Application for Re-evaluation

INSTRUCTIONS FOR COMPLETING THE RE-EVALUATION PROCESS

The information provided on this form will be used only to determine your ongoing eligibility for persons already receiving benefits.

If you want to add someone to your benefits, such as a newborn child or someone who has moved into your home, please complete the Add-A-Person page enclosed with this form.

1. **Use blue or black ink to complete all pages.**

   Carefully review the information on the form. You must provide current information about all people in your household. If you need to provide more information than space allows, attach extra sheets.

2. **Sign the Rights and Responsibilities page.**

   You or your authorized representative must sign the form for it to be complete and valid.

3. **Provide documents to prove the information provided on this form.**

   Gather documents (examples are listed throughout the form) that can be used to prove the information on the form. Send copies of these documents with your completed form. You may take original documents to a local office.

4. **Turn in all re-evaluation paperwork within 10 days of receiving this form.**

   Use the enclosed return envelope to mail your completed application and verifications. You may also fax paperwork to 1-866-434-8278, email it to mybenefits@dhw.idaho.gov, or take it to a Health & Welfare office near you.

You may be required to complete an interview to complete the re-evaluation process. To find out if you must complete an interview, check your recent re-evaluation notice, or contact the Department.

IMPORTANT NOTICE

If you need any assistance, please ask. The following services are free:

- Help filling out this form
- Accommodation for a disability
- Language Interpreter. Call 1-800-926-2588 or TDD 208-332-7205

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. ☐ Yes ☐ No

¿Necesita un Interpréte para su entrevista? Uno estará disponible sin costo alguno para usted ? ☐ Si ☐ No

Please contact your local office if you cannot participate in an interview during normal office hours or if you need interpreter services.

Print Form

HOUSEHOLD INFORMATION

Tell us about everyone living in your home.

Contact Information

Please provide contact information for the primary person on the case (the person mail is addressed to).

Primary person	Phone		Type ☐ Home ☐ Cell ☐ Work ☐ Other	
Street address	City	County	State	Zip code
Mailing address (if different)	City	County	State	Zip code

People Living in the Home

List everyone living in your home. Please tell us if the people you list below buy, prepare, and eat with you by answering yes or no to the "Purchase/prepare" question. Attach additional sheets of paper, if necessary.

Full name	Gender	DOB	Relationship to you	US citizen?	SSN or Alien ID #	Purchase /prepare?
	☐ M ☐ F		Self	☐ Yes ☐ No		☐ Yes ☐ No
	☐ M ☐ F			☐ Yes ☐ No		☐ Yes ☐ No
	☐ M ☐ F			☐ Yes ☐ No		☐ Yes ☐ No
	☐ M ☐ F			☐ Yes ☐ No		☐ Yes ☐ No
	☐ M ☐ F			☐ Yes ☐ No		☐ Yes ☐ No
	☐ M ☐ F			☐ Yes ☐ No		☐ Yes ☐ No
	☐ M ☐ F			☐ Yes ☐ No		☐ Yes ☐ No

Entering a name on this form will not automatically add someone to your benefits. If you want to add a new person to your benefits, please use the "Add A Person" form enclosed with this re-evaluation form.

NON-FINANCIAL INFORMATION

Tell us about medical conditions and school attendance of each individual in your home.

Medical Conditions

Tell us about everyone in the home who is pregnant.

Name	Due date

Tell us about everyone in the home who has a disability.

Name	Receiving/applied for Social Security benefits?
	☐ Yes ☐ No
	☐ Yes ☐ No
	☐ Yes ☐ No

School Attendance

Tell us about everyone in the home who is 17 or older and attending school.

Student name	School name	Expected graduation date	Awarded work study?	Student status
			☐ Yes ☐ No	☐ Full-time ☐ Part-time ☐ Not attending
			☐ Yes ☐ No	☐ Full-time ☐ Part-time ☐ Not attending
			☐ Yes ☐ No	☐ Full-time ☐ Part-time ☐ Not attending
			☐ Yes ☐ No	☐ Full-time ☐ Part-time ☐ Not attending

Tell us about everyone in the home who is between the ages of 6 and 18 years old and NOT attending school.

Name(s)

FINANCIAL INFORMATION

Tell us about your financial situation.

Income **Attach Proof**

Tell us about all income your household receives. We want to know about the most recent 4 weeks, as well as any money received quarterly or annually. Income is money earned (wages or salary) from a job or self-employment, or unearned from sources such as Social Security, child support, unemployment benefits, gifts, rental income, retirement income, etc.

☐ Check this box if there is no income coming into your household. Please attach a written statement explaining how you make ends meet.

Name of person with income		Source of income/employer name		Employer phone	
How often paid	Hours per week	Hourly rate of pay	Monthly income (pre-tax)	Start date	Expected to change? ☐ Yes ☐ No
Name of person with income		Source of income/employer name		Employer phone	
How often paid	Hours per week	Hourly rate of pay	Monthly income (pre-tax)	Start date	Expected to change? ☐ Yes ☐ No
Name of person with income		Source of income/employer name		Employer phone	
How often paid	Hours per week	Hourly rate of pay	Monthly income (pre-tax)	Start date	Expected to change? ☐ Yes ☐ No
Name of person with income		Source of income/employer name		Employer phone	
How often paid	Hours per week	Hourly rate of pay	Monthly income (pre-tax)	Start date	Expected to change? ☐ Yes ☐ No

Attach proof

Send us proof of all your income. Examples of acceptable proof include copies of the following:

- Wage stubs for the last 30 days
- Work verification form
- Termination of employment form
- Tax returns (personal and business for self-employed

PROPERTY AND RESOURCES

Tell us about the vehicles, monetary resources, and property that your household owns.

Motor Vehicles

Tell us about all vehicles—cars, trucks, motorcycles, trailers, boats, snowmobiles, and other recreational vehicles—your household owns.

Owner	Year, make, and model	Current value	What do you primarily use this for (choose 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)

Resources **Attach Proof**

Tell us about all other type of resources your household owns, including cash on-hand, checking and savings accounts, stocks, bonds, mutual funds, 401Ks, IRAs, trusts, CDs, life insurance policies, burial funds, etc.

Name/Owner	Resource type	Name of financial institution	Account number	Current value

Attach proof

Send us proof of all resources you own. Examples of acceptable proof include copies of the following:

- Most recent bank statements
- Printouts from local bank (clearly showing account name, number, and current value)
- Statements showing current value of stocks, bonds, trust funds, life insurance, burial policies, etc.

Property **Attach Proof**

Tell us about all other property (including your home) owned by anyone living in your home.

Owner	Property type	Property Address	Value	What do you primarily use this property for (choose one)?
				☐ Home ☐ Rental income ☐ Businesss/Self-employment ☐ Other:
				☐ Home ☐ Rental income ☐ Businesss/Self-employment ☐ Other:
				☐ Home ☐ Rental income ☐ Businesss/Self-employment ☐ Other:

Attach proof

Send us proof of all property you own. Examples of acceptable proof include copies of the following:

- Property tax assessment notice
- Property deed
- Current mortgage statement

EXPENSES

Please tell us about your expenses, including rent, utilities, child care, and medical insurance. **Note:** If you do not tell us about any of the expenses indicated below, we will take that to mean that you do not want a deduction for those expenses. After this re-evaluation is complete, we will not be able to add or change expenses until your next re-evaluation.

Household Expenses **Attach Proof**

Tell us about your recurring expenses. When telling us the amount of each expense, include only the amount ***you*** pay. If your mortgage payments include other payments such as irrigation, property taxes, HOA fees, etc., please break them out and record them separately below.

Rent per month	Mortgage per month	2nd Mortgage per month	Space rent per month
$	$	$	$

Irrigation			Property tax			HOA fees			Homeowners insurance		
$	per		$	per		$	per		$	per	

Please check the boxes below to tell us what utilities you pay that are not included in your rent or mortgage.

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

Landlord's name:	Landlord's contact number:

Attach proof

Send us proof of all household expenses. Examples of acceptable proof include copies of the following:

- Mortgage or rent statement
- Home Owners Association Dues (HOAs)
- Property taxes
- Utility bills

Individual Expenses **Attach Proof**

Use the space below to tell us about any individual expenses. Allowable expenses include child support paid and some medical expenses for household members who are disabled or over the age of 60. When telling us the amount of each expense, include only the amount ***you*** pay.

Name	Expense type	Amount	How often paid?

Attach proof

Send us proof of all expenses. Examples of acceptable proof include copies of the following:

- Statement of child support paid
- Medical expense receipts*
- Medical insurance premiums*
- Prescription receipts*

* For elderly or disabled household members only.

Dependant Care Expenses **Attach Proof**

Use the space below to tell us about any child care, adult disabled care, or elderly care.

Dependant name	Total amount	Amount you pay	How often paid
Provider name	Provider address		Provider phone

Dependant name	Total amount	Amount you pay	How often paid
Provider name	Provider address		Provider name

Dependant name	Total amount	Amount you pay	How often paid
Provider name	Provider address		Provider name

Attach proof

Send us proof of all dependant care expenses. Examples of acceptable proof include copies of the following:

- Statement from child care provider
- Dependant Care Charges Form

Health Coverage **Attach Proof**

Tell us about everyone in your home who is receiving or has received health coverage within the last six months.

Name of person insured	Insurance company name		Insurance company phone	
Policy holder	Policy number	Start date	End date	Monthly premium amount

Name of person insured	Insurance company name		Insurance company phone	
Policy holder	Policy number	Start date	End date	Monthly premium amount

Name of person insured	Insurance company name		Insurance company phone	
Policy holder	Policy number	Start date	End date	Monthly premium amount

Name of person insured	Insurance company name		Insurance company phone	
Policy holder	Policy number	Start date	End date	Monthly premium amount

Name of person insured	Insurance company name		Insurance company phone	
Policy holder	Policy number	Start date	End date	Monthly premium amount

Name of person insured	Insurance company name		Insurance company phone	
Policy holder	Policy number	Start date	End date	Monthly premium amount

Attach proof

Send us proof of your health coverage. Examples of acceptable proof include copies of the following:

- Insurance card (front and back)
- Health insurance policy

RE-EVALUATION CHECKLIST

Use the checklist below to help make sure you have completed all necessary parts of the re-evaluation process. If the Department needs more information, you will receive a notice in the mail.

Please make sure you:

- ☐ Check all information and answer all questions on the form.
- ☐ Attach proof of all income, resources, and expenses as listed throughout the form.
- ☐ Read, sign, and date the Rights and Responsibilities page at the end of this form.
- ☐ Complete an interview if one is required (check your re-evaluation notice or contact the Department if you don't know).
- ☐ Return or mail this form along with all proofs to the Department.

Mail: Self Reliance Programs
PO Box 83720
Boise, ID 83720-0026

Fax: 1-866-434-8278

Email: mybenefits@dhw.idaho.gov

Failure to complete all of these steps may cause your benefits to be late or close.

I UNDERSTAND THAT…

- I could be sanctioned and required to return any benefit I receive if my information is 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. 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 further benefits or services.

- I understand that I will be notified of the right to appeal Department decisions and I can contact the Department for information on the appeal process.

- I have read and understand the plan choices and that I might be responsible for paying part of the cost of my child's health plan.

- My signature certifies that the citizenship status marked on this form is correct for each child/person applying.

- 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.

- I am required to report changes in my circumstance, including income, assets, and living situation within 10 days of the change.

- By applying for benefits for a minor child, a child support case must be opened, when applicable.

- If a third party is responsible for my child's disease or injury, I give the Idaho health plan any rights I may have, or may acquire in the future, to be compensated by the responsible party for any medical benefits I receive for my children.

- My signature or the signature of my representative authorizes State offices to communicate with insurance companies related to my child's medical assistance.

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

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

- 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.

- To receive Food Assistance, I may be required to participate in work programs. Failure to do so may result in a loss or decrease in benefits.

- I may be required to cooperate with state or federal reviewers who are making sure my benefits are correct. I may not be eligible to receive benefits if I do not cooperate.

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

SIGNATURE -- MUST BE COMPLETED

Under penalty of perjury, I swear or affirm the information I have provided is true and complete. My signature confirms that I have read and understand the Rights and Responsibilities listed on this page.

Signature of Applicant	Date
Signature of other adult in the home	Date

Personal / Authorized Representative

You may authorize someone else to apply for benefits for you and use your Food Stamp benefits to buy food for you. Authorized Representatives are also allowed to report or request information about your benefits. To do so, enter their name, phone , and address below. **NOTE:** If your Authorized Representative gives 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
Address / City / State / ZIP	
Signature of Authorized Representative	Date