Application for Benefits

Tear off and keep pages A through H for your records.

What is this application for?
Use this application to see if you and members of your household qualify for:

- Free or low-cost insurance from AHCCCS
- Help with your Medicare costs
- Nutrition Assistance
- Cash Assistance/Temporary Assistance for Needy Families (TANF)
- Tuberculosis Control
- A new tax credit that can help pay your health insurance premiums

See page B for a description of each program.

Who can use this application?
An application may be completed by you or anyone you choose who knows or can get the information needed to complete the application for you and your household members. You can use this application to apply for anyone in your household, even if they already have benefits, including health insurance.

Your household includes:

- Your spouse, if married
- Your children under age 22 who live with you
- Your partner who lives with you (but only if you have a child together who needs health insurance or Cash Assistance)
- People you claim on your income tax return even if they do not live with you
- Relatives in your care who are under the age of 19 and live with you
- People who you live with that purchase and prepare food with you

If you want to select a representative to complete your application, complete the Authorized Representative form on page 1 of the application.

Where else can I apply?
You can apply faster online at www.healthearizonaplus.gov.
You can also apply in person at any local Department of Economic Security (DES)/Family Assistance Administration (FAA) office.
You can find a list of local FAA offices at www.azdes.gov/faa or call our 24 hour Interactive Voice Response system at 1-855-HEA-PLUS (432-7587).

What information do I need to complete this application?
For everyone in your household, you may need:

- Birth dates
- Social Security numbers
- Employer and income information for everyone in your household
- Resources (e.g., bank account, cash, property)
- Expenses
- Information for any current health insurance
- Information about any job-related health insurance available to members of your household
- Other information needed to complete your application

Note: You can file an application with only your name, address, and the signature of a responsible household member or your authorized representative. This will hold your date of application but eligibility cannot be determined until you complete a full application and an interview, if needed.

Why do we ask for so much information?
We ask about income and other information to make sure you and members of your household get the correct benefits for your household.
We will keep all information you provide private, as required by law.

What happens next?
Send your completed, signed application to the address on Page 17 or take it to your local DES office. If you do not have all of the information available, you can still submit your application and we will help you get the rest of the information.

What if I need help?
If you need help filling out this application, please tell us. If you need a language interpreter or accommodations for a disability, please check the kind of help you need on page 1 of the application.

Online: www.healthearizonaplus.gov
Phone: 1-855-HEA-PLUS (432-7587)
In person: Visit www.azdes.gov/faa to find the office closest to you.
Program Information:

You can use this application to apply for one or more programs. Each program has a symbol. On the application, look for the symbol for the program(s) you want to apply for and answer those questions. These are the symbols you will see on this application:

- Health Insurance Costs (AHCCCS Medical Assistance, Medicare Savings Program, Tax Credits)
- Nutrition Assistance
- Cash Assistance
- Tuberculosis Control

What is AHCCCS Medical Assistance?

AHCCCS stands for Arizona Health Care Cost Containment System, and it is the State of Arizona’s Medicaid program. AHCCCS can provide medical benefits and help with Medicare costs to Arizona residents who meet certain income and other eligibility standards.

AHCCCS Medical Assistance covers the following medical services:

- Prescription Medication*
- Doctor's Office Visits**
- Laboratory and X-ray Services
- Hospital Services
- Dialysis
- Medical Supplies
- Medically Necessary Transportation
- Medically Necessary Specialist Care
- Behavioral Health Care
- Immunizations (shots)
- Chemotherapy
- Emergency Medical Care
- Rehabilitation Services
- 90 days of nursing care services

* AHCCCS prescription coverage is limited for people who have Medicare.
** Wellness visits for people age 21 and over are not covered.

What is Medicare Savings Program?

Medicare Savings Program may pay:

- Medicare Part A premium
- Medicare Part B premium
- Medicare deductibles and copayments
- Automatic Extra Help for Medicare Part D prescription expenses

What are Nutrition Assistance benefits?

Nutrition Assistance benefits help low-income families or individuals buy food for a healthier diet. If you have little or no money, you may be eligible for Emergency Nutrition Assistance benefits. Be sure to answer the Emergency Nutrition Assistance benefits questions on page 2 of this application.

What is Cash Assistance?

Cash Assistance gives temporary cash benefits to low income families. Parents or relatives of dependent children who are in their care may be eligible. Some families may qualify for a one-time lump sum cash assistance payment. We will determine if you qualify for this payment option.

What is Tuberculosis Control?

Tuberculosis Control gives cash support to individuals who are determined unable to work by the Department of Health Services as a result of communicable Tuberculosis.

What if I am not eligible for AHCCCS Medical Assistance?

If you are not eligible for AHCCCS Medical Assistance, you may be eligible for federal tax credits to help with your health insurance premiums. If you are not eligible for any programs through AHCCCS, we will send your information to the federal Health Insurance Marketplace to see about health insurance tax credits.
### How does AHCCCS Medical Assistance work?

If you are approved for AHCCCS Medical Assistance, you will receive your health care from an AHCCCS health plan unless:
- You are American Indian and you choose American Indian Health Program as your health plan.
- You are just asking for help with your Medicare costs. If you are approved for one of the Medicare Savings Programs (QMB), AHCCCS may pay your Medicare premiums and Medicare coinsurance and deductibles.
- AHCCCS can only pay for your emergency services because of your status with United States Citizenship and Immigration Services (USCIS). If you are approved for emergency services only, you may receive medical services from any provider (doctor, hospital, etc.) that has an agreement to bill AHCCCS for covered emergency services.

### How much does AHCCCS Medical Assistance cost?

**Premiums:**
- Most people do not have to pay a monthly premium for AHCCCS Medical Assistance.
- Some people with income too high to qualify for AHCCCS Medical Assistance with no monthly premium may be able to get it by paying a monthly premium. If you have to pay a premium, the premium amounts are $10 to $35 per person for employed people with disabilities.

**Co-payments:**
A co-payment is the amount you pay a health care provider when you receive a medical service. Your co-payment amount will vary depending on which AHCCCS program you are enrolled in and the services you need. For some AHCCCS programs, the provider can deny services if the co-payments are not made. Co-payments for services are:
- $2.30 to $10.00 for prescriptions
- $0 to $30.00 for non-emergency use of an emergency room
- $3.40 to $5.00 for outpatient visits for evaluation and management services including doctor's office visits
- $2.30 to $3.00 for physical, occupational or speech therapy

Remember to report any changes in income because this may change your co-payment amount.

**The following people are never asked to pay co-payments:**
- Children under age 19
- People determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services
- Individuals through age 20 eligible to receive services from the Children’s Rehabilitative Services (CRS) program
- People who are temporarily residing in nursing homes or residential facilities such as an Assisted Living Home and only when the acute care member’s medical condition would otherwise require hospitalization. The exemption from co-payments is limited to 90 days in a contract year
- People who receive hospice care

**Co-payments are never charged for the following services for anyone:**
- Hospitalizations
- Services paid on a fee-for-service basis
- Emergency services
- Pregnancy related health care including tobacco cessation for pregnant women
- Family planning services
Do I need a Social Security number?


- If you or anyone you are applying for does not have a Social Security number, we will refer you to the Social Security office to apply for one. Immigrants who are not legally able to get a Social Security number are not required to give one or apply for one. Any person you are applying for who is legally able to get a Social Security number but does not have one or does not apply for one will not be eligible for benefits.
- If you are not applying for benefits for yourself, you do not have to give us your Social Security number. However, it may reduce the total amount of Nutrition Assistance and/or Cash Assistance benefits for the person you are applying for for because we will not include you in the benefit amount.
- We will not use your SSN as your DES or AHCCCS identification number.
- We will not give any Social Security numbers to the United States Citizenship and Immigration Services (USCIS).

We use your information, including Social Security number, to:
- Verify identity
- Verify citizenship and immigration status
- Verify income and resources
- Prevent duplicate benefits
- Establish and enforce child support
- Computer match with state, local and federal agencies and our other programs to verify information
- Collect money we overpaid you in the form of benefits
- Share with other government agencies and their contractors to assess Nutrition Assistance and/or Cash Assistance program management and compliance
- We may give your information to law enforcement officials for the purpose of arresting persons fleeing to avoid the law

If we are not able to find proof of the information you have given us through the sources available to us, then you must provide proof of the information for us to decide if you are eligible.

DES and/or AHCCCS will keep your information for at least 7 years.

Do I have to give information about my citizenship and immigration status?

- To get the most help, you need to give us information about citizenship and immigration status for each person who is applying for help.
- Giving us the citizenship and immigration status for all people who are eligible for benefits allows us to include them in the Nutrition Assistance and/or Cash Assistance benefit amount. When you do not give us this information, it will not affect the eligibility of the people you are applying for who have given us verification of their citizenship or qualified non-citizen status, but it may affect the amount of the benefits for these people.
- If you choose not to give us information regarding immigration status but still want AHCCCS Medical Assistance, you may only be eligible for emergency medical services.
- You do not need to give us information about citizenship and immigration status for any person who is not applying.
- You do need to give us information on income, resources, or other information for those who have not given us citizenship or immigration status information to complete the application process.
- Under federal law, certain non-citizens such as refugees or political asylees may qualify for Medical Assistance, Nutrition Assistance, and/or Cash Assistance. For those non-citizens, United States Citizenship and Immigration Services (USCIS) guidelines state that use of these benefits will not affect your ability to become a Lawful Permanent Resident.
- If you are not applying for any benefits or if you chose not to provide citizenship or immigration information, we will not try to find out this information from USCIS.
- We will not report you, a family, or a household member to U.S. Immigration and Customs Enforcement (ICE) unless you inform us that you, your family or a household member is in the U.S. illegally.
Will I have to do an interview?

When applying for AHCCCS Medical Assistance and/or help with Medicare costs, an interview is not needed. When applying for Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control you or your representative must complete an interview in person or by phone. If you need special accommodations for an interview, please tell us on page 1 of the application so we can be ready for your interview.

How long does it take to find out if I am eligible for benefits after you receive my application?

For AHCCCS Medical Assistance and/or help with Medicare costs, we will make a decision within 45 days.
- If you are pregnant, we will make a decision within 20 days.
- If you need a disability determination report, we will make a decision within 90 days.

For Nutrition Assistance, we will make a decision within 30 days.
- If you are eligible for Emergency Nutrition Assistance, we will make a decision within 7 days.

For Cash Assistance, we will make a decision within 45 days.
- If you are a relative or legal guardian applying only for children who are not your own, we will determine if the children qualify within 20 days.

How will I know if I am eligible?

- If you are approved for benefits, you will receive a letter explaining the benefits you are eligible for and the amount of benefits you will get.
- If you are denied, we will send you a letter explaining the reason for our decision.

How can I get my benefits when my application is approved?

If you are approved for AHCCCS Medical Assistance and/or help with Medicare costs, you will get an approval letter. You will get your AHCCCS ID card from your enrollment plan 10 to 14 business days after you get your approval letter. If you need medical services before you get your AHCCCS ID card, contact your enrollment plan.

If you are approved for Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control:
- You will get an Electronic Benefit Transfer (EBT) card. This card works like a debit card. You will get a pamphlet with instructions on how to use your card.
- Your benefits are put on your EBT card after approval. It can take up to 48 hours for the benefits to be available. You can call the Customer Service number on the back of the card to check the balance of your benefits.
- If you are eligible for Emergency Nutrition Assistance, you may get an EBT card at your local DES/FAA office.
- If you qualify for Nutrition Assistance benefits, you can use the EBT card to buy approved food items. If you qualify for Cash Assistance benefits, you can use your EBT card to get cash or buy non-food items at any store where EBT cards are accepted. You may also withdraw your Cash Assistance benefits at ATMs, but there may be a fee.
What is expected of me?

For all programs:
• You must provide DES and/or AHCCCS with the needed information to correctly determine your eligibility and authorize DES and/or AHCCCS to investigate and contact any sources necessary to confirm the accuracy of the information for your eligibility.
• If you are approved for benefits, you will get a letter telling you what changes you must report. You MUST report your changes timely.

Program-specific expectations:
If applying for help with AHCCCS Medical Assistance, help with Medicare costs, and/or Cash Assistance, you must take necessary steps to obtain any annuities, pensions, retirement and disability benefits to which you may be entitled, including, but not limited to, Social Security benefits, Railroad retirement, Veterans benefits and unemployment compensation.

For AHCCCS Medical Assistance and/or Cash Assistance, you must give us any information you have about an absent parent. If you have reason for not providing this information (such as adoption pending, abuse, incest, neglect, etc.) you may claim good cause. You must cooperate with the Division of Child Support Services (DCSS) to establish paternity, unless you can prove good cause.

All adult household members and minor parents who are eligible for Nutrition Assistance and/or Cash Assistance benefits must be fingerprint imaged. Exceptions may apply.

For Nutrition Assistance and/or Cash Assistance you must tell us and provide proof to receive deductions, for the following expenses: court ordered child support paid, child/adult dependent care expenses, medical expenses, transportation costs to and from the provider of medical care or daily care of a child/adult dependent, rent or mortgage payments, utility or other shelter costs.

What are my rights?

You have the RIGHT to:
• Courteous and professional treatment.
• Be treated fairly and equally regardless of race, color, religion, national origin, sex, age, disability, or political beliefs.
• Apply for benefits and be given a letter that tells you if you are eligible or not, and/or get a letter before your benefits are reduced or stopped.
• Review DES and AHCCCS policy manuals that show the rules and regulations of AHCCCS Medical Assistance, Medicare Savings Program, Nutrition Assistance, Cash Assistance, and Tuberculosis Control if you want to know the reason for our decision.
• Talk about your case with a worker or supervisor.
• Have all information you give regarding your eligibility kept private according to state and federal law.
• Ask for a fair hearing if you disagree with your application being denied, your benefits ended, or are being reduced, or if a decision is not made on your application within the allowable number of days and the delay is due to DES or AHCCCS.
• Look at your file before a fair hearing.
• Bring an attorney or any other person to a fair hearing.

To file a discrimination complaint, contact:
U.S. Department of Health and Human Services
Director, Office for Civil Rights
Room 515-F
200 Independence Avenue, S.W.
Washington, DC 20201
1-202-619-0403 (voice)
1-800-537-7697 (TTY)

Form:
http://www.ascr.usda.gov/complaint_filing_cust.html

U.S. Department of Agriculture
Director, Office of Adjudication
1400 Independence Avenue, SW
Washington, DC 20250-9410
Fax: 1- 202-690-7442
E-mail: program.intake@usda.gov

For help filling out the form, you may call:
1-866-632-9992 (Toll-free Customer Service)
1-800-877-8339 (Local or Federal relay)
1-866-377-8642 (Relay voice users)
What are the Rules and Penalties?

If you, your representative, or any household member hides information or gives false information on purpose to get or continue to get Nutrition Assistance and/or Cash Assistance benefits that you are not entitled to, that person will be subject to:

- Criminal Prosecution
- Fines
- Imprisonment
- Other penalties provided for by state and federal laws

If you get Nutrition Assistance and/or Cash Assistance, you must follow the rules below:

- Do not make false statements or hide information. If you are not truthful, you may have to pay back DES for benefits you receive and you may be taken to court.
- Do not do anything dishonest to get benefits that you are not supposed to get.
- Do not buy, sell, trade, exchange or otherwise transfer your or someone else’s Nutrition Assistance benefits or EBT card.
- Do not take containers with deposits for the purpose of discarding the product and returning the containers to get cash refund deposits.
- Do not sell products bought with Nutrition Assistance benefits to exchange them for cash or items other than eligible food.
- Do not buy products originally bought with Nutrition Assistance benefits to exchange those products for cash or items other than eligible food.
- Do not steal Nutrition Assistance or Cash Assistance benefits.
- Do not use your Nutrition Assistance benefits to buy non-food items such as alcohol and tobacco.
- Do not alter an EBT card.
- Do not use someone else’s EBT card unless you are an authorized user approved by DES.

If you knowingly break the rules and get Nutrition Assistance and/or Cash Assistance benefits, we will disqualify you from getting benefits for:

- 12 months for the first violation
- 24 months for the second violation
- Permanently for the third violation

You or a household member will not be eligible to get Nutrition Assistance and/or Cash Assistance benefits if you or the household member:

- Is a fleeing felon or probation/parole violator.
- Has been convicted of using or getting Nutrition Assistance benefits in a transaction involving the sale of firearms, ammunition or explosives. This person can never get Nutrition Assistance benefits again.
- Has been found guilty of using or getting Nutrition Assistance benefits in a transaction involving the sale of a controlled substance. This person is not eligible to get Nutrition Assistance benefits for 2 years for the first violation and permanently for the second violation.
- Has committed and was convicted of a federal or state felony on or after August 23, 1996 for the possession, use or distribution of a controlled substance.
- Has committed and was convicted of using or getting Nutrition Assistance benefits in a transaction involving the sale of a controlled substance.
- Has been found by a court of law to have given false identification or residence information in order to get benefits in more than one case. This person is not eligible to get benefits for 10 years.
- Refuses to sign and comply with the Personal Responsibility Agreement (PRA). We give you the PRA during the interview process.
- Is an adult recipient (18 years or older) of Cash Assistance when any of the following apply:
  - The recipient does not return the completed Illegal Drug Use Statement. We send the Illegal Drug Use Statement by U.S. Mail after Cash Assistance has been approved.
  - The recipient fails to take a required drug test.
  - The recipient fails the drug test.

You must pay DES back for any Nutrition Assistance and/or Cash Assistance benefits you received for which your household was not eligible. You can make a repayment agreement. If you do not keep your repayment agreement, we may reduce your Nutrition Assistance and/or Cash Assistance benefits, take your income tax refunds, or take other legal action, including taking the amounts from your earnings.

The following additional penalties apply to the Nutrition Assistance Program:

- An additional disqualification, of up to 18 months, may be ordered by a court.
- Any participant or household member who makes false statements or hides information can be fined up to $250,000.00, imprisoned for up to 20 years, or both.
- You and/or your household members may be subject to further prosecution under federal laws.
How to Choose an AHCCCS Health Care Plan:

You need to choose a health plan that services your county.

- All AHCCCS health plans provide the same covered medical services.
- Review the health plans for your county listed below. American Indians may choose American Indian Health Program or an AHCCCS health plan.
- Before you choose a plan, check with your doctor, pharmacy, or hospital to see if they work with the plan that you want. If you want more information about the doctors, specialists, or hospitals that work with a health plan that serves your county, call the number listed below for the health plan.

If you do not choose a health plan, one will be assigned to you. If you have been enrolled in an AHCCCS health plan within the past 90 days, you may be enrolled with your previous health plan.

Enter the health plan choice on this application.

### APACHE COUNTY
UnitedHealthcare Community Plan ................. 1-800-348-4058
Health Choice Arizona .................................... 1-800-322-8670
American Indian Health Program ..................... 1-800-654-8713

If your zip code is 85943, you must choose from the health plans listed under Navajo County.

### COCHISE COUNTY
University Family Care .................................. 1-800-582-8686
UnitedHealthcare Community Plan .................. 1-800-348-4058
American Indian Health Program ..................... 1-800-654-8713

If your zip code is 86336 or 86340, you must choose from the health plans listed under Yavapai County.

### COCONINO COUNTY
UnitedHealthcare Community Plan ................... 1-800-348-4058
Health Choice Arizona .................................... 1-800-322-8670
American Indian Health Program ..................... 1-800-654-8713

If your zip code is 86035 or 86037, you must choose from the health plans listed under Navajo County.

### GILA COUNTY
Health Choice Arizona .................................... 1-800-322-8670
University Family Care .................................. 1-800-582-8686
American Indian Health Program ..................... 1-800-654-8713

If your zip code is 85292 you must choose from the health plans listed under Maricopa County.

### GRAHAM COUNTY
University Family Care .................................. 1-800-582-8686
UnitedHealthcare Community Plan .................. 1-800-348-4058
American Indian Health Program ..................... 1-800-654-8713

If your zip code is 85643, you must choose from the health plans listed under Cochise County.

### GREENLEE COUNTY
University Family Care .................................. 1-800-582-8686
UnitedHealthcare Community Plan .................. 1-800-348-4058
American Indian Health Program ..................... 1-800-654-8713

### LA PAZ COUNTY
UnitedHealthcare Community Plan .................. 1-800-348-4058
University Family Care .................................. 1-800-582-8686
American Indian Health Program ..................... 1-800-654-8713

### MARICOPA COUNTY
Health Net of Arizona ..................................... 1-888-788-4408
Care 1st Arizona ............................................ 1-866-560-4042
Health Choice Arizona .................................... 1-800-322-8670
UnitedHealthcare Community Plan................... 1-800-348-4058
Mercy Care Plan .......................................... 1-800-624-3879
Maricopa Health Plan .................................... 1-800-582-8686
American Indian Health Program ..................... 602-417-4000

### MOHAVE COUNTY
UnitedHealthcare Community Plan .................. 1-800-348-4058
Health Choice Arizona .................................... 1-800-322-8670
American Indian Health Program ..................... 1-800-654-8713

If your zip code is 86434, you must choose from the health plans listed under Yavapai County.

### NAVAJO COUNTY
UnitedHealthcare Community Plan .................. 1-800-348-4058
Health Choice Arizona .................................... 1-800-322-8670
American Indian Health Program ..................... 1-800-654-8713

### PIMA COUNTY
Health Choice Arizona .................................... 1-800-322-8670
University Family Care .................................. 1-800-582-8686
American Indian Health Program ..................... 1-800-654-8713

### PINAL COUNTY
University Family Care .................................. 1-800-582-8686
UnitedHealthcare Community Plan .................. 1-800-348-4058
American Indian Health Program ..................... 1-800-654-8713

If your zip code is 85242 or 85220, you must choose from the health plans listed under Maricopa County.

If your zip code is 85292 you must choose from the health plans listed under Gila County.

### SANTA CRUZ COUNTY
University Family Care .................................. 1-800-582-8686
UnitedHealthcare Community Plan .................. 1-800-348-4058
American Indian Health Service ..................... 1-800-654-8713

### YAVAPAI COUNTY
UnitedHealthcare Community Plan .................. 1-800-348-4058
Health Choice Arizona .................................... 1-800-322-8670
Care 1st Arizona ............................................ 1-866-560-4042
University Family Care .................................. 1-800-582-8686
Mercy Care Plan .......................................... 1-800-624-3879
American Indian Health Program ..................... 1-800-654-8713

If your zip code is 85342, 85358 or 85390, you must choose from the health plans listed under Maricopa County.

If your zip code is 85342, 85358 or 85390, you must choose from the health plans listed under Yavapai County.

### YUMA COUNTY
UnitedHealthcare Community Plan .................. 1-800-348-4058
University Family Care .................................. 1-800-582-8686
American Indian Health Program ..................... 1-800-654-8713

If your zip code is 86351, you must choose from the health plans listed under Cochise County.
Application for Benefits

Contact Information:

Tell us how we can contact an adult member of your household.

Name (First, Middle, Last): _____________________________________________
Home Address: ____________________________________________ Apt. #: ______ City: ___________ State: _____ Zip Code: ___________
Mailing Address (if different): ____________________________________________ Apt. #: ______ City: ___________ State: _____ Zip Code: ___________
Do you live in a shelter? [ ] Yes [ ] No If 'Yes,' what kind of shelter? ____________________________
Phone Number: ____________________________ This number is: [ ] Home [ ] Cell [ ] Work [ ] Message [ ] Other: __________________________
Representative’s Other Phone Number: ____________________________ This number is: [ ] Home [ ] Cell [ ] Work [ ] Message [ ] Other: __________________________
What is the preferred SPOKEN household language? [ ] English [ ] Spanish [ ] Other: __________________________
What is the preferred WRITTEN household language? [ ] English [ ] Spanish [ ] Other: __________________________
I would like to get information about this application by:
Email: [ ] Yes [ ] No Email address: ____________________________________________
Text: [ ] Yes [ ] No Number to text (standard text rates apply):
If 'Yes' is not marked for Email or Text, all information for this application will be sent via U.S. Mail to the mailing address provided.

I need the following help with this application (check all that apply):
[ ] Reading/understanding this application [ ] Filling out this application [ ] Other: __________________________
[ ] American Sign Language [ ] Braille [ ] Language Interpreter Language: __________________________

Authorized Representative:

This section is OPTIONAL. You may authorize someone else to represent you in the application process. DES and/or AHCCCS cannot release any information about your eligibility without your written consent.

Representative’s Name: ________________________________________ Is representative your legal guardian? [ ] Yes [ ] No
Representative’s Mailing Address: ____________________________________________ City: ___________ State: _____ Zip Code: ___________
Representative’s Phone Number: ____________________________ This number is: [ ] Home [ ] Cell [ ] Work [ ] Message [ ] Other: __________________________
Representative’s Other Phone Number: ____________________________ This number is: [ ] Home [ ] Cell [ ] Work [ ] Message [ ] Other: __________________________
What is the representative’s preferred SPOKEN language? [ ] English [ ] Spanish [ ] Other: __________________________
What is the representative’s preferred WRITTEN language? [ ] English [ ] Spanish [ ] Other: __________________________
My representative would like to get information about this application by:
Email: [ ] Yes [ ] No Email address: ____________________________________________
Text: [ ] Yes [ ] No Number to text (standard text rates apply):
If 'Yes' is not marked for Email or Text, all information for this application will be sent via U.S. Mail to the mailing address provided.

By signing below, I, the customer, give permission for the person listed above as my representative to act on my behalf in the process of qualifying me for help with insurance costs, help with Medicare costs, Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control. I, therefore:
• Give permission for my representative to complete and sign my application.
• Give permission for my representative to provide any documents requested, including personal information.
• Give permission to my representative to sign on my behalf to permit other people, businesses, or agencies to give personal information about me to DES and/or AHCCCS, including protected health information needed to determine if I am disabled.
• Agree to give information about my personal circumstances to my representative.
• Agree to allow my representative to assign all my rights to medical reimbursement claims to AHCCCS on my behalf.

Date: _____________________________________________________________
Signature of Applicant: _______________________________________

By signing below, I, the representative, agree to act on the customer’s behalf. I also agree to:
• Provide only truthful and complete information under penalty of perjury.
• Fill in and sign needed forms.
• Obtain and give to DES and/or AHCCCS all information needed to determine if the customer can qualify for help with healthcare costs, help with Medicare costs, Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control, such as the customer’s Social Security number, income, assets, citizenship, residency, medical insurance, and information about the customer’s spouse, minor children, and parents (if the customer is a minor child).
• Tell DES and/or AHCCCS right away if the customer:
  o Has an increase or decrease in income;
  o Has an increase or decrease in assets;
  o Changes ownership of assets, including opening or closing financial accounts;
  o Has a change in address; or
  o Has a change in health insurance or the amount of premiums paid.

If I am determined eligible, this authorization will stay in effect until I or my representative tells you to stop it. This authorization will expire when my application for assistance is withdrawn or denied, or when my eligibility ends. However, this authorization will continue during any time while I am contesting my eligibility in an administrative hearing or court proceeding.

Date: _____________________________________________________________
Signature of Representative: _______________________________________

Do you live in a shelter? [ ] Yes [ ] No If 'Yes,' what kind of shelter? ____________________________
Phone Number: ____________________________ This number is: [ ] Home [ ] Cell [ ] Work [ ] Message [ ] Other: __________________________
Representative’s Other Phone Number: ____________________________ This number is: [ ] Home [ ] Cell [ ] Work [ ] Message [ ] Other: __________________________
What is the preferred SPOKEN household language? [ ] English [ ] Spanish [ ] Other: __________________________
What is the preferred WRITTEN household language? [ ] English [ ] Spanish [ ] Other: __________________________
I would like to get information about this application by:
Email: [ ] Yes [ ] No Email address: ____________________________________________
Text: [ ] Yes [ ] No Number to text (standard text rates apply):
If 'Yes' is not marked for Email or Text, all information for this application will be sent via U.S. Mail to the mailing address provided.

I need the following help with this application (check all that apply):
[ ] Reading/understanding this application [ ] Filling out this application [ ] Other: __________________________
[ ] American Sign Language [ ] Braille [ ] Language Interpreter Language: __________________________

Authorized Representative:

This section is OPTIONAL. You may authorize someone else to represent you in the application process. DES and/or AHCCCS cannot release any information about your eligibility without your written consent.

Representative’s Name: ________________________________________ Is representative your legal guardian? [ ] Yes [ ] No
Representative’s Mailing Address: ____________________________________________ City: ___________ State: _____ Zip Code: ___________
Representative’s Phone Number: ____________________________ This number is: [ ] Home [ ] Cell [ ] Work [ ] Message [ ] Other: __________________________
Representative’s Other Phone Number: ____________________________ This number is: [ ] Home [ ] Cell [ ] Work [ ] Message [ ] Other: __________________________
What is the representative’s preferred SPOKEN language? [ ] English [ ] Spanish [ ] Other: __________________________
What is the representative’s preferred WRITTEN language? [ ] English [ ] Spanish [ ] Other: __________________________
My representative would like to get information about this application by:
Email: [ ] Yes [ ] No Email address: ____________________________________________
Text: [ ] Yes [ ] No Number to text (standard text rates apply):
If 'Yes' is not marked for Email or Text, all information for this application will be sent via U.S. Mail to the mailing address provided.

By signing below, I, the customer, give permission for the person listed above as my representative to act on my behalf in the process of qualifying me for help with insurance costs, help with Medicare costs, Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control. I, therefore:
• Give permission for my representative to complete and sign my application.
• Give permission for my representative to provide any documents requested, including personal information.
• Give permission to my representative to sign on my behalf to permit other people, businesses, or agencies to give personal information about me to DES and/or AHCCCS, including protected health information needed to determine if I am disabled.
• Agree to give information about my personal circumstances to my representative.
• Agree to allow my representative to assign all my rights to medical reimbursement claims to AHCCCS on my behalf.

Date: _____________________________________________________________
Signature of Applicant: _______________________________________

By signing below, I, the representative, agree to act on the customer’s behalf. I also agree to:
• Provide only truthful and complete information under penalty of perjury.
• Fill in and sign needed forms.
• Obtain and give to DES and/or AHCCCS all information needed to determine if the customer can qualify for help with healthcare costs, help with Medicare costs, Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control, such as the customer’s Social Security number, income, assets, citizenship, residency, medical insurance, and information about the customer’s spouse, minor children, and parents (if the customer is a minor child).
• Tell DES and/or AHCCCS right away if the customer:
  o Has an increase or decrease in income;
  o Has an increase or decrease in assets;
  o Changes ownership of assets, including opening or closing financial accounts;
  o Has a change in address; or
  o Has a change in health insurance or the amount of premiums paid.

If I am determined eligible, this authorization will stay in effect until I or my representative tells you to stop it. This authorization will expire when my application for assistance is withdrawn or denied, or when my eligibility ends. However, this authorization will continue during any time while I am contesting my eligibility in an administrative hearing or court proceeding.

Date: _____________________________________________________________
Signature of Representative: _______________________________________

Do you live in a shelter? [ ] Yes [ ] No If 'Yes,' what kind of shelter? ____________________________
Phone Number: ____________________________ This number is: [ ] Home [ ] Cell [ ] Work [ ] Message [ ] Other: __________________________
Representative’s Other Phone Number: ____________________________ This number is: [ ] Home [ ] Cell [ ] Work [ ] Message [ ] Other: __________________________
What is the preferred SPOKEN household language? [ ] English [ ] Spanish [ ] Other: __________________________
What is the preferred WRITTEN household language? [ ] English [ ] Spanish [ ] Other: __________________________
I would like to get information about this application by:
Email: [ ] Yes [ ] No Email address: ____________________________________________
Text: [ ] Yes [ ] No Number to text (standard text rates apply):
If 'Yes' is not marked for Email or Text, all information for this application will be sent via U.S. Mail to the mailing address provided.

I need the following help with this application (check all that apply):
[ ] Reading/understanding this application [ ] Filling out this application [ ] Other: __________________________
[ ] American Sign Language [ ] Braille [ ] Language Interpreter Language: __________________________
Release of Information to Hospitals/Hospital Agents/Organizations/Agencies:

You may give permission to DES and AHCCCS to release information about applicant eligibility. AHCCCS and DES cannot share any information about applicants without the applicant’s written permission. This section is OPTIONAL.

Name of Hospital/Hospital’s Agent/Organization/Agency: ________________________________________________________
Contact Person: _____________________________ Phone Number: _____________________________
Mailing Address: __________________________________ City: _____________________________ State: _____________ Zip Code: _____________

I give permission for DES and/or AHCCCS staff to tell the hospital, hospital agent, organization, or agency listed above:

- That I have applied for help with insurance costs;
- The information or proof needed to see if I can get help with insurance costs; and
- If approved for help with insurance costs, the effective date of my eligibility, the redetermination due date, and the category of assistance for which I was approved. If denied for help with insurance costs, the reason I was denied.

Signature of Applicant: _____________________________ Date: _____________________________

Access to Electronic Benefit Transfer (EBT) Account:

This section is OPTIONAL. If you are applying for Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control, you may choose a person, called an Alternate Cardholder, to get your benefits for you. If you need an Alternate Cardholder, choose a person you trust. Remember, lost or stolen benefits will not be replaced.

EBT Representative’s Name: _____________________________________________ EBT Representative’s Date of Birth: _________________
EBT Representative’s Mailing Address: __________________________________ City: _________________ State: ___ Zip Code: ________
EBT Representative’s Phone Number: ____________________________________
- Home  □ Cell  □ Work  □ Message  □ Other: __________
EBT Representative’s Other Phone Number: _______________________
- Home  □ Cell  □ Work  □ Message  □ Other: __________

Signature of Applicant: _____________________________ Date: _____________________________

Someone Who Knows You Well:

We often need to contact people or organizations that can verify information to determine your eligibility for public assistance. When we contact these people or organizations we tell them your name, our title and that we work for the Department of Economic Security (DES). We are prohibited by law from telling them anything about you or about your assistance case. Please provide contact information below.

Name of someone who knows you well: _____________________________________________ Relationship to you: _____________________________
Mailing Address: __________________________________ City: _________________ State: _____ Zip Code: _____________
Daytime Phone Number: ______________________________________________________________________________________________

Name of Landlord: _____________________________ Are you related to the Landlord?  □ Yes  □ No  If yes, how? __________
Mailing Address: __________________________________ City: _________________ State: _____ Zip Code: _____________
Daytime Phone Number: ______________________________________________________________________________________________

Emergency Nutrition Assistance:

Is anyone in your household applying for Emergency Nutrition Assistance? If YES: fill out this section. If NO: go to page 3.

What is the total amount of income, before deductions, you expect to get this month? $ _____________________________
What is the total amount of cash on hand and money in your checking and savings account? $ _____________________________
What are the total monthly housing costs (rent or mortgage, taxes, homeowner/rental insurance, etc.)? $ _____________________________
What are the total monthly utility costs (gas, electric, water, etc.)? $ _____________________________
What is your monthly telephone cost? $ _____________________________
Does anyone receive Tribal Food Distribution? □ Yes □ No
Is anyone a migrant or seasonal farm worker? □ Yes □ No
Did anyone get Nutrition Assistance benefits from any other state? □ Yes □ No
If Yes, who received? _____________________________ When? _______________ State: ________
**Personal Information:**

Tell us about each person in your household, starting with you. See page A for a definition of whom you must include. If you are a representative, tell us about who you are representing and others in the household.

<table>
<thead>
<tr>
<th>Name Last, First M.I.</th>
<th>Applying for?</th>
<th>Relationship to Main Contact (1.) (spouse, child/step child, parent, grandchild, niece/nephew, legal guardian, other (please describe))</th>
<th>Marital Status (never married, married, divorced, or widowed)</th>
<th>Date of Birth</th>
<th>Social Security Number (If not applying, optional)</th>
<th>Sex (Male or Female)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

**Citizenship:** Complete ONLY for each person applying. If a person is not applying for benefits, skip this section for that person. For those applying, you may need to provide proof of citizenship.

Is the MAIN CONTACT a U.S. citizen or U.S. national? See page D for more information. □ Yes □ No □ Choose not to answer

If the MAIN CONTACT is NOT a U.S. citizen, what is his/her immigration status?

- □ Lawful Permanent Resident (LPR)
- □ Lawful Temporary Resident
- □ Non-Immigrant Status
- □ Asylee
- □ Refugee
- □ Conditional Entrant granted before 1980
- □ Other
- □ I do not want to provide
- □ Registry Applicants
- □ Removal/Suspension of Deportation
- □ Special Immigrant Juvenile Status Applicant
- □ Temporary Protection Status (TPS)
- □ Victim of Trafficking
- □ Withholding of Deportation
- □ Applicant for Asylum, LPR, TPS, or Withholding Deportation

What immigration document does MAIN CONTACT have? Immigration Document Number: ________________________________

Is PERSON 2 a U.S. citizen or U.S. national? See page D for more information. □ Yes □ No □ Choose not to answer

If PERSON 2 is NOT a U.S. citizen, what is his/her immigration status?

- □ Lawful Permanent Resident (LPR)
- □ Lawful Temporary Resident
- □ Non-Immigrant Status
- □ Asylee
- □ Refugee
- □ Conditional Entrant granted before 1980
- □ Other
- □ I do not want to provide
- □ Registry Applicants
- □ Removal/Suspension of Deportation
- □ Special Immigrant Juvenile Status Applicant
- □ Temporary Protection Status (TPS)
- □ Victim of Trafficking
- □ Withholding of Deportation
- □ Applicant for Asylum, LPR, TPS, or Withholding Deportation

What immigration document does PERSON 2 have? Immigration Document Number: ________________________________

Has PERSON 2 lived in the U.S. since August 22, 1996? □ Yes □ No
Is PERSON 3 a U.S. citizen or U.S. national?  See page D for more information.  □ Yes □ No □ Choose not to answer

<table>
<thead>
<tr>
<th>What immigration document does PERSON 3 have?</th>
<th></th>
<th>Immigration Document Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Permanent Resident card</td>
<td>□ I-94</td>
<td>Visa</td>
</tr>
<tr>
<td>□ Foreign Passport</td>
<td>□ None</td>
<td>Other: _____________________</td>
</tr>
</tbody>
</table>

Has PERSON 3 lived in the U.S. since August 22, 1996?  □ Yes □ No

Is PERSON 4 a U.S. citizen or U.S. national?  See page D for more information.  □ Yes □ No □ Choose not to answer

<table>
<thead>
<tr>
<th>What immigration document does PERSON 4 have?</th>
<th></th>
<th>Immigration Document Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Permanent Resident card</td>
<td>□ I-94</td>
<td>Visa</td>
</tr>
<tr>
<td>□ Foreign Passport</td>
<td>□ None</td>
<td>Other: _____________________</td>
</tr>
</tbody>
</table>

Has PERSON 4 lived in the U.S. since August 22, 1996?  □ Yes □ No

Is PERSON 5 a U.S. citizen or U.S. national?  See page D for more information.  □ Yes □ No □ Choose not to answer

<table>
<thead>
<tr>
<th>What immigration document does PERSON 5 have?</th>
<th></th>
<th>Immigration Document Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Permanent Resident card</td>
<td>□ I-94</td>
<td>Visa</td>
</tr>
<tr>
<td>□ Foreign Passport</td>
<td>□ None</td>
<td>Other: _____________________</td>
</tr>
</tbody>
</table>

Has PERSON 5 lived in the U.S. since August 22, 1996?  □ Yes □ No

Is PERSON 6 a U.S. citizen or U.S. national?  See page D for more information.  □ Yes □ No □ Choose not to answer

<table>
<thead>
<tr>
<th>What immigration document does PERSON 6 have?</th>
<th></th>
<th>Immigration Document Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Permanent Resident card</td>
<td>□ I-94</td>
<td>Visa</td>
</tr>
<tr>
<td>□ Foreign Passport</td>
<td>□ None</td>
<td>Other: _____________________</td>
</tr>
</tbody>
</table>

Has PERSON 6 lived in the U.S. since August 22, 1996?  □ Yes □ No
Federal Income Tax Filing: Tell us NEXT YEAR’S tax filing information for everyone applying

<table>
<thead>
<tr>
<th>Main Contact</th>
<th>Plan to file Federal income tax return?</th>
<th>Filing Status:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Yes  ☐ No</td>
<td>☐ Head of Household ☐ Qualifying Widow(er) ☐ Single ☐ Married-Filing Separate Return ☐ Married-Filing Joint Return - spouse’s name:</td>
</tr>
<tr>
<td>Will claim dependents on own tax return?</td>
<td>☐ Yes  ☐ No</td>
<td></td>
</tr>
<tr>
<td>If yes, list dependents’ names:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Claimed as dependent on someone else’s tax return?

☐ Yes  ☐ No

If yes, name of tax filer claiming this person:

<table>
<thead>
<tr>
<th>Person 2</th>
<th>Plan to file Federal income tax return?</th>
<th>Filing Status:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Yes  ☐ No</td>
<td>☐ Head of Household ☐ Qualifying Widow(er) ☐ Single ☐ Married-Filing Separate Return ☐ Married-Filing Joint Return - spouse’s name:</td>
</tr>
<tr>
<td>Will claim dependents on own tax return?</td>
<td>☐ Yes  ☐ No</td>
<td></td>
</tr>
<tr>
<td>If yes, list dependents’ names:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Claimed as dependent on someone else’s tax return?

☐ Yes  ☐ No

If yes, name of tax filer claiming this person:

<table>
<thead>
<tr>
<th>Person 3</th>
<th>Plan to file Federal income tax return?</th>
<th>Filing Status:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Yes  ☐ No</td>
<td>☐ Head of Household ☐ Qualifying Widow(er) ☐ Single ☐ Married-Filing Separate Return ☐ Married-Filing Joint Return - spouse’s name:</td>
</tr>
<tr>
<td>Will claim dependents on own tax return?</td>
<td>☐ Yes  ☐ No</td>
<td></td>
</tr>
<tr>
<td>If yes, list dependents’ names:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Claimed as dependent on someone else’s tax return?

☐ Yes  ☐ No

If yes, name of tax filer claiming this person:

<table>
<thead>
<tr>
<th>Person 4</th>
<th>Plan to file Federal income tax return?</th>
<th>Filing Status:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Yes  ☐ No</td>
<td>☐ Head of Household ☐ Qualifying Widow(er) ☐ Single ☐ Married-Filing Separate Return ☐ Married-Filing Joint Return - spouse’s name:</td>
</tr>
<tr>
<td>Will claim dependents on own tax return?</td>
<td>☐ Yes  ☐ No</td>
<td></td>
</tr>
<tr>
<td>If yes, list dependents’ names:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Claimed as dependent on someone else’s tax return?

☐ Yes  ☐ No

If yes, name of tax filer claiming this person:

<table>
<thead>
<tr>
<th>Person 5</th>
<th>Plan to file Federal income tax return?</th>
<th>Filing Status:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Yes  ☐ No</td>
<td>☐ Head of Household ☐ Qualifying Widow(er) ☐ Single ☐ Married-Filing Separate Return ☐ Married-Filing Joint Return - spouse’s name:</td>
</tr>
<tr>
<td>Will claim dependents on own tax return?</td>
<td>☐ Yes  ☐ No</td>
<td></td>
</tr>
<tr>
<td>If yes, list dependents’ names:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Claimed as dependent on someone else’s tax return?

☐ Yes  ☐ No

If yes, name of tax filer claiming this person:

<table>
<thead>
<tr>
<th>Person 6</th>
<th>Plan to file Federal income tax return?</th>
<th>Filing Status:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Yes  ☐ No</td>
<td>☐ Head of Household ☐ Qualifying Widow(er) ☐ Single ☐ Married-Filing Separate Return ☐ Married-Filing Joint Return - spouse’s name:</td>
</tr>
<tr>
<td>Will claim dependents on own tax return?</td>
<td>☐ Yes  ☐ No</td>
<td></td>
</tr>
<tr>
<td>If yes, list dependents’ names:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Claimed as dependent on someone else’s tax return?

☐ Yes  ☐ No

If yes, name of tax filer claiming this person:

Food Preparation: Tell us how your household buys and prepares food.

Does anyone at your address buy and prepare his/her own food separate from others in the household? ☐ Yes  ☐ No

If Yes, tell us about the people who buy and prepare their own food:

<table>
<thead>
<tr>
<th>Name (First &amp; Last):</th>
<th>Age:</th>
<th>Relationship to MAIN CONTACT:</th>
<th>Does this person pay expenses?</th>
<th>What expenses?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>☐ Yes  ☐ No</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>☐ Yes  ☐ No</td>
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<td>☐ Yes  ☐ No</td>
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<td>☐ Yes  ☐ No</td>
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<td>☐ Yes  ☐ No</td>
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<td></td>
<td>☐ Yes  ☐ No</td>
<td></td>
</tr>
</tbody>
</table>
### Prior Medical Expenses:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does anyone applying for benefits also need help with medical bills in any of the last three months?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does anyone in this application have Medicare and want help paying their Medicare Part B premium for any of the last three months?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Temporary Absence:
Tell us about any people who are temporarily living outside of your home that are expected to return.

<table>
<thead>
<tr>
<th>Name (First and Last)</th>
<th>Date Left</th>
<th>Expected Return Date</th>
<th>Temporary Address</th>
<th>Why are they out of the home?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

### Residency for All Applicants:
Tell us about residency. You may need to provide proof of residency.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>If No, who is not?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is each person applying for benefits a resident of Arizona?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did any of the persons applying for benefits move to Arizona within the last four months?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Questions for All Applicants:
Answer the following questions for anyone who is applying for benefits.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>If Yes, who?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is anyone applying for benefits currently in jail, prison or detention center?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is this person currently serving a sentence based on being convicted of a crime?</td>
<td></td>
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</tr>
<tr>
<td>Expected release date:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has anyone applying for benefits been released from a jail, prison or detention center within the last four months?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Yes, who?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Release date:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Race/Ethnicity: Select one or more answers for each person applying for benefits (optional).

<table>
<thead>
<tr>
<th>Person</th>
<th>American Indian or Alaskan Native</th>
<th>Asian Indian</th>
<th>Black or African American</th>
<th>Chinese</th>
<th>Filipino</th>
<th>Guamanian or Chamorro</th>
<th>Japanese</th>
<th>Korean</th>
<th>Native Hawaiian</th>
<th>Other Asian</th>
<th>Other Pacific Islander</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Contact</td>
<td></td>
<td></td>
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<tr>
<td>Person 2</td>
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<tr>
<td>Person 3</td>
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<tr>
<td>Person 4</td>
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<tr>
<td>Person 5</td>
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<tr>
<td>Person 6</td>
<td></td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Person</th>
<th>Samoan</th>
<th>Vietnamese</th>
<th>White</th>
<th>Mexican</th>
<th>Mexican American</th>
<th>Chicano/a</th>
<th>Puerto Rican</th>
<th>Cuban</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Contact</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Person 2</td>
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<tr>
<td>Person 3</td>
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<tr>
<td>Person 4</td>
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<td>Person 5</td>
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<td>Person 6</td>
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</tr>
</tbody>
</table>

American Indian and Alaskan Native Persons: Complete this section if anyone applying is an American Indian or Alaska Native.

<table>
<thead>
<tr>
<th>Person</th>
<th>Enrolled in Federally Recognized Tribe</th>
<th>Name of Tribe</th>
<th>Received services from</th>
<th>If no, is the person eligible to receive services?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes □ No</td>
<td></td>
<td></td>
<td>Yes □ No</td>
</tr>
<tr>
<td></td>
<td>Yes □ No</td>
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<td>Yes □ No</td>
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<td></td>
<td>Yes □ No</td>
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<td>Yes □ No</td>
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<td></td>
<td>Yes □ No</td>
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<td></td>
<td>Yes □ No</td>
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<tr>
<td></td>
<td>Yes □ No</td>
<td></td>
<td></td>
<td>Yes □ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Person</th>
<th>Living on a Reservation?</th>
<th>Name of Reservation</th>
<th>Tribal Census Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes □ No</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Yes □ No</td>
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<td></td>
<td>Yes □ No</td>
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<td>Yes □ No</td>
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<td>Yes □ No</td>
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<td></td>
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<tr>
<td></td>
<td>Yes □ No</td>
<td></td>
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</tr>
</tbody>
</table>

Do you need help with this application? Visit [www.healthearizonaplus.gov](http://www.healthearizonaplus.gov) or call 1-855-HEA-PLUS (432-7587).
Help with Health Insurance Costs, Help with Medicare Costs, and Cash Assistance Questions:
Complete this section for anyone who is applying for help with insurance costs and/or help with Medicare costs, and/or Cash Assistance.

<table>
<thead>
<tr>
<th>Is anyone you are applying for pregnant?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For anyone applying under age 19, are both of his/her parents living in the home?  ❑ Yes  ❑ No
If No, complete the information below:

Who?
Parent's Name (First, Last)  Social Security Number  Date of Birth
Mailing Address  City, State  Zip Code
Phone Number:  Reason parent is absent:  ❑ Deceased  ❑ Out of Home

Who?
Parent's Name (First, Last)  Social Security Number  Date of Birth
Mailing Address  City, State  Zip Code
Phone Number:  Reason parent is absent:  ❑ Deceased  ❑ Out of Home

Who?
Parent's Name (First, Last)  Social Security Number  Date of Birth
Mailing Address  City, State  Zip Code
Phone Number:  Reason parent is absent:  ❑ Deceased  ❑ Out of Home

Who?
Parent's Name (First, Last)  Social Security Number  Date of Birth
Mailing Address  City, State  Zip Code
Phone Number:  Reason parent is absent:  ❑ Deceased  ❑ Out of Home

Has anyone ever received Supplemental Security Income (SSI)?  ❑ Yes  ❑ No

Who?

Does anyone have Medicare Coverage?  ❑ Yes  ❑ No

Who?

Foster Care and Adult with Child:  Answer the following questions for anyone who is applying for benefits.

Was anyone in Arizona Foster Care on his/her 18th birthday?  ❑ Yes  ❑ No

Who?

Does any adult live with at least one child under age 19 and is the main caretaker of the child?  ❑ Yes  ❑ No

Who?
### Potential Benefits

Tell us about everyone applying to help determine if he/she may be eligible for additional benefits.

| Has anyone you are applying for, their spouse or deceased spouse, worked for: |
|-----------------------------|-----------------------------|
| • A government agency       | ☐ Yes ☐ No                   |
| • An employer with a pension plan? | ☐ Yes ☐ No |
| Is anyone you are applying for |
| • A person who served in the U.S military |
| • The spouse of a person who served in the U.S. military |
| • The widow or widower of a person who served in the U.S. military |
| • The child of a person who served in the U.S. military |
| ☐ Yes ☐ No                   | If Yes, who?_________________|
|                             | Employer name:________________|
|                             | Dates of employment:__________|

### Expenses

Answer the following questions if anyone in your household is applying for Nutrition Assistance and/or Cash Assistance.

<table>
<thead>
<tr>
<th>Do you or anyone in your household pay for the care of a child or disabled adult in order to work, look for work, attend training or school?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>If Yes, amount: $__________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do you or anyone in your household have transportation costs to travel to/from the person or agency that provides after school care or adult daycare?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>If Yes, who pays?__________________________________________________________________</td>
</tr>
<tr>
<td>Amount paid: $__________________________</td>
</tr>
<tr>
<td>How often paid?__________________________________________________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do you or anyone in your household pay court-ordered child support?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>If Yes, who pays?__________________________________________________________________</td>
</tr>
<tr>
<td>Amount paid: $__________________________</td>
</tr>
<tr>
<td>How often paid?__________________________________________________________________</td>
</tr>
</tbody>
</table>

### Employment

Tell us about everyone's employment, including self-employment and rental income. You may need to provide proof of income. If self-employed, please attach the most current federal tax forms: 1040, SE and applicable schedules such as C, C-EZ, E, F and K1. If you do not have tax forms, attach proof of business income and expenses for at least the last and current calendar month.

<table>
<thead>
<tr>
<th>Does ANYONE work?</th>
<th>☐ Yes ☐ No</th>
<th>If Yes, give employment information below:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Who</th>
<th>Employer’s Name and Phone Number:</th>
<th>How often paid? Weekly, Biweekly, Semi Monthly, Monthly</th>
<th>Gross Earnings Per Pay check and date (before deductions):</th>
<th>How many hours worked per week?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Did anyone leave a job in the last thirty (30) days?</th>
<th>☐ Yes ☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If Yes, who?________________________________________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is ANYONE self-employed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>If Yes, who?</td>
</tr>
<tr>
<td>Type of work:</td>
</tr>
<tr>
<td>Annual gross income (before business expenses): $</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Has business been in existence for 12 months?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>If No, date business started:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is more than one person self-employed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>If Yes, who?</td>
</tr>
<tr>
<td>Type of work:</td>
</tr>
<tr>
<td>Annual gross income (before business expenses): $</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Has business been in existence for 12 months?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>If No, date business started:</td>
</tr>
</tbody>
</table>
**Other Income:** Tell us about other income everyone receives. You may need to provide proof of income.

<table>
<thead>
<tr>
<th>Type of Income</th>
<th>Who Receives?</th>
<th>Amount</th>
<th>How often received?</th>
<th>Who pays the income?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is anyone in the household an owner or member of a franchise, corporation or limited liability corporation?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Security Benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplemental Security Income (SSI Cash)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retirement/pension</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability/worker’s compensation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Support [ ] Court Ordered [ ] Other ____________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spousal Maintenance (Alimony)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veterans benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gifts, contributions or loans</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tribal money [ ] Gaming [ ] Other: ____________</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Rental income</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per capita payments from natural resources, usage rights, leases or royalties</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Money from selling things that have cultural significance</td>
<td></td>
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<tr>
<td>Other: ________________________________________</td>
<td></td>
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</tbody>
</table>

Check here if no other income [ ]

**Expected Income Changes:**

In the next twelve (12) months, does anyone in the household expect income changes because of seasonal work or contract employment? Please tell us only about the changes that happen regularly.

[ ] Yes  [ ] No  If Yes, who?

Name of sources _________________________________

Amount expected to make in the next 12 months $__________

Does anyone in the household expect changes in income for any other reason in the next twelve (12) months?  

[ ] Yes  [ ] No  If Yes, who?

Please explain:

**Allowed deductions from taxes/income:** Tell us if anyone has the following expenses that can be taken for taxes. Do not include self-employment expenses.

<table>
<thead>
<tr>
<th>Who has the expense?</th>
<th>Expense</th>
<th>Amount</th>
<th>How Often?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deductions from pay for expenses like retirement and insurance taken out before taxes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Deductions from pay for expenses like retirement and insurance taken out before taxes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Spousal Maintenance (Alimony)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Spousal Maintenance (Alimony)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Student Loan Interest</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Student Loan Interest</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other (Type) _________________________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other (Type) _________________________________________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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### Questions for All Applicants

**Is any adult you are applying for not able to work because of a medical or mental condition that has lasted or may last 12 months, or might result in death?**

- [ ] Yes
- [ ] No

If Yes, who?

Date of last day worked?

Expected return date:

**Does any child you are applying for have a physical or mental condition that is disabling and has lasted or may last 12 months, or result in death?**

- [ ] Yes
- [ ] No

If Yes, who?

When did the condition begin?

**Is anyone you are applying for under age 65, have a disability expected to last at least 12 months and is working?**

- [ ] Yes
- [ ] No

**Does anyone you are applying for need help with activities of daily living (bathing, dressing, etc.) through personal assistance, services, nursing home, or other medical facility?**

- [ ] Yes
- [ ] No

If Yes, who?

**Does anyone you are applying for have a legal guardian?**

- [ ] Yes
- [ ] No

If Yes, who?

Name of legal guardian:

---

### Nutrition Assistance and Cash Assistance

**Are you a migrant or seasonal farm worker?**

- [ ] Yes
- [ ] No

Is this person under contract/agreement to begin employment within 30 days?

- [ ] Yes
- [ ] No

Is this person working a minimum of 30 hours a week?

- [ ] Yes
- [ ] No

**Has anyone you are applying for been determined to be blind or have a disability by:**
- [ ] the Social Security Administration (SSA), or
- [ ] the Veterans Administration (VA)?

- [ ] Yes
- [ ] No

If Yes, who?

**Has anyone you are applying for had a felony conviction for possession, use, or distribution of a controlled substance on or after August 23, 1996?**

- [ ] Yes
- [ ] No

City/state of conviction:

Date of conviction:

Type of conviction:

**Is anyone you are applying for:**
- [ ] Running from the law on any felony charges, or
- [ ] In violation of probation or parole?

- [ ] Yes
- [ ] No

If Yes, who?

**Has anyone been found to have committed a Nutrition Assistance and/or Cash Assistance Intentional Program Violation in Arizona or any other state?**

- [ ] Yes
- [ ] No

If Yes, who?

What state?
Questions for All Applicants: Answer the following questions for everyone who is applying for benefits.

Is anyone on this application attending school?  

<table>
<thead>
<tr>
<th>Who</th>
<th>Name of School</th>
<th>Address</th>
<th>Full/Part Time</th>
<th>Grade Level</th>
<th>Start Date</th>
<th>Graduation date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Expenses: Answer the following questions if anyone in your household is applying for Nutrition Assistance and/or Cash Assistance.

Are you living in HUD housing?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Amount $ ____________________</th>
</tr>
</thead>
</table>

What are your monthly housing costs for:  

- Rent $ __________  
- Mortgage $ __________  
- Taxes $ __________  
- Homeowner/rental insurance $ __________  
- Other $ __________

What are the total monthly utility costs for:  

- Gas $ __________  
- Electric $ __________  
- Water $ __________  
- Other $ __________

Are the persons you are applying for living in government-assisted housing?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Are the persons you are applying for homeless?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Other Benefits and Expenses: Answer the following questions about receiving benefits from other states and expenses for anyone disabled or over age 60.

Has anyone on the application received Nutrition Assistance from another state?  

| Yes | No | If Yes, who?  
What type of benefits?  
When did benefits stop?  
Name of state/county: |

Has anyone on the application received Cash Assistance benefits from another state?  

| Yes | No | If Yes, who?  
When did benefits stop?  
Name of state/county: |

Is anyone on the application living in an assisted living facility or group home?  

| Yes | No | If Yes, who? |

Is anyone disabled or over age 60, does he/she have any paid or unpaid medical expenses, even if he/she has medical insurance (example: travel expenses to and from medical provider, doctor visits, prescriptions, lab work, etc.)?  

| Yes | No | If Yes, who?  
Average Total Monthly Medical Expenses $ ____________________ |

Average Total Monthly Medical Expenses $ __________

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587).
# Cash Assistance Questions

Answer these questions for everyone who is under age 19 and applying for Cash Assistance.

### Do all children you are applying for who are under the age of 19 have current immunizations (shots)?

- [ ] Yes
- [ ] No

If No, who does not?

### Has anyone you are applying for received Cash Assistance this month?

- [ ] Yes
- [ ] No

If Yes, who?

When did benefits stop?

Name of city/state:

What type of benefits?

### Resources

Answer the following questions if anyone in your household is applying for Nutrition Assistance and/or Cash Assistance.

#### Does anyone you are applying for have any type of bank account?

- [ ] Yes
- [ ] No

If Yes, total value: $

Who owns?

#### Does anyone you are applying for have any:

- Cash
- Uncashed checks
- Money on a pre-paid debit card

- [ ] Yes
- [ ] No

If Yes, total value: $

Who owns?

#### Does anyone you are applying for have any:

- Retirement account
- Annuity

- [ ] Yes
- [ ] No

If Yes, total value: $

Who owns?

Name of financial institution:

#### Do you or anyone in your household own or have their name on:

- stock
- bond
- money market account,
- Certificates of Deposit (CDs)
- trust funds
- life insurance

- [ ] Yes
- [ ] No

If Yes, total value: $

Who owns?

Name of financial institution:

#### Does anyone you are applying for own the home where they live?

- [ ] Yes
- [ ] No

If Yes, total value: $

Who owns?

Where?

#### Does anyone you are applying for own any vehicles? (cars, trucks, boats, RVs, etc.)

- [ ] Yes
- [ ] No

If Yes, total value: $

Who owns?

How many vehicles?

#### Does anyone you are applying for own any other land or buildings anywhere?

- [ ] Yes
- [ ] No

If Yes, total value: $

Who owns?

Where?
No Income: If no one has income, explain how you pay your bills below:

- Living with friends
- Using money from savings or checking accounts
- Living off credit cards
- Working odd jobs
- Monthly income: $__________
- Other

Are you:

- Getting loans from people
- Someone is giving me money
- Someone is paying bills directly
- Working in exchange for rent

If Yes, complete grid below:

Name of person helping: __________________________ Telephone number: __________________________

Email: __________________________

If loan, amount: $__________ When does it need to be paid back? __________________________

If gift, amount: $__________

If paying bills, which ones? __________________________

If working in exchange, amount of rent: $__________

**Medical Assistance Questions:** Answer the following questions for everyone applying for help with health insurance costs and/or help with Medicare costs.

<table>
<thead>
<tr>
<th>Do any applicants have an injury or illness due to an accident or medical malpractice?</th>
<th>Yes</th>
<th>No</th>
<th>If Yes, who?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Are any applicants currently admitted to a hospital?</th>
<th>Yes</th>
<th>No</th>
<th>If Yes, who?</th>
</tr>
</thead>
</table>

**Health Insurance Coverage:** Answer the following questions if anyone in your household is applying for help with health insurance costs, help with Medicare costs, and/or Cash Assistance.

<table>
<thead>
<tr>
<th>Do any applicants have health insurance other than AHCCCS or Medicare?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If ‘Yes,’ give the following information:

<table>
<thead>
<tr>
<th>Name of Insured</th>
<th>Name of Insurance Provider</th>
<th>Policy Number</th>
<th>Coverage Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

**Health Plan Choice:** Please see page H for enrollment plan choices for everyone applying for Medical Assistance.

<table>
<thead>
<tr>
<th>Name</th>
<th>Health Plan Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person 1</td>
<td></td>
</tr>
<tr>
<td>Person 2</td>
<td></td>
</tr>
<tr>
<td>Person 3</td>
<td></td>
</tr>
<tr>
<td>Person 4</td>
<td></td>
</tr>
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Health Insurance Tax Credits:
If you are not eligible for help with health insurance cost, you may be eligible for federal tax credits to help with your health insurance premiums. If you are not eligible for any programs through AHCCCS, we will send your information to the federal Health Insurance Marketplace to see about health insurance tax credits.

Insurance from Jobs: Tell us about health insurance that may be offered through a job.

If anyone eligible for health insurance coverage offered by an employer, or will you become eligible for coverage in the next 60 days?  Yes  No  I do not know  
If YES: answer the questions below.  If NO or I DO NOT KNOW: go to the next page.

Tell us about the job that offers health insurance coverage. If there are plans offered by more than one employer and you need more space, please attach additional pages. If you need help with the information, contact the employer.

Employee Name: ___________________________  Employee Social Security Number: ___________________________
Employer Name: ___________________________  Employer Identification Number (EIN): _______________________
Employer Address: ___________________________  City: __________________  State: __________  Zip Code: ______________

Whom may we contact about employment health insurance coverage at this job? __________________________________________

If you are in a waiting or probationary period for insurance offered by an employer, when can you enroll in coverage?  ____________________________________________

Who is eligible for coverage from this job? ____________________________________________________________________________

Does the employer offer a health plan that meets the minimum value standard? Yes  No  I do not know  
If YES: answer the questions below. If NO or I DO NOT KNOW: go to the next page.

*An employer-sponsored health plan meets "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs.

For the lowest-cost plan that meets the minimum value standard* offered only to the employee (do not include family plans):

If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs:  
How much will the employee have to pay in premiums for that plan? $ ___________________________  I do not know
How often will the employee have to pay the premium?
  □ Weekly  □ Twice a month  □ Every 2 Weeks  □ Monthly  □ Quarterly  □ Yearly  I do not know  Other: ____

What changes will the employer make for the new plan year (if known)?
  □ Employer will not offer health coverage
  □ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard*.
  How much will the employee have to pay in premiums for that plan? $ ___________________________  I do not know
  How often will the employee have to pay the premium?
  □ Weekly  □ Twice a month  □ Every 2 Weeks  □ Monthly  □ Quarterly  □ Yearly  I do not know  Other: ____
  I do not know

Renewal of Tax Credit Coverage in Future Years:
To make it easier for the Federal Facilitated Marketplace to determine my eligibility for help paying for health coverage in future years, I agree to allow the Marketplace to use income data, including information from tax returns. The Marketplace will send me a notice, let me make changes, and I can opt out at any time.

Yes, renew my eligibility for the next:  □ 5 years  □ 4 years  □ 3 years  □ 2 years  □ 1 year
No, do not use information from tax returns to renew my coverage  □

Go to the next page to sign the application.
**Sign the Application:**

The application is not valid until it is signed. All unrelated adults without a child in common must sign the application. Otherwise, the application must be signed by one of the following:

- The applicant or the applicant’s designee (we must have documentation showing this person is authorized to act on the applicant’s behalf); or
- The applicant’s spouse, if married and living within the same household; or
- The parent/legal guardian of a minor child.

**Penalty Warning**

The information provided on this form may be verified by federal, state, and local officials. If any information is inaccurate, you may be denied benefits. You must not knowingly withhold or give false information with the intent to receive or to continue receiving DES and/or AHCCCS benefits to which you are not entitled.

- You will be required to pay back DES and/or AHCCCS any benefits you receive as a result of withholding or giving false information and you will be subject to criminal prosecution.
- It is fraud for any person to knowingly withhold information with the intent to receive or continue to receive benefits to which he/she is not eligible. Any person found guilty of fraud may be subject to fines, criminal prosecution, imprisonment or other penalties as provided for by applicable State and Federal laws.

**Release of Information**

I authorize DES and/or AHCCCS to investigate and contact any sources necessary to establish eligibility and the accuracy of financial information that pertains to AHCCCS eligibility.

**Assignment of Rights to Other Benefits for Medical Care**

I understand that if I am or members of my household are approved for DES and/or AHCCCS benefits, DES and/or AHCCCS can collect payment from any other parties who may be responsible for paying for my/our health costs. This includes:

- Private or employer-sponsored health insurance (not including Medicare)
- Persons, such as an absent spouse or parent, who are legally responsible for providing medical support
- Private or employer-sponsored disability insurance
- Private or employer-sponsored accident insurance
- Insurance claims, jury awards, or legal settlements resulting from injuries

I understand that DES and/or AHCCCS cannot collect more than the costs paid by DES and/or AHCCCS. I also understand that I must give information about other responsible parties and take any action needed to receive medical support. This includes establishing paternity of my children, unless I can prove good cause not to do so.

I understand that DES and/or AHCCCS and/or their contractors will release information to DES/Division of Child Support Services (DCSS), for a parent of a child who does not live in the home and the child has AHCCCS or private health insurance. DCSS may use this information to get a medical support order.

**Assignment of Rights to Other Benefits for Cash Assistance**

State and federal law (A.R.S. 46-407) provide that the legal rights to child support and spousal maintenance must be assigned to the State of Arizona for all persons receiving Cash Assistance. I understand:

- While receiving Cash Assistance, the State has the right to keep child support or spousal maintenance collections, including support or spousal maintenance that was owed while Cash Assistance was paid.
- When Cash Assistance stops, current support payments will be paid to me. The state may continue to collect any assigned back payments for support (assigned arrears) owed before and during the time I received Cash Assistance.
- Child support payments will be used to pay back the state for Cash Assistance paid to me or anyone on my application.
- The State will not keep more from my collected current support or assigned arrears than the total amount of Cash Assistance I received.
- Also the State will not keep any arrears that are more than the total amount of Cash Assistance I received.

**Statement of Truth**

By signing this application:

- I agree I have read and understand the rules and penalties on page G included with the application. I have read and understand my rights and responsibilities, and provided Social Security numbers for each applicant that has a Social Security number.
- I agree I have read and understand the assignment or rights to other benefits for Medical Care above.
- I agree I have read and understand the assignment of support rights for Cash Assistance above.
- I agree that certain Nutrition Assistance and/or Cash Assistance household members will cooperate with the work programs, which includes looking for work and accepting training and/or a job. If anyone does not, or will not, look for work, attend training, or accept a job, my benefits may be reduced or stopped.
- I agree to cooperate with Arizona or Federal personnel in the completion of a quality control review on my eligibility for benefits.
- In the event DES or its agents engage in child support enforcement activities involving me, I understand the Assistant Attorneys General and Deputy County Attorneys handling the cases represent DES, and not me or my children.
- If my child support case goes to court, I understand certain personal information contained in this application or my DES records may be released to the court and other parties to the case and becomes a public record document.
- I also hereby agree to accept service of process by first class mail with regard to any paternity or child support proceeding initiated by DES and its agents.
- I understand that my records will be kept confidential and will only be released for purposes authorized by federal and state law.

I swear under penalty of perjury that the statements and documents provided about myself and persons in my home, that relates to my eligibility for benefits, is true and correct to the best of my knowledge, and that I have not withheld any information. I swear under penalty of perjury that any photocopied information I have provided are the same as the original documents.

| Signature of Applicant:          | Date: ________________ |
| Signature of Spouse:             | Date: ________________ |
| Signature of Other Adult in Household: | Date: ________________ |
| Signature of Authorized Representative: | Date: ________________ |
| Signature of Witness (if signed with mark): | Date: ________________ |
Voter Registration:

Tell us if any person over the age of 18 listed on this application would like to register to vote.

If you are not registered to vote where you live now, would you like to apply to register to vote here today? Please go to the last attached page of this application, which is the “Offer of Voter Registration” form. Read the information, check “Yes” or “No”, and then sign and date the form where indicated.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you do not check either box, you will be considered to have decided not to register to vote at this time.

If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the State Election Director, Secretary of State’s Office, 1700 West Washington, Phoenix, AZ 85007, 602-542-8683.

You may also get a voter registration form at www.azsos.gov/election/voterinformation.htm.

Submit the Application:

Submit your completed and signed application along with any supporting documents to the:

Arizona Department of Economic Security
Family Assistance Administration
P.O. Box 19009
Phoenix, Arizona 85005-9009

If any additional information is needed, you will be contacted.
You will be notified of our decision.

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S Department of Agriculture also prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination with USDA, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.
Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish, or call the State Information/Hotline Numbers line (the listing of hotline numbers by State can be found online at http://www.fns.usda.gov/snap/contact_info/hotlines.htm).

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

USDA and HHS are equal opportunity providers and employers.

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**OFFER OF VOTER REGISTRATION FORM**

The *Offer of Voter Registration* form is the next (last) sheet. Please read it, answer “Yes” or “No”, sign where it says “Signature of Client”, and date it.
OFFER OF VOTER REGISTRATION

Applying to register to vote or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you are not registered to vote where you live now, would you like to apply to register to vote today?  ☐ Yes  ☐ No

IF YOU DO NOT MARK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. You may take the form with you and mail it to the county recorder yourself or you may complete the registration here and deposit it in the box provided.

If you choose to register to vote here, the information regarding the agency where the registration took place will remain confidential and will be used only for voter registration purposes. If you choose not to register to vote at this time, that information will remain confidential and will be used only for voter registration purposes.

Signature of Client (or initials of staff person) ____________ Date ____________

If you believe that someone has interfered with your right to register to vote or to decline to register to vote, your right to privacy in deciding whether to register to vote or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

State Election Director
Secretary of State’s Office
1700 West Washington
Phoenix, Arizona 85007
(602) 542-8683

PROPOSICIÓN DE EMPADRONAMIENTO

La cantidad de ayuda que esta oficina le va a proveer no será afectada por su decisión de empadronarse para votar o de no empadronarse para votar.

Si usted no esta empadronado para votar donde usted actualmente vive, ¿le conviniera solicitar empadronamiento para votar hoy día aquí mismo?
☐ Sí  ☐ No

SI USTED NO MARCA NINGUNA DE LAS RESPUESTAS, SE CONSIDERARÁ QUE USTED HIZO LA DECISIÓN DE NO EMPADRONARSE PARA VOTAR HOY DÍA.

Si usted necesita ayuda para completar el formulario de solicitud de empadronamiento, nosotros estamos dispuestos a ayudarle. La decisión de procurar o aceptar ayuda es suya. Se le permite completar el formulario de solicitud en privado. Usted tiene la opción de llevarse el formulario consigo y regresararlo por correo al registrador del condado o usted puede completar su empadronamiento aquí y depositarlo en el depósito que se proporciona.

Si usted se decide a empadronarse para votar, la información tocante la oficina donde se efectuó el empadronamiento permanecerá confidencial y se usará únicamente para los propósitos de empadronamiento de votantes.

Firma del Cliente (o iniciales del miembro del personal) ____________ Fecha ____________

Si usted cree que alguien se ha impedido con su derecho de empadronarse para votar o de no empadronarse para votar, su derecho a privacidad en decidiendo de empadronarse o en solicitar empadronamiento para votar, o su derecho de seleccionar su propio partido político u otra preferencia política, usted puede entablart su queja con:

State Election Director
Secretary of State’s Office
1700 West Washington
Phoenix, Arizona 85007
(602) 542-8683