Medicaid and CHIP MAC Learning Collaboratives

Medicaid and CHIP Coverage Learning Collaborative
Integrated Human Services Application Analysis
High-Level Summary Chart

June 2013

High Level Summary of Recommendations: Data Elements

Must Include because it is either a new question (as marked with an asterisk below) or requires significant revision.	
Question Category	**Data Element**
Household Contact	• **Preferred Method to Get Information***
	• **Language Spoken/Read**
Household Member Information (applicants and/or non-applicants)	• **Federal Tax Filing Information***
	• **CHIP Waiting Periods* (if applicable)**
	• **Former Foster Care Child Category**
	• **Citizenship/Immigration Status**
	• **Full-Time Student**
	• **SSN Instructions**
	• **Pregnant**
	• **Non-MAGI Screening Questions**
	• **Applying for Health Coverage**
Income	• **Projected Annual Income***
	• **Deductions***
	• **Yearly Income**
	• **Other Income**
	• **Self Employment**
Health Coverage	• **Access to Employer Health Coverage***
	• **Offers of Employer Health Coverage*** *(located in Appendix)*
Rights and Responsibilities	• **Ability to Use Tax Data During Renewal***
	• **Absent Parent**
Other	• **Authorized Representative**
	• **Navigators/Application Assistor* (if applicable)**
	• **American Indian/Alaska Native**

High Level Summary of Recommendations: Single Streamlined Application Questions

Must Include because it is either a new question or requires significant revision.		
#	**Data Element**	**Single Streamlined Application Question**
Household Contact		
1.	**Preferred method to get information**	• Do you want to get information about this application by email? (Yes/No) • Email address:_____
2.	**Language Spoken/Read:**	• Preferred spoken or written language (if not English)
Household Member Information (applicants and/or non-applicants)		

3.	**Federal Tax Filing Information**	• Does PERSON X plan to file a federal income tax return NEXT YEAR? (Yes/No)
		• If yes: Will PERSON X file jointly with a spouse? (Yes/No)
		  • If yes, name of spouse:
		• Will PERSON X claim any dependents on his or her tax return? (Yes/No)
		  • If yes, list name(s) of dependents:
		• Will PERSON X be claimed as a dependent on someone's tax return? (Yes/No)
		  • If yes, please list the name of the tax filer:
		  • How is PERSON X related to the tax filer?

4.	**CHIP Waiting Periods**	Please answer the following questions if PERSON *X* is 18 or younger: • Did PERSON *X* have insurance through a job and lose it within the past 3 months? (Yes/No) • If yes, end date: • Reason the insurance ended:
5.	**Former Foster Care Child Category**	• Was PERSON *X* in foster care at age 18 or older? (Yes/No)
6.	**Citizenship/Immigration Status**	• Is Person X a U.S. citizen or U.S. national? (Yes/No) • If PERSON *X* isn't a U.S. citizen or U.S. national, do they have eligible immigration status? (Yes/No). (Note: May want to include an

		instructions sheet with a list of eligible statuses and/or document types.) • Immigration document type: • Document ID number: • Has PERSON *X* lived in the U.S. since 1996? (Yes/No) • Is Person X, or their spouse or parent a veteran or an active-duty member of the U.S. military? (Yes/No)
7.	**Full-Time Student:**	Please answer the following question if PERSON *X* is 22 or younger: Is PERSON *X* a full-time student (Yes/No)
9.	**SSN Instructions:**	• We need this if you want health coverage and have a SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.
10.	**Pregnant:**	• Are you pregnant? (Yes/No) • If yes, how many babies are expected during pregnancy? ____
11.	**Non-MAGI Screening Questions**	• Does Person X 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?
12.	**Applying for Health Coverage**	• Does PERSON *X* need health coverage? (Yes/No)
Income		
13.	**Projected Annual Income**	• Person X's total income next year (if you think it will be different): $
14.	**Deductions**	• If PERSON X 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. • Alimony paid; $ ___ How often? • Student loan interest; $ ___ How often? • Other deductions; Type: $ ___ How often?
15.	**Yearly Income**	• Complete only if your income changes from month. If you don't expect changes to your monthly income, skip to the next person. • Person X's total income this year: $ ___
16.	**Other Income**	• Check all that apply, and give the amount and how often you get it. • None • Unemployment; $ ___ How often?

		• Pensions; $ ___ How often? • Social Security; $ ___ How often? • Retirement accounts; $ ___ How often? • Alimony received; $ ___ How often? • Net farming/fishing; $ ___ How often? • Net rental/royalty; $ ___ How often? • Other Income; $ ___ How often?
17.	**Self-Employment**	If self-employed, please answer the following questions: • Type of Work: • How much net income (profits once business expenses are paid) will PERSON X get from this self-employment this month? $ ___
Health Coverage		

	Other Health Coverage	• Is anyone enrolled in health coverage now from the following? Yes. If yes, check the type of coverage and write the person(s)' name(s) next to the coverage they have. No.
		  • Medicaid
		  • CHIP
		  • Medicare
		  • TRICARE (Don't check if you have direct care or Line of Duty)
		  • VA health care programs
		  • Peace Corps
		  • Employer insurance
		  • Name of insurance ____
		  • Policy number
		  • Is this COBRA coverage (Yes/No)
		  • Is this a retiree health plan? (Yes/No)
		  • Other
		  • Name of health insurance:
		  • Policy number:
		  • Is this a limited-benefit plan (like a school accident policy) (Yes/No)

18.	**Access to Employer Health**	• Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone else's job, such

	Coverage	as a parent or spouse. (Yes/No) If yes, go to Appendix. • Is this a state employee benefit plan?
19.	**Offers of Employer Health Coverage** *(Should be located in Appendix)*	Tell us about the job that offers coverage • Employer Name • Employer Address • Employer Phone Number • Employer Identification Number (EIN) _ _ - _ _ _ _ _ _ _ • Who can we contact about employee health coverage at this job? (contact, phone number, email address)
20.	**Offers of Employer Health Coverage** *(Should be located in Appendix)*	• Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months? • If yes, if you're in a waiting or probationary period, when can you enroll in coverage? (mm/dd/yyyy) • List the names of anyone else who is eligible for coverage from this job • Name: _____
21.	**Offers of Employer Health Coverage: Minimum Value** *(Should be located in Appendix)*	• Does the employer offer a health plan that meets the minimum value standard? (Yes/No)
22.	**Offers of Employer Health Coverage: Affordability** *(Should be located in Appendix)*	• For the lowest-cost plan that meets minimum value offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs. • a. How much would the employee have to pay in premiums for this plan? $ • b. How often? • Weekly • Every 2 weeks • Twice a month • Quarterly • Yearly

23.	**Offers of Employer Health Coverage: Projected Coverage**
	(Should be located in Appendix)
		• What change will the employer make for the new plan year (if known)?
		• Employer won't offer health coverage
		• Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard. (Premium should reflect the discount for wellness programs).
		  • How much will the employee have to pay in premiums for that plan? $ ___
		  • How often?
		  • • Weekly • Every 2 weeks • Twice a month • Quarterly • Yearly
		  • Date of change (mm/dd/yyyy):

Rights and Responsibilities		
26.	**Ability to Use Tax Data during Renewal**	• 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 the Marketplace to use income data, including information from tax returns. The Marketplace 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 • __ 5 years (the maximum number of years allowed) __ 4 years __ 3 years • __ 2 years __ 1 year __ Don't use information from tax returns to renew my coverage
27.	**Absent Parent:**	• Does any child on this application have a parent living outside of the home? (Yes/No)
Other		
28.	**Authorized Representative:** *(Could be located in Appendix)*	• Name of authorized representative (First name, Middle name, Last name) • Address • Phone Number • Organization name • ID number (if applicable) • By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.
28.	**Navigator/Application Assistor: Start Date (Contingent upon state's utilization of application assistors)** *(Could be located in Appendix)*	• Application start date • Counselor First Name, Middle Name, Last Name, & Suffix • Organization name • ID Number (if applicable)
29.	**American Indian/Alaska Native: Household**	• Are you or is anyone in your family American Indian or Alaska Native (AI/AN?) • If No, skip to Step 4 • Yes. If yes, go to Appendix B.
30.	**American Indian /Alaska Native: Federally-Recognized Tribe** *(Could be located in Appendix)*	• Member of a federally-recognized tribe? If yes, give tribe name:
31.	**American Indian /Alaska Native:**	• Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program or through

	Indian Health Service *(Could be located in Appendix)*	a referral from one of these programs? (Yes/No) • If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs or through a referral from one of these programs?
32.	**American Indian /Alaska Native: Tribal Land Use Income** *(Could be located in Appendix)*	• Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List below any income (amount and how often) reported on your application that includes money from the following 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?