A.R.S. § 43-210
Application for Certificate of Eligibility for the Health Insurance Premium Tax Credit – Individuals Only

Please Print

Individual Applicant First Name: Last Name:
Individual Applicant Address Number and Street or PO Box:
City: State ZIP Code
Individual Applicant Day-Time Phone Number
Family size (Total # - self, spouse and dependent children)
Check one: ☐ Applying for Certification for Applicant Only. ☐ Applying for Certification for Applicant's Dependent Child(ren) Only. Number of Dependent Children ___ ☐ Applying for Certification for Applicant plus Family (spouse or spouse and children)
Gross Yearly Income **$**
Check one: ☐ I am a legal resident of Arizona and a citizen of the United States. ☐ I am a legal resident alien living in Arizona.

I declare that I have not been covered under a health insurance policy for at least six consecutive months prior to this application and I am not currently enrolled in the Arizona Health Care Cost Containment System (AHCCCS), Medicare or any other state or federal government health insurance program.

Under penalties of perjury, I declare that I have examined this application and to the best of my knowledge and belief, this information is true, correct and complete.

Print

Signature _____ Date _____

This application should be mailed to the following address:

Arizona Department of Revenue
Office of Economic Research and Analysis
Darlene Teller, Senior Economist
PO Box 29099
Phoenix, AZ 85038

If you have questions regarding completion of this form, contact Darlene Teller at (602) 716-6436.