IDAHO DEPARTMENT OF
HEALTH & WELFARE

APPLICATION FOR ASSISTANCE

FOOD ASSISTANCE | **HEALTH COVERAGE ASSISTANCE** | **CASH ASSISTANCE** | **CHILD CARE ASSISTANCE**

IMPORTANT NOTICE: If you need any of the following assistance, please ask. These services are free:

- Language Interpreter. (Nosotros proveemos los servicios de un interprete, sin costo alguno.) Call 2-1-1 or 1-800-926-2588 or TDD 208-332-7205.
- Help filling out this form.
- Accommodation for a disability.

INSTRUCTIONS: Read all questions and instructions carefully. The instructions include tips to help you fill out the application quickly and easily. Read the back side of each page for more information. If you want Food Stamps only, you can start the application process immediately: fill out this page, sign it, and turn it in. Then complete the rest of the application and turn it in as soon as possible. If you need to provide more information than space allows, attach extra sheets.

CONTACT INFORMATION: **Mail:** Self Reliance Programs, PO Box 83720, Boise, ID 83720-0026 **Email:** MyBenefits@dhw.idaho.gov **Fax:** 1-866-434-8278 (toll free)

What is your preferred language? Spoken_____ Written_____

Do you want an interpreter if you are interviewed? One will be provided at no cost to you. ☐ No ☐ Yes

¿Usted necesita a intérprete si usted tiene una entrevista? Uno estará disponible en ningún costo para usted. ☐ No ☐ Sí

Tell Us Who You Are

First Name	Middle Initial	Last Name	Date of Birth	Former Names, if any
Physical Address	City	State	Zip Code	County
Mailing Address (if different)	City	State	Zip Code	County
Daytime Phone Number (work, home, or cell)		If none, where can we leave a message? Phone:		E-Mail Address

COMPLETE THIS SECTION IF YOU ARE APPLYING FOR EMERGENCY FOOD STAMPS.

Are any members of your household migrant or seasonal farm workers? ☐ No ☐ Yes

Is your income before taxes this month less than $150? ☐ No ☐ Yes

Are your monthly housing & utility costs more than your total monthly income & resources? ☐ No ☐ Yes

Are your resources (cash, checking, savings) less than $100? ☐ No ☐ Yes

If you qualify, emergency Food Stamp benefits can begin within seven days.

_____ _____

Signature of Applicant/Authorized Representative to request Food Stamps **Date**

The **Idaho Telecommunications Service Assistance Program (ITSAP)** helps pay telephone installation and monthly telephone service costs for low-income households. Do you want telephone assistance for your household? ☐ No ☐ Yes

If yes, name of phone company:_____ Phone #:_____ Name on bill: _____

File Name:_____ ICCP #: _____ TAFI #: _____ Date Scanned: _____ Appt. Date:_____

AABD #: _____ FS #:_____ LTC #:_____ Assigned To: _____ Appt. Time:_____

FM #:_____ **Expedite?** ☐ No ☐ Yes **OFFICE USE** Source Code

HW 2000 Revised 06/12

APPLICATION INSTRUCTIONS: The application includes tips to direct you through the questions you need to answer for the services you want. When you see a red stop sign like this, read and follow the instructions carefully to make sure that you give us all the information we need. You will find references to the back side of the application pages where you can find more information about the application process and the service(s) you want.

Once you complete the application, read and initial the **Rights and Responsibilities**, sign page 8, and submit the application by mail, fax, or email (see contact information on page 1). Office listings are available online at www.healthandwelfare.idaho.gov or by calling Idaho CareLine at 2-1-1 or 1-800-926-2588.

If you have a question about this application, the application process, or need help completing the application, call the Department at 1-877-456-1233 or Idaho CareLine by dialing 2-1-1 or 1-800-926-2588.

OUR SERVICES:

Food Assistance - this program can help you buy food for good health. Go to the back side of page 4 for more information.

Health Coverage - this program can help you get health coverage for children, adults with children, pregnant women, and the elderly, blind, or disabled. Go to the back side of page 3 for more information about Health Coverage for Children; go to the back side of page 5 for more information about Health Coverage for adults with children, pregnant women, and the elderly, blind, or disabled.

Cash Assistance - this program provides cash assistance for emergency situations, families with children, and the elderly, blind, or disabled. Go to the back side of page 4 for more information about Cash Assistance for emergency situations, families, and children; go the back side of page 5 for more information about Cash Assistance for the elderly, blind, or disabled.

Child Care Assistance - this program can help you pay part of your costs for child care. Go to the back side of page 2 for more information.

HEALTHY CONNECTIONS: Healthy Connections is a mandatory Primary Care Case Management program for Idaho Medicaid. Most people participating in either Medicaid benefits plan (Basic or Enhanced) must enroll in Healthy Connections, unless they qualify for an exemption, such as having a current relationship with a doctor that is not participating in Healthy Connections. Enrollment means you choose one doctor or clinic who will guide your healthcare. **Please list the doctor or clinic of your choice on page 2 in the CLINIC/DOCTOR box.** You can also let Healthy Connections choose a doctor for you. Details about Medicaid benefits and Healthy Connections are available at www.healthandwelfare.idaho.gov.

CHILD SUPPORT: By applying for medical services you may be referred to Child Support Services for medical support; by applying for cash assistance, you may be required to cooperate with Child Support Services. If your household includes minor children and one or both parents are not living in the home, and you would like help obtaining a child support order, call 1-800-356-9868. A fee may be required for this service.

TO COMPLETE THE TABLE ON PAGE 2: Fill out all fields for each person in your household. Mark the appropriate box next to the name field for each of the services each person wants to apply for. If someone in your household does not want benefits, do not mark the boxes for that person. Use the Code Key to indicate the marriage status and race of each person.

Example of how to complete page 2.

☒ Cash Assistance ☐ Premium Assistance ☐ Health Coverage ☐ Child Care Assistance ☐ Food Assistance	Name: (First) (Middle) (Last) Jon Nathan Doe			Date of Birth: 01-02-1957	Former Names, if any:		Relationship: SELF
	Sex: ☒ M ☐ F	Social security #: 012-34-5678	Pregnant? ☐ YES ☐ NO Due Date: _____ How many due:	Marital Status: WI	Race: AL	Hispanic or Latino? (Optional) ☐ YES ☒ NO	U.S. Citizen? ☒ YES ☐ NO Alien ID #:
	Birth Country: US		Birth State (if born in US): Idaho		Clinic/Doctor Name (first and last) Dr. Stan Pepper		Phone Number: (208) 555-1234

☒ Cash Assistance ☐ Premium Assistance ☒ Health Coverage ☐ Child Care Assistance ☐ Food Assistance	Name: (First) (Middle) (Last) Jo Anna Doette			Date of Birth: 05-06-1997	Former Names, if any:		Relationship: Step-daughter
	Sex: ☐ M ☒ F	Social security #: 234-56-7890	Pregnant? ☐ YES ☒ NO Due Date: _____ How many due:	Marital Status: NM	Race: AL	Hispanic or Latino? (Optional) ☐ YES ☒ NO	U.S. Citizen? ☒ YES ☐ NO Alien ID #:
	Birth Country: US		Birth State (if born in US): Kansas		Clinic/Doctor Name (first and last) Dr. Jill Doolittle		Phone Number: (208) 555-6789

Tell Us What Services You Want

* If you need to provide more information, please attach extra sheets

List every person living in your home. If a person does NOT want assistance, list them below but do not mark the boxes indicating the type of benefits wanted. Social Security numbers and citizenship status are required for those applying for services. See the back of page 1 for an example of how to complete the table below. Use the code key to indicate your Marital Status and Race. Your responses to the Race and Hispanic/Latino boxes are optional.

FOR STATE ASSISTANCE:

Cash Assistance - Mark this box for each person who wants cash assistance (for emergency, families, elderly and disabled).
Premium Assistance - Mark this box for each person who wants help paying premiums for private health coverage.
Health Coverage - Mark this box for each person who wants health coverage or help paying for health coverage.
Child Care Assistance - Mark this box for each person who wants help paying for child care.
Food Assistance - Mark this box for each person who wants help buying food.

Race Codes:

White - WH
Black - BL
Asian - AS
American Indian/Alaska Native - AL
Native Hawaiian/Pacific Island - HP

Marital Status Codes:

Married -	MA
Never Married -	NM
Divorced -	DI
Separated -	SE
Widowed -	WI

☐ Cash Assistance
☐ Premium Assistance
☐ Health Coverage
☐ Child Care Assistance
☐ Food Assistance

Name: (First) (Middle) (Last)	Date of Birth:	Former Names, if any:	Relationship: SELF
Sex: ☐ M ☐ F	Social security #:	Pregnant? ☐ YES ☐ NO Due Date: _____ How many due:	Marital Status:
Race:	Hispanic or Latino? (Optional) ☐ YES ☐ NO	U.S. Citizen? ☐ YES ☐ NO Alien ID #:	
Birth Country:	Birth State (if born in US):	Clinic/Doctor Name (first and last)	Phone Number:

☐ Cash Assistance
☐ Premium Assistance
☐ Health Coverage
☐ Child Care Assistance
☐ Food Assistance

Name: (First) (Middle) (Last)	Date of Birth:	Former Names, if any:	Relationship to self:
Sex: ☐ M ☐ F	Social security #:	Pregnant? ☐ YES ☐ NO Due Date: _____ How many due:	Marital Status:
Race:	Hispanic or Latino? (Optional) ☐ YES ☐ NO	U.S. Citizen? ☐ YES ☐ NO Alien ID #:	
Birth Country:	Birth State (if born in US):	Clinic/Doctor Name (first and last)	Phone Number:

☐ Cash Assistance
☐ Premium Assistance
☐ Health Coverage
☐ Child Care Assistance
☐ Food Assistance

Name: (First) (Middle) (Last)	Date of Birth:	Former Names, if any:	Relationship to self:
Sex: ☐ M ☐ F	Social security #:	Pregnant? ☐ YES ☐ NO Due Date: _____ How many due:	Marital Status:
Race:	Hispanic or Latino? (Optional) ☐ YES ☐ NO	U.S. Citizen? ☐ YES ☐ NO Alien ID #:	
Birth Country:	Birth State (if born in US):	Clinic/Doctor Name (first and last)	Phone Number:

☐ Cash Assistance
☐ Premium Assistance
☐ Health Coverage
☐ Child Care Assistance
☐ Food Assistance

Name: (First) (Middle) (Last)	Date of Birth:	Former Names, if any:	Relationship to self:
Sex: ☐ M ☐ F	Social security #:	Pregnant? ☐ YES ☐ NO Due Date: _____ How many due:	Marital Status:
Race:	Hispanic or Latino? (Optional) ☐ YES ☐ NO	U.S. Citizen? ☐ YES ☐ NO Alien ID #:	
Birth Country:	Birth State (if born in US):	Clinic/Doctor Name (first and last)	Phone Number:

☐ Cash Assistance
☐ Premium Assistance
☐ Health Coverage
☐ Child Care Assistance
☐ Food Assistance

Name: (First) (Middle) (Last)	Date of Birth:	Former Names, if any:	Relationship to self:
Sex: ☐ M ☐ F	Social security #:	Pregnant? ☐ YES ☐ NO Due Date: _____ How many due:	Marital Status:
Race:	Hispanic or Latino? (Optional) ☐ YES ☐ NO	U.S. Citizen? ☐ YES ☐ NO Alien ID #:	
Birth Country:	Birth State (if born in US):	Clinic/Doctor Name (first and last)	Phone Number:

CHILD CARE ASSISTANCE is provided by the Idaho Child Care Program (ICCP) to help parents and caretakers pay part of the costs of child care while they are working, going to school, or participating in approved training activities.

TO APPLY for Child Care Assistance, complete pages 1-5, sign page 8, and submit the application by mail, fax, or email (see contact information on page 1). Office listings are available online at www.healthandwelfare.idaho.gov or by calling Idaho CareLine at 2-1-1 or 1-800-926-2588.

You may need to provide the following proof:

- Income, or any other money coming into your household. Proof may include wage stubs for the last 30 days, current federal income tax records if you are self-employed, and statement from people loaning or giving you cash.
- Social Security Number (optional).
- Child care costs.
- Immunization records for any children not yet in school. (If you do not immunize due to medical or religious reasons, please provide a written statement stating your reason.)
- Name of childcare provider.
- Current school schedule (if attending school) for parents/caretakers - this must include days and times in class.
- Child support paid for a child not living with you. Your child care benefit amount may increase if you provide this proof.

To receive Child Care Assistance, you must meet the following program requirements:

- If both parents are in the household, each parent must be working, or attending training or other approved education programs in order for the family to be approved for Child Care Assistance. ICCP only covers a part of your child care costs while you are actually at work or in training or education.
- You must pay any costs not covered by the Child Care program. In very few circumstances will ICCP cover 100% of child care costs.
- ICCP will cover part of your child care costs only when care is provided by an ICCP registered child care provider.

If you receive Child Care Assistance, you must report changes such as:

- When your work or education hours change from part-time (24 hours per week or less) to full-time (25 or more hours per week).
- When your work or education hours change from full-time (25 or more hours per week) to part-time (24 hours per week or less).
- When you are no longer participating in work or education activities.
- When you switch child care providers or stop using child care services.
- When your physical address changes.
- When your income exceeds the gross income limit for your household size (see www.benefitprograms.dhw.idaho.gov for income limits).

If you have questions about applying for Child Care Assistance, please call 1-877-456-1233. For information on how a child care provider can become registered with ICCP please contact the Idaho CareLine by dialing 2-1-1 or 1-800-926-2588.

Tell Us About Your Household

* If you need to provide more information, please attach extra sheets

Is anyone in your home already receiving or applying for services from one of the following programs?
Please check all that apply. Your answer to this question will not affect your eligibility for benefits.

☐ Other State's Assistance Programs ☐ Children's or Adult Developmental Disabilities ☐ Tribal Commodities
☐ Foster Care or Adoption Assistance

Has anyone in your home ever received assistance from another state? ☐ No ☐ Yes

If Yes, from where? City _____ State_____ County _____ When?_____

What types of assistance? _____

If applying for Health Coverage, would you like Healthy Connections to choose a doctor for you? ☐ No ☐ Yes

See **"Healthy Connections"** on the back side of page 1 for more information.

List anyone in your home that:

- Has a disability

_____

- Receives or has applied for Social Security

_____

- Receives or has applied for Medicare

_____

- Needs medical assistance at home

_____

- Lives with a relative who provides medical care

_____

- Lives in a medical care facility

_____

Name of Facility:

_____

Do You Have Any Students In Your Home? List any household member age 16 or older who is a student or planning to attend school.

STUDENT NAME	WHERE ATTENDING SCHOOL	STUDENT STATUS	EXPECTED GRADUATION DATE
		☐ FULL TIME ☐ PART TIME	
		☐ FULL TIME ☐ PART TIME	
		☐ FULL TIME ☐ PART TIME	

If you have any children in your home, are they current on immunizations? ☐ No ☐ Yes

If you have any children in your home, do any of them have a parent NOT living with them? ☐ No ☐ Yes

If you answered "Yes" you will be required to give information about the absent parent(s) to Child Support Services and open a Child Support case unless you fear harm to yourself or your children. See **"Child Support Cooperation"** on the back side of page 1 for more information.

List any Absent Parents of the children in your home.

NAME OF ABSENT PARENT	NAME OF CHILD	ABSENT PARENT'S SSN	ABSENT PARENT'S DOB

HEALTH COVERAGE FOR CHILDREN is provided by Idaho Medicaid to help you get health coverage for dependent children in your home. Idaho Medicaid offers options based on health needs:

- **The Medicaid Basic Plan** is for low-income children who do not have special health needs. Depending on the amount of your family income there may be a cost of $10 - $15/month per eligible child associated with this plan.
- **The Medicaid Enhanced Plan** is for persons with disabilities or special health needs.
- **The Children's Access Card** helps pay premiums for private health coverage for families who may have higher incomes. This program can help pay premiums up to $100/month per child, limited to $300 per family each month. If eligible for this plan, and your child currently does not have health insurance, you can add your child to your employer-sponsored insurance plan or you may enroll them in a private health plan of your choice. You will be responsible for any remaining premium payments, co-payments, and deductibles.

TO APPLY for Health Coverage for Children, complete pages 1-5, sign page 8, and submit the application by mail, fax, or email (see contact information on page 1). Office listings are available online at www.healthandwelfare.idaho.gov or by calling Idaho CareLine at 2-1-1 or 1-800-926-2588.

You may need to provide the following proof:

- Citizenship and identity.
- Social Security Number or proof that you have applied for one.
- Resident Alien Card (if not a U.S. citizen) or other residency documents.
- Other health insurance you have.
- Income, or any other money coming into your household such as wage stubs for the last 30 days or current federal income tax records, if self-employed. Providing this proof may speed the determination process.
- U.S. Citizenship and Identity for Medicaid applicants. Federal Law requires all Medicaid participants who claim U.S. citizenship to give hard copy proof of their U.S. citizenship and identity. Many documents will be acceptable to prove U.S. citizenship and/or identity. If you are enrolled in Medicare or receive Supplemental Security Income (SSI), or are a "Qualified Alien," you will not be affected by this law. **The Department can accept only original or certified documents.** Your worker will ask for this proof in a later notice. If you need help getting these documents, need more time, or have questions about which documents we can accept, please contact the Department at 1-877-456-1233 as soon as possible.

HEALTHY CONNECTIONS is a mandatory Primary Care Case Management program for Idaho Medicaid. Most people participating in either Medicaid benefits plan (Basic or Enhanced) must enroll in Healthy Connections, unless they qualify for an exemption, such as having a current relationship with a doctor that is not participating in Healthy Connections. Enrollment means you choose one doctor or clinic who will guide your healthcare. Make sure you list the doctor or clinic of your choice on page 2 in the CLINIC/DOCTOR box. You can also let Healthy Connections choose a doctor for you. Details about Medicaid benefits and Healthy Connections are available at www.healthandwelfare.idaho.gov.

IF YOU RECEIVE HEALTH COVERAGE FOR CHILDREN, you must report changes such as:

- Change of address or phone number
- Change in Social Security Number
- The birth of a baby

CHILD SUPPORT COOPERATION: If medical assistance is granted for a minor child and one or more parents are not in the home, a medical support case will be opened. If you are receiving any benefits for yourself as an adult, you must cooperate with Child Support Services to avoid a loss or decrease of your benefits, unless you fear harm to yourself or your children.

Tell Us About The Following Expenses

* If you need to provide more information, please attach extra sheets

The following expenses relate to child support payments and child or adult care costs. If you do not have these expenses, skip to the next section. Your Food Stamps may increase if you have expenses such as child care costs or child support paid for children not living with you. However, if you do not report or verify these expenses, it will mean that you do not want a deduction for the unreported or unverified expenses. See the back of page 4 for more information. If you have either or both of these expenses, please provide the following information.

List everyone in your home who PAYS court-ordered child support expenses.

NAME OF PERSON THAT PAYS CHILD SUPPORT	AMOUNT PAID PER MONTH	LAST DATE PAID	NAME OF PERSON WHO RECEIVES PAYMENT

List everyone in your home who PAYS child or adult care expenses due to work, school, job search, or participation in training.

Name:	**Reason for Care:** ☐ Work ☐ Work Seach ☐ School ☐ Training	**Name of Child/Adult in Care:**	**Amount paid: $**_____ How Often? _____
Name of Care Provider:	**Do you get help paying for care?** ☐ No ☐ Yes **If Yes, how much do you receive? $** _____ **Name of Person/Agency paying:**		
Name:	**Reason for Care:** ☐ Work ☐ Work Seach ☐ School ☐ Training	**Name of Child/Adult in Care:**	**Amount paid: $**_____ How Often? _____
Name of Care Provider:	**Do you get help paying for care?** ☐ No ☐ Yes **If Yes, how much do you receive? $** _____ **Name of Person/Agency paying:**		
Name:	**Reason for Care:** ☐ Work ☐ Work Seach ☐ School ☐ Training	**Name of Child/Adult in Care:**	**Amount paid: $**_____ How Often? _____
Name of Care Provider:	**Do you get help paying for care?** ☐ No ☐ Yes **If Yes, how much do you receive? $** _____ **Name of Person/Agency paying:**		

Tell Us About Your Household Income

* If you need to provide more information, please attach extra sheets

Do you have any money coming into your home? ☐ No ☐ Yes

Please list all money received and/or expected by all household members. Include all income from wages, self-employment, Social Security, Child Support, unemployment, tips, gifts or loans of cash, etc.

TYPE OF MONEY RECEIVED	WHO EARNED / RECEIVED MONEY	NAME OF EMPLOYER	HOW OFTEN PAID	$ PER HOUR	HOURS PER WEEK	TOTAL MONTHLY AMOUNT
			☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly ☐ Annually			
			☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly ☐ Annually			
			☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly ☐ Annually			
			☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly ☐ Annually			
			☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly ☐ Annually			

Is anyone in the household self-employed? ☐ No ☐ Yes Who? _____

Name of business: _____ Years in business: _____

FOOD ASSISTANCE is provided by the Food Stamps program to help people buy food for good health. Eligible families get a card for buying food items.

TO APPLY for Food Assistance, complete pages 1-7, sign page 8, and submit the application by mail, fax, or email (see contact information on page 1). Office listings are available online at www.healthandwelfare.idaho.gov or by calling Idaho CareLine at 2-1-1 or 1-800-926-2588. You may be required to complete a phone interview and provide proof to support the information on your application before we can make a decision about your benefits. Please contact the Department if you are unable to participate in an interview during normal office hours or need interpreter services.

You may need to provide the following proof:

- Identity.
- Student status (full or part time).
- Social Security Number or proof that you have applied for one.
- Resident Alien Card (if not a U.S. citizen) or other residency documents.
- Income, or any other money coming into your household such as wage stubs for the last 30 days or current federal income tax records, if self-employed.
- Most recent statements for any bank accounts (checking, credit union, savings, etc.).
- Value of cars/trucks or other vehicles such as motorcycles, boats, RVs.
- Current value of stocks/bonds, certificates of deposit, life insurance, trusts.
- Expenses (proof of these expenses may increase your food stamp amount) such as, child or adult care costs, child support paid for children not living with you, housing costs, medical expenses (including prescriptions) for people with disabilities or who are over 60, and utility costs. **NOTE:** Your Food Stamps may increase if you have expenses such as child or adult care costs, child support paid for children not living with you, housing costs, medical costs (including prescriptions) for people with disabilities or who are over 60, and utility costs. However, if you do not report or verify any of these expenses, it will mean that you do not want a deduction for the unreported or unverified expenses.

To receive Food Assistance, you must meet the following program requirements: You may be required to participate in work programs. Failure to do so may result in the loss or decrease of benefits.

CASH ASSISTANCE FOR CHILDREN AND FAMILIES is provided by the Temporary Assistance to Families in Idaho (TAFI) program to provide cash assistance for eligible families with children living in the home. Lifetime eligibility is limited to 24 months for adults. The maximum payment any family can receive is $309 per month, regardless of family size.

TO APPLY for Cash Assistance for Children & Families, complete pages 1-6, sign page 8, and submit the application by mail, fax, or email (see contact information on page 1). Office listings are available online at www.healthandwelfare.idaho.gov or by calling Idaho CareLine at 2-1-1 or 1-800-926-2588.

You may be required to provide the following proof:

- Citizenship.
- Social Security Number or proof that you have applied for one.
- Resident Alien Card (if not a U.S. citizen) or other residency documents.
- That you are a resident of Idaho.
- Income, or any other money coming into your household such as wage stubs for the last 30 days or current federal income tax records, if self-employed.
- Most recent statements for any bank accounts (checking, credit union, savings, etc.).
- Value of cars/trucks or other vehicles such as motorcycles, boats, RVs.
- Current value of stocks/bonds, certificates of deposit, life insurance, trusts.
- Immunization records for any children not yet in school.

To receive Cash Assistance for Children and Families, you must meet the following program requirements:

- TAFI participants are required to work, look for work, or participate in training to prepare you to go to work.
- All applicants for Temporary Assistance for Families in Idaho (TAFI) will be asked to participate in a substance-abuse assessment.
- Participants must sign and comply with a Personal Responsibilities Contract (PRC), which they complete with their case worker.

CHILD SUPPORT COOPERATION: You are required to cooperate with Child Support Services for cash assistance. If cash assistance is approved for a minor child and one or more parents are not in the home, you may be required to give information about the absent parent(s) to Child Support Services and open a Child Support case unless you fear harm to yourself or your children.

Tell Us About Your Current Health Coverage

* If you need to provide more information, please attach extra sheets

Does anyone applying for health coverage need help paying medical bills from the last three months? ☐ No ☐ Yes

If Yes, who? _____

List gross income amount (income before taxes) received by your family in each of the last three months.

$ _____ Last Month $ _____ Two Months Ago $ _____ Three Months Ago

List everyone in your household who currently has health insurance or had health insurance within the last 6 months.

POLICY HOLDER	NAME OF PERSON(S) INSURED	INSURANCE CO. & PHONE	POLICY NUMBER	START DATE	END DATE

Please indicate services covered by your health insurance:

☐ inpatient/outpatient hospital services ☐ physicians medical/surgical services ☐ lab services ☐ x-ray services

If your health insurance coverage has ended, please indicate the reason:

☐ Job of parent/step-parent ended or changed
☐ Insurance company will not insure the child
☐ Stopped/dropped by COBRA policy
☐ Family coverage dropped by parent/step-parent
☐ Premiums too expensive
☐ Stopped/dropped by someone other than parent/step-parent

Do you have access to any health insurance not listed above? ☐ No ☐ Yes

Please provide a copy of one of the following pieces of documentation to verify health insurance and check the box to indicate which one will be provided:

☐ Copy of Insurance Card ☐ Copy of Health Insurance Policy

Are any of the children applying for medical assistance dependants of a full-time State employee? ☐ No ☐ Yes

- If you want only **child care** or **health coverage for your children**, you are done giving us information. **Go to page 8 to sign the application.** See the back side of page 2 for more information about Child Care Assistance; and the back side of page 3 for more information about Health Coverage for Children.
- If you want **food assistance, cash assistance, or health coverage for pregnant women, adults with children, or the elderly, blind, or disabled,** then **proceed to the next section.**

Tell Us About Your Assets

* If you need to provide more information, please attach extra sheets

Does anyone in your household have cash? ☐ No ☐ Yes How much? $ _____

List everyone in your home who has a checking or savings account:

OWNER'S NAME	TYPE OF ACCOUNT	NAME OF BANK OR FINANCIAL INSTITUTION	ACCOUNT NUMBER	BALANCE

HEALTH COVERAGE FOR ADULTS with children and **Pregnant Women** is provided by Idaho Medicaid to help you get health care for eligible adults. Your family income and resources are used to determine your eligibility. Idaho Medicaid offers options based on health needs:

- **The Medicaid Basic Plan** is for working-age adults who do NOT have special health needs and have dependent children.
- **The Medicaid Enhanced Plan** is for persons with disabilities or special health needs, including the elderly.
- **Health Coverage for Pregnant Women** provides services related to pregnancy health care needs.

HEALTH COVERAGE AND CASH ASSISTANCE FOR THE ELDERLY, BLIND, OR DISABLED provides assistance to individuals or couples who are 65 or older or have been found to be blind or disabled by Social Security standards. This includes employed workers with disabilities. Idaho Medicaid also can help pay for Medicare Part B Premiums and in-home or nursing home care.

TO APPLY for:

- Health Coverage for Adults with children and Pregnant Women, complete pages 1-6 and sign page 8.
- Health Coverage for the elderly, blind, or disabled, complete pages 1-7 and sign page 8.
- Cash Assistance for the elderly, blind, or disabled, complete pages 1-7 and sign page 8.

Submit your completed application by mail, fax, or email (see contact information on page 1). Office listings are available online at www.healthandwelfare.idaho.gov or by calling Idaho CareLine at 2-1-1 or 1-800-926-2588.

You may be required to provide the following proof:

- Citizenship and identity.
- Social Security Number or proof that you have applied for one.
- Resident Alien Card (if not a U.S. citizen) or other residency documents.
- Other health insurance that you have.
- Income or any other money coming into your household such as wage stubs from the last 30 days (if you are employed) or current federal income tax records, if you are self-employed.
- Most recent statements for any bank accounts (checking, credit union, savings, etc.).
- Value of cars/trucks or other vehicles such as motorcycles, boats, RVs.
- Current value of stocks/bonds, certificates of deposit, life insurance, trusts.
- U.S. Citizenship and Identity for Medicaid applicants. A change in Federal Law requires all Medicaid participants who claim U.S. citizenship to give hard copy proof of their U.S. citizenship and identity. Many documents will be acceptable to prove U.S. citizenship and/or identity. If you are enrolled in Medicare or receive Supplemental Security Income (SSI), or are a "Qualified Alien," you will not be affected by this law. **The Department can only accept original or certified documents.** Your worker will request this proof in a later notice. If you need help in getting these documents, need more time, or have questions about which documents we can accept, please contact your local office as soon as possible.

HEALTHY CONNECTIONS is a mandatory Primary Care Case Management program for Idaho Medicaid. Most people participating in either Medicaid benefits plan (Basic or Enhanced) must enroll in Healthy Connections, unless they qualify for an exemption, such as having a current relationship with a doctor that is not participating in Healthy Connections. Enrollment means you choose one doctor or clinic who will guide your healthcare. Make sure you list the doctor or clinic of your choice on page 2 in the CLINIC/DOCTOR box. You can also let Healthy Connections choose a doctor for you. Details about Medicaid benefits and Healthy Connections are available at www.healthandwelfare.idaho.gov.

If you receive Health Coverage or Cash Assistance, you must report the following changes:

- Change of address or phone number.
- Change in income or resources.
- When someone joins or leaves your household.
- When a household member is (or expected to be) incarcerated for more than 30 days.

CHILD SUPPORT COOPERATION: If medical assistance is granted for a minor child and one or more parents are not in the home, a medical support case will be opened. If you are receiving any benefits for yourself as an adult, you must cooperate with Child Support Services to avoid a loss or decrease of your benefits, unless you fear harm to yourself or your children.

Tell Us About Your Assets, continued

* If you need to provide more information, please attach extra sheets

List everyone in your home who has assets such as stocks, bonds, CDs, mutual funds, 401K's, IRA's, trusts, annuities, etc:

OWNER'S NAME	TYPE OF ACCOUNT	NAME OF BANK OR FINANCIAL INSTITUTION	ACCOUNT NUMBER	$ VALUE

List everyone in your home who has Life Insurance Policies or Burial Funds or Policies:

OWNER'S NAME	TYPE OF ACCOUNT	NAME OF POLICY	$ FACE VALUE	$ CASH VALUE

List each car, truck, motorcycle, trailer, boat, snowmobile, and other recreational vehicles owned by anyone in your home:

OWNER'S NAME	YEAR, MAKE, AND MODEL	CURRENT VALUE	PRIMARY USE (SELECT ONE)
			☐ Business ☐ Get to work ☐ Work search ☐ Medical ☐ Recreational ☐ Residence ☐ Personal (other)
			☐ Business ☐ Get to work ☐ Work search ☐ Medical ☐ Recreational ☐ Residence ☐ Personal (other)
			☐ Business ☐ Get to work ☐ Work search ☐ Medical ☐ Recreational ☐ Residence ☐ Personal (other)
			☐ Business ☐ Get to work ☐ Work search ☐ Medical ☐ Recreational ☐ Residence ☐ Personal (other)
			☐ Business ☐ Get to work ☐ Work search ☐ Medical ☐ Recreational ☐ Residence ☐ Personal (other)

List the total value of other assets such as land or property, excluding the home you live in:

ITEM	VALUE	AMOUNT OWED

List everyone in your home who has sold, transferred or given away any cash, property, or other assets in the past 5 years:

NAME	DATE OF TRANSACTION	WHAT ASSETS	$ RECEIVED	FAIR MARKET VALUE

- If you want only **cash assistance for children and families, or health coverage for pregnant women and adults with children**, you are done giving us information. **Go to page 8 to sign the application.** See the back side of page 4 for more information about cash assistance for families and children; and the back side of page 5 for more information about health coverage for pregnant women and adults with children.
- If you want **cash assistance or health coverage for the elderly, blind, or disabled, or assistance buying food**, then **proceed to the next section**.

DO I HAVE TO BE A CITIZEN?

According to the U.S. Citizenship and Immigration Services, if you do NOT have a Resident Alien Card, members of your family who are eligible can use non-cash benefits, including Medicaid, Food Stamps, WIC, housing assistance, energy benefits, job training, child care, disaster relief, public health assistance, etc., without hurting your chances of getting a Resident Alien Card, becoming a U.S. citizen, or sponsoring relatives in the future.

DO I HAVE TO RELEASE MY SOCIAL SECURITY NUMBER (SSN) AND CITIZENSHIP STATUS?

Some family members of applicants may choose not to apply for Health and Welfare services. In that case, they do not have to provide a SSN or citizenship or immigration status. Benefits to applicants will not be delayed or denied because some family members do not apply.

Anyone who applies for services, except child care, must have a SSN or apply for one. If you want Emergency Medicaid only or you are a victim of domestic violence, you may not have to give a SSN or immigration status. You only have to give us citizenship or immigration status information for persons who want help, except when applying for child care.

We can help you apply for a SSN, and benefits will not be denied or delayed while the application is being processed. We need the SSN to help you establish paternity, get Child Support, and change or enforce Child Support orders, including medical insurance coverage for a child. SSN's will not be given to the U.S. Citizen and Immigration Services.

IS THERE EQUAL OPPORTUNITY FOR APPLICANTS?

In accordance with federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, the Department of Health and Welfare is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs.

To file a complaint of discrimination, contact USDA or HHS:

- USDA, Director, Office of Civil Rights
  1400 Independence Avenue, SW
  Washington, D.C. 20250-9410

  (800) 795.3272 (Voice)
  (202) 720.6382 (TTY)

- U.S. Department of Health & Human Services
  Room 506 F, 200 Independence Ave. SW
  Washington, D.C. 20201
  ocrcomplain@hhs.gov
  (202) 619.0403 (Voice)
  (202) 619.3257 (TTY)

USDA & HHS are equal opportunity providers and employers.

IDAHO MEDICAID PLAN CHOICE

If you are eligible for Medicaid, you have the right to choose the plan that is based on your health needs. Idaho Medicaid offers the Medicaid Basic Plan and the Medicaid Enhanced Plan to meet different health needs.

- **The Medicaid Basic Plan** is for low-income children and working-age adults with average health needs. This plan provides complete health, prevention, and wellness benefits for children and adults who don't have special health needs.
- **The Medicaid Enhanced Plan** is for individuals with disabilities or special health needs. This plan includes all benefits in the Basic Plan, plus additional benefits.

You may choose NOT to enroll in the plan that meets your health needs. You may choose to enroll in Standard Medicaid instead. Standard Medicaid does not include prescription drugs, certain prevention and wellness benefits, therapies, dental services, vision services, and other services. If you do not want to enroll in the benefit plan that meets your health needs, you must inform your Self-Reliance worker.

Tell Us About Your Living Situation and Expenses

* If you need to provide more information, please attach extra sheets

Your Food Stamps may increase if you have expenses such as adult care costs, housing costs, medical costs (including prescriptions) for people with disabilities or who are over 60, and utility costs. However, if you do not report or verify any of these expenses, it will mean that you do not want a deduction for the unreported or unverified expenses. See the back of page 4 for more information.

List the monthly housing costs for your household.

Rent: $_____ Mortgage: $ _____ Property Taxes: $ _____

Space Rent: $_____ 2nd Mortgage: $ _____ Home Insurance: $ _____

Association Fees: $_____ Irrigation Taxes: $ _____

Does your mortgage payment include property tax and home insurance? ☐ No ☐ Yes

Tip: If you receive statements and write separate checks for property taxes and home insurance, these expenses are not included in your mortgage payment.

Mark the utilities you pay that are NOT included in your rent or mortgage payments:

☐ Heating ☐ Cooling ☐ Water ☐ Sewer ☐ Trash ☐ Telephone

☐ Electrical ☐ Other: _____ ☐ Other: _____

If you are 60 or older, blind, or disabled, complete the following questions. Otherwise, skip the following questions and go to the next section on this page.

List your monthly medical costs:

Medicare: $ _____ Doctor: $_____ Dental: $ _____

Health Insurance: $ _____ Hospital: $_____ Prescriptions: $ _____

Work Expenses: $ _____ Service Animal: $_____ Medical Supplies: $ _____

Attendant Care: $ _____ Transportation/Lodging: $_____ Eye Glasses: $ _____

If married, does your spouse live with you? ☐ No ☐ Yes If "No," where does your spouse live?

☐ Own Home ☐ Apartment ☐ With relative providing medical care

☐ In a facility providing medical care Name of Facility: _____

Tell Us Some More About Your Household

* If you need to provide more information, please attach extra sheets

Has anyone in your household been convicted of a felony involving drugs? ☐ No ☐ Yes

If Yes, who:_____ Year: _____

Is anyone fleeing to avoid felony prosecution or jail time? ☐ No ☐ Yes Who: _____

Is anyone currently violating conditions of probation or parole? ☐ No ☐ Yes Who: _____

Has anyone been disqualified from public assistance due to an intentional program violation? ☐ No ☐ Yes

If Yes, who:_____ When/Where: _____

You are done providing us the information we need. Proceed to the next page to sign the application.

See the back side of page 4 for more information about getting food assistance, and the back side of page 5 for more information about health coverage or cash assistance for the elderly, blind, or disabled.

Rights and Responsibilities

By initialing the following provisions, I understand that . . .

_____ My signature certifies that the information on this application is true and accurate. I could be sanctioned and required to return any benefits I receive if I willfully misrepresent and/or conceal facts on this application or my information is otherwise not true. Sanctions may include administrative, civil, or criminal actions against me, including prosecution.

_____ I consent to the gathering, use, and disclosure of my information by the Idaho Department of Health and Welfare or its designees. I understand the information is needed for the purpose of providing benefits or services, obtaining payment for my benefits or services, and for normal business operations of the Department.

_____ I have the right to revoke this consent, in writing, at any time except to the extent the Department has already used and disclosed my information in reliance on this consent. If I revoke this consent, the Department may not provide me further benefits or services.

_____ I will be notified of the right to appeal Department decisions and can contact the Department for information about the appeal process.

_____ My signature indicates I have received a copy of the Department Privacy Practices.

_____ By applying for benefits for a minor child, a medical support case must be opened, when applicable. If I am receiving benefits for myself, failure to cooperate with Child Support Services may result in a loss or decrease of my benefits.

_____ By applying for heating and energy assistance, I authorize the Department to request information from and/or disclose necessary information to my utility companies for the purpose of determining my eligibility and providing benefits or services until I become ineligible or I request to end the benefits or services.

_____ I read and understand the plan choices and that I may be responsible for paying part of the cost of my health plan.

_____ If a third party is responsible for my disease or injury, I give to Medicaid any rights I may have, or may acquire in the future to be compensated by that responsible party for any Medicaid benefits I receive.

_____ My signature or the signature of my representative authorizes State offices to communicate with insurance companies related to my medical assistance.

_____ I have the right to choose my Healthy Connections Primary Care Doctor, to request referrals for services, and to change my doctor/clinic if my circumstances change.

_____ If I receive Medicaid after age 55, my estate may be subject to recovery of medical expenses paid on my behalf, and that any transfer of assets may be set aside by a court if I do not receive adequate value.

_____ If I receive Medicaid/Cash Assistance, I am required to report changes in my circumstances including income, assets and living situation within ten (10) days of the change.

_____ If I am determined eligible for Medicaid, I choose the plan that is based on my health needs, unless I tell my Self Reliance worker otherwise.

_____ If I receive a Child Support payment in error, Child Support Services will withhold future payments to recover the amount unless I submit written instructions to the contrary.

_____ If I receive cash assistance (TAFI), I may not withdraw cash benefits, or use cash benefit funds to purchase products and services, in gambling establishments, liquor and tobacco stores, adult entertainment venues, other establishments prohibiting persons under the age of 18, or tattoo, body piercing, or other branding parlors.

_____ It is illegal to give my Quest EBT card away or to trade the benefits on my card for cash, firearms, drugs, or other goods and services. Penalties include fines, imprisonment, and disqualification from future benefits.

Under penalty of perjury, I swear or affirm that the information I provide is true and complete.

_____ _____
Signature of Applicant Date

_____ _____
Signature of Other Adult in the Household Date

PERSONAL/AUTHORIZED REPRESENTATIVE: You may authorize someone else to apply for benefits for you and to use your Food Stamp benefits to buy food for you. If you want to authorize someone, enter his/her name, phone, and address below. **NOTE:** If your authorized representative gives us incorrect information that causes us to give you benefits you are not entitled to receive, you will have to repay the extra benefits to us.

_____
Name of Authorized Representative | Phone Number | Address | City | State | Zip

_____ _____
Signature of Authorized Representative/Guardian Date

You have completed the application. See the back side of page 1 for information about how to submit your application.