

**A.R.S. § 43-210**  
**APPLICATION FOR CERTIFICATE OF ELIGIBILITY FOR THE**  
**HEALTH INSURANCE PREMIUM TAX CREDIT**  
**SMALL BUSINESS ONLY**

*Please Print*

Small Business Applicant Name:		
Small Business Applicant Address Number and Street or PO Box:		
City:	State	ZIP Code
Small Business Owner or Contact Person Name(s)		
Small Business Owner or Contact Person Day-Time Phone Number		
Length of time Small Business has been in existence in Arizona		
Maximum number of employees at any time during the most recent calendar year		
Number of employees seeking Single Coverage		
Number of employees seeking Family Coverage		

I declare that the above-named Small Business has not provided health insurance to its employees for at least six consecutive months prior to this application.

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.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

This application should be mailed to the following address:

Darlene Teller, Economist  
Office of Economic Research and Analysis  
Arizona Department of Revenue  
PO Box 25248  
Phoenix, AZ 85002

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

**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: <ul style="list-style-type: none"> <li><input type="checkbox"/> Applying for Certification for Applicant Only.</li> <li><input type="checkbox"/> Applying for Certification for Applicant's Dependent Child(ren) Only.              Number of Dependent Children _____</li> <li><input type="checkbox"/> Applying for Certification for Applicant plus Family (spouse or spouse and children)</li> </ul>	
Gross Yearly Income	
\$	
Check one: <ul style="list-style-type: none"> <li><input type="checkbox"/> I am a legal resident of Arizona and a citizen of the United States.</li> <li><input type="checkbox"/> I am a legal resident alien living in Arizona.</li> </ul>	

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.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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Darlene Teller, Economist  
 Office of Economic Research and Analysis  
 Arizona Department of Revenue  
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 Phoenix, AZ 85002

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