



Tribal Premium Sponsorship Program
BCBS Marketplace Application

Northern Cheyenne Tribal Health



Tribal Premium Sponsorship Program

Tribal Premium Sponsorship Program TPSP

100 Eaglefeathers Street

PO Box 67

Lame Deer, MT 59043

406.477.6722

tpsp.rep@nctribalhealth.com

Dear Potential Marketplace Applicant,

Please ensure that your application is complete and **REMEMBER** it is your responsibility to provide the following required documents:

1. **Application Completeness:** Please confirm that the application is complete with all required signatures.
2. **Tribal Enrollment/CDIB Document:** Include your Certificate of Degree of Indian Blood (CDIB) AND/OR your **Tribal ID Card**.
3. **Proof of Residency:** Submit a document that verifies your residency or physical address on your application.
4. **Income Verification:** Provide the most current pay stub, earnings statement, or W-2 form as proof of income.

Once you gather these documents, please include them with your completed application and return them to us at your earliest convenience to avoid any delays in processing your application.

Néá'eše (Thank you).

Terms and Conditions:

1. I will provide any requested information made by the NC TPSP Program.
2. I will provide TPSP notification and documentation of any changes including life changes that are different from this original application.
3. I will notify TPSP if I move out of the IHS Service Delivery Area for the Northern Cheyenne Service Unit.
4. I will notify TPSP if my contact information changes including my address & phone number.
5. I understand that I will need to update, renew, or reapply each fiscal year to remain eligible for the NC TPSP Program.
6. I understand based upon a quarterly review of my sponsored Marketplace Healthcare Coverage and found that I have not used my sponsored Marketplace Healthcare Coverage, at all, I will be terminated from TPSP. I further understand that I will not be able to re-apply for sponsored coverage until the next available fiscal year.
7. I must utilize IHS (secure referral from NC Service Unit IHS before going to Billings or elsewhere) except for emergencies.
8. I must pay my own dental or vision premiums, Dental and Vision are NOT COVERED BY TPSP, I acknowledge failure to pay my own dental or vision premiums will result in immediate termination from the Marketplace healthcare coverage.
9. I acknowledge that TPSP's priority is to enroll me in the APTC Program dependent on if I qualify, and I must pay taxes, which I will receive a 1095-A Form and/or Form 8962 from TPSP or the IRS.
10. I must provide a copy of my Blue Cross Blue Shield Insurance Card to TPSP once enrolled, depending on eligibility confirmation.

I hereby agree with the above terms and conditions. I also authorize TPSP to use my personal identifying information for TPSP Office procedures.

Applicant Name (**Please Print**): _____

Applicant Signature: _____

Date: _____



Tribal Premium Sponsorship Program
Current Occupation & Social Media Form



Full Name (Please Print): _____

Current Occupation (Please Print): _____

Employer (Please Print): _____

Consent for Social Media Contact:

Do you give permission for the Northern Cheyenne Tribal Premium Sponsorship Program to contact you via your selected social media platforms?

Yes

No

Can we communicate with you via social media? (Select all that apply):

Facebook including Messenger

Instagram

Snapchat

X (formerly Twitter)

Social Media Handles (for contact purposes):

Facebook Handle: _____

Instagram Handle: _____

Snapchat Handle: _____

X (Twitter) Handle: _____

Signature: _____

Date: _____

Applicant Information:

Full Name *(Please Print):* _____

Date of Birth: _____

Social Security Number: _____

Mailing Address: _____

Physical Address: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Tribal Enrollment Affiliation: _____

Tribal Enrollment Number: _____

Income Verification:

Name of Employer: _____

Hours per week: _____ **Hourly Rate:** _____

Annual Salary: _____

Do you receive Alimony? Yes No *(Please check one)*

If Yes, how much: _____

Do you pay student loans? Yes No *(Please check one)*

If Yes, how much: _____

Do you receive Per Capita Payments? Yes No *(Please check one)*

If Yes, how much: _____

Do you receive payments from natural resources, farming, ranching, fishing, or leasing land designated as Indian land?

Yes No *(Please check one)*

If Yes, please describe, and how much:

Is all 3rd Party income verification included and attached?

Yes No *(Please check one)*

Do you have a special healthcare need, physical disability, or mental health condition that limits your ability to work, attend school, or take care of your daily needs?

Yes No *(Please check one)*

If Yes, please describe, and how much:

Household Information:

Tax Dependent(s): How many tax dependents are seeking coverage? _____

Full Legal Name: _____

Age: _____

Date of Birth: _____

Social Security Number: _____

Tribal Affiliation: _____



Full Legal Name: _____

Age: _____

Date of Birth: _____

Social Security Number: _____

Tribal Affiliation: _____



Full Legal Name: _____

Age: _____

Date of Birth: _____

Social Security Number: _____

Tribal Affiliation: _____



Full Legal Name: _____

Age: _____

Date of Birth: _____

Social Security Number: _____

Tribal Affiliation: _____

Additional Information:

Are you married? Yes No *(Please check one)*

If Yes, please provide the following:

Spouse's Name: _____

Spouse's Employer (if employed): _____

Hours per week: _____ Hourly Rate: _____

Annual Salary: _____

Will you be filing a joint tax return? Yes No (Please check one)

How many dependent(s) will you claim on your taxes? (Do not include yourself): _____

Are you currently eligible or offered healthcare coverage through a job? (Through a spouse or parent?)

Yes No (Please check one)

Do you plan to file a federal income tax for the current year?

Yes No (Please check one)

Do any household members who are seeking healthcare coverage need assistance with daily activities?

Yes No (Please check one)

If Yes, who, and provide name:

Do you have any dependents receiving the following (Please check) ?

Medicaid Tricare HMK/CHIP

VA Medicare Private Insurance

None

If Yes, who, and provide name:

Has anyone in your household been denied Medicaid/Montana Healthy Kids?

Yes No (Please check one)

If Yes, who, and provide name:



Tribal Premium Sponsorship Program

Advanced Premium Tax Credits Form



As a potential participant of the NC TPSP Program, I acknowledge that providing inaccurate information regarding my income or household size may lead to a reduction or repayment of credits. I am aware of my responsibility to report any changes in my income or household circumstances to TPSP in a timely manner.

I confirm that I have been given the opportunity to ask questions regarding the advanced premium tax credits subsidy and their implications.

****Disclaimer for Voluntary Enrollment in Advanced Premium Tax Credits***

By voluntarily enrolling in advanced premium tax credits (APTC) through the NC TPSP Program & the Health Insurance Marketplace, I acknowledge that I have read and understood the eligibility criteria and requirements associated with these credits. I further acknowledge that if I qualify within the 100% - 400% FPL I am eligible for APTC.

Terms and Conditions for Eligibility for Marketplace Health Insurance Coverage

I understand that the amount of advanced premium tax credits I may receive is based on my estimated annual income and household size, and that any discrepancies may result in a reconciliation of the credits when I file my federal tax return. I understand and acknowledge the following:

1. **TPSP APTC Subsidy Required and Prioritized:** All NC TPSP Marketplace eligible clients will be required and prioritized to voluntarily accept APTC before NC TPSP decides to pay a full monthly premium for the Marketplace eligible client. If a Marketplace eligible client refuses to voluntarily accept APTC, NC TPSP retains the right to determine the potential client ineligible for enrollment for Marketplace. As a potential participant I acknowledge that I may be found ineligible if I deny APTC.
2. **Cost-Savings:** I understand that the TPSP Program in utilizing APTC is cost-savings for both TPSP and its clients that are eligible through Marketplace and APTC.
3. **Eligibility:** I affirm that I meet the eligibility requirements for APTC as outlined by the NC TPSP Program and the Affordable Care Act.
4. **Potential Tax Implications:** I understand that receiving APTC may affect my tax filings and that I may need to reconcile these credits on my federal tax return.
5. **Potential Tax Overpayment/Income Tax Credit:** I understand that at the time of tax filing and in accordance with the 1095 A Form and/or the Form 8962 I bear the sole

responsibility of the undertaking of a tax overpayment or an income tax credit. I further understand that either outcome is solely my responsibility as the tax payor. NC TPSP is not liable for a tax overpayment or an income tax credit on my behalf.

6. **Data Privacy:** My personal information will be handled in accordance with applicable privacy laws, HIPAA law, and the policies of the NC TPSP Program.
7. **No Guarantees:** The benefits of APTC are subject to change based on federal regulations, and I acknowledge that the NC TPSP Program may have limitations based on the changes provided by the federal regulations.
8. **Over-Income:** If I am determined eligible, and over-income, I acknowledge and agree that I am responsible for the APTC on behalf of my Marketplace healthcare coverage and the specific details of this form, I further acknowledge that NC TPSP will sponsor my premium for me on my behalf to Marketplace. I further acknowledge that I may be found ineligible for Marketplace coverage all together on a case-by-case basis by TPSP.
9. **Form 8962 & 1095-A Form:** These forms will be provided upon my request to the TPSP Program to include with my upcoming tax filing.

By signing below, I confirm my understanding of the above points and consent to enroll in the Advanced Premium Tax Credits by the NC TPSP Program.

I, _____ (**Please Print**), acknowledge TPSP to enroll me into APTC on my behalf.

Participant Signature

Date