

NEW HOUSEHOLD MEMBER FORM
FAMILY ACCOUNT NUMBER: _____

If there are New Family Members in your household please complete the form below. Please make copies of this form if there are more than two new members. If there are New Members in your household also add her/his information in the Federal Tax Income question form attached to this letter.

NEW HOUSEHOLD MEMBER 1		1. First name, Middle name, Last name, Suffix _____	
2. Relationship to 1st Parent/Guardian _____		3. Relationship to 2nd Parent/Guardian _____	
4. Date of Birth (mm/dd/yyyy) _____	5. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		6. Social Security Number (SSN) _____-_____-_____
7. Is the New Household Member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many babies are expected during this pregnancy? _____ Due date: ____/____/____			
8. Does the New Household Member need health coverage? (Even if they have insurance, there might be a program with better coverage or lower costs.) <input type="checkbox"/> YES. If yes, answer all the questions below. <input type="checkbox"/> NO. If no, leave the rest of this page blank.			
9. Is the New Household Member a US citizen or US national? <input type="checkbox"/> Yes <input type="checkbox"/> No			
10. If the New Household Member isn't a U.S. citizen or U.S. national , does he/she have eligible immigration status? If yes. Fill in your document type and ID number below. a. Immigration document type _____ b. Document ID number _____ c. Has he/she lived in the U.S. since 1996? <input type="checkbox"/> Yes <input type="checkbox"/> No d. Is he/she, or his/her spouse or parent a veteran an active-duty member of the U.S. military? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please answer the following questions if the New Household Member is UNDER the age of 19.			
11. Did the New Household Member have health insurance and lose it within the past 2 months? <input type="checkbox"/> Yes <input type="checkbox"/> No a. If yes, end date: ____/____/____ b. Reason the insurance ended: _____			
12. Is the New Household Member enrolled in Health Coverage now? <input type="checkbox"/> Yes <input type="checkbox"/> No a. If yes, name of the insurance: _____ b. Policy number _____			
13. Race (OPTIONAL—check all that apply.) <input type="checkbox"/> White <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other _____			

NEW HOUSEHOLD MEMBER 2		1. First name, Middle name, Last name, Suffix _____	
2. Relationship to 1st Parent/Guardian _____		3. Relationship to 2nd Parent/Guardian _____	
4. Date of Birth (mm/dd/yyyy) _____	5. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		6. Social Security Number (SSN) _____-_____-_____
7. Is the New Household Member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many babies are expected during this pregnancy? _____ Due date: ____/____/____			
8. Does the New Household Member need health coverage? (Even if they have insurance, there might be a program with better coverage or lower costs.) <input type="checkbox"/> YES. If yes, answer all the questions below. <input type="checkbox"/> NO. If no, leave the rest of this page blank.			
9. Is the New Household Member a US citizen or US national? <input type="checkbox"/> Yes <input type="checkbox"/> No			
10. If the New Household Member isn't a U.S. citizen or U.S. national , does he/she have eligible immigration status? If yes. Fill in your document type and ID number below. a. Immigration document type _____ b. Document ID number _____ c. Has he/she lived in the U.S. since 1996? <input type="checkbox"/> Yes <input type="checkbox"/> No d. Is he/she, or his/her spouse or parent a veteran an active-duty member of the U.S. military? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please answer the following questions if the New Household Member is UNDER the age of 19.			
11. Did the New Household Member have health insurance and lose it within the past 2 months? <input type="checkbox"/> Yes <input type="checkbox"/> No a. If yes, end date: ____/____/____ b. Reason the insurance ended: _____			
12. Is the New Household Member enrolled in Health Coverage now? <input type="checkbox"/> Yes <input type="checkbox"/> No a. If yes, name of the insurance: _____ b. Policy number _____			
13. Race (OPTIONAL—check all that apply.) <input type="checkbox"/> White <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other _____			