Name:	
Street Address:	
Zip:	**Phone:**

HealthCare Access MARYLAND
COVERAGE. CARE. CONNECTIONS.

HEALTH INSURANCE ENROLLMENT - TRIAGE FORM

☐ **OPTION 1:** I don't have any health insurance and need to enroll.
Choose this option ONLY if you do not have any private health insurance, Medicaid, or Medicare.

☐ **OPTION 2:** I already have private health insurance, employer-sponsored coverage, Medicare or Medicaid.

☐ **OPTION 3:** I enrolled through the Maryland Health Connection last year and I need to re-enroll.

If you choose Option 3, please answer the following questions:

Who was your health insurance provider? _____

Have you had a change in your income or household size this year?
☐ Yes ☐ No

Do you have *ALL* of the following with you today for each member of your household?

1. State-issued ID	☐ Yes	☐ No
2. Income information (ex: pay stubs, tax filings)	☐ Yes	☐ No
3. Social Security numbers	☐ Yes	☐ No
4. Any immigration documents/IDs	☐ Yes	☐ No

If you do not have all of this information, you may need to come back when you do. We may not be able to help you obtain insurance without all of this information.

_____Consumer does not have outstanding medical bills and declines retroactive Medicaid coverage
(Initial)

HEALTH INSURANCE ENROLLMENT STATUS FORM

HealthCare Access MARYLAND
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DIRECTIONS: Please neatly print the name, sex and date of birth for every member of your household that you are enrolling for health insurance today.

			STAFF USE
Head of Household: FIRST LAST	☐M ☐F	DOB: MM/DD/YY	☐MA ☐QHP
Name: FIRST LAST	☐M ☐F	DOB: MM/DD/YY	☐MA ☐QHP
Name: FIRST LAST	☐M ☐F	DOB: MM/DD/YY	☐MA ☐QHP
Name: FIRST LAST	☐M ☐F	DOB: MM/DD/YY	☐MA ☐QHP
Name: FIRST LAST	☐M ☐F	DOB: MM/DD/YY	☐MA ☐QHP
Name: FIRST LAST	☐M ☐F	DOB: MM/DD/YY	☐MA ☐QHP
Name: FIRST LAST	☐M ☐F	DOB: MM/DD/YY	☐MA ☐QHP
Name: FIRST LAST	☐M ☐F	DOB: MM/DD/YY	☐MA ☐QHP

FOR STAFF USE Consumer Assistance Worker Name:

Household Size: Income: ☐biweekly ☐monthly ☐annually

Enrollment complete? ☐yes ☐no – wants time to plan shop ☐no – other *please specify:*

FOR QHP ENROLLMENTS

Selected Carrier			Plan Type	
☐ Care First	☐ Cigna	☐ United Healthcare	☐ Bronze	☐ Gold
☐ Kaiser Permanente	☐ Evergreen		☐ Silver	☐ Platinum

Plan Name:

REFERRED TO (CHECK ALL THAT APPLY)

HCAM Programs

☐CCP ☐Access Health
☐ATR ☐Eligibility
☐BHOP ☐MATCH

External Programs

☐CSC ☐Local Health Department
☐DSS ☐Attorney General's Health Education Advocacy Unit
☐MD Insurance Administration
☐MHBE Chief Compliance ☐DHMH Office of Inspector
☐SHOP Navigators ☐Producers