

## Appendix A: Data Elements for Application to Support Eligibility Determinations for Enrollment through Affordable Insurance Exchanges, Medicaid and Children’s Health Insurance Program Agencies

Baseline Applicant Information	Income and Additional information	Program-Specific Questions	Confirmation And Eligibility Determination	Qualified Health Plan Enrollment
<b>Household Contact Information</b> – name, address(es), phone number(s), language(s), paperless notices and other forms of communication (email, text), applying for coverage for self	<b>Projected Annual Income</b> – amount and option for “don’t know”	<b>Exchange</b> – employer name, EIN, contact information, hours per week, offer of health coverage, date of future enrollment, name of lowest cost plan, employee contribution and frequency, minimum value standard, eligibility for other public coverage, SSNs of tax filer(s) if not provided, Special Enrollment Period information	<b>Application Summary</b> – opportunity to make edits if needed	<b>Tobacco use</b> (TBD)
<b>Authorized Representative</b> – (if applicable, skip if no representative) name, organization, address, phone number, email, permissions, signature of applicant, or legal proxy	<b>Current/Monthly Income</b> – (if applicable, some people will skip) employment, self-employment, Social Security benefits, unemployment benefits, other income, frequency of income, adjustments to income		<b>Rights and Responsibilities &amp; Signatures</b>	<b>Plan Selection and Confirmation</b> – plan name(s)/ plan ID(s), start date
<b>Seeking help paying for health insurance and Privacy Statement</b>	<b>Discrepancies</b> – employment changes in last 6 months: loss of a job, decrease in hours, change in job	<b>Medicaid</b> – past medical expenses, pregnancy, absent parent	<b>Determination and Notice(s)</b> – withdrawal of a Medicaid application, Request for a full Medicaid determination	<b>Amount of APTC applied toward premium</b>
<b>Build Your Household</b> – list primary tax filer, spouse, dependent(s), and other relevant relatives, non-filers list household members, indicate whether each is applying for coverage	<b>Additional Information</b> – <i>All household members:</i> pregnancy, other addresses including intended change of residency <i>Applicants only:</i> blindness, disability, need for long-term care, full-time student, enrollment in other health insurance, American Indian/Alaska Native questions	<b>CHIP</b> – past health coverage end date and reason for termination, child of public employee		
<b>Applicant/Non-Applicant information</b> – date of birth, family relationship, SSN (optional for non-applicants) <b>Applicant(s)</b> – sex, citizenship, eligible immigration status, race/ethnicity (optional)				

<sup>1</sup> Pursuant to the National Voter Registration Act of 1993, 42 USC Sec. 1973 GG-5