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

Application for Benefits

Tear off and keep pages A through K 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 health insurance from AHCCCS Medical Assistance
- Help with your Medicare costs
- Nutrition Assistance/SNAP (formerly "Food Stamps")
- Cash Assistance/Temporary Assistance for Needy Families (TANF)
- Tuberculosis Control
- A tax credit that can help pay your health insurance premiums
- This application can be used as:
 - o An Initial application for one or more programs.
 - o Renewal application for one of more programs.
 - o Reporting changes.
 - A combination of all of the above.

See pages B and C 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 live with you that purchase and prepare food with you

If you want to select a representative to complete your application, complete the Authorized Representative form on pages 3 and 4 of the application.

What if I need help?

IMPORTANT: For NA and CA, applications are not valid and cannot be used without an address where mail can be delivered. When you do not have an address where you can get mail, talk to a worker before you give us this application so we can help you.

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 2 of the application.

Online: healthearizonaplus.gov

Phone: 1-855-HEA-PLUS (432-7587)

In person: Visit des.az.gov/ to find the office closest to you.

Where else can I apply?

You can apply faster online at <u>healthearizonaplus.gov</u>.

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 https://des.az.gov/ or call our 24 hour Interactive Voice Response system at 1-855-HEAPLUS (432-7587).

Address Requirements

This application must contain a valid home or mailing address where you can receive mail. Applications without an address where mail can be received are not valid and cannot be used.

When you do not have an address for receiving mail, talk to a worker so we can help you.

Domestic Violence Considerations

Some program requirements may be difficult or dangerous for victims or survivors of domestic violence, sexual harassment, sexual assault, or stalking, and their families. Speak with your eligibility specialist, to determine whether you may be exempt from these requirements.

All information you provide will remain confidential as required by law.

The Helplines listed below can provide information about sexual and domestic violence-related resources available in your community. They cannot answer questions regarding your application for NA, CA, or MA benefits.

- Arizona Sexual and Domestic Violence Services Helpline Monday-Friday 8:30 a.m. to 5:00 p.m., and until 7:00 p.m. on Tuesdays. You may call them at (602) 279-2980, 1-800-728-6400, or text (520) 720-3383
- National Domestic Violence Hotline Available 24 hours 1-800-799-SAFE (7233) or TTY 1-800-787-3224
- National Sexual Assault Hotline Available 24 hours 1-800-656-HOPE (4673)

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.

All information you provide will remain confidential as required by law.

What happens next?

Send your signed application to the address on page 31 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.

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 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 4 of this application. If you qualify for Emergency Nutrition Assistance benefits, you can get them within 7 days of your application date.

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.

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 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*
- Medical Supplies
- Chemotherapy
- Doctor's Office Visits
- Medically Necessary Transportation
- Emergency Medical Care
- Laboratory and X-ray Services

- Medically Necessary Specialist Care
- Rehabilitation Services
- Hospital Services
- Behavioral Health Care
- 90 days of nursing care
- Dialysis
- Immunizations (shots)

^{*}AHCCCS prescription coverage is limited for people who have Medicare.

What is Medicare Savings Program?



Medicare Savings Program may pay:

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

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.

If you are waiting for your application to be processed or you are not eligible for AHCCCS Medical Assistance, you may qualify to receive drug and alcohol and mental health treatment services through other funding sources administered by the Regional Behavioral Health Authority, or RBHA. For more information, contact the RBHA in your area at: Central Arizona – (602) 586-1841 or toll-free (800) 564-5465; Northern Arizona – (800) 640-2123; or Southern Arizona – (866) 495-6738.

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 an American Indian and you choose American Indian Health Program as your health plan.
- You are only 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.

Copayments:

- 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. Remember to report any changes in income because this may change your co-payment amount. Co-payments for services are:
 - \$2.30 to \$10 for prescriptions.
 - \$0 to \$30 for non-emergency use of an emergency room.
 - \$3.40 to \$5 for outpatient visits for evaluation and management services including doctor's office visits.
 - \$2.30 to \$3 for physical, occupational or speech therapy.

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

- Children under age 19.
- People determined to be Seriously Mentally III (SMI) by the Arizona Department of Health Services.
- Individuals through age 20 who receive services from the Children's Rehabilitative Services (CRS) program.
- People who are residing in nursing home 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 calendar days in a contract year.
- People who receive hospice care.

The following services are always provided at no cost for anyone enrolled in an AHCCCS program:

- 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 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. 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.
- 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 chose 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 U.S. 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 calendar days.

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

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

- If you are eligible for Emergency Nutrition Assistance, we will make a decision within 7 calendar days. For Cash Assistance, we will make a decision within 45 calendar 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 calendar days.

How will I know if I am eligible?







If you are approved, you will receive a letter explaining the benefits you are eligible for and the amount of benefits you will get, or you will be provided information on AHCCCS medical coverage.

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. It can take up to 48 hours for the benefits to be available after approval. You can call the Customer Service number on the back of the card to check the balance of your benefits. Important: It is illegal to use your EBT card to do any of the following:

- Withdraw Cash Assistance benefits at ATMs located inside liquor stores, casinos, and horse or dog racing facilities.
- Make purchases at Point of Sale machines located inside liquor stores, casinos, horse or dog racing facilities, adult entertainment establishments, or Medical Marijuana Dispensaries (A.R.S. §46-297)
- Use your EBT card to purchase lottery tickets.
- Pay for food purchased on credit with Nutrition Assistance benefits.

If you request more than three EBT replacement cards in a 12 month period, you will be required to contact DES to answer questions to determine whether fraud is being committed.

If you use more than 10% of your Cash Assistance balance on out-of-state purchases in a 6 month period, you will be required to contact DES to answer questions to determine whether fraud is being committed. If you lose your EBT card you may have to pay for a new one.

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 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 AHCCCS Medical Assistance, the requirement to cooperate with DCSS in establishing the identity of a child's parents and in obtaining medical support is suspended under a temporary waiver from 09/01/2023 through 06/30/2025.

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.
- Ask for a legal review of your case if you disagree with a decision or action taken by DES. This review is called an Appeal. You can ask for an Appeal on any DES decisions, actions, or inaction, which may or may not affect the participation of the household in any program.
- Ask for an appeal if a request for supplemental or replacement benefits is denied or is not acted on in a timely manner.
- Ask for an appeal if an overpayment determination or amount of an overpayment is disputed.
- Ask for an appeal if a change is not acted on.
- Ask for an appeal if you disagree with a decision made on your application 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 the appeal.
- Bring an attorney or any other person to the appeal.
- Have all information you give regarding your eligibility kept private according to state and federal law.
- 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 appeal 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.

What are the rules and penalties?





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

- It is mandatory for you to cooperate with a fraud investigation. For Cash Assistance, 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 your or someone else's Nutrition Assistance benefits or EBT card. Allowing someone else to use your EBT card or Nutrition Assistance (NA) benefits without requiring them to return the items purchased to you is considered a transfer of benefits.
- Do not use someone else's EBT card unless you are an authorized user. It is against the rules to keep items you buy with someone else's 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 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 or tobacco.
- Do not alter an EBT card.
- For Cash Assistance, if you refuse to sign and comply with the Personal Responsibility Agreement (PRA) you will not be eligible. We give you the PRA during the interview process.
- An adult recipient (18 years or older) of Cash Assistance will be disqualified 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.
 - o The recipient fails to take a required drug test.
 - The recipient fails the drug test.

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

- Has their Cash Assistance benefits sanctioned. You or the household member will be sanctioned 50% for the first occurrence and 100% for the second occurrence of noncompliance, This includes, if any adult has voluntarily quit a job without good cause or has sold, possessed or used a controlled substance in violation of A.R.S. Title 13.
- Knowingly breaks the rules to get Cash Assistance or Nutrition Assistance benefits. We will disqualify you for a period of time for the first and second offences and permanently for all other offences.
- Is a fleeing felon or probation/parole violator.
- When convicted of the following crimes and are not in compliance with the terms of the sentence, is a fleeing felon, or is a parole or probation violator:
 - Aggravated sexual abuse
 - Murder
 - Sexual Exploitation and other abuse of children involving sexual assault

- 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. If the person with the felony drug conviction
 agrees to random drug testing and they meet at least one additional requirement, they may be eligible
 to receive Nutrition Assistance.
- 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.
 - o Is currently accepted for treatment, and is participating in a substance abuse treatment program.
 - o Has successfully completed a substance abuse treatment program after the offense in question.
 - o Is determined by a licensed medical provider to not need substance abuse treatment.
 - If on probation/parole for a felony drug conviction, is in compliance with the terms of probation/parole.
- For Cash Assistance the following applies:

End for the CA Drug Conviction Sanction

- The person who is convicted August 9, 2017 or later, can end the sanction for others in the household when they agree to random drug testing and meet at least one of the following criteria:
- Successfully completes, or is accepted into, a substance abuse treatment program. The person also meets this criteria if they are either of the following:
 - 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.
 - o Currently accepted for treatment, and is participating in a substance abuse treatment program.
- Is determined by licensed medical provider to not need substance abuse treatment.
- If applicable, is in compliance with all terms of probation related to the conviction they were sanctioned for.

As part of the change reporting requirements, all households must report when any household member receives lottery or gambling winnings of **\$4500** or more **in a single game**.

You must pay DES back for any Nutrition Assistance and/or Cash Assistance 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.

Health Insurance Tax Credit Information



If you are not eligible for help with health Insurance costs, 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.

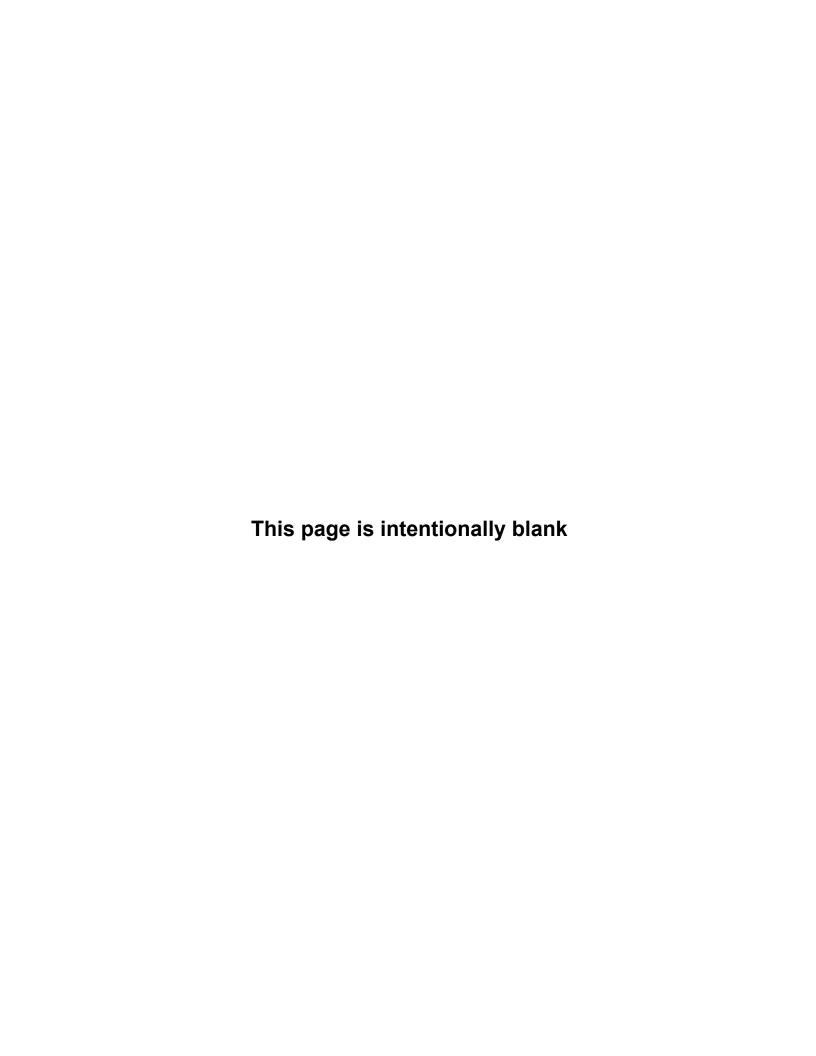
How to choose a health plan

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.

North	 American Indian Health Program Care1st Health Plan Blue Cross Blue Shield of Arizona Health Choice 			
 Central Maricopa Gila Pinal, excluding ZIP codes 85542, 85192, and 85550 	 American Indian Health Program Arizona Complete Health - Complete Care Plan (formerly Health Net Access) Banner-University Family Care Molina Health Care Mercy Care Blue Cross Blue Shield of Arizona Health Choice UnitedHealthcare Community Plan 			
South Cochise Graham Greenlee La Paz Pima Santa Cruz Yuma ZIP codes 85542, 85192, and 85550	 American Indian Health Program Arizona Complete Health - Complete Care Plan (formerly Health Net Access) Banner-University Family Care UnitedHealthcare Community Plan (Pima County Only) 			

Health Plan Name	Phone Number	Website
American Indian Health Program	Maricopa County: 602-417-7100 All other counties: 1-800-334-5283	azahcccs.gov/AmericanIndians/AIHP/
Arizona Complete Health - Complete Care Plan (formerly Health Net Access)	1-888-788-4408	azcompletehealth.com/completecare
Banner-University Family Care	1-800-582-8686	bannerufc.com/acc
Care1st Health Plan	1-866-560-4042	care1staz.com
Molina Health Care	1-800-424-5891	mccofaz.com
Mercy Care	1-800-624-3879	mercycareaz.org
Blue Cross Blue Shield of Arizona Health Choice	1-800-322-8670	azblue.com/medicaid
UnitedHealthcare Community Plan	1-800-348-4058	uhccommunityplan.com



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

For Agency use
Date:
Case#

Application for Benefits

Contact Information:			
Tell us how we can contact an adult member of your h		•	
live, please give us a mailing address. If you do not ha	ave a mailing a	ddress to give us, please	contact us for help.
Legal Name (First, Middle, Last):			
Home Address (include suite number/apartment no	•		
City:	State:	ZIP Code	;
Mailing Address (if different):			
City: Do you live in a shelter?	State:	ZIP Code	;
Phone Number (Home, Work, Cell, Message):			
What is the preferred language you and your hous	-		
○ English ○ Spanish ○ Other			
What is the preferred language you and your hous			
○ English ○ Spanish ○ Other			
I would like to get information about this application	=		
Email: O Yes O No Email address:			
Text: Yes No Number to text (standar			
If 'Yes' is not marked for Email or Text, all informat mailing address provided.	ion ioi uns ap	plication will be sent via	U.S. Mail to the
SIGN THE APPLICATION:			
For Nutrition Assistance (NA) and Cash Assistance We can accept your application if it contains at lea Assistance (MA), we can accept your application version However, DES and/or AHCCCS cannot determine applying for are answered and the application is si	e (CA), this ap st your name vithout a signa eligibility unti	, address, and signature ature. I all questions for each p	e. For Medical
I affirm under penalty of perjury that I will answer que this application applying for benefits truthfully to the regarding citizenship or alien status. I have not and perjury that any photocopied information I provide is provide are true and correct to the best of my knowled that the statements I provide regarding felony convictorect. I understand my rights and responsibilities the assignment of rights to other benefits on page 31 rights to other benefits for Medical Care on page 31	best of my kr will not withho s the same as ledge. For NA ctions and co for each progr 31. For MA, I u	nowledge. This includes a old any information. I affin the original documents a and CA, I also affirm und mpliance with probation/pram. For CA, I understan	any information rm under penalty of and any documents I der penalty of perjury parole are true and d I must agree to
Signature of Applicant or Authorized Representative	/e:		Date:
Signature of Other Adult in Household (MA Only):			Date:
Signature of Witness (if signed with mark):			Date:

Help and Special Accommodations:
I need the following help with this application (check all that apply):
☐ Reading/understanding this application ☐ Filling out this application
☐ American Sign Language ☐ Language Interpreter
Other: What language?
I have an impairment that requires the following accommodations for this application (check all that apply):
☐ Hearing ☐ Speaking ☐ Visual ☐ Writing ☐ Walking ☐ Other:
Does the customer, authorized representative, or legal guardian have a visual impairment that requires an
alternative format for printed letters?
If yes, who needs the accommodation:
If yes, what kind of alternative format do you need? Please choose one option:
Letters in Health-e-Arizona Plus account (note: this person must have an HEAplus account)
Readable PDF sent by secure email
Large print: larger print letters sent by U.S. mail will be provided in Arial 24 point font.
Other:
Emergency Nutrition Assistance:
Your application will be screened for Emergency Nutrition Assistance (NA) benefits and, if
eligible, your household will receive NA benefits within 7 days of your application date.
 To qualify for Emergency NA benefits, you must have valid identification and meet any of the following: Households with less than \$150 in monthly gross income and \$100 or less in cash and bank accounts Migrant or seasonal farm worker households who are destitute provided their cash and bank accounts are \$100 or less Households with combined monthly gross income and cash and bank accounts that are less than the households monthly housing and utility costs
To determine if your household is eligible for Emergency Nutrition Assistance, fill out this section.
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 is your total monthly rent or mortgage costs?
Are you billed separately (from your rent or mortgage) and responsible for paying any of the utility
expenses listed below? If yes, check all the utilities you are paying.
☐ Electricity ☐ Gas or propane ☐ Coal, oil, or wood
☐ Garbage, sewer, or trash ☐ Water
How do you heat (central heating, stove, fireplace) or cool (air conditioning, evaporative cooler) your
home?Are you responsible for paying a telephone bill? O Yes O No
Does anyone receive Tribal Food Distribution?
Is anyone a migrant or seasonal farm worker?

Aut	horiz	ed Re	pres	enta	tive:

— — — — ().	authorize someone else to represent you in the CCCS cannot release any information about your permission.
Representative's Name:	No
•	ate: ZIP Code
Representative's Phone Number:	
This number is: Home Cell Work	Message Other:
What is the representative's preferred language to specific English OSpanish Other	
What is the representative's preferred language to real Composition Compositio	
My representative would like to get information about the Email: Yes O No Email address:	
Text: O Yes O No Number to text (standard te	xt rates apply):
If 'Yes' is not marked for Email or Text, all information mailing address provided. Is the representative acting on behalf of an organization.	on? O Yes O No
This section must also be completed when requesti	
Representative:	ng a Nutrition Assistance (NA) Authorized
I understand that if my NA Authorized Representative is currently disqualified from NA for an intentional program violation (IPV), they cannot act as an NA Authorized Representative. (when this happens, check one of the following boxes): I will select another person to serve as my NA Authorized Representative. This is the only person that is available to be my NA Authorized Representative.	I understand that if I am disqualified from NA for an intentional program violation (IPV), I cannot act as an NA Authorized Representative unless there is no one else available to represent this person. Please provide your date of birth and check one of the following boxes: (this is the NA Authorized Representative's date of birth) I am currently serving a disqualification for a Nutrition Assistance IPV. I am not currently serving a disqualification for a Nutrition Assistance IPV.
Signature of Applicant: Date:	Signature of Representative: Date:

Authorized Representative Authorization

Please read carefully. Your signature below means you have, read, understand, and accept these statements.

Applicant: Authorized Representative: By signing below, I (the customer) give By signing below, I (the representative) agree to act on permission for the person listed on the customer's behalf. I also agree to the following: previous page to act on my behalf as my Provide only truthful and complete information representative. That person is allowed to under penalty of perjury. help me in the process of qualifying for help • Fill in and sign needed forms. with Medical Assistance, and Medicare costs, Obtain and give to DES and/or AHCCCS all Nutrition Assistance, Cash Assistance, and/ information needed for Medical Assistance. or Tuberculosis Control. I give permission and Medicare Costs, Nutrition Assistance, Cash agree that my representative may do all the Assistance, and/or Tuberculosis Control, such as: following on my behalf: Social Security number Complete and sign my application. Income Provide any documents requested, Assets including personal information. Citizenship • Sign on my behalf to permit other people, Residency businesses, or agencies to give personal Medical Insurance and expenses information about me to DES and/or o Information about the customer's spouse, minor children, and parents (if the customer is AHCCCS, including protected health information needed to determine if I have a minor parent). a disability. I also agree to report when any of the following changes I also agree to give information about my occur: Increase or decrease in income; personal circumstances to my representative Increase or decrease in assets; and agree to allow my representative to assign Ownership of assets, including opening or closing all my rights to medical reimbursement claims

to AHCCCS on my behalf.

- financial accounts:
- Address; or
- Health insurance or the amount of premiums paid.
- Medical expenses (when age 60 or older or a person with a disability)

Maintain confidentiality of any information regarding the applicant or beneficiary provided by the agency.

If I am determined eligible, this authorization will stay in effect until I or my representative tells you to stop the authorization. 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:

When a legal guardian has been appointed for the only adult applicant in the household, the applicant's signature is not required for the legal guardian to be appointed as the authorized representative. Only the authorized representative's signature is needed.

How do I begin the application process?

You must file an application to begin the application process. You may 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.

Eligibility cannot be determined until we get a completed application. For Nutrition Assistance and Cash Assistance, you must also complete an interview.

In most cases, when you are eligible for benefits, benefits are provided from the date your application is received by our agency. This may not always be true for certain medical programs or when the application is filed while the applicant resides in an institution such as jail.

How will my information be used?

We will use your information to determine eligibility. We will 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 the amount of benefits you will receive.

We may also use your information, including your SSN to:

- Verify identity
- Verify income and resources
- Prevent duplicate benefits
- Establish and enforce child support
- Collect money we overpaid to 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

	Food P	Proporation Tol		call 1-855-HEA-PLU	,	
_	s anyone	e at your addres	s buy an		n food separately fror	n others in the household?
\bigcup	es 🔾	No If Yes, tell	us about	the people who buy	and prepare their ow	n food using the table below.
	Name (1	first & last)	Age	Relationship to MAIN CONTACT	Does this person pay expenses?	What expenses?
Acc	ess to E	lectronic Benef	it Transf	er (EBT) Account:		
	\$ &	your benefits for Please note the responsibility to	or you. If at lost or o advise ems purc	you need an Alterna stolen benefits will n the person I appoint chased with my NA b	te Cardholder, choose ot be replaced. I unde as my Alternate Card	· ·
EBT	Repres	entative's (Rep)	Name: ₋			
	•					
	-	=				ZIP Code
EBT	Rep's F	hone Number:				
Sign	ature of	Applicant:				Date:
Rel	ease of i	nformation to F	lospitals	/Hospital Agents/Org	ganizations/Agencies	:
+	about y	ou or a family n	nember's		and DES cannot shar	to release information e any information about you
Nan	ne of Hos	spital/Hospital's	Agent/Or	ganization/Agency:		
		•	•			
Pho	ne Numb	oer:				
	•					
	e permis d above:		ıd/or AHC	CCS staff to tell the	hospital, hospital age	ZIP Code nt, organization, or agency
with the i	insurand edeterm	ce costs, and if a	approved d the cate	for help with insurar egory of assistance t	ice costs, the effective	ed to see if I can get help e date of my eligibility, or. If denied for help with

Date: __

Do I need a Social Security Number?

Applying and providing information is voluntary, but some information is required for the agency to make an eligibility determination. For example, every applicant must provide or apply for a Social Security number (SSN). (Immigrants who are not legally able to obtain a Social Security number are not required to provide one.) Therefore, if personal information is not provided, you may not be eligible for benefits. SSNs are verified through computer matching programs and may be shared with federal and state agencies or private claims collection agencies. For Nutrition Assistance, requesting your SSN is authorized under the Food and Nutrition Act of 2008.

When applying for Nutrition Assistance, persons in your household may choose not to get Nutrition Assistance benefits. These persons are not required to provide a SSN or citizenship/immigration information. However, for Nutrition Assistance and Cash Assistance, some persons in the household may be required to be included. The amount of Nutrition Assistance benefits depends on the number of persons requesting benefits, but eligible persons in the household can get benefits even though some of the persons in the household are not applying for benefits. Persons in the household who are not applying for benefits may be required to provide financial information (e.g. income) when it is needed to determine eligibility or the benefit amount for the persons who are applying.

Federal law requires that you provide a 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 an SSN, we will refer you to the Social Security office to apply for one. Immigrants who are not legally able to get an SSN are not required to give one or apply for one. Any person you are applying for who is legally able to get an SSN 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 SSN. 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 SSNs to the United States Citizenship and Immigration Services (USCIS).

Household 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.

	Applying for?				ale					
Name Last, First, M.I. (List name as shown on SSN card)	Help with Health Insurance	Help with Medicare costs	Nutrition Assistance	Cash Assistance	Tuberculosis Control	Relationship to Main Contact (1.)	Marital Status (never married, married, legally separated, divorced, or widowed)	Date of Birth	Social Security Number (If not applying, optional)	Gender M=Male F=Female
1.						Main Contact				
2.										
3.										
4.										
5.										
6.										
Have any of the people listed above ever used another name, (i.e. alias, maiden name, suffix)?										
If yes, who?										
Other Name(s):										

4	¢
7	•



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

State agencies must use the Systematic Alien Verification and Eligibility (SAVE) system. The alien status of persons requesting benefits may be subject to verification by USCIS through the submission of information from the application to USCIS. The information received from USCIS may affect the household's eligibility and benefit amount.

Is the MAIN contact a U.S. citizen or U.S. national? (see page F for more information)								
○ Yes ○ No ○ Choose not t	o answer							
If the MAIN contact is NOT a U.S.	Citizen, what is their immigration sta	tus?						
☐ Lawful Permanent Resident	☐ Lawful Temporary Resident	☐ Remove/Suspension of						
☐ Asylee	Refugee	Deportation						
☐ Special Immigrant Juvenile	☐ Battered Spouse, Child, Parent	☐ Paroled into United States						
Status Applicant	☐ Victim of Trafficking	Order of Supervision						
☐ Deferred Action Status	☐ Withholding of Deportation	Citizen of Republic of the						
Legalization under LIFE Act	☐ Conditional Entrant granted	Marshall Islands						
Legalization under IRCA Act	before 1980	☐ Citizen of Federated States of						
☐ Applicant for Asylum, LPR or	☐ Cuban-Haitian Entrant	Micronesia						
Withholding Deportation		Citizen of Republic of Palau						
☐ I do not want to provide this info	ormation	Other:						
What immigration document does	the MAIN contact have?							
Permanent Resident Card	I- 94	ort 🗌 None						
	· ·							
	Immigration Document N	umber:						
Other:								
Other: Has the MAIN contact lived in the	Immigration Document N	s O No						
Other: Has the MAIN contact lived in the	Immigration Document N U.S. since August 22, 1996? Ye S. national? (see page F for more info	s O No						
Is PERSON 2 a U.S. citizen or U.S. Yes No Choose not t	Immigration Document N U.S. since August 22, 1996? Ye S. national? (see page F for more info	s O No						
Is PERSON 2 a U.S. citizen or U.S. Yes No Choose not t	Immigration Document NU.S. since August 22, 1996? Yes. national? (see page F for more info	s O No						
Is PERSON 2 a U.S. citizen or U.S. Yes No Choose not t If PERSON 2 is NOT a U.S. Citizen	Immigration Document NU.S. since August 22, 1996? Yes. national? (see page F for more infooranswer n, what is their immigration status?	s No ormation)						
Is PERSON 2 a U.S. citizen or U.S. Yes No Choose not to If PERSON 2 is NOT a U.S. Citizen Lawful Permanent Resident	Immigration Document N U.S. since August 22, 1996? Ye S. national? (see page F for more info o answer n, what is their immigration status? Lawful Temporary Resident	s No ormation) Remove/Suspension of						
Is PERSON 2 a U.S. citizen or U.S. Yes No Choose not to the Person 2 is NOT a U.S. Citizen Lawful Permanent Resident Asylee	Immigration Document N U.S. since August 22, 1996? Ye S. national? (see page F for more info o answer n, what is their immigration status? Lawful Temporary Resident Refugee	Remove/Suspension of Deportation						
Has the MAIN contact lived in the US Is PERSON 2 a U.S. citizen or U.S. Yes ○ No ○ Choose not to If PERSON 2 is NOT a U.S. Citized □ Lawful Permanent Resident □ Asylee □ Special Immigrant Juvenile	Immigration Document N U.S. since August 22, 1996? Ye S. national? (see page F for more info o answer n, what is their immigration status? Lawful Temporary Resident Refugee Battered Spouse, Child, Parent	Remove/Suspension of Deportation Paroled into United States						
Has the MAIN contact lived in the US Is PERSON 2 a U.S. citizen or U.S. Yes ○ No ○ Choose not to If PERSON 2 is NOT a U.S. Citized □ Lawful Permanent Resident □ Asylee □ Special Immigrant Juvenile Status Applicant	Immigration Document N U.S. since August 22, 1996? Ye S. national? (see page F for more info o answer n, what is their immigration status? Lawful Temporary Resident Refugee Battered Spouse, Child, Parent Victim of Trafficking	Remove/Suspension of Deportation Paroled into United States Order of Supervision						
Has the MAIN contact lived in the US Is PERSON 2 a U.S. citizen or U.S. Yes No Choose not to If PERSON 2 is NOT a U.S. Citized Lawful Permanent Resident Asylee Special Immigrant Juvenile Status Applicant Deferred Action Status	Immigration Document N U.S. since August 22, 1996? Ye S. national? (see page F for more info o answer n, what is their immigration status? Lawful Temporary Resident Refugee Battered Spouse, Child, Parent Victim of Trafficking Withholding of Deportation	Remove/Suspension of Deportation Paroled into United States Order of Supervision Citizen of Republic of the						
Has the MAIN contact lived in the US Is PERSON 2 a U.S. citizen or U.S. Yes No Choose not to If PERSON 2 is NOT a U.S. Citized Lawful Permanent Resident Asylee Special Immigrant Juvenile Status Applicant Deferred Action Status Legalization under LIFE Act	Immigration Document N U.S. since August 22, 1996? Ye S. national? (see page F for more info o answer n, what is their immigration status? Lawful Temporary Resident Refugee Battered Spouse, Child, Parent Victim of Trafficking Withholding of Deportation Conditional Entrant granted	Remove/Suspension of Deportation Paroled into United States Order of Supervision Citizen of Republic of the Marshall Islands						
Has the MAIN contact lived in the last lived in the	Immigration Document N U.S. since August 22, 1996? Ye S. national? (see page F for more info o answer n, what is their immigration status? Lawful Temporary Resident Refugee Battered Spouse, Child, Parent Victim of Trafficking Withholding of Deportation Conditional Entrant granted before 1980	Remove/Suspension of Deportation Paroled into United States Order of Supervision Citizen of Republic of the Marshall Islands Citizen of Federated States of						

What immigration document does	PERSON 2 have?							
Permanent Resident Card	I- 94 ☐ Visa ☐ Foreign Passpo	ort 🗌 None						
Other: Immigration Document Number:								
Has PERSON 2 lived in the U.S. since August 22, 1996? O Yes O No								
Is PERSON 3 a U.S. citizen or U.S	6. national? (see page F for more info	ormation)						
○ Yes ○ No ○ Choose not to	o answer							
If PERSON 3 is NOT a U.S. Citizer	n, what is their immigration status?							
☐ Lawful Permanent Resident	☐ Lawful Temporary Resident	☐ Remove/Suspension of						
☐ Asylee	Refugee	Deportation						
☐ Special Immigrant Juvenile	Battered Spouse, Child, Parent	Paroled into United States						
Status Applicant	☐ Victim of Trafficking	Order of Supervision						
Deferred Action Status	☐ Withholding of Deportation	Citizen of Republic of the						
Legalization under LIFE Act	☐ Conditional Entrant granted	Marshall Islands						
Legalization under IRCA Act	before 1980	☐ Citizen of Federated States of						
☐ Applicant for Asylum, LPR or	☐ Cuban-Haitian Entrant	Micronesia						
Withholding Deportation		Citizen of Republic of Palau						
I do not want to provide this infe	ormation	☐ Other:						
☐ I do not want to provide this info		U Other.						
What immigration document does	PERSON 3 have?	_						
What immigration document does	PERSON 3 have? I- 94 Uisa Toreign Passpo	ort None						
What immigration document does Permanent Resident Card Other:	PERSON 3 have? I- 94	ort						
What immigration document does Permanent Resident Card Other:	PERSON 3 have? I- 94 Uisa Toreign Passpo	ort						
What immigration document does Permanent Resident Card Other: Has PERSON 3 lived in the U.S. si Is PERSON 4 a U.S. citizen or U.S.	PERSON 3 have? I- 94 Visa Foreign Passport Immigration Document Notes Street S	ort						
What immigration document does Permanent Resident Card Other: Has PERSON 3 lived in the U.S. si Is PERSON 4 a U.S. citizen or U.S Yes No Choose not to	PERSON 3 have? I- 94 Visa Foreign Passport Immigration Document Notes Yes ince August 22, 1996? Yes and August 22, 1996? Or more information answer	ort						
What immigration document does Permanent Resident Card Other: Has PERSON 3 lived in the U.S. si Is PERSON 4 a U.S. citizen or U.S Yes No Choose not to If PERSON 4 is NOT a U.S. Citizen	PERSON 3 have? I- 94 Visa Foreign Passport Immigration Document Notes Street S	ort						
What immigration document does Permanent Resident Card Other: Has PERSON 3 lived in the U.S. si Is PERSON 4 a U.S. citizen or U.S Yes No Choose not to If PERSON 4 is NOT a U.S. Citizen Lawful Permanent Resident	PERSON 3 have? I- 94 Visa Foreign Passport Immigration Document Notice August 22, 1996? Yes S. national? (see page F for more information answer In, what is their immigration status? Lawful Temporary Resident	ort						
What immigration document does Permanent Resident Card Other: Has PERSON 3 lived in the U.S. si Is PERSON 4 a U.S. citizen or U.S Yes No Choose not to If PERSON 4 is NOT a U.S. Citizen Lawful Permanent Resident Asylee	PERSON 3 have? I- 94 Visa Foreign Passport Immigration Document Notice August 22, 1996? Yes S. national? (see page F for more information answer notice), what is their immigration status?	ort None umber: No ormation) Remove/Suspension of Deportation						
What immigration document does Permanent Resident Card Other: Has PERSON 3 lived in the U.S. si Is PERSON 4 a U.S. citizen or U.S. Yes No Choose not to If PERSON 4 is NOT a U.S. Citizen Lawful Permanent Resident Asylee Special Immigrant Juvenile	PERSON 3 have? I- 94 Visa Foreign Passport Immigration Document Notice August 22, 1996? Yes S. national? (see page F for more information status?) In what is their immigration status? Lawful Temporary Resident Refugee Battered Spouse, Child, Parent	ort None umber: No ormation) Remove/Suspension of Deportation Paroled into United States						
What immigration document does Permanent Resident Card Other:	PERSON 3 have? I- 94 Visa Foreign Passport Immigration Document Notice August 22, 1996? Yes S. national? (see page F for more information status?) o answer n, what is their immigration status? Lawful Temporary Resident Refugee Battered Spouse, Child, Parent Victim of Trafficking	ort None umber: No ormation) Remove/Suspension of Deportation Paroled into United States Order of Supervision						
What immigration document does Permanent Resident Card Other:	PERSON 3 have? I- 94 Visa Foreign Passport Immigration Document Notice August 22, 1996? Yes S. national? (see page F for more information of answer In, what is their immigration status? Lawful Temporary Resident Refugee Battered Spouse, Child, Parent Victim of Trafficking Withholding of Deportation	ort None umber: No ormation) Remove/Suspension of Deportation Paroled into United States Order of Supervision Citizen of Republic of the						
What immigration document does Permanent Resident Card Other: Has PERSON 3 lived in the U.S. si Is PERSON 4 a U.S. citizen or U.S. Yes No Choose not to If PERSON 4 is NOT a U.S. Citizen Lawful Permanent Resident Asylee Special Immigrant Juvenile Status Applicant Deferred Action Status Legalization under LIFE Act	PERSON 3 have? I- 94 Visa Foreign Passport Immigration Document Notice August 22, 1996? Yes S. national? (see page F for more information answer In, what is their immigration status? Lawful Temporary Resident Refugee Battered Spouse, Child, Parent Victim of Trafficking Withholding of Deportation Conditional Entrant granted	ort None umber: No Ormation) Remove/Suspension of Deportation Paroled into United States Order of Supervision Citizen of Republic of the Marshall Islands						
What immigration document does Permanent Resident Card Other:	PERSON 3 have? I- 94 Visa Foreign Passport Immigration Document Notice August 22, 1996? Yes Immigration Document Notice August 22, 1996? Yes Immigration Document Notice August 22, 1996? Yes Immigration Deportation Status? Immigration Status	ort None umber: No ormation) Remove/Suspension of Deportation Paroled into United States Order of Supervision Citizen of Republic of the Marshall Islands Citizen of Federated States of						
What immigration document does Permanent Resident Card Other:	PERSON 3 have? I- 94 Visa Foreign Passport Immigration Document Notice August 22, 1996? Yes S. national? (see page F for more information answer In, what is their immigration status? Lawful Temporary Resident Refugee Battered Spouse, Child, Parent Victim of Trafficking Withholding of Deportation Conditional Entrant granted	ort None umber: No ormation) Remove/Suspension of Deportation Paroled into United States Order of Supervision Citizen of Republic of the Marshall Islands Citizen of Federated States of Micronesia						
What immigration document does Permanent Resident Card Other:	PERSON 3 have? I- 94 Visa Foreign Passport Immigration Document Notice August 22, 1996? Yes S. national? (see page F for more information of answer In, what is their immigration status? Lawful Temporary Resident Refugee Battered Spouse, Child, Parent Victim of Trafficking Withholding of Deportation Conditional Entrant granted before 1980 Cuban-Haitian Entrant	ort None umber: No ormation) Remove/Suspension of Deportation Paroled into United States Order of Supervision Citizen of Republic of the Marshall Islands Citizen of Federated States of						

What immigration document does F	PERSON 4 have?						
Permanent Resident Card	I- 94 Uisa Foreign Passpo	ort 🗌 None					
Other: Immigration Document Number:							
Has PERSON 4 lived in the U.S. si	nce August 22, 1996? 🔘 Yes 🔘	No					
Is PERSON 5 a U.S. citizen or U.S	. national? (see page F for more info	ormation)					
○ Yes ○ No ○ Choose not to	o answer						
If PERSON 5 is NOT a U.S. Citizer	n, what is their immigration status?						
Lawful Permanent Resident	☐ Lawful Temporary Resident	Remove/Suspension of					
Asylee	Refugee	Deportation					
☐ Special Immigrant Juvenile	Battered Spouse, Child, Parent	Paroled into United States					
Status Applicant	☐ Victim of Trafficking	Order of Supervision					
Deferred Action Status	☐ Withholding of Deportation	Citizen of Republic of the					
Legalization under LIFE Act	☐ Conditional Entrant granted	Marshall Islands					
Legalization under IRCA Act	before 1980	☐ Citizen of Federated States of					
☐ Applicant for Asylum, LPR or	☐ Cuban-Haitian Entrant	Micronesia					
Withholding Deportation		Citizen of Republic of Palau					
I do not want to provide this info	ormation	☐ Other:					
· ·							
What immigration document does I	PERSON 5 have?						
What immigration document does I		ort None					
What immigration document does F Permanent Resident Card Other:	PERSON 5 have? I- 94	umber:					
What immigration document does F	PERSON 5 have? I- 94	umber:					
What immigration document does For Permanent Resident Card Other: Has PERSON 5 lived in the U.S. si	PERSON 5 have? I- 94	umber: No					
What immigration document does For Permanent Resident Card Other: Has PERSON 5 lived in the U.S. si	PERSON 5 have? I- 94 Visa Foreign Passport Immigration Document Noce August 22, 1996? Yes national? (see page F for more info	umber: No					
What immigration document does in the U.S. si What immigration document does in the U.S. in the U.S. si Is PERSON 6 a U.S. citizen or U.S.	PERSON 5 have? I- 94 Visa Foreign Passport Immigration Document Note August 22, 1996? Yes The national? (see page F for more information answer	umber: No					
What immigration document does in the Permanent Resident Card Other: Has PERSON 5 lived in the U.S. si Is PERSON 6 a U.S. citizen or U.S Yes No Choose not to	PERSON 5 have? I- 94 Visa Foreign Passport Immigration Document Note August 22, 1996? Yes The national? (see page F for more information answer	umber: No					
What immigration document does R Permanent Resident Card Other: Has PERSON 5 lived in the U.S. si Is PERSON 6 a U.S. citizen or U.S Yes No Choose not to If PERSON 6 is NOT a U.S. Citizer	PERSON 5 have? I- 94 Visa Foreign Passport Immigration Document Note August 22, 1996? Yes national? (see page F for more information answer on, what is their immigration status?	no virialization)					
What immigration document does R Permanent Resident Card Other: Has PERSON 5 lived in the U.S. si Is PERSON 6 a U.S. citizen or U.S Yes No Choose not to If PERSON 6 is NOT a U.S. Citizer Lawful Permanent Resident	PERSON 5 have? I- 94 Visa Foreign Passport Immigration Document Note August 22, 1996? Yes national? (see page F for more information answer) what is their immigration status? Lawful Temporary Resident	umber: No ormation) Remove/Suspension of					
What immigration document does in the Permanent Resident Card Other: Has PERSON 5 lived in the U.S. si Is PERSON 6 a U.S. citizen or U.S Yes No Choose not to If PERSON 6 is NOT a U.S. Citizen Lawful Permanent Resident Asylee	PERSON 5 have? I- 94 Visa Foreign Passport Immigration Document Note August 22, 1996? Yes Inational? (see page F for more information answer In what is their immigration status? Lawful Temporary Resident Refugee	umber:					
What immigration document does Repermanent Resident Card Other: Has PERSON 5 lived in the U.S. si Is PERSON 6 a U.S. citizen or U.S. Yes No Choose not to If PERSON 6 is NOT a U.S. Citizer Lawful Permanent Resident Asylee Special Immigrant Juvenile	PERSON 5 have? I- 94 Visa Foreign Passport Immigration Document Note August 22, 1996? Yes national? (see page F for more information answer) n, what is their immigration status? Lawful Temporary Resident Refugee Battered Spouse, Child, Parent	no No Deportation Paroled into United States					
What immigration document does in the Permanent Resident Card Other: Has PERSON 5 lived in the U.S. si Is PERSON 6 a U.S. citizen or U.S. Yes No Choose not to If PERSON 6 is NOT a U.S. Citizen Lawful Permanent Resident Asylee Special Immigrant Juvenile Status Applicant	PERSON 5 have? I- 94 Visa Foreign Passport Immigration Document Note August 22, 1996? Yes national? (see page F for more information answer) national their immigration status? Lawful Temporary Resident Refugee Battered Spouse, Child, Parent Victim of Trafficking	no No Primation) Remove/Suspension of Deportation Paroled into United States Order of Supervision					
What immigration document does in the Permanent Resident Card Other: Has PERSON 5 lived in the U.S. si Is PERSON 6 a U.S. citizen or U.S. Yes No Choose not to the If PERSON 6 is NOT a U.S. Citizen Lawful Permanent Resident Asylee Special Immigrant Juvenile Status Applicant Deferred Action Status	PERSON 5 have? I- 94 Visa Foreign Passport Immigration Document Note August 22, 1996? Yes national? (see page F for more information answer n, what is their immigration status? Lawful Temporary Resident Refugee Battered Spouse, Child, Parent Victim of Trafficking Withholding of Deportation	number:					
What immigration document does Formanent Resident Card Other: Has PERSON 5 lived in the U.S. si Is PERSON 6 a U.S. citizen or U.S Yes No Choose not to If PERSON 6 is NOT a U.S. Citizer Lawful Permanent Resident Asylee Special Immigrant Juvenile Status Applicant Deferred Action Status Legalization under LIFE Act	PERSON 5 have? I- 94	no No Primation) Remove/Suspension of Deportation Paroled into United States Order of Supervision Citizen of Republic of the Marshall Islands					
What immigration document does in the Permanent Resident Card Other: Has PERSON 5 lived in the U.S. si Is PERSON 6 a U.S. citizen or U.S. Yes No Choose not to lif PERSON 6 is NOT a U.S. Citizen Lawful Permanent Resident Asylee Special Immigrant Juvenile Status Applicant Deferred Action Status Legalization under LIFE Act Legalization under IRCA Act	PERSON 5 have? I- 94 Visa Foreign Passport Immigration Document Note August 22, 1996? Yes national? (see page F for more information status?) answer n, what is their immigration status? Lawful Temporary Resident Refugee Battered Spouse, Child, Parent Victim of Trafficking Withholding of Deportation Conditional Entrant granted before 1980	no No Remove/Suspension of Deportation Paroled into United States Order of Supervision Citizen of Republic of the Marshall Islands Citizen of Federated States of					

I	ration document does							
Permanent Resident Card U I- 94 U Visa U Foreign Passport U None								
		Immigration Document Number:						
Has PERSC	N 6 lived in the U.S.	since August 22, 1996? O Yes O No						
Federal Inco	ome Tax Filing:							
Tell us I	NEXT YEAR'S tax filir	ng information for everyone applying:						
	Plan to file Federal income tax return?	Filing Status: Head of Household Single Married-Filing Separate Return						
	○ Yes ○ No	☐ Married-Filing Joint Return						
Main Contact	Will claim dependent If yes, list dependent	Spouse's name:						
	○ Yes ○ No	ent on someone else's tax return? Her claiming this person:						
	Plan to file Federal income tax return? Yes No	Filing Status: Head of Household Single Married-Filing Separate Return Married-Filing Joint Return Spouse's name:						
Person 2	Will claim dependents on own tax return? Yes No If yes, list dependents' names:							
	○ Yes ○ No	ent on someone else's tax return? Her claiming this person:						

	Plan to file Federal income tax return? Yes No	Filing Status: Head of Household Single Married-Filing Joint Return	☐ Qualifying Widow(er)☐ Married-Filing Separate Return				
Person 3		Spouse's name:ts on own tax return? O Yes (says names:	O No				
	○ Yes ○ No	ent on someone else's tax return?					
	Plan to file Federal income tax return? Yes No	Filing Status: Head of Household Single Married-Filing Joint Return Spouse's name:	☐ Qualifying Widow(er) ☐ Married-Filing Separate Return				
Person 4	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 Single Married-Filing Joint Return Spouse's name:	☐ Qualifying Widow(er) ☐ Married-Filing Separate Return				
1 013011 0	Will claim dependent	ts on own tax return? O Yes	No No				

	Claimed as depender	nt on sor	neone els	se's tax return′	?			
	○ Yes ○ No If yes, name of tax filer claiming this person:							
	Plan to file Federal income tax return? Yes No	Filing Sing Head Sing Mari	tatus: d of Hous lle ried-Filing		☐ Qualifying Wido ☐ Married-Filing S	` ,		
Person 6	Will claim dependents on own tax return? O Yes O No							
	Claimed as dependent on someone else's tax return? Yes No If yes, name of tax filer claiming this person:							
+ Prior M	ledical Expenses:							
					Who?	Month(s)?		
-	e applying for benefits ith medical bills in any onths?		○ Yes ○ No					
expenses pr	n needing help with me regnant or had a pregna st 5 months?		○ Yes ○ No					
Medicare an	e in this application having want help paying the art B premium for any conths?	eir	○ Yes ○ No					
→ Decease	sed Applicant:							
					Who?	Date Deceased		
Is anyone yo	ou are applying for Dec	eased?	○ Yes ○ No					

Temporary Absence: Tell us about any people who are temporarily living outside of your home who are expected to return.							
	xpected turn Date	Temporary Address	Why are they out of the home?				
Residency for All Application residency.	ants: Tell	us about residency. You ma	ay need to provide proof of				
Is each person applying for benefits a resident of Arizona?	O Yes	Who is not?					
+ 🍅 💲 🧸 Questions for All Applic	ants:						
Is anyone applying for benefits currently in a jail, prison or detention center?	○ Yes ○ No	If yes, who?					
Has anyone applying for benefits been released from a jail, prison or detention center within the last four months?	○ Yes ○ No	If yes, who?					
	<u> </u>						
Foster Care and Adult with	Child:						
Was anyone in Foster Care on their 18th birthday?	○ Yes ○ No	Who?					
Was anyone in Tribal Foster Care on their 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?					
Is anyone a foster child or foster adult?	○ Yes	Who?					

+ 🍅	\$	Ė
-----	----	---

Ethnicity/Race: Select one or more answers for each person applying for benefits. This information is used to ensure that program benefits are distributed without regard to race, color, or national origin. This information is optional and does not affect eligibility or benefit level.

Ethnicity			Rac	e												
Person	Hispanic/Latino	Not Hispanic/Latino	American Indian/ Alaskan Native	Asian Indian	Black or African American	Chinese	Filipino	Chamorro and Guamanian	Japanese	Korean	Native Hawaiian	Other Asian	Other Pacific Islander	Samoan	Vietnamese	White
Main Contact																
Person 2																
Person 3																
Person 4								Ш					Ш			
Person 4 Person 5																

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; through a referral from one of these programs?	If no, is the person eligible to receive these services?
	○ Yes		○ Yes	
	○ No		○ No	
	○ Yes		○ Yes	
	○ No		○ No	
	○ Yes		○ Yes	
	○ No		○ No	

Person	Enrolled in Federally Recognized Tribe?	Name of Tribe		Indian Ha tribal Iurban hthrough	lealth health ealth a ref	ices from Service; program; program; erral from programs?	to receive these
	○ Yes ○ No				O Ye		
	O Yes			(O Ye	s	
	○ No				\bigcirc Nc		
	○ Yes ○ No				O Ye		
* \$							
Person	boun	ithin the ds of a Nation?	Name of	Tribal Nation	1	Tribal Ce	nsus Number
	○ Yes						
	○ Yes	s O No					
	O Yes	s O No					
	O Yes	s O No					
	O Yes	s O No					
	O Yes	s O No					
+ \$ Help with Hea Questions:	Ith Insurance	Costs, Hel	p with Medica	are Costs, a	nd Ca	ash Assista	ance
Is anyone you are apply for pregnant?	ring		Who?			mber of pies Due	Expected Due Date
For anyone applying und	der age 19, are			ving in the h	ome?	,	
Child's Name:	Parent's N	ame:	Social Se	ecurity Numb	er:	Date of Birt	th:
	Mailing Ad	dress:	City, Stat	re:		ZIP Code:	
	Phone nun	nber:	I — ·	parent is abs		Home	Linknown

Child's Name:	nild's Name: Parent's Name:			Social Security Number: Date of Birth:		
	Mailing Address:			City, State: ZIP Code:		
	Pł	none number:	R		parent is absent:	Home Unknown
Has anyone ever receive	-	oplemental Security		, ,)	
		Who	?		Medicare Claim	or Railroad Number:
Does anyone have	Yes				☐ Part A	☐ Part B ☐ Part D
Medicare coverage?	No	Who	?		Medicare Claim	or Railroad Number:
					☐ Part A	☐ Part B ☐ Part D
\$ Potential Benefits	S :					
Has anyone you are ap or deceased spouse wo • A government agency • An employer with a p	or:	O Yes		, who? oyer Name:		
 An employer with a pension plan Is anyone you are applying for: A person who served in the U.S. military; A widow or widower of a person who served in the U.S. military; or A child of a deceased person who served in the U.S. Military and is: Not married, and Under age 18, or Under age 23 and is attending school, or Determined to have a permanent disability before age 18 A child (as defined above) or a spouse of a person who served in the U.S. Military who has a service connected disability 				Veter Veter Seria Bran Veter VA C	ran Name: ran SSN: al Service Numbe ch of Service: ran's Date of Birtl laim Number:	owing information:
Is anyone you are apply because of an injury or and may qualify for Wor	illness	received at work	O Yes		, who?	
and may qualify for Worker's Compensation? Is anyone you are applying for out of work because of an injury or illness and may qualify for Short-Term Disability or Long-Term Disability Payments through their employer or other company?				If yes	, who?	

Has anyone you are applying for lost employment in the past six months? When the answer is yes, you may be required to apply for Unemployment Benefits.	Yes No If yes, who?					
Nutrition Assistance and Cash Assistance Expenses: For Nutrition Assistance and/or Cash Assistance you must tell us about your expenses and provide proof to receive deductions, for the following expenses: court-ordered child and cash medical 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.						
Do you or anyone in your household pay for the care of a child or an adult with a disability in order to work, look for work, attend training, or school?	Yes No					
Do you or anyone in your household have transportation costs to travel to or from the person or agency that provides after school care or adult care?	Yes No If yes, who pays? Amount paid? \$ How often paid?					
Do you or anyone in your household pay court- ordered child support?	Yes No If yes, who pays?Amount paid? \$How often paid?					
S Nutrition Assistance and Cash Assist	stance:					
Are the persons you are applying for living in Government assisted housing?	○ Yes					
	○ No					
What are your monthly housing costs?	Rent or Mortgage \$					
What are your monthly housing costs? What are your monthly utility costs that are billed separately from your rent or mortgage?	Rent or Mortgage \$ Taxes \$					

Do you need help with this application? V	/isit <u>healthearizonaplus.gov</u>
or call 1-855-HEA-PLUS	(432-7587).

rer the E,F	nployment: Tell us a ntal income. You ma e most recent federa -, and K1. If you do penses for at least t	y need to provide Il tax forms: 1040 not have these ta	e proof of inc), SE and app ax forms, atta	ome. If s plicable s ach proof	elf-emplo schedule	oyed, plea s such as	se attach C, C-EZ,
Does anyone in this	application work?	○ Yes ○ No	If yes, give	employn	nent info	rmation be	elow.
Who	Employer's Name and Phone Number	How often paid? Weekly, biweekly, semi-monthly, monthly	Date last paid	Rate of pay	Hours per week	Normal range of hours per week (if varies)	Gross amount of past 30 days of pay
Did anyone leave a j ○ Yes ○ No If y			last 30 days1	?			
Wh	10	Employer's Phone N		Last work		ast pay date	Gross amount of last pay
Is anyone on a leave	e of absence from a	job? O Yes	O No If ye	s, give th	e inform	ation belov	N.
W	10	Employer's Phone N		Dat Lea Start	ve L	ast pay date	Expected Return Date



Other Income: Check YES or NO for each income type.

You may need to provide proof of income.

Type of Income	Yes or No
Is anyone in the household an owner or member of a franchise, corporation or limited liability corporation?	○ Yes ○ No
Social Security Benefits	O Yes
Supplemental Security Income (SSI Cash)	○ Yes ○ No
Retirement/pension	○ Yes ○ No
Unemployment	O Yes
Disability / worker's compensation	O Yes
Child support Court ordered Other:	O Yes
Spousal maintenance (alimony)	O Yes
Veterans benefits	O Yes
Gift, contributions or loans	O Yes
Tribal money Gaming Other:	O Yes
Rental income	O Yes
Per capita payments from natural resources, usage rights, leases or royalties	O Yes
Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land	O Yes
Lottery or Gambling winnings	O Yes
Other:	O Yes
Check here if no other income	

If you checked YES for any of the income types on the previous page, provide additional information below. If there is not enough space to list all income types, attach a piece of paper with the additional information.

Type of income:	Who re	eceives?	Amount	received	I Who	pays the income?
+ • \$ & Expe	ected Income	Changes:			•	
In the next twelve (12) work or contract emplo	oyment? Pleas	se tell us only a	about the cha	nges that ha	appen regu	
How many sources are						
Name of sources:						
Amount expected to m	ake in the ne	xt 12 months \$				
Does anyone in the hole of the No If Yes, who?	·	-	•		n in the nex	t twelve (12) months?
Please explain:						
Allowed deduct taken for taxes.		self-employme	ent expenses	s.		penses that can be
Expense		Who has	the expense	e? <i>F</i>	Amount	How Often?
Deductions from pay f like retirement and ins taken out before taxes	surance					
Student Loan Interest						
Spousal Maintenance	(Alimony)					
Other Type:						

+ • \$ • Questions for All Applicants:					
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 might 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 have a legal guardian?	○ Yes ○ No	If yes, who? Name of the legal guardian:			
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? To submit a request for an application by phone or for help, contact the Arizona Long Term Care System (ALTCS) at (602) 417-6600 or call (toll-free) (888) 621-6880.			
S Nutrition Assistance and Cash Assistance:					
Is anyone you are applying for a migrant or seasonal farm worker?	○ Yes ○ No	If yes, type of farm worker?			
Is this person under contract or agreement to begin employment within 30 days?	○ Yes ○ No				
Is this person working a minimum of 30 hours a week?	O Yes	If yes, who?			
Are you or anyone you are applying for on strike?	O Yes	If yes, who?			
Are you or anyone you are applying for a boarder?	O Yes	If yes, who?			
Are the persons you are applying for homeless?	○ Yes ○ No				
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?			

If yes, who? _____

Has anyone you are applying for had a felony		nv	If yes, who?						
conviction for possession, use, or distribution of a controlled substance on or after August 23, 1996?			City/state of conviction:						
			,	Date of conviction:					
If you or anyone you're applying for have a felony drug conviction and would like to get Nutrition Assistance or Cash Assistance, do you agree to random drug testing?			Type of conviction:						
Is anyone you are applying for: Running from the law on any felony charges, or			If yes, who?	If yes, who?					
 In violation of probation or parole? Has anyone you are applying for been convicted of any of the following felonies and is in violation of probation or parole: 			If yes, who?						
 Aggravated sexual abuse Murder Sexual exploitation and other abuse of children involving sexual assault 									
Has anyone been found to have committed a Nutrition Assistance or Cash Assistance Intentional Program Violation in Arizona or any other state?			If yes, who? What State?						
+ ⇒ \$ ċ , °	Questions for All Applica	ınts:							
	pplication attending school f yes , complete grid below								
Who	Name of School	Address	Full/part time	Grade	Start date	Graduation date			

Other Benefits and Expenses: Answer the following questions about receiving benefits.

household member who has a disal	oility, or is	nas a disability or is age 60 or over. When a sage 60 or over has medical expenses, the edical Deduction or actual out-of-pocket medical
Has anyone on the application received Nutrition Assistance from another state?	○ Yes ○ No	If yes, who? When did benefits stop? Name of state?
Has anyone on the application received Cash Assistance benefits from another state?	○ Yes ○ No	If yes, who? When did benefits stop? Name of state?
Does anyone receive Tribal Food Distribution?	○ Yes ○ No	If yes, who? When did benefits stop? Name of Tribe?
Is anyone on the application living in an assisted living facility or group home?	○ Yes ○ No	If yes, who?
Does anyone on the application have a disability or is age 60 or over?	○ Yes ○ No	If yes, who?
Does this person have any paid or unpaid medical expenses, even if they have medical insurance?	○ Yes ○ No	Average Total Monthly Medical Expenses \$
\$ Cash Assistance Questions		
Are you requesting an additional 12 months of Cash Assistance?	○ Yes ○ No	If yes, who?
Is any adult in the household currently sanctioned for Jobs Program noncompliance?	○ Yes ○ No	If yes, who?
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	If no, who?
Has anyone you are applying for received Cash Assistance this month?	○ Yes ○ No	If yes, who? When did benefits stop? Name of state?
Do all children under age 19 have current immunizations (shots)?	○ Yes ○ No	If no, who does not?

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

•



Nutrition Assistance and Cash Assistance:

Does anyone you are applying for have any	type of bank account?	O Yes	O No
If Yes, what is the total value?			
Who owns the account?			
If the account is interest-bearing, what is the	amount of interest earned monthly?		
Does anyone you are applying for have cash	n, uncashed checks,	_	_
money on a pre-paid debit card, or money tr	ansfer apps?	O Yes	O No
If Yes, what is the total value?			
Does anyone you are applying for have a re	tirement account or an annuity?	O Yes	O No
If Yes, what is the total value?	<u></u>		
Who is the owner?			
Name of financial Institution:			_
Do you or anyone in your household own or	have their name on stock, bonds,	_	_
money market accounts, Certificates of Dep	osit (CDs), trust funds, or life insurance?	O Yes	O No
If Yes, what is the total value?			
Who is the owner?			
Name of financial Institution:			
Does anyone you are applying for own any o	other land or buildings?	O Yes	\bigcirc No
If Yes, what is the total value?			
Who is the owner?			
Name of Mortgage Company:			
	llowing questions if you have no income.		
How do you pay your bills?			
Living with Friends	Using money from savings or checking	ng accounts	;
☐ Working odd jobs	Living off credit cards		
Monthly Income: \$	Other:		
Check the box below and answer questions	for all that apply:		
☐ You receive loans from people.	Amount: \$		
When does it need to be paid back?			
☐ Someone gives you money.	Amount: \$		
☐ Someone pays your bills directly.	Amount: \$		
Which Bills?			
☐ You work in exchange for rent			
Number of Hours worked per week:	Monthly Rent		

4	Medical Assistance	Questions:
---	--------------------	------------

•				
Do any applicants have an injury or illness due to an accident or medical malpractice? If Yes, who?		O Yes	O No	
Are any applicants currently admitted to a hospital? If Yes, who?		O Yes	○ No	
Name of the Hospital:				
+ \$ Health Insurance Coverage:				
Do any applicants have health insurance other than AHCCCS or Medicare? If Yes, provide details below. Who is the policy holder?			O Yes	○ No
Name of Insured	Name of Insurance Provider	Policy Number	Cove Effectiv	
 if they choose not to enroll) through the A parent or stepparent (in or out of the public agency) that offers health insurance covide ligible to get health insurance covide the child or child's spouse works for 	out of the home) works for an employer (state or other alth insurance coverage through the State of Arizona and nce coverage; OR orks for an employer (state or other public agency) that age through the State of Arizona and is eligible to get		O Yes	O No
Have any children under the age of 19 I days? If Yes, provide the information red	ost health insurance coverag	e in the last 90	O Yes	O No
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				

Cost too much money.	☐ Divorce or death of parent.		
☐ Coverage was through Medicare/KidsCare, or	☐ Employer stopped offering coverage for		
through Advance Premium Tax Credits (APTC),	dependents.		
or Cost Sharing Reductions.	Other:		
☐ Job changed or ended.			
If the health insurance cost too much:			
The monthly premium to cover one person is:	\$		
The monthly premium to cover family is:	\$		
	ored 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)			
If Yes, who?			
Health Plan Choice: Please see page J for enron Assistance.	ollment plan choices for everyone applying for Medical		
Name	Health Plan Choice		
Person 1:			
Person 2:			
Person 3:			
Person 4:			
Person 5:			
1 013011 01			
Person 6:			
	rance that may be offered through a job.		
Person 6: Insurance from Jobs: Tell us about health insurance coverage Is anyone eligible for health insurance coverage	rance that may be offered through a job. O Yes O No O I do not know		
Person 6: Insurance from Jobs: Tell us about health insurance coverage offered by an employer, or will you become eligible	○ Yes ○ No ○ I do not know		
Person 6: Insurance from Jobs: Tell us about health insurance coverage Is anyone eligible for health insurance coverage			
Person 6: Insurance from Jobs: Tell us about health insurance coverage offered by an employer, or will you become eligible	Yes No I do not know If YES, answer the questions below. If NO or I DO NOT KNOW, go to the next section. rage. If there are plans offered by more than one		
Person 6: Insurance from Jobs: Tell us about health insurance coverage offered by an employer, or will you become eligible for coverage in the next 60 days? Tell us about the job that offers health insurance cover employer and you need more space, please attach accontact the employer.	Yes No I do not know If YES, answer the questions below. If NO or I DO NOT KNOW, go to the next section. rage. If there are plans offered by more than one		
Person 6: Insurance from Jobs: Tell us about health insurance coverage offered by an employer, or will you become eligible for coverage in the next 60 days? Tell us about the job that offers health insurance cover employer and you need more space, please attach accontact the employer.	Yes No I do not know If YES, answer the questions below. If NO or I DO NOT KNOW, go to the next section. rage. If there are plans offered by more than one diditional pages. If you need help with the information, Employee SSN:		

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?*
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?*
coverage?
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. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (does not include family plans): If the employer has wellness programs, provide the premium that the employee would pay if employee received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs:
How much does the employee have to pay in premiums for that plan?
How often will the employee have to pay the premium? Weekly Weekly Understand 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 does the employee have to pay in premiums for that plan?
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: *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.
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 years No. do not use my information from tax returns to renew my coverage ☐

Who can sign the application?



For Medical Assistance the following people may sign the application:

- The applicant or the applicant's designee (we must have documentation showing this person is authorized to act on the applicant's behalf); or
- An adult who is in the applicant's MAGI budget group (tax group),
- The parent/legal guardian of a minor child.

The application is not valid until it is signed.







For Nutrition Assistance, Cash Assistance and Tuberculosis Control, the following people must sign the application:

• The applicant, a responsible household member, or a person representing the applicant

The application is not valid until it is signed.

Civil and criminal provisions and penalties for violations provided by the Food and Nutrition Act of 2008.

Any participant who breaks any of the rules on purpose can be barred from Nutrition Assistance for 12 months to permanently, fined up to \$250,000, and/or imprisoned up to 20 years. The participant may also be subject to prosecution under other applicable Federal and State laws. The participant may also be barred from Nutrition Assistance for an additional 18 months if court ordered.

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

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

- Has been convicted of 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.
- Intentionally breaks the rules to get Nutrition Assistance benefits. This person will be disqualified from getting Nutrition Assistance benefits for 12 months for the first offense, 24 months for the second offense and permanently for the third offense. In addition, this person can be fined up to \$250,000, imprisoned up to 20 years or both.
- Has been found by a court of law to give false identification or residence information to get benefits in more than one case at the same time. This person will not be eligible for Nutrition Assistance benefits for 10 years.
- Has been found guilty by a court of law of having trafficked benefits for a total amount of \$500 or more. This person will be permanently ineligible to participate in the Nutrition Assistance program upon the first occurrence of such violation.

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 they are 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 or 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 Medical Assistance)
- Persons, such as an absent spouse or parent, who are legally responsible for providing medical support
- Private or employer-sponsored disability or 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 of a child who does not live in the home and whose 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.
- The State will not keep any arrears that are more than the total amount of Cash Assistance I received.

Declarations

By signing this application:

- I agree I have read and understand the rules and penalties included with the application. I have read and understand my rights and responsibilities, and the requirement to provide Social Security numbers for each applicant that has a Social Security number.
- I agree I have read and understand the assignment of rights to other benefits for Medical Assistance.
- I agree I have read and understand the assignment of support rights for Cash Assistance.
- I agree that certain Nutrition Assistance 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.

Submitting the Application by Mail

Submit your signed application along with any supporting documents to the following address:







Arizona Department of Economic Security
Family Assistance Administration
P.O. Box 19009
Phoenix, Arizona 85005-9009 OR
Fax to (602)257-7031 or toll-free to (844)680-9840

Note: You can file an application with only your name, address, and the signature of a responsible household member or your authorized representative. Eligibility cannot be determined until you complete a full application and sign under penalty of perjury above.

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

Do Not Send Applications Here

USDA Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

1. mail:

Food and Nutrition Service, USDA 1320 Braddock Place, Room 334 Alexandria, VA 22314; or

2. fax:

(833) 256-1665 or (202) 690-7442; or

3. email:

FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.

Do Not Send Applications Here

To request this document in alternative format or for further information about this policy, contact your local office; TTY/TDD Services: 7-1-1. • Disponible en español en línea o en la oficina local.

Notice of Non-Discrimination

The Arizona Health Care Cost Containment System (AHCCCS) and the Department of Economic Security (DES) comply with applicable Federal civil rights laws and do 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, 801 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/smartscreen/main.jsf, or by mail at

Office for Civil Rights, U.S. Department of Health and Human Services; 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201; or by phone: (202) 368-1019 (voice), 800-368-1019 (toll-free), 800-537-7697 (TTY). Email: OCRComplaint@hhs.gov/civil-rights/ filing-a-complaint/complaint-process/index.html

Submit your DES discrimination complaint/grievance to: Arizona Department of Economic Security, Office of Equal Opportunity, P.O. Box 6123, Mail Drop 1119, Phoenix, Arizona 85005-6123; or by fax: (602) 364-3982. Email: OfficeofEqualOpportunity@azdes.gov

DHHS: Write DHHS, U.S. Department of Health and Human Services, Office for Civil Rights, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D. C. 20201 or call (202) 368-1019 (voice), (800) 368-1019 (toll-free) or (800) 537-7697 (TTY). Fax (202) 619-3818. Form: https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

Email: OCRComplaint@hhs.gov

USDA: You may complete the USDA Program Discrimination Complaint Form, found online at https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, or at any USDA office. For help filling out the form, call: (833) 620-1071 (toll-free customer service) or (800) 877-8339 (relay voice users). 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 Food and Nutrition Service, USDA, 1320 Braddock Place, Room 334, Alexandria, VA 22314; fax: (833) 256-1665 or (202) 690-7442; or email:

FNSCIVILRIGHTSCOMPLAINTS@usda.gov.

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 Healthe-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
801 E. Jefferson St.
MD 6200
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/smartscreen/main.jsf; o por correo a:

Office for Civil Rights

U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

O por teléfono al 800-368-1019 (teléfono gratuito), (202) 368-1019 (voz), 800-537-7697 (TTY), y (202) 619-3818 para fax. Correo electrónico: occamplaint@hhs.gov. La forma de querella está disponible mediante https://www.usda.gov/sites/default/files/documents/ad-3027s.pdf.

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

Presente su querella por discrimen contra DES a:

Arizona Department of Economic Security, Office of Equal Opportunity, P. O. Box 6123, Mail Drop 1119, Phoenix, Arizona 85005-6123; o por fax: (602) 364-3982. Correo electrónico: OfficeofEqualOpportunity@azdes.gov.

Ante la Secretaría Federal de Salud y Servicios Humanos (DHHS): Escriba a: U.S. Department of Health and Human Services, Office for Civil Rights, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D. C. 20201; o llame al (202) 368-1019 (por voz), (800) 368-1019 (teléfono gratuito), o (800) 537-7697 (TTY). Fax: (202) 619-3818. Correo electrónico: OCRComplaint@hhs.gov. La forma de querella está disponible mediante https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

Ante la Secretaría Federal de Agricultura (USDA): Podrá rellenar la *Forma de querella por discrimen en programas de la Secretaría Federal de Agricultura.* (USDA Program Discrimination Complaint Form) por Internet en_

https://www.usda.gov/sites/default/files/documents/ad-3027s.pdf o en cualquier oficina de USDA. Para obtener ayuda para completar el formulario, llame al: (833) 620-1071 (servicio de atención al cliente gratuito), (800) 877-8339 (retransmitir usuarios de voz). 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: Food and Nutrition Service, USDA, 1320 Braddock Place, Room 334, Alexandria, VA 22314; fax: (833) 256-1665 or (202) 690-7442; or email: FNSCIVILRIGHTSCOMPLAINTS@usda.gov.

English If you speak English, language assistance services, free of charge, are available to you. Call 1-855-432-

7587 (TTY: 711).

Spanish ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame

al 1-855-432-7587 (TTY: 711).

Navajo Díí baa akó nínízin: Díí saad bee yánílti go Diné Bizaad, saad bee áká ánída áwo déé, t'áá

jiik'eh, éí ná hóló, koji hódílnih 1-855-432-7587 (TTY: 711)

Apache Ndee'ke'go ca'ish'chii'nii Ndaa'ke'go ca'ish'chii'nii bii'kaa'nie'ill'kiid on'tii'yu Naa'nie'ii'ziid'ii Nubiil'kiid Besh

ba'niil'zud Da'laa'ha (1) saa'bii (8) ish'glaa'ii (5)ish'glaa'ii (5) dii'ii (4) taa'gii (3) Naakii (2) gus'tiid'ii (7)

ish'glaa'ii (5) saa'bii (8) gus'tiid'ii (7) aa'dah taa'gii (3) biil'wun'chiid (TTY: 711).

Chinese 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)。

Vietnamese 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 1-7587-885 (رقم هاتف الصم

والبكم: 711).

Tagalog 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).

Korean 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-432-7587

(TTY: 711) 번으로 전화해 주십시오.

French ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.

Appelez le 1-855-432-7587 (ATS: 711).

German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur

Verfügung. Rufnummer: 1-855-432-7587 (TTY: 711).

Russian ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.

Звоните 1-855-432-7587 (телетайп: 711).

Japanese 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。

Serbo-Croatian/Croatian 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).

جنتك 711: 432-7587 (TTY)).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما Persian/Farsi فراهم می باشد. با (TTY:711) 758-432-58-1 تماس بگیرید.

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

Italian 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).





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 "Voter Preference Question" 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 would like help in filling out the Voter Preference Question 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 preference form at https://servicearizona.com/VoterRegistration/selectLanguage.

Voter Preference Question Form

The Voter Preference Question form is on the last page. Please read the form and answer "Yes" or "No." Sign and date the form under "Signature of Client"

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

DES-1231A FORFF (12-23)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY

NATIONAL VOTER REGISTRATION ACT VOTER PREFERENCE QUESTION

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by the Arizona Department of Economic Security (DES) or affect your eligibility for a DES program or service. If you are not registered to vote where you live now, would you like to apply to register to vote here today? Yes \text{No} \text{No}
IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.
If you mark 'yes' or neither box is checked, a voter registration form will be provided to you. If you would like help filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application in private. You may take the form with you and mail it to the County Recorder yourself or you may complete the form here and provide it to an employee.
Whether or not you choose to register to vote, your choice and any information you provide is confidential. It will be used only for voter registration purposes. This form will be kept separate from any assistance-related documents. Any voter registration forms and attachments received by DES will be sent to the County Recorder's office.
NOTE: Free language assistance for DES services is available upon request. For additional information and instructions on how to complete the voter registration process, you can call 1-877-THE VOTE.
Signature of Client: Date:
(or initials of staff person when client doesn't want to sign the form)
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 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 Services Director - Office of the Secretary of State 1700 West Washington St. Phoenix, Arizona 85007 - (602) 542-8683 or (877) 843-8683
Official Use Only
Complete the Method of Encounter for every covered transaction.
Method of Encounter: ☐ In person (face to face) ☐ Remote (telephone, online, drop-off)
When the response to the question "Would you like to apply to register to vote here today?" above, is "Yes" or neither box is checked, please answer the two questions below:
Question 1: What was the customer's Voter Preference Question Response? ☐ Yes ☐ Neither box checked
Question 2: The Voter Registration form (DES-1232A) was provided: