Application for Benefits

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

What is this application for?

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

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

See page B for a description of each program.

Who can use this application?

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

Your household includes:

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

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

Where else can I apply?

You can apply faster online at www.healthearizonaplus.gov.

You can also apply in person at any local Department of Economic Security (DES)/Family Assistance Administration (FAA) office.

You can find a list of local FAA offices at www.azdes.gov/faa or call our 24 hour Interactive Voice Response system at 1-855-HEA-PLUS (432-7587).

What information do I need to complete this application?

For everyone in your household, you may need:

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

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

Why do we ask for so much information?

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

What happens next?

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

What if I need help?

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

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

Program Information:

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

= Health Insurance Costs (AHCCCS Medical Assistance, Medicare Savings Program, Tax Credits)

= Nutrition Assistance

= Cash Assistance

= Tuberculosis Control

What is AHCCCS Medical Assistance?

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

AHCCCS Medical Assistance covers the following medical services:

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

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

What is Medicare Savings Program?

Medicare Savings Program may pay:

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

What are Nutrition Assistance benefits?

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

What is Cash Assistance?

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

What is Tuberculosis Control?

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

What if I am not eligible for AHCCCS Medical Assistance?

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

How does AHCCCS Medical Assistance work?

If you are approved for AHCCCS Medical Assistance, you will receive your health care from an AHCCCS health plan unless:

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

How much does AHCCCS Medical Assistance cost?

Premiums:

- Most people do not have to pay a monthly premium for AHCCCS Medical Assistance.
- Some people with income too high to qualify for AHCCCS Medical Assistance with no monthly premium may be able to get it by paying a monthly premium. If you have to pay a premium, the premium amounts are:
  - $10 to $35 for customers on the Freedom to Work program.
  - $10 to $70 for customers on the KidsCare program.

Co-payments:

A co-payment is the amount you pay a health care provider when you receive a medical service. Your co-payment amount will vary depending on which AHCCCS program you are enrolled in and the services you need. For some AHCCCS programs, the provider can deny services if the co-payments are not made. Co-payments for services are:

- $2.30 to $10.00 for prescriptions
- $0 to $30.00 for non-emergency use of an emergency room
- $3.40 to $5.00 for outpatient visits for evaluation and management services including doctor's office visits
- $2.30 to $3.00 for physical, occupational or speech therapy

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

The following people are never asked to pay co-payments:

- Children under age 19
- People determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services.
- Individuals through age 20 eligible to receive services from the Children's Rehabilitative Services (CRS) program
- People who are temporarily residing in nursing homes or residential facilities such as an Assisted Living Home and only when the acute care member's medical condition would otherwise require hospitalization. The exemption from co-payments is limited to 90 days in a contract year
- People who receive hospice care

Co-payments are never charged for the following services for anyone:

- Hospitalizations
- Services paid on a fee-for service basis
- Emergency services
- Pregnancy related health care including tobacco cessation for pregnant women
- Family planning services

Do I need a Social Security number?

Federal law requires you give a Social Security number (SSN) for anyone who wants to get AHCCCS Medical Assistance, help with Medicare costs, Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control (42 U.S.C. § 1320b-7; 42 U.S.C. § 405(c)(2)(C), 7 U.S.C. §§ 2011-2036, and Social Security Act (SSA) of 1935 (Section 1137) as amended by P.L. 98-369).

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

We use your information, including Social Security number, to:

- Verify identity
- Verify citizenship and immigration status
- Verify income and resources
- Prevent duplicate benefits
- Establish and enforce child support
- Computer match with state, local and federal agencies and our other programs to verify information. Information available through the Income and Eligibility Verification System (IEVS) will be requested, used and may be verified through collateral contacts when discrepancies are found. This information may affect eligibility and benefit level.
- Collect money we overpaid you in the form of benefits
- Share with other government agencies and their contractors to assess Nutrition Assistance and/or Cash Assistance program management and compliance
- We may give your information to law enforcement officials for the purpose of arresting persons fleeing to avoid the law

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

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

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

To get the most help, you need to give us information about citizenship and immigration status for each person who is applying for help.

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

Will I Have To Do An Interview?

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

How Long Does It Take To Find If I Am Eligible After You Receive My Application?

For AHCCCS Medical Assistance and/or help with Medicare costs, we will make a decision within 45 days.

- If you are pregnant, we will make a decision within **20** days.
- If you need a disability determination report, we will make a decision within **90** days.

For Nutrition Assistance, we will make a decision within 30 days.

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

For Cash Assistance, we will make a decision within 45 days.

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

How Will I Know If I Am Eligible?

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

How Can I Get My Benefits When My Application Is Approved?

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

If you are approved for Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control:

- You will get an Electronic Benefit Transfer (EBT) card. This card works like a debit card. You will get a pamphlet with instructions on how to use your card.
- Your benefits are put on your EBT card after approval. It can take up to 48 hours for the benefits to be available. You can call the Customer Service number on the back of the card to check the balance of your benefits.
- If you are eligible for Emergency Nutrition Assistance, you may get an EBT card at your local DES/FAA office.
- If you qualify for Nutrition Assistance benefits, you can use the EBT card to buy approved food items. If you qualify for Cash Assistance benefits, you can use your EBT card to get cash or buy non-food items at any store where EBT cards are accepted. You may also withdraw your Cash Assistance benefits at ATMs, but there may be a fee.
- It is illegal to use your Cash Assistance benefits to make purchases or withdraw cash at Point of Sale machines and ATMs located inside liquor stores, casinos, horse or dog racing facilities, adult entertainment establishments, or Medical Marijuana Dispensaries (A.R.S. §46-297).
- You are not allowed to use your EBT card to purchase lottery tickets. You are not allowed to pay for food purchased on credit with SNAP benefits.
- If you request more than two EBT replacement cards in a 12 month period, you may be required to complete a contact with DES to answer questions to determine whether fraud is being committed.
- If more than 10% of the Cash Assistance benefits you receive in a six month period are used out-of-state during that six month period, you may be required to complete a contact with DES and answer questions to determine whether fraud is being committed.
- If you lose your EBT card you may have to pay for a new one. This amount will be taken out of your benefits.

What is expected of me?

For all programs:

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

Program-specific expectations:

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

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

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

What are my rights?

You have the RIGHT to:

- Courteous and professional treatment.
- Be treated fairly and equally regardless of race, color, religion, national origin, sex, age, disability, or political beliefs.
- Apply for benefits and be given a letter that tells you if you are eligible or not, and/or get a letter before your benefits are reduced or stopped.
- Review DES and AHCCCS policy manuals that show the rules and regulations of AHCCCS Medical Assistance, Medicare Savings Program, Nutrition Assistance, Cash Assistance, and Tuberculosis Control if you want to know the reason for our decision.
- Talk about your case with a worker or supervisor.
- Have all information you give regarding your eligibility kept private according to state and federal law.
- Ask for a fair hearing if you disagree with your application being denied, your benefits ended, or are being reduced, or if a decision is not made on your application within the allowable number of days and the delay is due to DES or AHCCCS.
- Look at your file before a fair hearing.
- Bring an attorney or any other person to a fair hearing.
- File for Nutrition Assistance benefits separately or at the same time you apply for other programs listed on the application. All Nutrition Assistance applications, regardless of whether they are joint applications or separate applications, must be processed for Nutrition Assistance purposes in accordance with procedural, timeliness, notice and fair hearing requirements. No household shall have its Nutrition Assistance benefits denied solely on the basis that another program applied for has been denied. A separate determination for Nutrition Assistance must be completed. When another program that is applied for is denied a new application for Nutrition Assistance shall not be required. Eligibility shall be determined based on Nutrition Assistance processing time frames from the date the joint application was initially accepted by the State agency.

To file a discrimination complaint, contact:

U.S. Department of Health and Human Services
Director, Office for Civil Rights
Room 515-F
200 Independence Avenue, S.W.
Washington, DC 20201

1-202-619-0403 (voice)
1-800-537-7697 (TTY)

Form:
http://www.ascr.usda.gov/complaint_filing_cust.html
U.S. Department of Agriculture
Director, Office of Adjudication
1400 Independence Avenue, SW
Washington, DC 20250-9410

Fax: 1- 202-690-7442
Email: program.intake@usda.gov

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

What are the rules and Penalties?

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

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

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

- For Cash Assistance, it is Mandatory for you to cooperate with a fraud investigation. Failure to cooperate may result in case closure and the termination of benefits within ten (10) days from the agency's notice of termination.
- Do not make false statements or hide information. If you are not truthful, you may have to pay back DES for benefits you receive and you may be taken to court.
- Do not do anything dishonest to get benefits that you are not supposed to get.
- Do not buy, sell, trade, exchange or otherwise transfer any Nutrition Assistance benefits or EBT card.
- Do not buy containers with deposits for the purpose of discarding the product and returning the containers to get cash refund deposits.
- Do not sell products bought with Nutrition Assistance benefits to exchange them for cash or items other than eligible food.
- Do not buy products originally bought with Nutrition Assistance benefits to exchange those products for cash or items other than eligible food.
- Do not steal Nutrition Assistance or Cash Assistance benefits.
- Do not use your Nutrition Assistance benefits to buy non-food items such as alcohol and tobacco.
- Do not alter an EBT card.
- Do not use someone else's EBT card unless you are an authorized user approved by DES.

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

- Is a fleeing felon or probation/parole violator.
- **Has been convicted or found guilty in a court of law of using or getting Nutrition Assistance benefits in a transaction involving the sale of firearms, ammunition or explosives. This person can never get Nutrition Assistance benefits again.**
- **Has been found guilty of using or getting Nutrition Assistance benefits in a transaction involving the sale of a controlled substance. This person is not eligible to get Nutrition Assistance benefits for 2 years for the first violation and permanently for the second violation.**
- Cash Assistance benefits will be sanctioned 50% for the first occurrence and 100% for the second occurrence if any adult has voluntarily quit a job without good cause or has sold, possessed or used a controlled substance in violation of ARS Title 13.
- **Knowingly breaks the rules to get Cash Assistance benefits. We will disqualify you from getting Cash Assistance benefits for 6 months for the 1st offense, 12 months for the 2nd offense and permanently for all other offenses.**
- **Knowingly breaks the rules to get Nutrition Assistance benefits. We will disqualify you from getting Nutrition Assistance benefits for 12 months for the 1st offense, 24 months for the 2nd offense and permanently for the third offense. In addition you can be fined up to $250,000, imprisoned up to 20 years or both. You and/or your household members may be subject to further prosecution under Federal laws and an additional disqualification, of up to 18 months, may be ordered by a court.**
- Has committed and was convicted of a federal or state felony on or after August 23, 1996 for the possession, use or distribution of a controlled substance.

What are the rules and Penalties?

- **Has been found by a court of law to give false identification or residence information in order to get benefits in more than one case. This person is not eligible to get benefits for 10 years.**
- **State agencies must use the Systematic Alien Verification and eligibility (SAVE) System. A court of law finds you guilty of having trafficked benefits for an aggregate amount of $500 or more, you will be permanently ineligible to participate in the Program upon the first occasion of such violation.**
- **The alien status of persons requesting benefits may be subject to verification by USCIS through the submission of information from the application to USCIS, and that the submitted information received from USCIS may affect the HH's eligibility and level of benefits.**
- For Cash Assistance if you refuse to sign and comply with the Personal Responsibility Agreement (PRA). We give you the PRA during the interview process.
- Is an adult recipient (18 years or older) of Cash Assistance when any of the following apply:
  - The recipient does not return the completed Illegal Drug Use Statement. We send the Illegal Drug Use Statement by U.S. Mail after Cash Assistance has been approved.
  - The recipient fails to take a required drug test.
  - The recipient fails the drug test.
- For Nutrition Assistance the following applies:
  A person who is convicted of a felony offense which has as an element of the offense "the use or possession of a controlled substance", may be eligible for Nutrition Assistance if the person agrees to random drug testing and meets at least one of the following:
  - Is currently accepted for treatment in a substance abuse treatment program but is on a waiting list. The person remains enrolled in the treatment program and enters the treatment program at the first available opportunity.
  - Is currently accepted for treatment, and is participating in a substance abuse treatment program.
  - Has successfully completed a substance abuse treatment program after the offense in question.
  - Is determined by a licensed medical provider to not need substance abuse treatment.
  - If on probation for a felony drug conviction, is in compliance with the terms of probation.

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

Cash Assistance benefits are limited to 12 months unless the child is a ward of the State, is in the legal custody of a tribal court or a tribal child welfare agency located in Arizona, or there is a hardship. An additional 12 months of cash assistance may be received when no adult has been sanctioned for noncompliance with a Jobs Program requirement and all children in the household who are required to attend school have a school attendance record of at least 90%, unless the child was excused.

How to choose a health plan

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

- All AHCCCS health plans provide the same covered medical services.
- Before choosing a health plan, check with your doctor, pharmacy or hospital to see if they work with the plan that you want. If you want more information about the doctors, specialists or hospitals that work with a health plan that serves your county, call the number listed below for the health plan or visit the plan's website.
- American Indian members may choose from American Indian Health Program or an AHCCCS health plan.
- If you do not choose a health plan, one will be assigned to you.
- If you have been enrolled in an AHCCCS health plan within the past 90 days, you may be enrolled with your previous health plan.
- If you need help selecting a health plan you may:
  - visit www.azahcccs.gov/choice; or
  - speak to a Beneficiary Support Specialist by calling (602) 417-7100.

Health Plan	Counties Served
United Health Care Community Plan Phone Number: 1-800-348-4058 Website: www.uhccommunityplan.com	• Apache • Cochise • Coconino • Graham • Greenlee • La Paz • Maricopa • Mohave • Navajo • Pima • Santa Cruz • Yavapai • Yuma
Health Choice Arizona Phone Number: 1-800-322-8670 Website: www.healthchoiceaz.com	• Apache • Coconino • Gila • Maricopa • Pima • Pinal
Health Net Access Phone Number: 888-788-4408 Website: www.healthnetaccess.com	• Maricopa
American Indian Health Program Phone Numbers: • All counties except Maricopa County: 1-800-654-8713 • Maricopa County: 602-417-7100 Website:www.azahcccs.gov/AmericanIndians/AIHP/	All Arizona Counties
University Family Care Phone Number: 1-800-582-8686 Website: www.ufcaz.com	• Cochise • Gila • Graham • Pima • Pinal • Santa Cruz • Yavapai • Yuma
Care First Arizona Phone Number: 1-866-560-4042 care1staz.com	• Maricopa • Pima
Mercy Care Plan Phone Number: 1-800-624-3879 Website: www.mercycareplan.com	• Maricopa • Pima

If the ZIP Code is:	A health plan must be selected from the following county:
85220, 85242, 85342, 85358 or 85390	Maricopa
85292	Gila
85643	Cochise
85645	Santa Cruz
85943	Navajo
86336, 86340 or 86434	Yavapai
86351	Coconino

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

Arizona Department of Economic Security Family Assistance Administration (DES/FAA)
Arizona Health Care Cost Containment System (AHCCCS)

For Agency Use Only
Date:
Group Number:

Application for Benefits

Contact Information:

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

Name (First, Middle, Last): _____

Home Address: _____ Apt. #: ____ City: _____ State: ____ Zip Code: _____

Mailing Address (if different): _____ Apt. #: ____ City: _____ State: ____ Zip Code: _____

Do you live in a shelter? ❑ Yes ❑ No If 'Yes,' what kind of shelter? _____

Phone Number: _____ This number is: ❑ Home ❑ Cell ❑ Work ❑ Message ❑ Other: _____

Other Phone Number: _____ This number is: ❑ Home ❑ Cell ❑ Work ❑ Message ❑ Other: _____

What is the preferred SPOKEN household language? ❑ English ❑ Spanish ❑ Other: _____

What is the preferred WRITTEN household language? ❑ English ❑ Spanish ❑ Other: _____

I would like to get information about this application by:

Email: ❑ Yes ❑ No Email address: _____

Text: ❑ Yes ❑ No Number to text (standard text rates apply): _____

If 'Yes' is not marked for Email or Text, all information for this application will be sent via U.S. Mail to the mailing address provided.

I need the following help with this application (check all that apply):

❑ Reading/understanding this application ❑ Filling out this application ❑ Other: _____

❑ American Sign Language ❑ Braille ❑ Language Interpreter Language: _____

I need the following accommodations for this application (check all that apply):

❑ Hearing ❑ Speaking ❑ Seeing ❑ Writing ❑ Walking ❑ Other: _____

Authorized Representative:

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

Representative's Name: _____ Is representative your legal guardian? ❑ Yes ❑ No

Representative's Mailing Address: _____ City: _____ State: ____ Zip Code: _____

Representative's Phone Number: _____ This number is: ❑ Home ❑ Cell ❑ Work ❑ Message ❑ Other: _____

Representative's Other Phone Number: _____ This number is: ❑ Home ❑ Cell ❑ Work ❑ Message ❑ Other: _____

What is the representative's preferred SPOKEN language? ❑English ❑ Spanish ❑ Other: _____

What is the representative's preferred WRITTEN language? ❑ English ❑ Spanish ❑ Other: _____

My representative would like to get information about this application by:

Email: ❑ Yes ❑ No Email address: _____

Text: ❑ Yes ❑ No Number to text (standard text rates apply): _____

If 'Yes' is not marked for Email or Text, all information for this application will be sent via U.S. Mail to the mailing address provided.

By signing below, I, the customer, give permission for the person listed above as my representative to act on my behalf in the process of qualifying me for help with insurance costs, help with Medicare costs, Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control. I, therefore:

- Give permission for my representative to complete and sign my application.
- Give permission for my representative to provide any documents requested, including personal information.
- Give permission to my representative to sign on my behalf to permit other people, businesses, or agencies to give personal information about me to DES and/or AHCCCS, including protected health information needed to determine if I am disabled.
- Agree to give information about my personal circumstances to my representative.
- Agree to allow my representative to assign all my rights to medical reimbursement claims to AHCCCS on my behalf.

By signing below, I, the representative, agree to act on the customer's behalf. I also agree to:

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

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

Signature of Applicant: _____
Date: _____

Signature of Representative: _____
Date: _____

Release of Information to Hospitals/Hospital Agents/Organizations/Agencies:

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

Name of Hospital/Hospital's Agent/Organization/Agency: _____
Contact Person: _____ Phone Number: _____
Mailing Address: _____ City: _____ State: _____ Zip Code: _____

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

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

Signature of Applicant: _____ Date: _____

Access to Electronic Benefit Transfer (EBT) Account:

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

EBT Representative's Name: _____ EBT Representative's Date of Birth: _____
EBT Representative's Mailing Address: _____ City: _____ State: ___ Zip Code: _____
EBT Representative's Phone Number: _____ ❑ Home ❑ Cell ❑ Work ❑ Message ❑ Other: _____
EBT Representative's Other Phone Number: _____ ❑ Home ❑ Cell ❑ Work ❑ Message ❑ Other: _____

Signature of Applicant: _____ Date: _____

Someone Who Knows You Well:

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

Name of someone who knows you well: _____ Relationship to you: _____
Mailing Address: _____ City: _____ State: _____ Zip Code: _____
Daytime Phone Number: _____

Name of Landlord: _____ Are you related to the Landlord? ❑ Yes ❑ No If yes, how? _____
Mailing Address: _____ City: _____ State: _____ Zip Code: _____
Daytime Phone Number: _____

Emergency Nutrition Assistance:

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

What is the total amount of income, before deductions, you expect to get this month?	$	
What is the total amount of cash on hand and money in your checking and savings account?	$	
What are the total monthly housing costs (rent or mortgage, taxes, homeowner/rental insurance, etc.)?	$	
What are the total monthly utility costs (gas, electric, water, etc.)?	$	
What is your monthly telephone cost?	$	
Does anyone receive Tribal Food Distribution?	❑ Yes	❑ No
Is anyone a migrant or seasonal farm worker?	❑ Yes	❑ No

Personal Information:

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

Name Last, First M.I. (Include Maiden, Alias, Suffix and other names)	Applying for?					Relationship to Main Contact (1.) (spouse, child/step child, parent, grandchild, niece/ nephew, legal guardian, other (please describe)	Marital Status (legally married, common law marriage, separated, divorced, widowed, never married, unmarried partner)	Date of Birth	Social Security Number (If not applying, optional)	Sex (Male or Female)
	Help with Health Insurance	Help with Medicare costs	Nutrition Assistance	Cash Assistance	Tuberculosis Control					
1.						Main Contact				
2.										
3.										
4.										
5.										
6.										

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

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

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

❑ Lawful Permanent Resident (LPR)
❑ Lawful Temporary Resident
❑ Non-Immigrant Status
❑ Asylee
❑ Refugee
❑ Conditional Entrant granted before 1980
❑ Other
❑ I do not want to provide
❑ Battered Spouse, Child or Parent
❑ Cuban-Haitian Entrant
❑ Deferred Action Status
❑ Deferred Enforced Departure
❑ Legalization under LIFE Act
❑ Legalization under IRCA Applicant
❑ Order of Supervision
❑ Paroled into United States
❑ Removal/Suspension of Deportation
❑ Registry Applicants
❑ Special Immigrant Juvenile Status Applicant
❑ Temporary Protection Status (TPS)
❑ Victim of Trafficking
❑ Withholding of Deportation
❑ Applicant for Asylum, LPR, TPS, or Withholding Deportation

What immigration document does MAIN CONTACT have?
❑ Permanent Resident card ❑ I-94 ❑ Visa
❑ Foreign Passport ❑ None ❑ Other: _____

Immigration Document Number: _____
Has MAIN CONTACT lived in the U.S. since August 22, 1996? ❑ Yes ❑

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

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

❑ Lawful Permanent Resident (LPR)
❑ Lawful Temporary Resident
❑ Non-Immigrant Status
❑ Asylee
❑ Refugee
❑ Conditional Entrant Granted before 1980
❑ Other
❑ I do not want to provide
❑ Battered Spouse, Child and Parent
❑ Cuban-Haitian Entrant
❑ Deferred Action Status
❑ Deferred Enforced Departure
❑ Legalization under LIFE Act
❑ Legalization under IRCA Applicant
❑ Order of Supervision
❑ Paroled into United States
❑ Removal/Suspension of Deportation
❑ Registry Applicants
❑ Special Immigrant Juvenile Status Applicant
❑ Temporary Protection Status (TPS)
❑ Victim of Trafficking
❑ Withholding of Deportation
❑ Applicant for Asylum, LPR, TPS, or Withholding Deportation

What immigration document does PERSON 2 have?
❑ Permanent Resident card ❑ I-94 ❑ Visa
❑ Foreign Passport ❑ None ❑ Other: _____

Immigration Document Number: _____
Has PERSON 2 lived in the U.S. since August 22, 1996? ❑ Yes ❑ No

Is PERSON 3 a U.S. citizen or U.S. national? See page D for more information. ❑ Yes ❑ No ❑ Choose not to answer

If PERSON 3 is NOT a U.S. citizen, what is his/her immigration status?

❑ Lawful Permanent Resident (LPR)
❑ Lawful Temporary Resident
❑ Non-Immigrant Status
❑ Asylee
❑ Refugee
❑ Conditional Entrant granted before 1980
❑ Other
❑ I do not want to provide
❑ Battered Spouse, Child or Parent
❑ Cuban-Haitian Entrant
❑ Deferred Action Status
❑ Deferred Enforced Departure
❑ Legalization under LIFE Act
❑ Legalization under IRCA Applicant
❑ Order of Supervision
❑ Paroled into United States
❑ Removal/Suspension of Deportation
❑ Registry Applicants
❑ Special Immigrant Juvenile Status Applicant
❑ Temporary Protection Status (TPS)
❑ Victim of Trafficking
❑ Withholding of Deportation
❑ Applicant for Asylum, LPR, TPS, or Withholding Deportation

What immigration document does PERSON 3 have?
❑ Permanent Resident card ❑ I-94 ❑ Visa
❑ Foreign Passport ❑ None ❑ Other: _____

Immigration Document Number: _____
Has PERSON 3 lived in the U.S. since August 22, 1996? ❑ Yes ❑ No

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

If PERSON 4 is NOT a U.S. citizen, what is his/her immigration status?

❑ Lawful Permanent Resident (LPR)
❑ Lawful Temporary Resident
❑ Non-Immigrant Status
❑ Asylee
❑ Refugee
❑ Conditional Entrant granted before 1980
❑ Other
❑ I do not want to provide
❑ Battered Spouse, Child or Parent
❑ Cuban-Haitian Entrant
❑ Deferred Action Status
❑ Deferred Enforced Departure
❑ Legalization under LIFE Act
❑ Legalization under IRCA Applicant
❑ Order of Supervision
❑ Paroled into United States
❑ Removal/Suspension of Deportation
❑ Registry Applicants
❑ Special Immigrant Juvenile Status Applicant
❑ Temporary Protection Status (TPS)
❑ Victim of Trafficking
❑ Withholding of Deportation
❑ Applicant for Asylum, LPR, TPS, or Withholding Deportation

What immigration document does PERSON 4 have?
❑ Permanent Resident card ❑ I-94 ❑ Visa
❑ Foreign Passport ❑ None ❑ Other: _____

Immigration Document Number: _____
Has PERSON 4 lived in the U.S. since August 22, 1996? ❑ Yes ❑

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

If PERSON 5 is NOT a U.S. citizen, what is his/her immigration status?

❑ Lawful Permanent Resident (LPR)
❑ Lawful Temporary Resident
❑ Non-Immigrant Status
❑ Asylee
❑ Refugee
❑ Conditional Entrant granted before 1980
❑ Other
❑ I do not want to provide
❑ Battered Spouse, Child or Parent
❑ Cuban-Haitian Entrant
❑ Deferred Action Status
❑ Deferred Enforced Departure
❑ Legalization under LIFE Act
❑ Legalization under IRCA Applicant
❑ Order of Supervision
❑ Paroled into United States
❑ Removal/Suspension of Deportation
❑ Registry Applicants
❑ Special Immigrant Juvenile Status Applicant
❑ Temporary Protection Status (TPS)
❑ Victim of Trafficking
❑ Withholding of Deportation
❑ Applicant for Asylum, LPR, TPS, or Withholding Deportation

What immigration document does PERSON 5 have?
❑ Permanent Resident card ❑ I-94 ❑ Visa
❑ Foreign Passport ❑ None ❑ Other: _____

Immigration Document Number: _____
Has PERSON 5 lived in the U.S. since August 22, 1996? ❑ Yes ❑ No

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

If PERSON 6 is NOT a U.S. citizen, what is his/her immigration status?

❑ Lawful Permanent Resident (LPR)
❑ Lawful Temporary Resident
❑ Non-Immigrant Status
❑ Asylee
❑ Refugee
❑ Conditional Entrant granted before 1980
❑ Other
❑ I do not want to provide
❑ Battered Spouse, Child or Parent
❑ Cuban-Haitian Entrant
❑ Deferred Action Status
❑ Deferred Enforced Departure
❑ Legalization under LIFE Act
❑ Legalization under IRCA Applicant
❑ Order of Supervision
❑ Paroled into United States
❑ Removal/Suspension of Deportation
❑ Registry Applicants
❑ Special Immigrant Juvenile Status Applicant
❑ Temporary Protection Status (TPS)
❑ Victim of Trafficking
❑ Withholding of Deportation
❑ Applicant for Asylum, LPR, TPS, or Withholding Deportation

What immigration document does PERSON 6 have?
❑ Permanent Resident card ❑ I-94 ❑ Visa
❑ Foreign Passport ❑ None ❑ Other: _____

Immigration Document Number: _____
Has PERSON 6 lived in the U.S. since August 22, 1996? ❑ Yes ❑ No

Federal Income Tax Filing: Tell us NEXT YEAR'S tax filing information for everyone applying

Main Contact	Plan to file Federal income tax return? ❑ Yes ❑ No	Filing Status: ❑ Head of Household ❑ Qualifying Widow(er) ❑ Single ❑ Married-Filing Separate Return ❑ Married-Filing Joint Return - spouse's name:
	Will claim dependents on own tax return? ❑ Yes ❑ No If yes, list dependents' names:	Claimed as dependent on someone else's tax return? ❑ Yes ❑ No If yes, name of tax filer claiming this person:
Person 2	Plan to file Federal income tax return? ❑ Yes ❑ No	Filing Status: ❑ Head of Household ❑ Qualifying Widow(er) ❑ Single ❑ Married-Filing Separate Return ❑ Married-Filing Joint Return - spouse's name:
	Will claim dependents on own tax return? ❑ Yes ❑ No If yes, list dependents' names:	Claimed as dependent on someone else's tax return? ❑ Yes ❑ No If yes, name of tax filer claiming this person:
Person 3	Plan to file Federal income tax return? ❑ Yes ❑ No	Filing Status: ❑ Head of Household ❑ Qualifying Widow(er) ❑ Single ❑ Married-Filing Separate Return ❑ Married-Filing Joint Return - spouse's name:
	Will claim dependents on own tax return? ❑ Yes ❑ No If yes, list dependents' names:	Claimed as dependent on someone else's tax return? ❑ Yes ❑ No If yes, name of tax filer claiming this person:
Person 4	Plan to file Federal income tax return? ❑ Yes ❑ No	Filing Status: ❑ Head of Household ❑ Qualifying Widow(er) ❑ Single ❑ Married-Filing Separate Return ❑ Married-Filing Joint Return - spouse's name:
	Will claim dependents on own tax return? ❑ Yes ❑ No If yes, list dependents' names:	Claimed as dependent on someone else's tax return? ❑ Yes ❑ No If yes, name of tax filer claiming this person:
Person 5	Plan to file Federal income tax return? ❑ Yes ❑ No	Filing Status: ❑ Head of Household ❑ Qualifying Widow(er) ❑ Single ❑ Married-Filing Separate Return ❑ Married-Filing Joint Return - spouse's name:
	Will claim dependents on own tax return? ❑ Yes ❑ No If yes, list dependents' names:	Claimed as dependent on someone else's tax return? ❑ Yes ❑ No If yes, name of tax filer claiming this person:
Person 6	Plan to file Federal income tax return? ❑ Yes ❑ No	Filing Status: ❑ Head of Household ❑ Qualifying Widow(er) ❑ Single ❑ Married-Filing Separate Return ❑ Married-Filing Joint Return - spouse's name:
	Will claim dependents on own tax return? ❑ Yes ❑ No If yes, list dependents' names:	Claimed as dependent on someone else's tax return? ❑ Yes ❑ No If yes, name of tax filer claiming this person:

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

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

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

Name (First & Last):	Age:	Relationship to MAIN CONTACT:	Does this person pay expenses?	What expenses?
			❑ Yes ❑ No	
			❑ Yes ❑ No	
			❑ Yes ❑ No	
			❑ Yes ❑ No	

Deceased Applicant:

	Who?	Date Deceased
Is anyone you are applying for Deceased? ❑ Yes ❑ No		

Prior Medical Expenses:

		Who?	Month(s)?
Does anyone applying for benefits also need help with medical bills in any of the last three months?	❑ Yes ❑ No		
Does anyone in this application have Medicare and want help paying their Medicare Part B premium for any of the last three months?	❑ Yes ❑ No		

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

Name (First and Last)	Date Left	Expected Return Date	Temporary Address	Why are they out of the home?

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

Is each person applying for benefits a resident of Arizona?	❑ Yes ❑ No	If No, who is not? _____
Did any of the persons applying for benefits move to Arizona within the last four months?	❑ Yes ❑ No	If Yes, who? _____ Date moved: _____

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

Is anyone applying for benefits currently in jail, prison or detention center?	❑ Yes ❑ No	If Yes, who? _____ Is this person currently serving a sentence based on being convicted of a crime? ❑ Yes ❑ No Expected release date: _____
Has anyone applying for benefits been released from a jail, prison or detention center within the last four months?	❑ Yes ❑ No	If Yes, who? _____ Release date: _____

Race/Ethnicity: Select one or more answers for each person applying for benefits is voluntary and will not effect eligibility or benefit level. This information is to assure that program benefits are distributed without regard to race, color, or national origin.

Race														If Hispanic/Latino, check ethnicity:					
Person	American Indian or Alaskan Native	Asian Indian	Black or African American	Chinese	Filipino	Guamanian or Chamorro	Japanese	Korean	Native Hawaiian	Other Asian	Other Pacific Islander	Samoan	Vietnamese	White	Mexican	Mexican American	Chicano/a	Puerto Rican	Cuban	Other
Main Contact																				
Person 2																				
Person 3																				
Person 4																				
Person 5																				
Person 6																				

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

Person	Enrolled in Federally Recognized Tribe	Name of Tribe	Received services from • Indian Health Service; • a tribal health program; • urban health program; or • through a referral from one of these programs?	If no, is the person eligible to receive services?
	❑ Yes ❑ No		❑ Yes ❑ No	
	❑ Yes ❑ No		❑ Yes ❑ No	
	❑ Yes ❑ No		❑ Yes ❑ No	
	❑ Yes ❑ No		❑ Yes ❑ No	
	❑ Yes ❑ No		❑ Yes ❑ No	
	❑ Yes ❑ No		❑ Yes ❑ No	

Person	Living on a Reservation?	Name of Reservation	Tribal Census Number
	❑ Yes ❑ No		
	❑ Yes ❑ No		
	❑ Yes ❑ No		
	❑ Yes ❑ No		
	❑ Yes ❑ No		
	❑ Yes ❑ No		

Help with Health Insurance Costs, Help with Medicare Costs, and Cash Assistance Questions:

Complete this section for anyone who is applying for help with insurance costs and/or help with Medicare costs, and/or Cash Assistance.

		Who?	Number of Babies Due	Expected Due Date
Is anyone you are applying for pregnant?	❑ Yes ❑ No			

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

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

Has anyone ever received Supplemental Security Income (SSI)?	❑ Yes ❑ No	Who? ________________	
Does anyone have Medicare Coverage?	❑ Yes ❑ No	Who? ____________ ____________	Medicare Claim or Railroad Retirement Number ____________ ❑ Part A – Hospital Insurance ❑ Part B – Medical Insurance ❑ Part D – Prescription Drug Plan
		Who? ____________ ____________	Medicare Claim or Railroad Retirement Number ____________ ❑ Part A – Hospital Insurance ❑ Part B – Medical Insurance ❑ Part D – Prescription Drug Plan

Foster Care and Adult with Child:

Answer the following questions for anyone who is applying for benefits.

Was anyone in Arizona Foster Care on his/her 18th birthday?	❑ Yes ❑ No	Who? ____________________
Was anyone in Arizona Tribal Foster Care on his/her 18th birthday?	❑ Yes ❑ No	Who? ____________________ What Tribe? ____________________
Does any adult live with at least one child under age 19 and is the main caretaker of the child?	❑ Yes ❑ No	Who? ____________________

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

Has anyone you are applying for, their spouse or deceased spouse, worked for: • A government agency • An employer with a pension plan?	❑ Yes ❑ No	If Yes, who? _____ Employer name: _____ Dates of employment: _____
Is anyone you are applying for: • A person who served in the U.S military, • The spouse of a person who served in the U.S. military, • The widow or widower of a person who served in the U.S. military, or • The child of a person who served in the U.S. military?	❑ Yes ❑ No	If Yes, provide the following information: Veteran's Name:_____ Veteran's Social Security Number: _____ Service Serial Number:_____ Branch of service:_____ Veteran's Date of Birth:_____ VA Claim Number:_____ Dates of service: _____

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

Do you or anyone in your household pay for the care of a child or disabled adult in order to work, look for work, attend training school?	❑ Yes ❑ No	If Yes, amount: $ _____
Do you or anyone in your household have transportation costs to travel to/from the person or agency that provides after school care or adult daycare?	❑ Yes ❑ No	If Yes, amount: $ _____
Do you or anyone in your household pay court-ordered child support?	❑ Yes ❑ No	If Yes, who pays? _____ Amount paid: $ _____ How often paid? _____

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

Does ANYONE work? ❑ Yes ❑ No If Yes, give employment information below:

Who	Employer's Name and Phone Number:	How often paid? Weekly, Biweekly, Semi Monthly, Monthly	Gross Earnings Per Pay check and date (before deductions):	How many hours worked per week?

Did anyone leave a job in the last thirty (30) days?	❑ Yes ❑ No	If Yes, who?_____
Is ANYONE self-employed?	❑ Yes ❑ No	If Yes, who?_____ Type of work: _____ Annual gross income (before business expenses): $_____ Annual business expenses: $ _____
Has business been in existence for 12 months?	❑ Yes ❑ No	If No, date business started: _____
Is more than one person self-employed?	❑ Yes ❑ No	If Yes, who?_____ Type of work: _____ Annual gross income (before business expenses): $_____ Annual business expenses: $ _____
Has business been in existence for 12 months?	❑ Yes ❑ No	If No, date business started: _____

Other Income: Tell us about other income everyone receives. You may need to provide proof of income.

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

Check here if no other income ❑

Expected Income Changes:

In the next twelve (12) months, does anyone in the household expect income changes because of seasonal work or contract employment? Please tell us only about the changes that happen regularly.	❑ Yes ❑ No If Yes, who? _____ How many sources are expected to change? _____ Name of sources _____ Amount expected to make in the next 12 months $_____
Does anyone in the household expect changes in income for any other reason in the next twelve (12) months?	❑ Yes ❑ No If Yes, who?_____ Please explain:

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

Expense	Who has the expense?	Amount	How Often?
Deductions from pay for expenses like retirement and insurance taken out before taxes			
Student Loan Interest			
Spousal Maintenance (Alimony)			
Other (Type) _____			

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

Is any adult you are applying for not able to work because of a medical or mental condition that has lasted or may last 12 months, or might result in death?	❑ Yes ❑ No	If Yes, who?_____ Date of last day worked?_____ Expected return date:_____
Does any child you are applying for have a physical or mental condition that is disabling and has lasted or may last 12 months, or result in death?	❑ Yes ❑ No	If Yes, who? _____ When did the condition begin? _____
Is anyone you are applying for under age 65, have a disability expected to last at least 12 months and is working?	❑ Yes ❑ No	If Yes, who? _____
Does anyone you are applying for need help with activities of daily living (bathing, dressing, etc.) through personal assistance, services, nursing home, or other medical facility?	❑ Yes ❑ No	If Yes, who? _____
Does anyone you are applying for have a legal guardian?	❑ Yes No	If Yes, who? _____ Name of legal guardian:_____

Nutrition Assistance and Cash Assistance: Answer these questions for anyone who is applying for Nutrition Assistance and/or Cash Assistance.

Is anyone you are applying for a migrant or seasonal farm worker?	❑ Yes ❑ No	If Yes, farm worker type:_____
Is this person under contract/agreement to begin employment within 30 days?	❑ Yes ❑ No	
Is this person working a minimum of 30 hours a week?	❑ Yes ❑ No	If Yes, who? _____
Are you or anyone you are applying for on strike?	❑ Yes ❑ No	If Yes, who?_____
Are you or anyone you are applying for a boarder?	❑ Yes ❑ No	If Yes, who?_____
Did anyone get Nutrition Assistance benefits from any other state?	❑ Yes ❑ No	If Yes, who received?_____ When?_____ State: _____

Nutrition Assistance and Cash Assistance Questions: Answer these questions if the MAIN CONTACT is applying for Nutrition Assistance and/or Cash Assistance. Everyone may still be able to get benefits if he/she has a felony drug conviction. See page G & H for more information.

Has anyone you are applying for been determined to be blind or have a disability by: • the Social Security Administration (SSA), or • the Veterans Administration (VA)?	❑ Yes ❑ No	If Yes, who? _____
Has anyone you are applying for had a felony conviction for possession, use, or distribution of a controlled substance on or after August 23, 1996?	❑ Yes ❑ No	City/state of conviction: _____ Date of conviction: _____ Type of conviction:_____
If you have a felony drug conviction and would like to get Nutrition Assistance and/or Cash Assistance, do you agree to random drug testing?	❑ Yes ❑ No	
Is anyone you are applying for: • Running from the law on any felony charges, or • In violation of probation or parole?	❑ Yes ❑ No	If Yes, who? _____
Has anyone been found to have committed a Nutrition Assistance and/or Cash Assistance Intentional Program Violation in Arizona or any other state?	❑ Yes ❑ No	If Yes, who? _____ What state?_____

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

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

Is anyone on this application attending school?	❑ Yes ❑ No	If Yes, complete grid below:

Who	Name of School	Address	Full/Part Time	Grade Level	Start Date	Graduation date

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

Are you living in HUD housing?	❑ Yes ❑ No	Amount $_____
What are your monthly housing costs for?	Rent $_____ , Mortgage $_____ , Taxes $_____ Homeowner/rental insurance $_____, Other $_____	
What are the total monthly utility costs for?	Gas $_____, Electric $_____, Water $_____, Other $_____	
Are the persons you are applying for living in government-assisted housing?	❑ Yes ❑ No	
Are the persons you are applying for homeless?	❑ Yes ❑ No	

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

Has anyone on the application received Nutrition Assistance from another state?	❑ Yes ❑ No	If Yes, who? _____ What type of benefits? _____ When did benefits stop? _____ Name of state/country? _____
Has anyone on the application received Cash Assistance benefits from another state?	❑ Yes ❑ No	If Yes, who? _____ When did the benefits stop? _____ Name of state/country? _____
Is anyone on the application living in an assisted living facility or group home?	❑ Yes ❑ No	If Yes, who? _____
Is anyone disabled or 60 or older?	❑ Yes ❑ No	If Yes, who? _____
Does he/she have any paid or unpaid medical expenses, even if he/she has medical insurance? (example: travel expenses to and from medical provider, doctor visits, prescriptions, lab work, etc.)	❑Yes ❑ No	Average Total Monthly Medical Expenses $_____

Cash Assistance Questions: Answer these questions for everyone applying for Cash Assistance

Cash Assistance benefits are limited to 12 months unless the child is a ward of the State, is in the legal custody of a tribal court or a tribal child welfare agency located in Arizona, or there is a hardship. An additional 12 months of cash assistance may be received when no adult has been sanctioned for noncompliance with a Jobs Program requirement and all children in the household who are required to attend school have a school attendance record of at least 90%, unless the child was excused.

Are you requesting an additional 12 months of Cash Assistance?	❑ Yes ❑ No	
Has any adult in the household ever been sanctioned for Jobs Program noncompliance?	❑ Yes ❑ No	
Do all children in the household who are ages 6-15 have a school attendance record of at least 90%, unless the child was excused pursuant to A.R.S. §15-802?	❑ Yes ❑ No	
Has anyone you are applying for received Cash Assistance this month?	❑ Yes ❑ No	If Yes, who? _____ When did benefits stop? _____ Name of city/state: _____ What type of benefits? _____
Do all children under age 19 have current immunizations (shots)?	❑ Yes ❑ No	If no, who does not? _____

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

Does anyone you are applying for have any type of bank account?	❑ Yes ❑ No	If Yes, total value:_____ Who owns?_____
Does anyone you are applying for have any: • Cash • Uncashed checks • Money on a pre-paid debit card?	❑ Yes ❑ No	If Yes, total value: $_____
Does anyone you are applying for have any: • Retirement account • Annuity?	❑ Yes ❑ No	If Yes, total value: $_____ Who owns? _____ Name of financial institution:_____ If Yes, total value: $_____ Who owns? _____ Name of financial institution:_____
Do you or anyone in your household own or have their name on: • stock • bond • money market account, • Certificates of Deposit (CDs) • trust funds • life insurance?	❑ Yes ❑ No	If Yes, total value: $_____ Who owns? _____ Name of financial institution:_____ If Yes, total value: $_____ Who owns? _____ Name of financial institution:_____
Does anyone you are applying for own any other land or buildings anywhere?	❑ Yes ❑ No	If Yes, total value: $_____ Who owns? _____ Where? _____

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

❑ Living with friends ❑ Using money from savings or checking accounts ❑ Living off credit cards
❑ Working odd jobs Monthly income: $_____ ❑ Other_____

Are you:
❑ Getting loans from people ❑ Having someone give you money ❑ Having someone pay bills directly ❑ Working in exchange for rent

If Yes, complete the section below:
Name of person helping: _____ Telephone number: _____

Email: _____
If loan, amount: $_____ When does it need to be paid back? _____
If gift, amount: $_____
If paying bills, which ones? _____
If working in exchange, amount of rent: $_____

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

Do any applicants have an injury or illness due to an accident or medical malpractice? ❑ Yes ❑ No If Yes, who? _____

Are any applicants currently admitted to a hospital? ❑ Yes ❑ No If Yes, who? _____

Name of the Hospital: _____

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

Do any applicants have health insurance other than AHCCCS or Medicare? ❑ Yes ❑ No
If 'Yes,' give the following information:

Name of Insured	Name of Insurance Provider	Policy Number	Coverage Effective Date

Does any child under age 19 in this application qualify for health benefits (even if they choose not to enroll) through the State of Arizona because:

- A parent or step parent (in or out of the home) works for an employer (State or other public agency) that offers health insurance coverage through the State of Arizona and is eligible to get health insurance coverage; or
- The child or child's spouse works for an employer (State or other public agency) that offers health insurance coverage through the State of Arizona and is eligible to get health insurance coverage?

❑ Yes ❑ No If Yes, who?_____

Have any children under the age of 19 lost health insurance coverage in the last 90 days? If 'Yes,' give the following information:

❑ Yes ❑ No

If YES, name of child(ren) who lost health insurance coverage:	
Name of Policy Holder	
Name of Insurance Company	
Group Number	
Policy Number	
Insurance Company Phone Number	
Coverage End Date	

Why did the health insurance coverage stop?

❑ Cost too much
❑Coverage was through Medicaid/CHIP, or through Advance Premium Tax Credits (APTC), or Cost Sharing Reductions
❑Divorce or death of parent
❑Employer stopped offering coverage for dependents
❑Job changed or ended
❑Other: _____

If the health insurance cost too much:

❑ The **monthly** premium to cover one person is: $_____
❑ The monthly premium to cover the family is: $_____
❑ Was approved for APTC because employer-sponsored insurance was determined to be unaffordable.

Do any children under the age of 19 you are applying for have a chronic illness? (Medical condition that requires frequent and ongoing treatment and that if not properly treated will seriously affect the person's overall health). ❑ Yes ❑ No If Yes, who? _____

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

Name	Health Plan Choice
Person 1	
Person 2	
Person 3	
Person 4	
Person 5	
Person 6	

Health Insurance Tax Credits:

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

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

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

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

Employee Name: _____ Employee Social Security Number: _____

Employer Name: _____ Employer Identification Number (EIN):_____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

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

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

_____

Who is eligible for coverage from this job? _____

Does the employer offer a health plan that meets the minimum value standard*? ❑ Yes ❑ No ❑ I do not know

If **YES:** answer the questions below. If **NO** or **I DO NOT KNOW:** go to the next section.

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

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

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

How much will the employee have to pay in premiums for that plan? $ _____ ❑ I do not know

How often will the employee have to pay the premium?

❑ Weekly ❑ Twice a month ❑ Every 2 Weeks ❑ Monthly ❑ Quarterly ❑ Yearly ❑ I do not know ❑ Other: _____

What changes will the employer make for the new plan year (if known)?

❑ Employer will not offer health coverage

❑ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard*.

How much will the employee have to pay in premiums for that plan? $ _____ ❑ I do not know

How often will the employee have to pay the premium?

❑ Weekly ❑ Twice a month ❑ Every 2 Weeks ❑ Monthly ❑ Quarterly ❑ Yearly ❑ I do not know ❑ Other: _____

Renewal of Tax Credit Coverage in Future Years:

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

Yes, renew my eligibility for the next: ❑ 5 years ❑ 4 years ❑ 3 years ❑ 2 years ❑ 1 year

No, do not use information from tax returns to renew my coverage ❑

Go to the next page to sign the application.

Sign the Application:

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

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

Penalty Warning

The information provided on this form may be verified by federal, state, and local officials. If any information is inaccurate, you may be denied benefits.

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

Release of Information

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

Assignment of Rights to Other Benefits for Medical Care

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

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

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

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

Assignment of Rights to Other Benefits for Cash Assistance

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

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

Declarations and Statement of Truth

By signing this application:

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

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

Signature of Applicant: _____ Date: _____

Signature of Spouse: _____ Date: _____

Signature of Other Adult in Household: _____ Date: _____

Signature of Authorized Representative: _____ Date: _____

Signature of Witness (if signed with mark): _____ Date: _____

Voter Registration:

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

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

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

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

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

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

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

Submit the Application:

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

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

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

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

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

If you wish to file a Civil Rights program complaint of discrimination with USDA, complete the **USDA Program Discrimination Complaint Form**, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

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

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

USDA and HHS are equal opportunity providers and employers.

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact your local office manage TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request. • Disponible en español en línea o en la oficina local.

OFFER OF VOTER REGISTRATION FORM

The *Offer of Voter Registration* form is the last page. Please read it, answer “Yes” or “No”, sign where it says “Signature of Client”, and date it.

NOTICE OF NON-DISCRIMINATION

The Arizona Health Care Cost Containment System (AHCCCS) and the Department of Economic Security (DES) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AHCCCS and DES do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. AHCCCS and DES provide free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, and other formats). AHCCCS and DES provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Health-e-Arizona Plus Customer Support Center at 1-855-432-7587 (TTY: 711). Also, under the Food Stamp Act and USDA policy, DES is prohibited from discriminating on the basis of religion or political beliefs.

If you believe that AHCCCS or DES failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance**.** You can file a grievance in person or by mail, fax, or email. Your grievance must be in writing and must be submitted within 180 days of the date that the person filing the grievance becomes aware of what is believed to be discrimination.

Submit your AHCCCS grievance to: General Counsel, AHCCCS Administration, Office of Administrative Legal Services, MD 6200, 701 E. Jefferson, Phoenix, AZ 85034 Fax: 602 253 9115 Email: EqualAccess@azahcccs.gov. You can also file an AHCCCS civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail at U.S. Department of Health and Human Services; 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201; or by phone: 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Submit your DES discrimination complaint/grievance to: Arizona Department of Economic Security, Director's Office, Mail Drop 1111, P. O. Box 6123 Phoenix, Arizona 85005-6123.

DHHS: Write DHHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D. C. 20201 or call 202-619-0403 (voice) or 202-619-3257 (TDD).

USDA: You may complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. You may also call 202-720-5964 (voice and TDD).

AVISO DE NO DISCRIMINACIÓN

El programa de seguro médico público estatal *Arizona Health Care Cost Containment System (AHCCCS)* y el Departamento de Seguridad Económica (*Department of Economic Security / DES)* cumplen con las leyes federales vigentes de derechos civiles y no discriminan por motivo de raza, color, origen nacional, edad, discapacidad o sexo. Las agencias *AHCCCS* y *DES* no excluyen a las personas ni las tratan de manera distinta por motivo de raza, color, origen nacional, edad, discapacidad o sexo. Las agencias *AHCCCS* y *DES* proporcionan ayudas y servicios gratuitos a las personas con discapacidades para comunicarse efectivamente con nosotros, tales como intérpretes de idioma de señas calificados e información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles y otros formatos). Las agencias *AHCCCS* y *DES* proporcionan servicios gratuitos de idiomas para las personas cuyas lenguas vernáculas no sean el inglés, tales como intérpretes calificados e información escrita en otros idiomas. Si necesitara estos servicios, comuníquese con el Centro de Servicios a Clientes de *Health-e-Arizona Plus* al 1-855-432-7587 (TTY: 711). Además, de conformidad con la Ley General de las Estampillas Para Alimentos (*Food Stamp Act*) y la política de la Secretaría Federal de Agricultura de los Estados Unidos (*United States Department of Agriculture*), se le prohíbe al *DES* discriminar por motivo de creencias religiosas o políticas.

Si le pareciera que las agencias *AHCCCS* o *DES* no le proporcionaron estos servicios o discriminaron de cualquier otra manera por motivo de raza, color, origen nacional, edad, discapacidad o sexo, podrá presentar una querella. Podrá presentar la querella en persona, por correo, por fax o por correo electrónico (*email*). Su querella deberá constar por escrito y deberá presentarse en los 180 días siguientes a la fecha en la que la persona que presente la querella se percatara de lo que le pareciera un discrimen.

Presente su querella contra *AHCCCS* a:
General Counsel
AHCCCS Administration
Office of Administrative Legal Services
MD 6200
701 E. Jefferson St.
Phoenix, AZ 85034

Por fax al 602 253 9115; por correo electrónico (*email*) mediante EqualAccess@azahcccs.gov.

También podrá presentar una querella de derechos civiles contra *AHCCCS* ante la Oficina de Derechos Civiles de la Secretaría Federal de Salud y Servicios Humanos (*U.S. Department of Health and Human Services, Office for Civil Rights*) electrónicamente mediante el Portal de Querellas de la Oficina de Derechos Civiles (*Office for Civil Rights Complaint Portal*), disponible mediante https://ocrportal.hhs.gov/ocr/portal/lobby.jsf ; o por correo a:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

O por teléfono al 1-800-368-1019, 800-537-7697 (TDD). La forma de querella está disponible mediante http://www.hhs.gov/ocr/office/file/index.html.

Presente su querella por discrimen contra *DES* a:
Arizona Department of Economic Security, Director's Office, Mail Drop 1111 P. O. Box 6123 Phoenix, Arizona 85005-6123.

Ante la Secretaría Federal de Salud y Servicios Humanos (*DHHS*): Escriba a: *DHHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D. C. 20201;* o llame al 202-619-0403 (por voz) ó al 202-619-3257 (TDD).

Ante la Secretaría Federal de Agricultura (*USDA*): Podrá rellenar la *Forma de querella por discrimen en programas de la Secretaría de Agricultura de los EE. UU.* (*USDA Program Discrimination Complaint Form*) por Internet en http://www.ascr.usda.gov/complaint_filing_cust.html o en cualquier oficina de *USDA*, o llamar al (866) 632-9992 para pedir la forma. También podrá escribir una carta que contenga toda la información que se solicita en la forma. Envíenos su forma rellenada o carta de querella por correo a: *U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410*; por fax al (202) 690-7442; o por correo electrónico (*email*) a program.intake@usda.gov. También pudiera llamar al 202-720-5964 (voz y TDD).

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dę́ę́', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-855-432-7587（TTY: 711）

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-432-7587（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-432-7587 (TTY:711).

ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-885-432-7587 (رقم هاتف الصم والبكم:711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-432-7587 (TTY:711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-432-7587 (TTY: 711) 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-432-7587 (ATS : 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-432-7587 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-432-7587 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-432-7587（TTY: 711）まで、お電話にてご連絡ください。

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-432-7587 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

ܙܘܗܪܐ: ܐܢ ܐܢܬ ܟܐ ܗܡܙܡܬ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܨܝܬ ܕܩܒܠܬ ܚܠܡܬ ܕܗܝܪܐ ܒܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܝ ܥܠ ܡܢܝܢܐ 1-855-432-7587 (TTY: 711)).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY:711) 1-855-432-7587 تماس بگیرید.

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-432-7587 (TTY:711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-432-7587 (TTY: 711).

NVRA-5 (English)

OFFER OF VOTER REGISTRATION

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

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

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

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

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

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

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

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

NVRA-5 (Spanish)

PROPOSICIÓN DE EMPADRONAMIENTO

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

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

☐ Si ☐ No

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

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

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

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

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

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