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. If applying for Health Coverage, everyone listed on the application who is age 5 or older should complete a Health Questionnaire and turn it in with the application.

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 coste para usted. ☐ No ☐ Sí

Tell Us Who You Are

First Name	Middle Initial	Last Name	Date of Birth	Former Names, if any
Home 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, what phone company do you use? _____

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 Rev. 1/07

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 finish filling out the application, read the **Rights and Responsibilities**, sign page 7, and submit the application to your local Health and Welfare office. You can find local office listings by going online to 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 your local Health and Welfare office 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 COOPERATION: By applying for our services you may be referred to Child Support Services. If your household includes minor children and one or both parents are not living in the home, you will be required to cooperate with Child Support Services to avoid a loss or decrease of your benefits, unless you fear harm to yourself or your children.

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.

CODE KEY

Marital Status Codes:		Race Codes:	
Married -	**MA**	White -	**WH**
Never Married -	**NM**	Black -	**BL**
Divorced -	**DI**	Asian -	**AS**
Separated -	**SE**	American Indian/Alaska Native -	**AL**
Widowed -	**WI**	Native Hawaiian/Pacific Island -	**HP**

Example of how to complete the top portion of page 2.

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

Cash	Health	Child Care	Food	Name: (First) (Middle) (Last)	Relationship:	Date of Birth:	Sex:	Marital Status:
X				Jon Nathan Doe	SELF	01 / 02 / 1957	☒ M ☐ F	WI
				Pregnant? Due Date: ☒ NO ☐ YES How many due:	**Social security #** 012 - 34 - 5678	**U.S. Citizen?** ☒ YES ☐ NO Alien ID #:	**Clinic/Doctor Name** (first and last) Dr. John Pepper	**Phone Number:** (208) 555.1234	**Race:** AL	**Hispanic or Latino?** ☐ YES ☒ NO
X	X			**Name:** (First) (Middle) (Last)	**Relationship:**	**Date of Birth:**	**Sex:**	**Marital Status:**
				Jo Anna Doette	Step-daughter	05 / 06 / 1997	☐ M ☒ F	NM
				Pregnant? Due Date: ☒ NO ☐ YES How many due:	**Social security #** 234 - 56 - 7890	**U.S. Citizen?** ☒ YES ☐ NO Alien ID #:	**Clinic/Doctor Name** (first and last) Dr. Jill Smith	**Phone Number:** (208) 555.6789	**Race:** AL	**Hispanic or Latino?** ☐ YES ☒ NO

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. Add an additional sheet if you need to include more household members. Social Security numbers and citizenship status are required for those applying for services. Look at the back side of page 1 for an example of how to complete the table below. Use the **code key** on the back side of page 1 to indicate your Marital Status and Race. **NOTE**: Your responses to the Race and Hispanic/Latino boxes are optional.

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

Cash / Health / Child Care / Food	Name: (First) (Middle) (Last)		Relationship:	Date of Birth:	Sex:	Marital Status:
☐ ☐ ☐ ☐			SELF	____/____/______	☐ M ☐ F	
Pregnant? Due Date: ☐ NO ☐ YES How many due:	**Social security #** ____-____-________	**U.S. Citizen?** ☐ YES ☐ NO Alien ID #:	**Clinic/Doctor Name** (first and last)	**Phone Number:**	**Race:**	**Hispanic or Latino?** ☐ YES ☐ NO
☐ ☐ ☐ ☐				____/____/______	☐ M ☐ F	
Pregnant? Due Date: ☐ NO ☐ YES How many due:	**Social security #** ____-____-________	**U.S. Citizen?** ☐ YES ☐ NO Alien ID #:	**Clinic/Doctor Name** (first and last)	**Phone Number:**	**Race:**	**Hispanic or Latino?** ☐ YES ☐ NO
☐ ☐ ☐ ☐				____/____/______	☐ M ☐ F	
Pregnant? Due Date: ☐ NO ☐ YES How many due:	**Social security #** ____-____-________	**U.S. Citizen?** ☐ YES ☐ NO Alien ID #:	**Clinic/Doctor Name** (first and last)	**Phone Number:**	**Race:**	**Hispanic or Latino?** ☐ YES ☐ NO
☐ ☐ ☐ ☐				____/____/______	☐ M ☐ F	
Pregnant? Due Date: ☐ NO ☐ YES How many due:	**Social security #** ____-____-________	**U.S. Citizen?** ☐ YES ☐ NO Alien ID #:	**Clinic/Doctor Name** (first and last)	**Phone Number:**	**Race:**	**Hispanic or Latino?** ☐ YES ☐ NO
☐ ☐ ☐ ☐				____/____/______	☐ M ☐ F	
Pregnant? Due Date: ☐ NO ☐ YES How many due:	**Social security #** ____-____-________	**U.S. Citizen?** ☐ YES ☐ NO Alien ID #:	**Clinic/Doctor Name** (first and last)	**Phone Number:**	**Race:**	**Hispanic or Latino?** ☐ YES ☐ NO

* If you need to list more household members, please attach an extra sheet.

Is anyone in your home already getting services 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.

☐ Infant and Toddler ☐ Children's or Adult Mental Health
☐ Children's or Adult Developmental Disabilities ☐ Foster Care or Adoption 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.

Do you or anyone in your home:

- Have a disability? ☐ No ☐ Yes Who? ______________________
- Receive or have you/they applied for Social Security? ☐ No ☐ Yes Who? ______________________
- Receive or have you/they applied for Medicare? ☐ No ☐ Yes Who? ______________________
- Need medical assistance at home? ☐ No ☐ Yes Who? ______________________
- Live with a relative providing medical care? ☐ No ☐ Yes Who? ______________________
- Live in a facility providing medical care? ☐ No ☐ Yes Who? ______________________

Name of Facility: ______________________

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 training, or looking for work.

TO APPLY for Child Care Assistance, complete pages 1-4, sign page 7, and return your completed application to your local Health and Welfare office. You can find office listings by going online to www.healthandwelfare.idaho.gov or dialing 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 such as wage stubs for the last 30 days or current federal income tax records, if self-employed.
- 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, attending training or education programs, or looking for work 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 be in a full-time job, or participate in full-time education or training activities to receive full-time Child Care Assistance.
- You must pay the remaining costs not covered by the Child Care program. ICCP will never pay 100% of your child care costs.
- If you are looking for work, and you are not receiving family cash assistance, you will be allowed 80 hours of job search for up to three months in a year. ICCP will pay part of the full-time child care while you look for work. If you place your child in full-time care while looking for work, you will be responsible for the additional 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:

- Change in income.
- Change in the number of hours your child is in care.
- Change in the amount of money you are charged for childcare.

If you have questions about applying for Child Care Assistance, please call 1-866-343-2027. 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.

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

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

If "Yes", from where? City ______________________ State ________ County ______________________

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.

Name of Absent Parent(s): ______________________ ______________________ ______________________

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 page. 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 or school.

Name:	**Reason for Care:** ☐ Work ☐ School ☐ Work Search	**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 ☐ School ☐ Work Search	**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 ☐ School ☐ Work Search	**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:**		

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 1-4, sign page 7, and return your completed application to your local Health and Welfare office. You can find office listings by going online to www.healthandwelfare.idaho.gov or dialing 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. 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 new 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 your local office as soon as possible.

To receive Health Coverage for Children, you must meet the following program requirements:

- 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.
- In order for Medicaid to determine which plan is better for you, everyone listed on the application who is age 5 and older should complete a **Health Questionnaire** and submit it with the application. This questionnaire is part of a health risk assessment that helps Medicaid understand your health needs. This information will not be used to determine your Medicaid eligibility and will be kept confidential.

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

- Change of address or phone number
- Change in Social Security Number
- If you become disabled
- 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 child 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 Household Income

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

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

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

Name of business: _____ Years in business: _____

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.

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

List everyone in your household who had health insurance end in the last six months.

NAME OF PERSON(S) INSURED	DATE INSURANCE ENDED	INSURANCE COMPANY	TYPE OF COVERAGE

Reason the Insurance Ended:

☐ 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

Do you want to receive help paying for private or employer-sponsored health coverage for your children? ☐ No ☐ Yes

See **"The Children's Access Card"** on the back side of page 3 for more information.

- If you want only **child care** or **health coverage for your children**, you are done giving us information. **Go to page 7 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.**

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 1-6, sign page 7, and return your completed application to your local Health and Welfare office. You can find office listings by going online to www.healthandwelfare.idaho.gov or dialing 2-1-1 or 1-800-926-2588. You may be required to attend an interview and give us proof to support the information on your application before we can make a decision about your benefits. Please contact your local office if you can't participate in an interview during normal office hours or if you 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:** Failure to report or verify any of the above listed expenses 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.

CHILD SUPPORT COOPERATION: If your household includes minor children and one or both parents are not living in the home, you will be referred to Child Support Services. 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.

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 1-5, sign page 7, and return your completed application to your local Health and Welfare office. You can find office listings by going online to www.healthandwelfare.idaho.gov or dialing 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 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.

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 INSTITUTION	ACCOUNT NUMBER	BALANCE

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

OWNER'S NAME	TYPE OF ACCOUNT	NAME OF BANK OR 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:

YEAR	MAKE	MODEL	AMOUNT OWED	VALUE

What is 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	WHAT ASSETS	$ RECEIVED	FAIR MARKET VALUE

- If you want **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 7 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**.

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 1-5 and sign page 7.
- Health Coverage for the elderly, blind, or disabled, complete pages 1-6 and sign page 7.
- Cash Assistance for the elderly, blind, or disabled, complete pages 1-6 and sign page 7.

Return your completed application to your local Health and Welfare office. You can find office listings by going online to www.healthandwelfare.idaho.gov or dialing 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 new 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.

To receive Health Coverage, you must meet the following program requirements: 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.

In order for Medicaid to determine which plan is better for you, everyone listed on the application who is age 5 or older should complete a **Health Questionnaire** and submit it with the application. This questionnaire is part of a health risk assessment that helps Medicaid understand your health needs. This information will not be used to determine your Medicaid eligibility and will be kept confidential.

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.

Child Support Cooperation: If you are receiving any benefits for yourself as an adult, and you are caring for a minor child with one or more parents are not in the home, a child support case will be opened. 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 Living Situation and Expenses

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

List the monthly housing costs for your household:

Rent:	$_____	Mortgage:	$_____	Property Taxes:	$_____
Space Rent:	$_____	2nd Mortgage:	$_____	Home Insurance:	$_____
Association Fees:	$_____			Irrigation Taxes:	$_____

If you are 60 or older, blind, or disabled, complete the following questions. Otherwise, skip the following questions and go to the first stop sign on this page and follow the instructions.

List your monthly medical costs:

Medicare:	$_____	Doctor:	$_____	Dental:	$_____
Health Insurance:	$_____	Hospital:	$_____	Prescriptions:	$_____
Work Expenses:	$_____	Service Animal:	$_____	Medical Supplies:	$_____
Attendant Care:	$_____	Transportation/Lodging:	$_____	Eye Glasses:	$_____

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: _____

- If you want **health coverage or cash assistance for the elderly, blind, or disabled**, you are done giving us information. **Go to page 7 to sign the application**. See the back side of page 5 for more information about these programs.
- If you want **assistance buying food**, then **proceed to the next section**.

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 on 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: _____

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

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

☐ Other: _____ ☐ Other: _____

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.

DO I HAVE TO BE A CITIZEN?

According to the U.S. Citizenship and Immigration Services, if you do NOT have a green 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 green 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.

RIGHTS AND RESPONSIBILITIES

BY INITIALING THE FOLLOWING PROVISIONS, I UNDERSTAND THAT . . .

_____ I could be sanctioned and required to return any benefits 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 me 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.

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

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

_____ My signature certifies that the citizenship / immigration status marked on page 2 is correct for each person applying.

_____ By applying for benefits for a minor child, a child 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.

_____ 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.

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 and are ready to turn it in to your local Health and Welfare office. See the back side of page 1 for instructions on finding your local Health and Welfare office.

IDAHO DEPARTMENT OF HEALTH & WELFARE

Notice of Privacy Practices

Effective April 14, 2003

HW-0320
Revised 03/07

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

- If you have any questions about this Notice, please contact the Idaho Department of Health and Welfare's Privacy Office at 208-334-6519 or by email at PrivacyOffice@dhw.idaho.gov.

- You may request a copy of this notice at any time. Copies of this notice are available at the Department of Health and Welfare offices. This notice is also available on the Department of Health and Welfare's website at http://www.healthandwelfare.idaho.gov

PURPOSE OF THIS NOTICE

This Notice of Privacy Practices describes how the Idaho Department of Health and Welfare (Department) handles confidential information, following state and federal requirements. All programs in the Department may share your confidential information with each other as needed to provide you benefits or services, and for normal business purposes. The Department may also share your confidential information with others outside of the Department as needed to provide you benefits or services.

We are dedicated to protecting your confidential information. We create records of the benefits or services you receive from the Department. We need these records to give you quality care and services. We also need these records to follow various local, state and federal laws.
We are required to:

- use and disclose confidential information as required by law;
- maintain the privacy of your information;
- give you this notice of our legal duties and privacy practices for your information; and
- follow the terms of the notice that is currently in effect.

This Notice of Privacy Practices does not affect your eligibility for benefits or services.

YOUR RIGHTS ABOUT YOUR CONFIDENTIAL INFORMATION

1. Right to Review and Copy

You have the right to ask to review and copy your information as allowed by law.

If you would like to ask to review and copy your information, a "Records Request" form is available at Department offices. You must complete this form and return it to a Department office for processing. The Department will respond to your request within 3 working days of receipt of your request. The Department may extend the response time to 7 additional working days if the information you have requested cannot be located or retrieved within the original 3 days. You will be sent a notification of an extension and the reason for the extension.

If you ask to receive a copy of the information, we may charge a fee. If you request 100 pages or more from our files, the fee will be 10¢ per page.

You will be told if there is information we are legally prevented from disclosing to you.

2. Right to Amend

You have the right to ask us to make changes to your information if you feel that the information we have about you is wrong or not complete.

If you would like to ask the Department to change your information, a "Request to Amend Records" form is available at Department offices. You must complete this form and return it to a Department office for processing. The Department will respond to your request within 10 days.

We may deny your request if you ask us to change information that:

- Was not created by the Department;
- Is not part of the information kept by or for the Department;
- Is not part of the information which you would be allowed to review and copy; or
- We determine is correct and complete.

3. Right to Restrict Health Information Disclosures

You have the right to ask us not to share your health information for your treatment or services, or normal business purposes. You must tell us what information you do not want us to share and who we should not share it with.

If you would like to ask the Department to not share your information, a "Request to Restrict Health Information Disclosures" form is available at Department offices. You must complete this form and return it to a Department office for processing. The Department will respond to your request within 10 days.

If we agree to your request, we will comply unless the information is needed to give you emergency treatment, or until you end the restriction.

4. Right to an Alternate Means of Delivery

You have the right to ask that we deliver your information to you at different mailing address. For example, you can ask that we send your information from one program to a different mailing address from other programs that you receive services or benefits from.

If you would like to ask for an alternate means of delivery for your information, a "Request for Alternate Means of Delivery" form is available at Department offices. You must complete this form and return it to a Department office for processing. The Department will respond to your request within 10 days.

We will not ask you the reason for your request. Reasonable requests will be approved.

5. Right to a Report of Health Information Disclosures

You have the right to ask for a report of the disclosures of your health information. This report of disclosures will not include when we have shared your health information for treatment, payment for your treatment or normal business purposes, or the times you authorized us to share your information.

If you would like to ask for a report of your health information disclosures, a "Request to Receive a Report of Health Information Disclosures" form is available at Department offices. You must complete this form and return it to a Department office for processing. The Department will respond to your request within 10 days.

The first report you ask for and receive within a calendar year will be free of charge. For additional reports within the same calendar year, we may charge you for the costs of providing the report. We will tell you the cost and you may choose to remove or change your request at that time before any costs are charged to you.

HOW THE DEPARTMENT MAY USE AND SHARE YOUR INFORMATION

Times when your permission is not needed

- **For Treatment**. We may use your information to give you benefits, treatment or services. We may share your information with a nurse, medical professional or other personnel who are giving you treatment or services. The programs in the Department may also share your information in order to bring together the services that you may need. We also may share your information with people outside of the Department who are involved in your care, such as family members, informal or legal representatives, or others that give you services as part of your care.

- **For Payment**. We may use and share your information so that the treatment and services you receive through the Department can be paid. For example, we may need to give your medical insurance company information about the treatment or services that you received so that your medical insurance can pay for the treatment or services.

- **For Business Operations**. We may use and share your information for business operational purposes. This is necessary for the daily operation of the Department and to make sure that all of our clients receive quality care. For example, we may use your information to review our provision of treatment and services and to evaluate the performance of our staff in providing services for you.

Times when your permission is needed

- **For reasons other than Treatment, Payment or Business Operations.** There may be times when the Department may need to use and share your information for reasons other than for treatment, payment and business operations as explained above. For example, if the Department is asked for information from your employer or school that is not part of treatment, payment or business operations, the Department will ask you for a written authorization permitting us to share that information. If you give us permission to use or share your information, you may stop that permission at any time, if it is in writing. If you stop your permission, we will no longer use or share that information. You must understand that we are unable to take back any information already shared with your permission.

- **Individuals that are part of your care or payment for your care.** We may give your information to a family member, legal representative, or someone you designate who is part of your care. We may also give your information to someone who helps pay for your care. If you are unable to say yes or no to such a release, we may share such information as needed if we determine that it is in your best interest based on our professional opinion. Also, we may share your information in a disaster so that your family or legal representative can be told about your condition, status and location.

Other uses and sharing of your information that may be made without your permission

- For Appointment Reminders
- For Treatment Alternatives
- As Required by Law
- For Public Health Risks
- To Law Enforcement
- For Lawsuits and Disputes
- To Coroners, Medical Examiners, Funeral Directors
- For Organ and Tissue Donation
- For Emergency Treatment
- To Prevent a Serious Threat to Health or Safety
- To Military and Veterans organizations
- For Health Oversight Activities
- For National Security and Intelligence Activities
- To Correctional Institutions

SPECIAL REQUIREMENTS

Information that has been received from a federally funded substance abuse treatment program or through the infant and toddler program will not be released without specific authorization from the individual or legal representative.

CHANGES TO THIS NOTICE

The Department has the right to change this notice. A copy of this notice is posted at our Department offices. The effective date of this notice is shown in the top right-hand corner of each page. If the Department makes any changes to this Notice of Privacy Practices, the Department will follow the terms of the notice that is currently in effect.

COMPLAINTS

If you believe your confidential information privacy rights have been violated, you may file a written complaint with the Idaho Department of Health and Welfare. All complaints turned in to the Department must be in writing on the "Privacy Complaint" form that is available at Department offices. To file a complaint with the Department, send your completed Privacy Complaint form to:

Idaho Department of Health and Welfare
Privacy Office
P.O. Box 83720
Boise, ID 83720-0036

If you believe your health information privacy rights have been violated, you may also file a complaint with the U.S Department of Health and Human Services. Your complaint must be in writing and you must name the organization that is the subject of your complaint and describe what you believe was violated. Send your written complaint to:

Region 10
Office for Civil Rights
U. S Department of Health and Human Services
2201 Sixth Avenue-Suite 900
Seattle, Washington 98121-1831

For all complaints filed by e-mail send to OCRComplaint@hhs.gov

A complaint filed with either the Idaho Department of Health and Welfare or the Secretary of Health and Human Services must be filed within 180 days of when you believe the privacy violation occurred. This time limit for filing complaints may be waived for good cause.

You will not be punished or retaliated against for filing a complaint.