

Additional People in your household

Answer the questions for the next person in your household.

73. First name, Middle name, Last name, & Suffix			74. Relationship to you?		
74a. Is this person a full-time or part-time member of your household?			Full-time	Part-time	
If part time, what percentage of the time does this person reside with you? _____% (1 - 100)					
75. Social Security number	76. Date of Birth (mm/dd/yyyy)	76a. Marital Status	77. Sex	Male	Female
78. Do you plan to file a federal income tax return NEXT YEAR? You can apply for health insurance even if you don't file a tax return.			Yes.		
a. Will you file jointly with a spouse?			No. Skip to question C		
Name of spouse: _____			Yes No		
b. Will you claim any dependents on your tax return?			Yes No		
List name(s) of dependents: _____			Yes No		
c. Will you be claimed as a dependent on someone's tax return?			Yes No		
List the name of the tax filer: _____			Relation to tax filer? _____		
79. Are you pregnant?	Yes	No	How many babies expected this pregnancy? _____ Due date: _____		
80. Do you need public assistance services for yourself? Even if you have insurance there might be a program with better coverage or lower cost.			Yes.		
			No. Skip questions 81-90.		
81. Do you have a physical, mental, or emotional health condition that causes limitations (like bathing, dressing, chores) or live in a medical facility or nursing home?			<input type="checkbox"/> Yes <input type="checkbox"/> No		
82. Are you a U.S. citizen or U.S. national?			<input type="checkbox"/> Yes <input type="checkbox"/> No		
83. If you aren't a U.S. citizen or national, do you have eligible immigration status?			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Fill in your document type and ID number below.					
a. Immigration document type: _____			Document ID number: _____		
b. Have you lived in the U.S. since August 22, 1996?			<input type="checkbox"/> Yes <input type="checkbox"/> No		
c. Are you, your spouse, or parent a veteran or active-duty member of the U.S. military?			<input type="checkbox"/> Yes <input type="checkbox"/> No		
84. Do you want help paying for medical bills from the last 3 months? Which months? _____			Yes No		
<i>If you are a tribal member and have been seen at a tribal medical facility in the last three months, you may have medical expenses that could be covered by retroactive Medicaid</i>					
85. Do you have medical costs due to an accident?			<input type="checkbox"/> Yes <input type="checkbox"/> No		
86. Do you live with a child under age 19, for whom you are the primary caretaker?			<input type="checkbox"/> Yes <input type="checkbox"/> No		
87. Are you attending an institution of higher education (schooling beyond high school)?			Yes	No	Full time or part time? _____
88. Were you in foster care at age 18 or older?			<input type="checkbox"/> Yes <input type="checkbox"/> No		
89. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)					
<input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other _____					
90. Race (OPTIONAL—check all that apply.)					
<input type="checkbox"/> White	<input type="checkbox"/> American Indian	<input type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Guamanian or Chamorro	
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Samoan	
<input type="checkbox"/> Alaska Native	<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander	
				<input type="checkbox"/> Other _____	