-573-2005</p> <p>If you don’t have all the information we ask for, submit your application anyway. We will contact you for the missing information if we cannot complete the determination based on the information you give us.</p> <p>If we can make a determination, we will send you detailed information about the steps you will need to follow to select a plan. You will need to go online, call us, or get assistance from an insurance agent or kynector to enroll in a plan.</p>
<p>To get help</p>	<p>Online: www.kynect.ky.gov By phone: Call Customer Service at 1-855- 4kynect (459-6328) In person: Find a list of places near where you live by visiting our website or calling us. En Español: Llame a nuestro Servicio al Cliente gratis al 1-855- 4kynect (459-6328) For TTY services call 1-855-326-4654</p>

Health Coverage & Help Paying Costs

Application for One Person

STEP 1 Tell Us about Yourself



If someone else is helping you fill out this application, use **Appendix B** to give us that person's information.)



1. First Name, Middle initial, Last name, Suffix (as it appears on your Social Security card)

2. Social Security Number (SSN)

We need your SSN if you want coverage and have a SSN. We use SSNs to check income and other information to see if you are eligible for help with health coverage costs.

3. If you **want coverage** and SSN is not provided, select reason for not providing it.

- Religious Objection
 Not eligible to receive SSN due to alien status
 Applied for SSN
 Does not have an SSN and may only be issued an SSN for a valid non-work reason
 Refuse to provide SSN

4. Date of Birth (mm/dd/yyyy)

5. Gender

6. Used tobacco at least 4 times a week in the past 6 months?

- Male Female
 Yes No

7. Do you live in Kentucky and plan to stay in Kentucky? Yes No

8. Home Address - **Check here if you do not have a Home Address. You will still have to enter a Mailing Address below.**

9. City 10. State 11. Zip Code 12. County

13. Mailing Address (Only required if different from home address)

14. City

15. State

16. Zip Code

17. County

18. Primary Phone Number Home Work Cell
()

19. Secondary Phone Number Home Work Cell
()

Check here to allow kynect to send text message alerts to your primary phone number.

Check here to allow kynect to send text message alerts to your secondary phone number.

22. Preferred Spoken Language (if not English)

23. Preferred Written Language (if not English)

24. Have you had a pregnancy end (giving birth or losing a pregnancy) in the past three months or are you currently pregnant? Yes. **If yes**, answer questions a–c. No

a. What is the due date or the last date of pregnancy? (mm/dd/yyyy)

- b. How many children are/were expected with this pregnancy? _____
- c. Would you like to be referred to the program that offers food to Women, Infants and Children (WIC)? Yes No

25. Are you offered health coverage from a job (including someone else's job, like a parent's job)?
 Yes. **If yes**, you will need to complete and include Appendix A with this application. No

26. Do you want help paying for medical bills from the last 3 months? Yes No **If yes**, which month(s)?

27. Do you plan to file a federal income tax return for coverage year 2014?
 (You can apply for health insurance even if you don't file a federal income tax return.)

YES. **If yes**, answer questions a & b. **NO**. **If no**, go to question b.

- a. Will you file as a single person with no dependents? Yes No
If No, stop using this form. Use the *Health Coverage & Help Paying Costs Application for More Than One Person* to include your tax dependents (even if you do not want to apply for health coverage for them.)
- b. Are you claimed as a dependent on someone else's tax return? Yes No
If Yes, stop using this form. You will need to apply for coverage with the person claiming you on their tax return (even if that person does not want coverage.)

28. Are you a U.S. citizen or national? Yes No
 29. If you are not a U.S. citizen or national, do you have immigration status?
 citizen or national? **Yes**. Answer questions a–d below.

<input type="checkbox"/> Yes <input type="checkbox"/> No	a. Immigration Document Type: _____ b. Document ID Number: _____ c. Have you lived in the U.S. since 1996? <input type="checkbox"/> Yes <input type="checkbox"/> No d. Are you a veteran or active-duty member of the U.S. military? <input type="checkbox"/> Yes <input type="checkbox"/> No 30.
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Are you of Hispanic, Latino or Spanish origin? (OPTIONAL) Yes No

31. Race (OPTIONAL)

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

32. If you are American Indian or Alaska Native, are you a member of a federally recognized tribe, band, nation, community or other group? Yes. **If yes**, answer questions a-c. No

- a. What is the name of the tribe? _____
- b. What state is the tribe primarily located in? _____

c. Are you eligible to receive or have you ever received a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? Yes No

35. Are you currently in prison or jail or have you been released in the past three months?

Yes. **If yes**, answer questions a–c. No

a. When did you enter prison? (mm/dd/yyyy) _____

b. When did you leave prison? (mm/dd/yyyy) _____

c. Are you currently waiting for a decision on charges? Yes No

36. Do you need help with activities of daily living (like bathing, dressing, etc.) or live in a medical facility or nursing home?

Yes No

37. Are you blind or permanently disabled? Yes No

38. Were you receiving Medicaid when you became too old to be eligible for foster care placement? Yes No

If yes, in what state were you living? _____ How old were you? _____

39. If you are filling out this application on behalf of a person who recently passed away, enter the deceased person's date of death: _____

STEP 2 Current Job and Income Information

Use additional sheets of paper if you need to add more than two jobs.

Income from Job 1	1. Employer Name	<input type="checkbox"/> Check here if income is from self-employment
	2. What is the gross amount you make (before taxes)? \$	3. How often? <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Every two weeks <input type="checkbox"/> Monthly
Income from Job 2	4. Employer Name	<input type="checkbox"/> Check here if income is from self-employment
	What is the gross amount you make (before taxes)? \$	How often? <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Every two weeks <input type="checkbox"/> Monthly

7. **Additional Income:** List here any additional income you may receive, give the amount and how often you get it. Do not include income from child support, Supplemental Security Income (SSI), veteran's income, or Worker's Compensation. **If none, leave blank.**

Type of Income	How Much?	How Often?		
<input type="checkbox"/> Social Security	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Pensions	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Interest or Dividend	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Disability Payments	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Unemployment	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Other _____	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly

8. **Household Deductions:** Give us information about things that you pay _____ and that can be _____ deducted on an income tax return. Giving us this information could make the cost of health insurance lower.

Type of Deduction	How Much?	How Often?		
<input type="checkbox"/> Alimony Paid	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Student Loan Interest	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Educator Expenses	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> School Tuition and Fees	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly

Yearly Income: What is your estimated **yearly** income for the coverage year (including any monthly changes, bonuses, seasonal income, etc.)?
 \$ _____

STEP 3 Other Healthcare Coverage

Do you have health coverage now, including **dental and major medical coverage** that is not Medicaid or KCHIP?

YES. If yes, complete the information below. **NO.**

Type of coverage _____ Policy Number _____

Name of policy holder _____ Coverage start date _____

Name of insurance company _____ Coverage end date _____

Insurance Company's Address _____

STEP 4 Sign and Date this Application

- I am signing this application under penalty of perjury which means I have given true answers to all the questions on this form to the best of my knowledge and belief. I know that I may be subject to penalties under federal law if I provide false and/or untrue information.
- I know that I must tell kynect if anything changes from what I wrote on this application within 30 days of the change. I can visit kynect.ky.gov or call **1-855-4kynect (459-6328)** to report any changes.
- If I think kynect has made a mistake, I can appeal its decision. To appeal means to tell someone at kynect that I think the action is wrong, and ask for a fair review of the action. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I understand that kynect will check my answers using information in databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or any other trusted source. If the information does not match, I may be asked to send proof.

Renewal of coverage in future years: To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow kynect to use income data, including information from tax returns and other trusted data sources. kynect will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next: (select one)

5 years (maximum allowed) 4 years 3 years 2 years 1 year

Do not use information from tax returns or other data sources to renew my coverage.

Voter Registration: If I am not registered to vote or not registered where I currently live, I can choose to register to vote by checking yes below. If I check yes, I will receive a voter registration application in the mail. Checking yes or no below does not affect the outcome of this application.

Yes, I want to apply to register to vote. An application will be mailed to me. **No**, I don't want to register to vote.

If I am eligible for Medicaid:

- I understand that if Medicaid pays for a medical expense, any other health insurance or legal settlement payments will go to Medicaid to reimburse it for the expense.
- I understand that my application may be reviewed to make sure that eligibility was determined correctly. If my application is reviewed, I must cooperate with the review.

Signature

Date (mm/dd/yyyy)