Complete a copy of this form for each additional person applying for Medicaid.

STEP 2: ADDTIONAL PERSON # ____

Complete a new copy of this form for each extra person who lives with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about whom to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

2. Relationship to you?

3. Date of birth (mm/dd/yyyy)

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
We need this information if this person wants health coverage and has an SSN.

6. Does this PERSON live at the same address as you? ☐ Yes ☐ No
If no, list address: ____________

7. **Does this person plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.

a. Will this person file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: ____________

b. Will this person claim any dependents on his or her tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: ____________

c. Will this person be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: ____________
How is this person related to the tax filer? ____________

8. Is this person pregnant? ☐ Yes ☐ No **If yes,** a. How many babies are expected during this pregnancy? ____________
b. What is this person's due date? ____________

9. **Does this person need health coverage?**
(Even if they have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes,** answer all the questions below.

☐ **NO. If no,** SKIP to the income questions on page 5. Leave the rest of this page blank.

10. Do you have a disabling physical, mental, or emotional health condition that causes limitations in activities? ☐ Yes ☐ No

11. Do you need to live in a medical facility or nursing home or need nursing services at home? ☐ Yes ☐ No

12. Have you been diagnosed with and are receiving treatment for any of the following? ☐ Yes ☐ No
- Breast Cancer
- Cervical Cancer
- Atypical Breast Hyperplasia
- Precancerous Cervical Lesion (CIN 2/3)

13. Is this person a U.S. citizen or U.S. national? ☐ Yes ☐ No

14. **If this person isn't a U.S. citizen or U.S. national,** do they have eligible immigration status?
☐ Yes. Fill in their document type and ID number below.
a. Document type ____________
b. Document ID number ____________
c. Has this person lived in the U.S. since 1996? ☐ Yes ☐ No
d. Is this person, or their spouse or parent, a veteran or an active-duty member in the U.S. military? ☐ Yes ☐ No

15. Does this person want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

16. Does this person live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

17. Was this person in foster care in South Carolina at age 18 or older? ☐ Yes ☐ No

18. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other ____________

19. **Race (OPTIONAL—check all that apply.)**
☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other ____________

Now, tell us about any income from this person on the back.

NEED HELP WITH YOUR APPLICATION? Visit SCDHHS.gov or call us at **1-888-549-0820**. Para obtener una copia de este formulario en Español, llame **1-888-549-0820**. If you need help in a language other than English, call **1-888-549-0820** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-753-8583**.

STEP 2: ADDTIONAL PERSON# ______

Current Job & Income Information

☐ **Employed**
If this person is currently employed, tell us about this income. Start with question 21.

☐ **Not employed**
Skip to question 30.

☐ **Self-employed**
Skip to question 29.

CURRENT JOB 1:

20. Employer name and address

21. Employer phone number
(   )   –

22. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$ ______________

23. Average hours worked each Week

CURRENT JOB 2: (If this person has more jobs and needs more space, attach another sheet of paper.)

24. Employer name and address

25. Employer phone number
(   )   –

26. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$ ______________

27. Average hours worked each Week

28. **In the past year, did this person:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

29. **If self-employed, answer the following questions:**

a. Type of work

____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$ ______________

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.
NOTE: You don't need to tell us about child support, veteran's payment or Supplemental Security Income (SSI).

☐ 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 **$** ________ How often? __________
☐ Other income
Type: ______________ **$** ________ How often? __________
Type: ______________ **$** ________ How often? __________

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.
If this person 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 (question 30b).

☐ Alimony paid **$** ________ How often? __________
☐ Student loan interest **$** ________ How often? __________
☐ Other deductions **$** ________ How often? __________
Type: ______________

32. **YEARLY INCOME: Complete only if this person's income changes from month to month.**

If you don't expect changes to this person's monthly income, add another person or skip to the next section.

This person's total income **this year**	This person's total income **next year** (if you think it will be different)
$	**$**

THANKS! This is all we need to know about this person.

If you have more people to add to this application, complete another form for each extra person.

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