



**APPLICATION FOR
MCHA PREMIUM ASSISTANCE PROGRAM**

Subscriber Information

| | | |
|------------------|-------------------------|--------------------------|
| Last Name | First Name | Social Security # |
| Street | City, State, ZIP | Telephone |

IMPORTANT INFORMATION

To be eligible for the Premium Assistance Program, you (applicant) must meet the following eligibility requirements. You MUST:

- Be a Montana resident for at least 30 days.
- Have NO other health insurance coverage (including Medicaid).
- Have been rejected by two insurers, offered ridered coverage or have a listed medical condition (Please attach two rejections from other health insurance companies or proof of a listed medical condition, such as a claim with the diagnosis listed.) (See application pages 1 & 2.)
- Have household income not exceeding the qualifying income amount on the income guideline chart.

Program Information

Enrollment in this program is limited and on a first-come basis. The Premium Assistance Program funding is provided by a federal grant. After the funding is exhausted, you will be responsible for paying the regular MCHA premium. The deductible is \$1,000 per calendar year. Preexisting health conditions will not be covered for the first four (4) months.

If you qualify, the Premium Assistance Program will subsidize a percentage of your health insurance premium for Traditional MCHA coverage. The subsidy will be 45% of premium.

Please complete the reverse side of this application and submit this form and income documentation (such as a recent pay stub), and an MCHA Traditional application form (with required documentation of your medical condition or rejections) to MCHA, P.O. Box 4309, Helena, MT 59604.

I certify that I meet the eligibility criteria listed above. I certify the family income and expense information listed on the reverse side of this application is accurate and complete. I certify that I have read the above statement and that I understand that I am responsible to pay the amount of premium that is not covered by the Premium Assistance Program funding. I further understand that I will be responsible for paying the entire premium when the Premium Assistance Program ends in order to continue coverage. I certify that my answers and statements are true and complete to the best of my knowledge. I understand that a false statement or misrepresentation on this application may result in loss of coverage. I understand that a person who submits an application or files a claim with the intent to defraud or helps commit fraud against an insurer or health plan is guilty of a crime under Montana law (33-1-12, MCA.)

SIGNATURE OF APPLICANT

DATE

(OVER)

Please indicate number of household members

INCOME VERIFICATION

Employment Income

Include documentation supporting employment income when submitting the application (for example, at least two recent wage/salary pay stubs, W-2 forms, last year's income tax form (if it reflects current earnings); for self-employed individuals (i.e., farmers/ranchers), documentation could include current income/expense statement or last year's income tax form (if it reflects current earnings).

List all adult family members who currently work. Include all full- and part-time employment, self-employment, temporary jobs, tips, and commissions. For self-employment, include income less cost-of-doing-business expenses and state average monthly income.

| Employee Name | Employer Name | Employer Address | Employer Telephone No. | Average Hours Worked per Week | Hourly Pay | Pay Period <small>(e.g., weekly, biweekly, monthly, semimonthly, annually)</small> | Last Month's Total Gross Income | Last 12 Months' Average Total Gross Income |
|---------------|---------------|------------------|------------------------|-------------------------------|------------|---|---------------------------------|--|
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Unearned Income (You do not need to include documentation for this unearned income.)

Income received from sources other than employment or self employment. List all unearned income received by all family members (include children's income). Unearned income includes, but is not limited to, Social Security, Disability, Unemployment Insurance, Pensions, Military Allotments, Child Support, Alimony, Lease or Rental Income, Supplemental Security Income, Foster Care Payments, Veterans' Benefits, Retirement Income, Tribal Assistance Payments, Dividends, Interest, and Temporary Disability.

| Name | Type of Income | Source of Income | Income Pay Period <small>(e.g., weekly, biweekly, monthly, semimonthly, annually)</small> | Amount Received Last Month | Amount Received Previous 12 Months' Average |
|------|----------------|------------------|--|----------------------------|---|
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If anyone in the family pays for the care of a dependent child or a disabled or elderly adult so someone can work, please complete the following and provide verification (e.g., receipts).

| Name of Person Receiving Care | Name of Person Paying for Care | Amount Paid/Billed | Name of Person Providing Care | Address of Person Providing Care | Date Paid <small>mo / day / year</small> | Hours of Care per Month <small>(Approximate)</small> |
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