IDAHO DEPARTMENT OF HEALTH & WELFARE

Application for Assistance

HW2000 | REV 08/2018

Food Assistance

The Idaho Food Stamp Program is a supplemental nutrition assistance program that helps families buy food for good health. Eligible families get a debit-like card to buy food items. Participants may be required to participate in work programs and cooperate with Child Support Services. Benefits are prorated from your application date.

Cash Assistance

The Temporary Assistance for Families in Idaho Program provides cash assistance for emergency situations and families with children. Eligible families receive a one-time or on-going payment, depending on the needs of the household. The Aid to the Aged, Blind, and Disabled Program provides cash assistance to individuals eligible for SSI and who meet other guidelines.

Health Coverage Assistance

The Health Coverage Assistance Program provides health coverage assistance according to individual needs. Eligible families may qualify for Medicaid or Advance Payment of Premium Tax Credit (APTC) to help pay health coverage premiums or affordable private health insurance plans.

Child Care Assistance

Child Care Assistance helps parents and caretakers pay for a part of their child care costs while working, going to school, or participating in approved training activities. Eligible families receive a portion of child care costs paid to the provider.

Who can use this application

Anyone may use this application to:

- Apply for assistance for themselves and their household members
- Apply for just one type of assistance or for multiple types of assistance

What you may need to apply

Attaching proof of the household's **income** to this application may help us determine your eligibility faster.

We may need other proof, such as verification of resources or expenses, to process your application, but we'll ask for this only if we need it.

Why we ask for this information

We keep all information private and secure, as required by law. We ask for this information for a few reasons:

- To figure out what types of assistance you qualify for
- To figure out how much assistance you qualify for
- To make sure you get the right amount of assistance based on your situation

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 Idaho 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 on the basis of religion or political beliefs.

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

- U.S. Department of Agriculture
  Office of the Assistant Secretary for Civil Rights
  1400 Independence Avenue, SW
  Washington, D.C. 20250-9410
  Fax: (202) 690.7442
  Email: program.intake@usda.gov

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

What happens next

Send your complete, signed application to the address below. Eligibility determinations shall be based on the rules and requirements which pertain to the program you are applying for. We will tell you if you're eligible or not, or give you further instructions for completing your application.

Self-Reliance Programs - Statewide Application Team
PO Box 83720
Boise, ID 83720-0026
Fax: 1-866-434-8278
Email: MyBenefits@dhw.idaho.gov

Get help with this application

- **Online:** healthandwelfare.idaho.gov
- **Phone:** 1-877-456-1233
- **Email:** MyBenefits@dhw.idaho.gov
- **In person:** Visit our website or call 1-877-456-1233 to find a local office
- **Language Interpreter:** Call 1-877-456-1233 or TTY 1-888-791-3004

Tell us about yourself

You will be the primary contact person for this application.

Information that is optional or not required

- Social Security Number - optional for people not applying, and for people applying for emergency health coverage or child care assistance
- Race - optional for all types of assistance
- Hispanic or Latino - optional for all types of assistance
- U.S. citizen or national questions - optional for household members who are not applying for assistance

If applying for Food Assistance only, **you do not need to answer questions 14 or 22** on this page.

1. Type(s) of assistance you are requesting: ☐ **Food** ☐ **Health Coverage** ☐ **Cash** ☐ **Child Care** ☐ **None**

2. First Name	Middle Name	Last Name	Suffix	3. Former Names, if any

4. Social Security Number	5. Date of Birth	6. Sex	7. Marital Status
		☐ M ☐ F	☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Never Married

8. Physical Address	City	State	Zip Code	County

9. Mailing Address (if different)	City	State	Zip code	County

10. Email address	11. Phone Number	Phone type *(choose one)*	12. If none, what number may we use to leave a message?
		☐ Home ☐ Work ☐ Cell	

13. Pregnant? ☐ No ☐ Yes. Complete a-b. a. Due date b. How many due?

14. Immunized? ☐ No ☐ Yes

15. Preferred language spoken (if not English):

16. Preferred language written/read (if not English):

17. Do you want an interpreter if you are interviewed (one will be provided at no cost to you)?
¿Quiere usted un intérprete si usted sea entrevistado (se le proporcionara uno sin costo alguno)? ☐ No ☐ Yes

18. Race ☐ White ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Island, Name of Tribe: _____
☐ American Indian/Alaska Native, Name of Tribe:

19. Hispanic or Latino? ☐ No ☐ Yes 20. U.S. citizen or national? ☐ No ☐ Yes

21. If not a U.S. citizen or national, do you have eligible immigration status? ☐ No ☐ Yes. Complete questions a-b.

a. Immigration document type: _____ b. Document ID number: _____

Alien status is subject to verification by submission of information on your application to USCIS. The response from USCIS may affect your household's eligibility and benefit amount.

22. Do you plan to file a federal tax return for the CURRENT YEAR? ☐ No. Skip to question c. ☐ Yes. Complete questions a-c.

a. Do you plan to file jointly with a spouse? ☐ No ☐ Yes. Complete parts i and ii. i. Name of spouse: _____

If your household is approved for Advance Payment of Premium Tax Credit (APTC), and you decide to purchase insurance through Your Health Idaho (YHI), one adult tax filer will be assigned as the primary account holder for your household. Choose which spouse you wish to be assigned as the primary account holder for your household.

ii. Name of preferred primary account holder: _____

b. Do you plan to claim dependents? ☐ No ☐ Yes. **If yes**, names of dependents: _____

c. Will you be claimed as a dependent on someone else's tax return? ☐ No ☐ Yes. **If yes,** name of tax filer:

23. Does anyone who is applying live in a medical care facility? ☐ No ☐ Yes. **If yes**, complete a-d.

a. Who?	b. Name of the facility	c. Type of facility	d. Facility phone
		☐ Nursing Home ☐ In-home Care ☐ Other	

24. Would you like to name someone as your authorized representative? ☐ No ☐ Yes. Complete **Appendix A**.

You may give a trusted friend, partner, or third party representative permission as an "authorized representative" to talk to the Department, see your information, and act on your behalf for all matters relating to your case.

If applying for Food Assistance, you may start the application process immediately by filling out your name and address in the space provided above and sign below. You must complete the rest of the application and submit it as soon as possible to receive a benefit determination. Your filing date is the date we receive an application with your name, address, and signature.

25. **If applying for Food Assistance,** does your household meet one of the following situations (check all that apply)?

- ☐ Your household will have less than $150 income and less than $100 liquid resources (cash, checking, savings) this month
- ☐ Your household's income and resources are less than your monthly housing and utility costs
- ☐ Your household includes a migrant or seasonal farm worker

If you qualify, emergency Food Stamp benefits can begin within 7 days of the date on this application.

Printed name of applicant/authorized representative to request Food Stamps _____ Signature of applicant/authorized representative to request Food Stamps _____ Date _____

Tell us about everyone else in your household

Who you need to include on this application

- Regardless of the types of assistance you are applying for, we need information about ***everyone*** who lives at the physical address you wrote down in the "Tell Us About Yourself" section on the previous page.
- If applying for health coverage assistance for anyone under 65 and not disabled, we need information about everyone you plan to include on your federal tax return for this year, even if they don't live with you. Note that you do not need to file taxes to get health coverage.

Information that is optional or not required

- Social Security Number - optional for people not applying, and for people applying for emergency health coverage or child care assistance
- Race - optional for all types of assistance
- Hispanic or Latino - optional for all types of assistance
- U.S. citizen or national questions - optional for household members who are not applying for assistance

If applying for Food Assistance, **you do not need to answer questions 10 or 16** in this section.

PERSON 1

1. Type(s) of assistance requested for this person: ☐ Food ☐ Health Coverage ☐ Cash ☐ Child Care ☐ None

2. Relationship to you

3. First Name | Middle Name | Last Name | 4. Suffix | 5. Former Names, if any

6. Social Security Number | 7. Date of Birth | 8. Sex ☐ M ☐ F | 9. Marital Status ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Never Married | 10. Immunized? ☐ No ☐ Yes

11. Pregnant? ☐ No ☐ Yes. Complete a-b. a. Due date b. How many due?

12. Hispanic or Latino? ☐ No ☐ Yes

13. U.S. Citizen or national? ☐ No ☐ Yes

14. If not a U.S. citizen or national, do you have eligible immigration status? ☐ No ☐ Yes. Complete questions a-b.

a. Immigration document type: _____ b. Document ID number: _____

Alien status is subject to verification by submission of information on your application to USCIS. The response from USCIS may affect your household's eligibility and benefit amount.

15. Race ☐ White ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Island, Name of Tribe: _____ ☐ American Indian/Alaska Native, Name of Tribe:

16. Does this person plan to file a federal tax return for the CURRENT YEAR? ☐ **No.** Skip to question c. ☐ **Yes.** Complete questions a-c.

a. Does this person plan to file jointly with a spouse? ☐ No ☐ Yes. **If yes**, name of spouse: _____

b. Does this person plan to claim dependents? ☐ No ☐ Yes. **If yes**, names of dependents: _____

c. Will this person be claimed as a dependent on someone else's tax return? ☐ No ☐ Yes. **If yes**, name of tax filer:

PERSON 2

1. Type(s) of assistance requested for this person: ☐ Food ☐ Health Coverage ☐ Cash ☐ Child Care ☐ None

2. Relationship to you

3. First Name | Middle Name | Last Name | 4. Suffix | 5. Former Names, if any

6. Social Security Number | 7. Date of Birth | 8. Sex ☐ M ☐ F | 9. Marital Status ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Never Married | 10. Immunized? ☐ No ☐ Yes

11. Pregnant? ☐ No ☐ Yes. Complete a-b. a. Due date b. How many due?

12. Hispanic or Latino? ☐ No ☐ Yes

13. U.S. Citizen or national? ☐ No ☐ Yes

14. If not a U.S. citizen or national, do you have eligible immigration status? ☐ No ☐ Yes. Complete questions a-b.

a. Immigration document type: _____ b. Document ID number: _____

Alien status is subject to verification by submission of information on your application to USCIS. The response from USCIS may affect your household's eligibility and benefit amount.

15. Race ☐ White ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Island, Name of Tribe: _____ ☐ American Indian/Alaska Native, Name of Tribe:

16. Does this person plan to file a federal tax return for the CURRENT YEAR? ☐ **No.** Skip to question c. ☐ **Yes.** Complete questions a-c.

a. Does this person plan to file jointly with a spouse? ☐ No ☐ Yes. **If yes**, name of spouse: _____

b. Does this person plan to claim dependents? ☐ No ☐ Yes. **If yes**, names of dependents: _____

c. Will this person be claimed as a dependent on someone else's tax return? ☐ No ☐ Yes. **If yes**, name of tax filer:

If you have more household members, continue telling us about everyone in your household on the next page.

PERSON 3

1. Type(s) of assistance requested for this person: ☐ Food ☐ Health Coverage ☐ Cash ☐ Child Care ☐ None

2. Relationship to you

3. First Name | Middle Name | Last Name | 4. Suffix | 5. Former Names, if any

6. Social Security Number | 7. Date of Birth | 8. Sex ☐ M ☐ F | 9. Marital Status ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Never Married | 10. Immunized? ☐ No ☐ Yes

11. Pregnant? ☐ No ☐ Yes. Complete a-b. a. Due date b. How many due?

12. Hispanic or Latino? ☐ No ☐ Yes

13. U.S. Citizen or national? ☐ No ☐ Yes

14. If not a U.S. citizen or national, do you have eligible immigration status? ☐ No ☐ Yes. Complete questions a-b.

a. Immigration document type: _____ b. Document ID number: _____

Alien status is subject to verification by submission of information on your application to USCIS. The response from USCIS may affect your household's eligibility and benefit amount.

15. Race ☐ White ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Island, Name of Tribe: _____
☐ American Indian/Alaska Native, Name of Tribe:

16. Does this person plan to file a federal tax return for the CURRENT YEAR? ☐ **No.** Skip to question c. ☐ **Yes.** Complete questions a-c.

a. Does this person plan to file jointly with a spouse? ☐ No ☐ Yes. **If yes**, name of spouse: _____

b. Does this person plan to claim dependents? ☐ No ☐ Yes. **If yes**, names of dependents: _____

c. Will this person be claimed as a dependent on someone else's tax return? ☐ No ☐ Yes. **If yes**, name of tax filer:

PERSON 4

1. Type(s) of assistance requested for this person: ☐ Food ☐ Health Coverage ☐ Cash ☐ Child Care ☐ None

2. Relationship to you

3. First Name | Middle Name | Last Name | 4. Suffix | 5. Former Names, if any

6. Social Security Number | 7. Date of Birth | 8. Sex ☐ M ☐ F | 9. Marital Status ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Never Married | 10. Immunized? ☐ No ☐ Yes

11. Pregnant? ☐ No ☐ Yes. Complete a-b. a. Due date b. How many due?

12. Hispanic or Latino? ☐ No ☐ Yes

13. U.S. Citizen or national? ☐ No ☐ Yes

14. If not a U.S. citizen or national, do you have eligible immigration status? ☐ No ☐ Yes. Complete questions a-b.

a. Immigration document type: _____ b. Document ID number: _____

Alien status is subject to verification by submission of information on your application to USCIS. The response from USCIS may affect your household's eligibility and benefit amount.

15. Race ☐ White ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Island, Name of Tribe: _____
☐ American Indian/Alaska Native, Name of Tribe:

16. Does this person plan to file a federal tax return for the CURRENT YEAR? ☐ **No.** Skip to question c. ☐ **Yes.** Complete questions a-c.

a. Does this person plan to file jointly with a spouse? ☐ No ☐ Yes. **If yes**, name of spouse: _____

b. Does this person plan to claim dependents? ☐ No ☐ Yes. **If yes**, names of dependents: _____

c. Will this person be claimed as a dependent on someone else's tax return? ☐ No ☐ Yes. **If yes**, name of tax filer:

PERSON 5

1. Type(s) of assistance requested for this person: ☐ Food ☐ Health Coverage ☐ Cash ☐ Child Care ☐ None

2. Relationship to you

3. First Name | Middle Name | Last Name | 4. Suffix | 5. Former Names, if any

6. Social Security Number | 7. Date of Birth | 8. Sex ☐ M ☐ F | 9. Marital Status ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Never Married | 10. Immunized? ☐ No ☐ Yes

11. Pregnant? ☐ No ☐ Yes. Complete a-b. a. Due date b. How many due?

12. Hispanic or Latino? ☐ No ☐ Yes

13. U.S. Citizen or national? ☐ No ☐ Yes

14. If not a U.S. citizen or national, do you have eligible immigration status? ☐ No ☐ Yes. Complete questions a-b.

a. Immigration document type: _____ b. Document ID number: _____

Alien status is subject to verification by submission of information on your application to USCIS. The response from USCIS may affect your household's eligibility and benefit amount.

15. Race ☐ White ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Island, Name of Tribe: _____
☐ American Indian/Alaska Native, Name of Tribe:

16. Does this person plan to file a federal tax return for the CURRENT YEAR? ☐ **No.** Skip to question c. ☐ **Yes.** Complete questions a-c.

a. Does this person plan to file jointly with a spouse? ☐ No ☐ Yes. **If yes**, name of spouse: _____

b. Does this person plan to claim dependents? ☐ No ☐ Yes. **If yes**, names of dependents: _____

c. Will this person be claimed as a dependent on someone else's tax return? ☐ No ☐ Yes. **If yes**, name of tax filer:

Tell us about your household situation

If applying for Food Assistance, **skip question 10** in this section.

1. Is anyone in your household American Indian or Alaska Native?	☐ No ☐ Yes	If yes, who?
2. Is anyone in your household applying for or already receiving Tribal Commodities?	☐ No ☐ Yes	If yes, who?
3. Is anyone in your household applying for or already receiving Foster Care or Adoption Assistance?	☐ No ☐ Yes	If yes, who?
4. Was anyone in Idaho foster care when they turned 18?	☐ No ☐ Yes	If yes, who?
5. Is anyone in your household currently receiving assistance from another state?	☐ No ☐ Yes	If yes, tell us when, where, and the type by completing a-c.
a. Date (month/year) From: To:	b. City State County	c. Type of assistance received
6. Is anyone in your household 65 or over or disabled?	☐ No ☐ Yes	If yes, who?
7. Does anyone in your household receive Social Security benefits?	☐ No ☐ Yes	If yes, who?
8. Does anyone who is applying have a pending application for Social Security disability?	☐ No ☐ Yes	If yes, who?
9. Is anyone in your household working and believe that they would meet disability status as determined by the Social Security Administration?	☐ No ☐ Yes	If yes, who?
10. Does anyone who is applying need medical services provided in the home?	☐ No ☐ Yes	If yes, who?
11. Is anyone listed on this application currently incarcerated?	☐ No ☐ Yes	If yes, who?

If applying for health coverage only, and all household members are under 65 and not disabled, **skip to page 5**. Otherwise, complete this section.

1. Has anyone in your household been disqualified from public assistance due to an intentional program violation?	☐ No ☐ Yes	If yes, who? _____ When? State?
2. Has anyone in your household been convicted of a felony involving drugs?	☐ No ☐ Yes	If yes, who? _____ When?
3. Is anyone in your household fleeing to avoid felony prosecution or jail time?	☐ No ☐ Yes	If yes, who?
4. Has anyone in your household been convicted of trading Food Stamp benefits for guns, ammunitions, or explosives?	☐ No ☐ Yes	If yes, who?
5. Has anyone in your household been convicted of buying or selling Food Stamp benefits over $500?	☐ No ☐ Yes	If yes, who?
6. Has anyone in your household been convicted of receiving duplicate Food Stamp benefits in any state?	☐ No ☐ Yes	If yes, who?
7. Is anyone in your household currently violating conditions of probation or parole?	☐ No ☐ Yes	If yes, who?

8. Use the table below to specify the names of any applicant between the ages of 16 and 49 that is attending school (High School or Higher Education).

Student name	School name	Hours per week	Graduation date	School type *(choose one)*
				☐ High School ☐ Higher Education. Complete questions a-d.
a. Enrollment Type: ☐ Undergraduate ☐ Graduate	b. Student Status: ☐ Full time ☐ Half time ☐ Less than half time		c. Were you awarded Work Study? ☐ No ☐ Yes	d. Are all classes online? ☐ No ☐ Yes
				☐ High School ☐ Higher Education. Complete questions a-d.
a. Enrollment Type: ☐ Undergraduate ☐ Graduate	b. Student Status: ☐ Full time ☐ Half time ☐ Less than half time		c. Were you awarded Work Study? ☐ No ☐ Yes	d. Are all classes online? ☐ No ☐ Yes

9. Is anyone in your household participating in a work/training program provided by a homeless shelter? ☐ No ☐ Yes If yes, have the agency provide the **Child Care Activity Form.**

Tell us about other parents

Complete the following for each child who has a parent (or parents) NOT living with them. Any information will be provided to Child Support Services in order to pursue a child support case if eligible. You must cooperate with Child Support Services unless you fear harm to yourself or your children as a result of the opening of the child support case.

Other Parent 1

☐ Check this box if you fear harm to yourself or your children as a result of opening a child support case.

1. Child Name	2. Other Parent First Name	Middle Name	Last Name	Suffix

3. Social Security Number	4. Date of Birth	5. Approximate Age	6. Sex ☐ M ☐ F

7. Physical Address	City	State	Zip Code	County

8. Mailing Address (if different)	City	State	Zip code	County

9. Email Address	10. Phone Number	11. Last Known Employer	Last Known Employer City

Other Parent 2

☐ Check this box if you fear harm to yourself or your children as a result of opening a child support case.

1. Child Name	2. Other Parent First Name	Middle Name	Last Name	Suffix

3. Social Security Number	4. Date of Birth	5. Approximate Age	6. Sex ☐ M ☐ F

7. Physical Address	City	State	Zip Code	County

8. Mailing Address (if different)	City	State	Zip code	County

9. Email Address	10. Phone Number	11. Last Known Employer	Last Known Employer City

Other Parent 3

☐ Check this box if you fear harm to yourself or your children as a result of opening a child support case.

1. Child Name	2. Other Parent First Name	Middle Name	Last Name	Suffix

3. Social Security Number	4. Date of Birth	5. Approximate Age	6. Sex ☐ M ☐ F

7. Physical Address	City	State	Zip Code	County

8. Mailing Address (if different)	City	State	Zip code	County

9. Email Address	10. Phone Number	11. Last Known Employer	Last Known Employer City

Other Parent 4

☐ Check this box if you fear harm to yourself or your children as a result of opening a child support case.

1. Child Name	2. Other Parent First Name	Middle Name	Last Name	Suffix

3. Social Security Number	4. Date of Birth	5. Approximate Age	6. Sex ☐ M ☐ F

7. Physical Address	City	State	Zip Code	County

8. Mailing Address (if different)	City	State	Zip code	County

9. Email Address	10. Phone Number	11. Last Known Employer	Last Known Employer City

Tell us about your household income (required for all types of assistance)

Tell us about all income your household receives. We want to know about the last 30 days, as well as any money received quarterly or annually. Income is money earned (wages or salary) from a job or self-employment (including owning your own business, doing odd jobs, baby-sitting, collecting cans, donating plasma, etc.), or unearned income from sources such as Social Security, child support, unemployment benefits, gifts, rental income, retirement income, tribal gaming payments, BIA General Assistance, mineral and oil rights, Tribal TANF, Federal per capita (from judgement funds), Alaska Native Corporation cash distributions, or leases of Tribal or individually owned land, etc.

Income 1

1. Name of person with income:

Income from a job - Tell us about any income this person gets from working a job.

2. Employer name	3. Employer phone	4. Average hours worked each week

5. Wages/tips (before taxes)

$ _____ paid ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

6. Income expected to change (raise, hours changed, etc.)

☐ No ☐ Yes Why?

Income from your own business - Tell us about any income this person gets from a business they own.

7. Name of business	a. Type of work	b. Years in business	c. Estimated gross income this month	d. Average hours worked each week

Income from other sources - Tell us about any other income sources for this person, such as Social Security, child support, etc.

8. Source of income	a. Amount	b. How often paid
		☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
		☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
		☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

Income 2

1. Name of person with income:

Income from a job - Tell us about any income this person gets from working a job.

2. Employer name	3. Employer phone	4. Average hours worked each week

5. Wages/tips (before taxes)

$ _____ paid ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

6. Income expected to change (raise, hours changed, etc.)

☐ No ☐ Yes Why?

Income from your own business - Tell us about any income this person gets from a business they own.

7. Name of business	a. Type of work	b. Years in business	c. Estimated gross income this month	d. Average hours worked each week

Income from other sources - Tell us about any other income sources for this person, such as Social Security, child support, etc.

8. Source of income	a. Amount	b. How often paid
		☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
		☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
		☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

Income 3

1. Name of person with income:

Income from a job - Tell us about any income this person gets from working a job.

2. Employer name	3. Employer phone	4. Average hours worked each week

5. Wages/tips (before taxes)

$ _____ paid ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

6. Income expected to change (raise, hours changed, etc.)

☐ No ☐ Yes Why?

Income from your own business - Tell us about any income this person gets from a business they own.

7. Name of business	a. Type of work	b. Years in business	c. Estimated gross income this month	d. Average hours worked each week

Income from other sources - Tell us about any other income sources for this person, such as Social Security, child support, etc.

8. Source of income	a. Amount	b. How often paid
		☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
		☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
		☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

Tell us about your Anticipated Annual Income

If applying for health coverage, you must complete **Appendix D**. You do not need to provide this information if applying for Food Assistance only.

Tell us about your vehicles, resources, and property

If applying for health coverage only, and all household members are under 65 and not disabled, **skip to page 9.** Otherwise, complete this section.

1. Motor Vehicles - Tell us about all vehicles, including cars, trucks, motorcycles, trailers, boats, snowmobiles, and other recreational vehicles that your household owns.

Owner	Year, make, and model	Current value	Primary use for this vehicle (choose one)
			☐ Business ☐ Get to work ☐ Recreational ☐ Income-producing ☐ Medical ☐ Work search ☐ Residence ☐ Personal (other)
			☐ Business ☐ Get to work ☐ Recreational ☐ Income-producing ☐ Medical ☐ Work search ☐ Residence ☐ Personal (other)
			☐ Business ☐ Get to work ☐ Recreational ☐ Income-producing ☐ Medical ☐ Work search ☐ Residence ☐ Personal (other)

2. Resources - Tell us about all 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 of resource	Resource type	Name of financial institution	Account number	Current value

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

Name/owner of property	Property type	Property Address	Value	Primary use for this property *(choose one)*
				☐ Home ☐ Rental income ☐ Business/Self-employment ☐ Other:
				☐ Home ☐ Rental income ☐ Business/Self-employment ☐ Other:
				☐ Home ☐ Rental income ☐ Business/Self-employment ☐ Other:

4. Sale or transfer of resources and property - Tell us about everyone in your home who has sold, transferred or given away cash, property, or other assets within the last five years.

Name	Date of Transaction	What Assets	Amount Received	Fair Market Value

Tell us about your household expenses

If applying for health coverage only, and all household members are under 65 and not disabled, **skip to page 9.** Otherwise, complete this section.

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 65, 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.

1. Shelter Expenses - 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., 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

Check the boxes below for each utility you pay that is NOT included in your rent or mortgage:

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

Landlord's name	Landlord's contact number

2. Dependent Care Expenses - Use the space below to tell us about any child care, adult disabled care, or elderly care. If applying for Child Care Assistance, also have your provider complete a **Child Care Provider Form**.

Dependent name	Total charge for care	Amount you pay	How often you pay
Provider name	Provider address		Provider phone
Dependent name	Total charge for care	Amount you pay	How often you pay
Provider name	Provider address		Provider phone
Dependent name	Total charge for care	Amount you pay	How often you pay
Provider name	Provider address		Provider phone

3. Child Support Expense - Use the space below to tell us about any court ordered child support expense or arrears you pay to someone who is not in your household.

Name of person with expense	Amount	Who receives payment?	How often paid?
	$		
	$		
	$		

4. Individual Expenses - Use the space below to tell us about any individual expenses only for the individual in your household who is over 65 (over 60 for Food Stamps) or disabled. Allowable expenses include some medical expenses and health insurance premiums.

Name of person with expense	Expense type	Amount	How often paid?
		$	
		$	
		$	
		$	
		$	
		$	
		$	

Tell us about your health coverage situation

If applying for Food or Child Care Assistance only, **skip to page 10**.

1. Does anyone who is applying for health coverage want help paying for medical costs from the **last 3 months**?

☐ **No.** Skip to #2. ☐ **Yes.** Complete questions a-b.

a. If yes, tell us who?

b. If yes, tell us for which of the last 3 months you need assistance, and the gross household income (before taxes) received by your family in each of those months:

Month (name)	Amount ($)	Month (name)	Amount ($)	Month (name)	Amount ($)

2. Is anyone applying for health coverage assistance currently receiving coverage from any of the following?

☐ No ☐ Yes. If yes, check the type of coverage below and write the name of the person(s) next to the coverage type.

☐ CHIP Who? _____

☐ Medicare Who? _____

☐ TRICARE Who? _____

☐ VA Health Care Who? _____

☐ Employer Insurance Who? _____

☐ Peace Corps Who? _____

☐ Other Who? _____

If other, list the insurance carrier _____

If other, was this coverage purchased from the insurance marketplace? ☐ No ☐ Yes

3. Does anyone have access to health insurance from a job? Check "yes" even if the coverage is from someone else's job such as a parent or a spouse.

☐ No ☐ Yes. Complete **Appendix B**.

4. For any children (under the age of 19) who are applying, use the table below to tell us if they are currently receiving health coverage and what services are covered by that health insurance.

Name of insured child	**Covered services** *(Check all that apply)*
	☐ Inpatient/outpatient hospital services ☐ Physicians medical/surgical service ☐ Lab services ☐ X-ray services ☐ None of the above
	☐ Inpatient/outpatient hospital services ☐ Physicians medical/surgical service ☐ Lab services ☐ X-ray services ☐ None of the above
	☐ Inpatient/outpatient hospital services ☐ Physicians medical/surgical service ☐ Lab services ☐ X-ray services ☐ None of the above
	☐ Inpatient/outpatient hospital services ☐ Physicians medical/surgical service ☐ Lab services ☐ X-ray services ☐ None of the above

Tell us about your qualifying life event

If applying for health coverage, complete **Appendix C**. This information will be used to help determine eligibility for Advance Payment of Premium Tax Credit (APTC). You do not need to provide this information if applying for Food or Child Care Assistance only.

Rights and Responsibilities

I understand that (initial each statement below)...

_____ **My signature certifies that the information on this application is true and accurate. 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 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 consent to the gathering and use of income data, including information from tax returns for determining eligibility for help paying for health coverage in future years (up to 5 years). I will receive notice when this occurs, be able to make changes, and may opt out at any time.

_____ 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 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.

_____ 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.

_____ 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.

_____ 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.

_____ If I am determined eligible for Medicaid, the plan I will be enrolled in depends on my individual needs.

_____ If I am determined eligible for Medicaid, I may be responsible for paying part of the cost of my child's health coverage, and I will be notified of my co-pay amount.

_____ My signature or the signature of my representative authorizes State offices to communicate with insurance companies related to my/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 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 a third party is responsible for my child's disease or injury, I give to Medicaid 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 myself/my children.

_____ If I receive Health Coverage Assistance, I am required to report specific mandatory changes that are required for that program outlined in the Approval Notice.

_____ 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.

_____ 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.

_____ 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.

_____ 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.

_____ If I am determined eligible to receive an Advance Payment of Premium Tax Credit (APTC) and use these funds towards the purchase of a Qualified Health Plan (QHP), any discrepancies between my reported income, which was used to determine eligibility, and the amount of the tax credit, will be reconciled with the final income reported on my taxes at the end of the calendar year. The IRS will be responsible for conducting this reconciliation, and any discrepancies may result in an adjustment of the tax credit, including entitlement to additional funds or re-payment of funds overpaid to me.

Before you complete this application:

- If you want someone to be your Authorized Representative, complete **Appendix A.**
- If anyone in your household has access to health insurance from a job, even if the coverage is from someone else's job such as a parent or a spouse, or if you currently have health insurance from a job, you MUST complete **Appendix B**.
- If anyone in your household is applying for health coverage, complete **Appendices C** and **D**.
- If anyone in your household is applying for Child Care, have your provider complete the **Child Care Provider Form**, available online at **livebetteridaho.org**.

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 and understand my reporting requirements.

Printed name of applicant/authorized representative	Signature of applicant/authorized representative	Date
Printed name of applicant/authorized representative	Signature of applicant/authorized representative	Date

Appendix A

IDAHO DEPARTMENT OF HEALTH & WELFARE

Authorized Representative Form

You can name someone as an authorized representative.

You may give a trusted person, such as a friend, partner, or third party caseworker permission to talk about this application with us, see your information, and act for you on all matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative."

If you ever need to change your authorized representative, contact the Department to complete a new Authorized Representative Form.

If you're a legally appointed representative for someone on this application, submit proof with the application.

Tell us who you want to name as your authorized representative

First Name	Middle Name	Last Name	Relationship to application

Organization Name (if third party caseworker)	Organization ID (if applicable)

Address	Apartment or suite number

City	State	Zip Code	County

Phone	Phone type (choose one)	Email
	☐ Home ☐ Work ☐ Cell	

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with the Department.

Printed Name of Applicant	Signature of Applicant	Date

Appendix B

IDAHO DEPARTMENT OF HEALTH & WELFARE

Health Coverage from Jobs

Complete this appendix if someone in the household has access to or is currently covered by health coverage from a job. Attach a copy of this page for each job that offers coverage. **You do not need to complete this appendix if applying for Food or Child Care Assistance only.**

Employee Information

First Name	Middle Name	Last Name	SSN

Address	City	State	Zip code

Phone number	Email address

List everyone who is eligible for coverage from this job: _____

Did you miss your employer's open enrollment period and have to wait to enroll in health coverage until the next open enrollment period?

☐ Yes. If yes, do NOT answer the question below. ☐ No

If you're in a waiting or probationary period, when can you enroll in coverage (MM/DD/YYYY)? _____

Health plan information (must be completed by employer)

1. Does the plan meet minimum value standard?* ☐ Yes ☐ No

2. Does the plan meet minimum essential coverage (MEC)? ** ☐ Yes ☐ No

Please complete this section for the lowest-cost plan that meets the minimum value standard* offered only to the employee (do not include family plans).

3. If the employer has wellness programs, provide the premium amount that the employee would pay if he/she received the maximum discount for any tobacco-cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? **$** _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

Employer Information

Employer name	Phone number	Email address

Name of person completing form	Who may we contact about employee health coverage at this job (if different)?

Signature (must be completed)

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

_____ _____

Signature of Employer Date

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (section 36B(c)(2)(C)(ii) of the Internal Revenue code of 1986.

**An employer-sponsored health plan meets the "minimum essential coverage" if it meets the essential health benefits as defined in 1302(a) of the Affordable Care Act.

Appendix C

IDAHO DEPARTMENT OF HEALTH & WELFARE

Qualifying Life Event

Complete this appendix if anyone in the household is applying for health coverage assistance. This information may be necessary as part of your eligibility determination for Advance Payment of Premium Tax Credit (APTC). You do not need to complete this appendix if applying for Food Assistance only.

Full name of primary tax filer for the household: _____

- If you have more than one tax filer (not counting a spouse filling jointly) in your household, you must complete one appendix for **each** tax household.*
- Make sure to write the full name of the tax filer on each appendix you complete. Only include information about the members of the tax household associated with that tax filer.

Complete the questions below based on any life events within the last 60 days, unless otherwise noted.

1. Did any member of your household recently lose or expect to lose health insurance coverage within the next 60 days?

☐ No ☐ Yes. If yes, when did (or will) the event occur? _____

2. Did any member of your household recently become a citizen or lawful immigrant in the U.S.?

☐ No ☐ Yes. If yes, when did the event occur? _____

3. Did any person move into or leave your household? ☐ No ☐ Yes. If yes, complete the following:

When did the event occur? _____

Why did someone enter or leave your household? ☐ Had a baby ☐ Got married ☐ Had a divorce ☐ Adopted or is fostering a child ☐ Other

4. Did any existing tax filer in your household recently gain a new Tax Dependent?

☐ No ☐ Yes. If yes, when did the event occur? _____

5. Did your household recently move to Idaho?

☐ No ☐ Yes. If yes, when did the event occur? _____

6. Did your household recently move within Idaho?

☐ No ☐ Yes. If yes, when did the event occur? _____

7. Did your household's income recently change? ☐ No ☐ Yes. If yes, complete the following:

When did the event occur? _____

Did the household income increase or decrease? ☐ Increase ☐ Decrease

*Refer to question 16 on pages 2-3 of this application. If you checked "yes" for more than one person, and the additional person(s) is not a spouse filing jointly or a dependent, you may have more than one tax household.

Appendix D

IDAHO DEPARTMENT OF HEALTH & WELFARE

Anticipated Annual Income Worksheet

Complete this worksheet if anyone in your household is applying for health coverage assistance. We will use the information you provide to determine eligibility for APTC. You do not need to complete this appendix if applying for Food Assistance only.

Your Anticipated Annual Income (AAI) is the gross, taxable income you expect to receive for the current (January-December) year.

Complete each income section that applies to your household for the whole year. Project or estimate income for future months based on your current situation and anticipated changes. If you need help determining who to count in your household, see page 1 of this application.

If you already know the total AAI for your household, you may skip to the second page of this worksheet to enter the annual figure as one number.

Earned Income

Income is money earned (wages or salary) from a job or self-employment (including owning your own business, doing odd jobs, baby-sitting, collecting cans, donating plasma, etc.) Use the tables below to enter gross earned income (income before taxes) for all members of your household for each month of the current year. Enter any self-employment income as net (instead of gross) income. Include the name of the source of income, like an employer name, for each entry. Ask for or make a copy of this worksheet if you have more than three household members with earned income.

Name of Person 1: _____

	Jan	Feb	Mar	Apr	May	June
Source 1:	$	$	$	$	$	$
Source 2:	$	$	$	$	$	$
	July	Aug	Sept	Oct	Nov	Dec
Source 1 (cont.)	$	$	$	$	$	$
Source 2 (cont.)	$	$	$	$	$	$

Name of Person 2: _____

	Jan	Feb	Mar	Apr	May	June
Source 1:	$	$	$	$	$	$
Source 2:	$	$	$	$	$	$
	July	Aug	Sept	Oct	Nov	Dec
Source 1 (cont.)	$	$	$	$	$	$
Source 2 (cont.)	$	$	$	$	$	$

Name of Person 3: _____

	Jan	Feb	Mar	Apr	May	June
Source 1:	$	$	$	$	$	$
Source 2:	$	$	$	$	$	$
	July	Aug	Sept	Oct	Nov	Dec
Source 1 (cont.)	$	$	$	$	$	$
Source 2 (cont.)	$	$	$	$	$	$

Continue to the next page/back-side of this worksheet to enter information about unearned income for your household or to enter your AAI as a single number.

Unearned Income

Social Security Income

Use the table below to enter the total Social Security Income for all members of your household for each month of the current year. Do NOT subtract any payments you may make out of your entitlement amount. Include Social Security Disability and Social Security Retirement Income. Do NOT include Social Security survivors or Supplemental Security Income (also known as Title XVI).

	Jan	Feb	Mar	Apr	May	June
Recipient 1 Name:	$	$	$	$	$	$
Recipient 2 Name:	$	$	$	$	$	$
	July	Aug	Sept	Oct	Nov	Dec
Recipient 1 (cont.)	$	$	$	$	$	$
Recipient 2 (cont.)	$	$	$	$	$	$

Other Unearned Income

Use the tables below to enter unearned income such as rental, retirement, unemployment, and tribal gaming payments for all members of your household each month of the current year. Ask for or make a copy of this worksheet if you have more than two household members with other unearned income. DO NOT include tribal income other than tribal gaming payments, or any income that is non-taxable.

Name of Person 1: _____

	Jan	Feb	Mar	Apr	May	June
Source 1:	$	$	$	$	$	$
Source 2:	$	$	$	$	$	$
	July	Aug	Sept	Oct	Nov	Dec
Source 1 (cont.)	$	$	$	$	$	$
Source 2 (cont.)	$	$	$	$	$	$

Name of Person 2: _____

	Jan	Feb	Mar	Apr	May	June
Source 1:	$	$	$	$	$	$
Source 2:	$	$	$	$	$	$
	July	Aug	Sept	Oct	Nov	Dec
Source 1 (cont.)	$	$	$	$	$	$
Source 2 (cont.)	$	$	$	$	$	$

Anticipated Annual Income (AAI) as a single figure

You may choose to provide your AAI as a single figure below. Include all gross taxable income for your tax household for the current year. Do not include income that is non-taxable.

$ _____