



Request for Temporary KY- HCTC Bridge Grant Payment

American Recovery & Reinvestment Act of 2009

WORKER NAME (FIRST, MIDDLE INITIAL, LAST)		SOCIAL SECURITY NUMBER	
ADDRESS (STREET NUMBER)			Primary Phone
CITY	STATE	ZIP CODE + 4	Alternate Phones (if necessary)
DATE OF BIRTH	NUMBER PEOPLE ON POLICY	Former Employer	Petition Number

Part A. Temporary KY-HCTC Bridge Grant Qualifying Information

**I am providing an invoice to reflect that I have the following qualified health coverage):
(Please check appropriate boxes below)**

COBRA Continuation Coverage if the employer/former employer pays less than 50% the cost of coverage
 State-qualified health plans: Anthem Individual Blue Access TAA
 Individual coverage in effect 30 days prior to separation from trade affected employer
 Spouse's insurance from work, if the employer contributes less than 50% of the total health plan premium

Are you currently enrolled in any of the following? Yes No

(If you checked no to previous question, go to Part B, if you checked yes, please check appropriate boxes below.)

Enrolled in a health plan maintained by an employer / former employer that pays at least 50% the coverage
 Entitled to Medicare Part A or enrolled in Medicare Part B
 Enrolled in a plan in the Federal Employees Health Benefit Program (FEHBP)
 Recently imprisoned by a federal, state or local authority
 Enrolled in Kentucky's Medicaid Insurance Program
 Entitled to health coverage through the US Military Health System (TRICARE/CHAMPUS)

Part B. Worker Certification

The above information has been supplied to support my request for the Temporary KY-HCTC Bridge Grant Payment. The information contained in this request is correct and complete to the best of my knowledge. I understand that if I am determined eligible, 80%*, of my monthly qualified health care premium will be paid while I am in the process of applying for the advanced payment through the US Department of Treasury, Internal Revenue Service. I know that this information is subject to verification and that penalties are prescribed by law for willful misrepresentation of facts in order to obtain payment(s) for which I am not entitled.

*The payment will be calculated at 65% for payments on coverage prior to May 1, 2009.

SIGNATURE OF WORKER _____ **DATE SIGNED** _____

IMPORTANT NOTE: All shaded areas must be filled out appropriately on both pages

Part C. Payment Calculation

Name of Insurance Company: _____

- 1. Enter the total monthly premium paid for the health plan policy.....
 - 2. Enter the total monthly premium paid for non-qualified family members on your policy...
 - 3. Enter the total of monthly premiums paid for exceptions on this policy (for example, Vision and dental coverage).....
 - 4. Enter the amount of your monthly premium that you pay using funds from an Archer MSA (Medical Savings Account).....
 - 5. Add lines 2, 3 and 4. Enter the result here. This is the estimated total monthly **ineligible** premium amount.....
 - 6. Subtract line 5 from line 1 and enter the result here. This is the estimated monthly **HCTC-eligible** premium amount.....
 - 7. Multiply line 6 by 20% (.20)* and enter the result here.....
- (*Payments for coverage prior to May 1, 2009 must be calculated at 35%)
- 8. Add lines 5 and 7. This is an estimate of your total monthly payment responsibility for this policy. **Include your payment for this amount**.....

Part D. Payment Information

I elect to pay by: Money Order Check (Check only one box)

**** (Make Payment to: Kentucky State Treasury)**

Please note the verification & payment process may take up to 2 weeks for Kentucky’s Bridge Grant Program. **Your request and payment must be received by the 27th of each month.** In the event that you cannot meet the required time frame, you should continue to pay 100% of your health plan premium directly to your health plan administrator.

***Payments for coverage prior to May 1, 2009 must be calculated at 35% for the participant's share.**
For additional information, please call the State Trade Unit, HCTC Customer Care Center at:
1-502-564-7456 and ask for Ruth Mayes

Mail your completed Request for KY-HCTC Bridge Grant assistance, current month’s invoice and payment to:

Attn: Stella Carriss
Office of Employment and Training
275 E. Main Street, 2 C-A
Frankfort, Kentucky 40621

Attach current month healthcare insurance invoice, this two page completed form & include your portion of payment from Line 8 above.

