



Request for Medicaid Eligibility Determination  
Medically Indigent Program

*This coversheet must be completed prior to submitting the application to Health & Welfare*

TO: Idaho Department of Health & Welfare Medicaid Services Application - Idaho Falls Fax: (208) 528.3771 Email: SRCU-CntyHospApp@dhw.idaho.gov	FROM: _____ Fax: _____ Email: _____
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**HOSPITAL/COUNTY CONTACT INFORMATION:**

Date Medical Service was provided: \_\_\_\_\_

**Hospital Contact Information:**

Hospital: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Contact Person: \_\_\_\_\_

**County Contact Information:**

County (Idaho): \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Contact Person: \_\_\_\_\_

By signing below and requesting a Medicaid eligibility determination under the Medically Indigent Program, county/hospital accepts and acknowledges that they have read, understand, and will comply with the rules promulgated by the Department of Health & Welfare and the Board of the Catastrophic Health Care Cost Program, pursuant to Title 31, Chapter 35, Idaho Code.

\_\_\_\_\_  
Signature of Authorized Representative

\_\_\_\_\_  
Title and Date

# Request for Medicaid Eligibility Determination

## HOSPITAL INSTRUCTIONS:

- Hospital staff will assist the patient in completing, in its entirety, the Combined Idaho Department of Health & Welfare and County Application for Assistance.
- The completed application **must be transmitted to the Idaho Department of Health & Welfare Medicaid Services Application**. Applications may be transmitted by:
  - Email: SRCU-CntyHospApp@dhw.idaho.gov
  - Fax: 208-528-3771
  - Mail: P.O. Box 83720  
Boise, Id 83720-0003

## COUNTY INSTRUCTIONS:

- County staff will assist the patient in completing, in its entirety, the Combined Idaho Department of Health & Welfare and County Application for Assistance.
- The completed application **must be transmitted to the Idaho Department of Health & Welfare Medicaid Services Application**. Applications may be transmitted by:
  - Email: SRCU-CntyHospApp@dhw.idaho.gov
  - Fax: 208-528-3771
  - Mail: P.O. Box 83720  
Boise, Id 83720-0003



# COMBINED APPLICATION FOR ASSISTANCE

State and County Medical Assistance Programs



**FOOD ASSISTANCE**



**HEALTH COVERAGE ASSISTANCE**



**CASH ASSISTANCE**



**CHILD CARE ASSISTANCE**

**IMPORTANT NOTICE:** If you need any of the following assistance, please ask. These services are free:

- Language Interpreter. (Nosotros proveemos los servicios de un interprete, sin costo alguno.) Call 2-1-1 or 1-800-926-2588 or TDD 208-332-7205.
- Help filling out this form.
- Accommodation for a disability.

**INSTRUCTIONS:** Read all questions and instructions carefully. The instructions include tips to help you fill out the application quickly and easily. Read the back side of each page for more information. If you want Food Stamps only, you can start the application process immediately: fill out this page, sign it, and turn it in. Then complete the rest of the application and turn it in as soon as possible. If you need to provide more information than space allows, attach extra sheets.

What is your preferred language? Spoken \_\_\_\_\_ Written \_\_\_\_\_

Do you want an interpreter if you are interviewed? One will be provided at no cost to you.  No  Yes

¿Usted necesita a intérprete si usted tiene una entrevista? Uno estará disponible en ningún costo para usted.  No  Sí

## Tell Us Who You Are

First Name	Middle Initial	Last Name	Date of Birth	Former Names, if any
Physical Address	City	State	Zip Code	County
Mailing Address (if different)	City	State	Zip Code	County
Daytime Phone Number (work, home, or cell)	If none, where can we leave a message? Phone:		E-Mail Address	

### COMPLETE THIS SECTION IF YOU ARE APPLYING FOR EMERGENCY FOOD STAMPS.

- Are any members of your household migrant or seasonal farm workers?  No  Yes
- Is your income before taxes this month less than \$150?  No  Yes
- Are your monthly housing & utility costs more than your total monthly income & resources?  No  Yes
- Are your resources (cash, checking, savings) less than \$100?  No  Yes

**If you qualify, emergency Food Stamp benefits can begin within seven days.**

Signature of Applicant/Authorized Representative to request Food Stamps \_\_\_\_\_

Date \_\_\_\_\_

The **Idaho Telecommunications Service Assistance Program (ITSAP)** helps pay telephone installation and monthly telephone service costs for low-income households. Do you want telephone assistance for your household?  No  Yes

If yes, what phone company do you use? \_\_\_\_\_


File Name: \_\_\_\_\_ ICCP #: \_\_\_\_\_ TAFI #: \_\_\_\_\_ Date Scanned: \_\_\_\_\_ Appt. Date: \_\_\_\_\_

AABD #: \_\_\_\_\_ FS #: \_\_\_\_\_ LTC #: \_\_\_\_\_ Assigned To: \_\_\_\_\_ Appt. Time: \_\_\_\_\_

FM #: \_\_\_\_\_ Expedite?  No  Yes

**OFFICE USE**

Source Code

**APPLICATION INSTRUCTIONS:** The application includes tips to direct you through the questions you need to answer for the services you want. When you see a red stop sign like this,  read and follow the instructions carefully to make sure that you give us all the information we need. You will find references to the back side of the application pages where you can find more information about the application process and the service(s) you want.

Once you finish filling out the application, read the **Rights and Responsibilities**, sign pages 12 and 13, and submit the application to your local Health and Welfare office. You can find local office listings by going online to [www.healthandwelfare.idaho.gov](http://www.healthandwelfare.idaho.gov) or by calling Idaho CareLine at 2-1-1 or 1-800-926-2588.

If you have a question about this application, the application process, or need help completing the application, call your local Health and Welfare office or Idaho CareLine by dialing 2-1-1 or 1-800-926-2588.

**OUR SERVICES FOR STATE ASSISTANCE:**

**Food Assistance** - this program can help you buy food for good health. Go to the back side of page 4 for more information.

**Health Coverage** - this program can help you get health coverage for children, adults with children, pregnant women, and the elderly, blind, or disabled. Go to the back side of page 3 for more information about Health Coverage for Children; go to the back side of page 5 for more information about Health Coverage for adults with children, pregnant women, and the elderly, blind, or disabled.

**Cash Assistance** - this program provides cash assistance for emergency situations, families with children, and the elderly, blind, or disabled. Go to the back side of page 4 for more information about Cash Assistance for emergency situations, families, and children; go the back side of page 5 for more information about Cash Assistance for the elderly, blind, or disabled.

**Child Care Assistance** - this program can help you pay part of your costs for child care. Go to the back side of page 2 for more information.

**HEALTHY CONNECTIONS:** Healthy Connections is a mandatory Primary Care Case Management program for Idaho Medicaid. Most people participating in either Medicaid benefits plan (Basic or Enhanced) must enroll in Healthy Connections, unless they qualify for an exemption, such as having a current relationship with a doctor that is not participating in Healthy Connections. Enrollment means you choose one doctor or clinic who will guide your healthcare. **Please list the doctor or clinic of your choice on page 2 in the CLINIC/DOCTOR box.** You can also let Healthy Connections choose a doctor for you. Details about Medicaid benefits and Healthy Connections are available at [www.healthandwelfare.idaho.gov](http://www.healthandwelfare.idaho.gov).

**CHILD SUPPORT:** By applying for medical services you may be referred to Child Support Services for medical support; by applying for cash assistance, you may be required to cooperate with Child Support Services. If your household includes minor children and one or both parents are not living in the home, and you would like help obtaining a child support order, call 1-800-356-9868. A fee may be required for this service.

**TO COMPLETE THE TABLE ON PAGE 2:** Fill out all fields for each person in your household. Mark the appropriate box next to the name field for each of the services each person wants to apply for. If someone in your household does not want benefits, do not mark the boxes for that person. Use the Code Key to indicate the marriage status and race of each person.

**Example of how to complete page 2.**

<input checked="" type="checkbox"/> Cash Assistance	Name: (First) (Middle) (Last)			Date of Birth:	Social security #:	Relationship:	
<input type="checkbox"/> Premium Assistance	Jon Nathan Doe			01-02-1957	012-34-5678	SELF	
<input type="checkbox"/> Health Coverage	Sex: <input checked="" type="checkbox"/> M <input type="checkbox"/> F	Pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO	Marital Status: Wi		Race: AI	Hispanic or Latino? (Optional) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	U.S. Citizen? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Child Care Assistance	Due Date:		How many due:		Alien ID #:		
<input type="checkbox"/> Food Assistance	Birth Country: US	Birth State (if born in US): Idaho		Clinic/Doctor Name (first and last) Dr. Stan Pepper		Phone Number: (208) 555-1234	
<input checked="" type="checkbox"/> Cash Assistance	Name: (First) (Middle) (Last)			Date of Birth:	Social security #:	Relationship:	
<input type="checkbox"/> Premium Assistance	Jo Anna Doette			05-06-1997	234-56-7890	Step-daughter	
<input checked="" type="checkbox"/> Health Coverage	Sex: <input type="checkbox"/> M <input checked="" type="checkbox"/> F	Pregnant? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	Marital Status: NM		Race: AI	Hispanic or Latino? (Optional) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	U.S. Citizen? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Child Care Assistance	Due Date:		How many due:		Alien ID #:		
<input type="checkbox"/> Food Assistance	Birth Country: US	Birth State (if born in US): Kansas		Clinic/Doctor Name (first and last) Dr. Jill Doolittle		Phone Number: (208) 555-6789	

# Tell Us What Services You Want

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

**List every person living in your home.** If a person does NOT want assistance, list them below but do not mark the boxes indicating the type of benefits wanted. Add an additional sheet if you need to include more household members. Social Security numbers and citizenship status are required for those applying for services. See the back of page 1 for an example of how to complete the table below. Use the code key to indicate your Marital Status and Race. **NOTE:** Your responses to the Race and Hispanic/Latino boxes are optional.

## FOR STATE ASSISTANCE:

Cash Assistance - Mark this box for each person who wants cash assistance (for emergency, families, elderly and disabled).

Premium Assistance - Mark this box for each person who wants help paying premiums for private health coverage.

Health Coverage - Mark this box for each person who wants health coverage or help paying for health coverage.

Child Care Assistance - Mark this box for each person who wants help paying for child care.

Food Assistance - Mark this box for each person who wants help buying food.

## Race Codes:

White - WH  
 Black - BL  
 Asian - AS  
 American Indian/Alaska Native - AL  
 Native Hawaiian/Pacific Island - HP

## Marital Status Codes:

Married - MA  
 Never Married - NM  
 Divorced - DI  
 Separated - SE  
 Widowed - WI

<input type="checkbox"/> Cash Assistance <input type="checkbox"/> Premium Assistance <input type="checkbox"/> Health Coverage <input type="checkbox"/> Child Care Assistance <input type="checkbox"/> Food Assistance	Name: (First) (Middle) (Last)			Date of Birth:	Social security #:	Relationship: <b>SELF</b>	
	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO	Marital Status:		Race:	Hispanic or Latino? (Optional) <input type="checkbox"/> YES <input type="checkbox"/> NO	U.S. Citizen? <input type="checkbox"/> YES <input type="checkbox"/> NO
	Due Date:		How many due:		Alien ID #:		
	Birth Country:		Birth State (if born in US):		Clinic/Doctor Name (first and last):		Phone Number:

<input type="checkbox"/> Cash Assistance <input type="checkbox"/> Premium Assistance <input type="checkbox"/> Health Coverage <input type="checkbox"/> Child Care Assistance <input type="checkbox"/> Food Assistance	Name: (First) (Middle) (Last)			Date of Birth:	Social security #:	Relationship to self:	
	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO	Marital Status:		Race:	Hispanic or Latino? (Optional) <input type="checkbox"/> YES <input type="checkbox"/> NO	U.S. Citizen? <input type="checkbox"/> YES <input type="checkbox"/> NO
	Due Date:		How many due:		Alien ID #:		
	Birth Country:		Birth State (if born in US):		Clinic/Doctor Name (first and last):		Phone Number:

<input type="checkbox"/> Cash Assistance <input type="checkbox"/> Premium Assistance <input type="checkbox"/> Health Coverage <input type="checkbox"/> Child Care Assistance <input type="checkbox"/> Food Assistance	Name: (First) (Middle) (Last)			Date of Birth:	Social security #:	Relationship to self:	
	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO	Marital Status:		Race:	Hispanic or Latino? (Optional) <input type="checkbox"/> YES <input type="checkbox"/> NO	U.S. Citizen? <input type="checkbox"/> YES <input type="checkbox"/> NO
	Due Date:		How many due:		Alien ID #:		
	Birth Country:		Birth State (if born in US):		Clinic/Doctor Name (first and last):		Phone Number:

<input type="checkbox"/> Cash Assistance <input type="checkbox"/> Premium Assistance <input type="checkbox"/> Health Coverage <input type="checkbox"/> Child Care Assistance <input type="checkbox"/> Food Assistance	Name: (First) (Middle) (Last)			Date of Birth:	Social security #:	Relationship to self:	
	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO	Marital Status:		Race:	Hispanic or Latino? (Optional) <input type="checkbox"/> YES <input type="checkbox"/> NO	U.S. Citizen? <input type="checkbox"/> YES <input type="checkbox"/> NO
	Due Date:		How many due:		Alien ID #:		
	Birth Country:		Birth State (if born in US):		Clinic/Doctor Name (first and last):		Phone Number:

<input type="checkbox"/> Cash Assistance <input type="checkbox"/> Premium Assistance <input type="checkbox"/> Health Coverage <input type="checkbox"/> Child Care Assistance <input type="checkbox"/> Food Assistance	Name: (First) (Middle) (Last)			Date of Birth:	Social security #:	Relationship to self:	
	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO	Marital Status:		Race:	Hispanic or Latino? (Optional) <input type="checkbox"/> YES <input type="checkbox"/> NO	U.S. Citizen? <input type="checkbox"/> YES <input type="checkbox"/> NO
	Due Date:		How many due:		Alien ID #:		
	Birth Country:		Birth State (if born in US):		Clinic/Doctor Name (first and last):		Phone Number:

**CHILD CARE ASSISTANCE** is provided by the Idaho Child Care Program (ICCP) to help parents and caretakers pay part of the costs of child care while working, going to school or training, or looking for work.

**TO APPLY** for Child Care Assistance, complete pages 1-5, sign pages 12 and 13, and return your completed application to your local Health and Welfare office. You can find office listings by going online to [www.healthandwelfare.idaho.gov](http://www.healthandwelfare.idaho.gov) or dialing 2-1-1 or 1-800-926-2588.

**You may need to provide the following proof:**

- Income, or any other money coming into your household such as wage stubs for the last 30 days or current federal income tax records, if self-employed.
- Social Security Number (optional).
- Child care costs.
- Immunization records for any children not yet in school. (If you do not immunize due to medical or religious reasons, please provide a written statement stating your reason.)
- Name of childcare provider.
- Current school schedule (if attending school) for parents/caretakers - this must include days and times in class.
- Child support paid for a child not living with you. Your child care benefit amount may increase if you provide this proof.

**To receive Child Care Assistance, you must meet the following program requirements:**

- If both parents are in the household, each parent must be working, attending training or education programs, or looking for work in order for the family to be approved for Child Care Assistance. ICCP only covers a part of your child care costs while you are actually at work or in training or education.
- You must be in a full-time job, or participate in full-time education or training activities to receive full-time Child Care Assistance.
- You must pay the remaining costs not covered by the Child Care program. ICCP will never pay 100% of your child care costs.
- If you are looking for work, and you are not receiving family cash assistance, you will be allowed 80 hours of job search for up to three months in a year. ICCP will pay part of the full-time child care while you look for work. If you place your child in full-time care while looking for work, you will be responsible for the additional costs.
- ICCP will cover part of your child care costs only when care is provided by an ICCP registered child care provider.

**If you receive Child Care Assistance, you must report changes such as:**

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

If you have questions about applying for Child Care Assistance, please call 1-866-343-2027. For information on how a child care provider can become registered with ICCP please contact the Idaho CareLine by dialing 2-1-1 or 1-800-926-2588.

# Tell Us About Your Household

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

Is anyone in your home already getting services or applying for services from one of the following programs?

Please check all that apply. Your answer to this question will not affect your eligibility for benefits.

- Other State's Assistance Programs     
  Childrens or Adult Developmental Disabilities     
  Infant and Toddler  
 Childrens or Adult Mental Health     
  Foster Care or Adoption Assistance

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

If Yes, from where? City \_\_\_\_\_ State \_\_\_\_\_ County \_\_\_\_\_ When? \_\_\_\_\_

If applying for Health Coverage, would you like Healthy Connections to choose a doctor for you?  No  Yes

See **"Healthy Connections"** on the back side of page 1 for more information.

List anyone in your home that:

- Has a disability

\_\_\_\_\_

- Receives or has applied for Social Security

\_\_\_\_\_

- Receives or has applied for Medicare

\_\_\_\_\_

- Needs medical assistance at home

\_\_\_\_\_

- Lives with a relative who provides medical care

\_\_\_\_\_

- Lives in a medical care facility

\_\_\_\_\_

Name of Facility:

\_\_\_\_\_

List any household member age 16 or older who is a student or planning to attend school.

STUDENT NAME	WHERE ATTENDING SCHOOL	STUDENT STATUS	EXPECTED GRADUATION DATE
		<input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME	
		<input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME	
		<input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME	

If you have any children in your home, are they current on immunizations?  No  Yes

If you have any children in your home, do any of them have a parent NOT living with them?  No  Yes

If you answered "Yes" you will be required to give information about the absent parent(s) to Child Support Services and open a Child Support case unless you fear harm to yourself or your children. See **"Child Support Cooperation"** on the back side of page 1 for more information.

List any Absent Parents of the children in your home.

NAME OF ABSENT PARENT	NAME OF CHILD	ABSENT PARENT'S SSN	ABSENT PARENT'S DOB

**HEALTH COVERAGE FOR CHILDREN** is provided by Idaho Medicaid to help you get health coverage for dependent children in your home. Idaho Medicaid offers options based on health needs:

- **The Medicaid Basic Plan** is for low-income children who do not have special health needs. Depending on the amount of your family income, there may be a cost of \$10 - \$15/month per eligible child associated with this plan.
- **The Medicaid Enhanced Plan** is for persons with disabilities or special health needs.
- **The Children's Access Card** helps pay premiums for private health coverage for families who may have higher incomes. This program can help pay premiums up to \$100/month per child, limited to \$300 per family each month. If eligible for this plan, and your child currently does not have health insurance, you can add your child to your employer-sponsored insurance plan or you may enroll them in a private health plan of your choice. You will be responsible for any remaining premium payments, co-payments, and deductibles.

**TO APPLY** for Health Coverage for Children, complete pages 1-5, sign page 12 and return your completed application to your local Health and Welfare office. You can find office listings by going online to [www.healthandwelfare.idaho.gov](http://www.healthandwelfare.idaho.gov) or dialing 2-1-1 or 1-800-926-2588.

**You may need to provide the following proof:**

- Citizenship and identity.
- Social Security Number or proof that you have applied for one.
- Resident Alien Card (if not a U.S. citizen) or other residency documents.
- Other health insurance you have.
- Income, or any other money coming into your household such as wage stubs for the last 30 days or current federal income tax records, if self-employed. Providing this proof may speed the determination process.
- U.S. Citizenship and Identity for Medicaid applicants. Federal Law requires all Medicaid participants who claim U.S. citizenship to give hard copy proof of their U.S. citizenship and identity. Many documents will be acceptable to prove U.S. citizenship and/or identity. If you are enrolled in Medicare or receive Supplemental Security Income (SSI), or are a "Qualified Alien," you are not affected by this law. **The Department can accept only original or certified documents.** Your worker will ask for this proof in a later notice. If you need help getting these documents, need more time, or have questions about which documents we can accept, please contact your local office as soon as possible.

**HEALTHY CONNECTIONS** is a mandatory Primary Care Case Management program for Idaho Medicaid. Most people participating in either Medicaid benefits plan (Basic or Enhanced) must enroll in Healthy Connections, unless they qualify for an exemption, such as having a current relationship with a doctor that is not participating in Healthy Connections. Enrollment means you choose one doctor or clinic who will guide your healthcare. Make sure you list the doctor or clinic of your choice on page 2 in the CLINIC/DOCTOR box. Healthy Connections can choose a doctor for you. Details about Medicaid benefits and Healthy Connections are available at [www.healthandwelfare.idaho.gov](http://www.healthandwelfare.idaho.gov).

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

- Change of address or phone number.
- Change in Social Security Number.
- If you become disabled.
- The birth of a baby.

**CHILD SUPPORT COOPERATION:** If medical assistance is granted for a minor child and one or more parents are not in the home, a medical support case will be opened. If you are receiving any benefits for yourself as an adult, you must cooperate with Child Support Services to avoid a loss or decrease of your benefits, unless you fear harm to yourself or your children.

# Tell Us About The Following Expenses

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

The following expenses relate to child support payments and child or adult care costs. If you do not have these expenses, skip to the next section. If you have either or both of these expenses, please provide the following information. Your Food Stamps may increase if you pay child care costs or child support for children not living with you. However, if you do not report or verify these expenses, it will mean that you do not want a deduction for the unreported or unverified expenses. See the back of page 4 for more information.

List everyone in your home who PAYS court-ordered child support expenses.

NAME OF PERSON THAT PAYS CHILD SUPPORT	AMOUNT PAID PER MONTH	LAST DATE PAID	NAME OF PERSON WHO RECEIVES PAYMENT

List everyone in your home who PAYS child or adult care expenses due to work or school.

<b>Name:</b>	<b>Reason for Care:</b> <input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Work Search	<b>Name of Child/Adult in Care:</b>	<b>Amount paid: \$</b> _____ How Often? _____
<b>Name of Care Provider:</b>	<b>Do you get help paying for care?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <b>If Yes, how much do you receive?</b> \$ _____ <b>Name of Person/Agency paying:</b>		
<b>Name:</b>	<b>Reason for Care:</b> <input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Work Search	<b>Name of Child/Adult in Care:</b>	<b>Amount paid: \$</b> _____ How Often? _____
<b>Name of Care Provider:</b>	<b>Do you get help paying for care?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <b>If Yes, how much do you receive?</b> \$ _____ <b>Name of Person/Agency paying:</b>		
<b>Name:</b>	<b>Reason for Care:</b> <input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Work Search	<b>Name of Child/Adult in Care:</b>	<b>Amount paid: \$</b> _____ How Often? _____
<b>Name of Care Provider:</b>	<b>Do you get help paying for care?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <b>If Yes, how much do you receive?</b> \$ _____ <b>Name of Person/Agency paying:</b>		
<b>Name:</b>	<b>Reason for Care:</b> <input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Work Search	<b>Name of Child/Adult in Care:</b>	<b>Amount paid: \$</b> _____ How Often? _____
<b>Name of Care Provider:</b>	<b>Do you get help paying for care?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <b>If Yes, how much do you receive?</b> \$ _____ <b>Name of Person/Agency paying:</b>		

# Tell Us About Your Household Income

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

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

TYPE OF MONEY RECEIVED	WHO EARNED / RECEIVED MONEY	NAME OF EMPLOYER	HOW OFTEN PAID	\$ PER HOUR	HOURS PER WEEK	TOTAL MONTHLY AMOUNT
			<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually			
			<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually			
			<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually			

Is anyone in the household self-employed?  No  Yes Who? \_\_\_\_\_

Name of business: \_\_\_\_\_ Years in business: \_\_\_\_\_

**FOOD ASSISTANCE** is provided by the Food Stamps program to help people buy food for good health. Eligible families get a card for buying food items.

**TO APPLY** for Food Assistance, complete pages 1-7, sign page 12, and return your completed application to your local Health and Welfare office. You can find office listings by going online to [www.healthandwelfare.idaho.gov](http://www.healthandwelfare.idaho.gov) or dialing 2-1-1 or 1-800-926-2588. You may be required to attend an interview and give us proof to support the information on your application before we can make a decision about your benefits. Please contact your local office if you can't participate in an interview during normal office hours or if you need interpreter services.

**You may need to provide the following proof:**

- Identity.
- Student status (full or part time).
- Social Security Number or proof that you have applied for one.
- Resident Alien Card (if not a U.S. citizen) or other residency documents.
- Income, or any other money coming into your household such as wage stubs for the last 30 days or current federal income tax records, if self-employed.
- Most recent statements for any bank accounts (checking, credit union, savings, etc.).
- Value of cars/trucks or other vehicles such as motorcycles, boats, RVs.
- Current value of stocks/bonds, certificates of deposit, life insurance, trusts.
- Expenses (proof of these expenses may increase your food stamp amount) such as, child or adult care costs, child support paid for children not living with you, housing costs, medical expenses (including prescriptions) for people with disabilities or who are over 60, and utility costs. **NOTE:** Your Food Stamps may increase if you have expenses such as child or adult care costs, child support paid for children not living with you, housing costs, medical costs (including prescriptions) for people with disabilities or who are over 60, and utility costs. However, if you do not report or verify any of these expenses, it will mean that you do not want a deduction for the unreported or unverified expenses.

**To receive Food Assistance, you must meet the following program requirements:** You may be required to participate in work programs. Failure to do so may result in the loss or decrease of benefits.

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**CASH ASSISTANCE FOR CHILDREN AND FAMILIES** is provided by the Temporary Assistance to Families in Idaho (TAFI) program to provide cash assistance for eligible families with children living in the home. Lifetime eligibility is limited to 24 months for adults. The maximum payment any family can receive is \$309 per month, regardless of family size.

**TO APPLY** for Cash Assistance for Children & Families, complete pages 1-6, sign page 12, and return your completed application to your local Health and Welfare office. You can find office listings by going online to [www.healthandwelfare.idaho.gov](http://www.healthandwelfare.idaho.gov) or dialing 2-1-1 or 1-800-926-2588.

**You may be required to provide the following proof:**

- Citizenship.
- Social Security Number or proof that you have applied for one.
- Resident Alien Card (if not a U.S. citizen) or other residency documents.
- That you are a resident of Idaho.
- Income, or any other money coming into your household such as wage stubs for the last 30 days or current federal income tax records, if self-employed.
- Most recent statements for any bank accounts (checking, credit union, savings, etc.).
- Value of cars/trucks or other vehicles such as motorcycles, boats, RVs.
- Current value of stocks/bonds, certificates of deposit, life insurance, trusts.
- Immunization records for any children not yet in school.

**To receive Cash Assistance for Children and Families, you must meet the following program requirements:**

- TAFI participants are required to work, look for work, or participate in training to prepare you to go to work.
- All applicants for Temporary Assistance for Families in Idaho (TAFI) will be asked to participate in a substance-abuse assessment.
- Participants must sign and comply with a Personal Responsibilities Contract (PRC), which they complete with their case worker.

**CHILD SUPPORT COOPERATION:** You are required to cooperate with Child Support Services for cash assistance. If cash assistance is approved for a minor child and one or more parents are not in the home, you will be required to give information about the absent parent(s) to Child Support Services and open a Child Support case unless you fear harm to yourself or your children.

# Tell Us About Your Current Health Coverage

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

Does anyone applying for health coverage need help paying medical bills from the last three months?  No  Yes

If Yes, who? \_\_\_\_\_

List gross income amount (income before taxes) received by your family in each of the last three months.

\$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_  
 Last Month Two Months Ago Three Months Ago

List everyone in your household who currently has health insurance.

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

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

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

Reason the Insurance Ended:

- Job of parent/step-parent ended or changed
- Insurance company will not insure the child
- Stopped/dropped by COBRA policy
- Family coverage dropped by parent/step-parent
- Premiums too expensive
- Stopped/dropped by someone other than parent/step-parent

Do you have access to any health insurance not listed above?  No  Yes

Do you have health insurance that covers inpatient/outpatient hospital, physician's medical and surgical, lab, and x-ray services?  No  Yes

Are you a dependant of a full-time State employee?  No  Yes



- If you want only **child care** or **health coverage for your children**, you are done giving us information. **Go to page 8 to sign the application.** See the back side of page 2 for more information about Child Care Assistance; and the back side of page 3 for more information about Health Coverage for Children.
- If you want **food assistance, cash assistance, or health coverage for pregnant women, adults with children, or the elderly, blind, or disabled**, then **proceed to the next section.**

# Tell Us About Your Assets

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

Does anyone in your household have cash?  No  Yes How much? \$ \_\_\_\_\_

List everyone in your home who has a checking or savings account:

OWNER'S NAME	TYPE OF ACCOUNT	NAME OF BANK OR FINANCIAL INSTITUTION	ACCOUNT NUMBER	BALANCE

**HEALTH COVERAGE FOR ADULTS** with children and **Pregnant Women** is provided by Idaho Medicaid to help you get health care for eligible adults. Your family income and resources are used to determine your eligibility. Idaho Medicaid offers options based on health needs:

- **The Medicaid Basic Plan** is for working-age adults who do NOT have special health needs and have dependent children.
- **The Medicaid Enhanced Plan** is for persons with disabilities or special health needs, including the elderly.
- **Health Coverage for Pregnant Women** provides services related to pregnancy health care needs.

**HEALTH COVERAGE AND CASH ASSISTANCE FOR THE ELDERLY, BLIND, OR DISABLED** provides assistance to individuals or couples who are 65 or older or have been found to be blind or disabled by Social Security standards. This includes employed workers with disabilities. Idaho Medicaid also can help pay for Medicare Part B premiums and in-home or nursing home care.

**TO APPLY** for:

- Health Coverage for Adults with children and Pregnant Women, complete pages 1-6 and sign pages 12 and 13.
- Health Coverage for the elderly, blind, or disabled, complete pages 1-7 and sign pages 12 and 13.
- Cash Assistance for the elderly, blind, or disabled, complete pages 1-7 and sign pages 12 and 13.

Return your completed application to your local Health and Welfare office. You can find office listings by going online to [www.healthandwelfare.idaho.gov](http://www.healthandwelfare.idaho.gov) or dialing 2-1-1 or 1-800-926-2588.

**You may be required to provide the following proof:**

- Citizenship and identity.
- Social Security Number or proof that you have applied for one.
- Resident Alien Card (if not a U.S. citizen) or other residency documents.
- Other health insurance that you have.
- Income or any other money coming into your household such as wage stubs from the last 30 days (if you are employed) or current federal income tax records, if you are self-employed.
- Most recent statements for any bank accounts (checking, credit union, savings, etc.).
- Value of cars/trucks or other vehicles such as motorcycles, boats, RVs.
- Current value of stocks/bonds, certificates of deposit, life insurance, trusts.
- U.S. Citizenship and Identity for Medicaid applicants. Federal Law requires all Medicaid participants who claim U.S. citizenship to give hard copy proof of their U.S. citizenship and identity. Many documents will be acceptable to prove U.S. citizenship and/or identity. If you are enrolled in Medicare or receive Supplemental Security Income (SSI), or are a "Qualified Alien," you are not affected by this law. **The Department can only accept original or certified documents.** Your worker will request this proof in a later notice. If you need help in getting these documents, need more time, or have questions about which documents we can accept, please contact your local office as soon as possible.

**HEALTHY CONNECTIONS** is a mandatory Primary Care Case Management program for Idaho Medicaid. Most people participating in either Medicaid benefits plan (Basic or Enhanced) must enroll in Healthy Connections, unless they qualify for an exemption, such as having a current relationship with a doctor that is not participating in Healthy Connections. Enrollment means you choose one doctor or clinic who will guide your healthcare. Make sure you list the doctor or clinic of your choice on page 2 in the CLINIC/DOCTOR box. Healthy Connections can choose a doctor for you. Details about Medicaid benefits and Healthy Connections are available at [www.healthandwelfare.idaho.gov](http://www.healthandwelfare.idaho.gov).

**If you receive Health Coverage or Cash Assistance, you must report the following changes:**

- Change of address or phone number.
- Change in income or resources.

**CHILD SUPPORT COOPERATION:** If medical assistance is granted for a minor child and one or more parents are not in the home, a medical support case will be opened. If you are receiving any benefits for yourself as an adult, you must cooperate with Child Support Services to avoid a loss or decrease of your benefits, unless you fear harm to yourself or your children.

# Tell Us About Your Assets, continued

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

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

OWNER'S NAME	TYPE OF ACCOUNT	NAME OF BANK OR FINANCIAL INSTITUTION	ACCOUNT NUMBER	\$ VALUE

List everyone in your home who has Life Insurance Policies or Burial Funds or Policies:

OWNER'S NAME	TYPE OF ACCOUNT	NAME OF POLICY	\$ FACE VALUE	\$ CASH VALUE

List each car, truck, motorcycle, trailer, boat, snowmobile, and other recreational vehicles owned by anyone in your home:

YEAR	MAKE	MODEL	AMOUNT OWED	VALUE

List the total value of other assets such as land or property, excluding the home you live in?

ITEM	VALUE	AMOUNT OWED

List everyone in your home who has sold, transferred or given away any cash, property, or other assets in the past 5 years:

NAME	DATE OF TRANSACTION	WHAT ASSETS	\$ RECEIVED	FAIR MARKET VALUE



- If you want **cash assistance for children and families, or health coverage for pregnant women and adults with children**, you are done giving us information. **Go to pages 12 and 13 to sign the application.** See the back side of page 4 for more information about cash assistance for families and children; and the back side of page 5 for more information about health coverage for pregnant women and adults with children.
- If you want **cash assistance or health coverage for the elderly, blind, or disabled, or assistance buying food**, then **proceed to the next section.**

## DO I HAVE TO BE A CITIZEN?

According to the U.S. Citizenship and Immigration Services, if you do NOT have a green card, members of your family who are eligible can use non-cash benefits, including Medicaid, Food Stamps, WIC, housing assistance, energy benefits, job training, child care, disaster relief, public health assistance, etc., without hurting your chances of getting a green card, becoming a U.S. citizen, or sponsoring relatives in the future.

## DO I HAVE TO RELEASE MY SOCIAL SECURITY NUMBER (SSN) AND CITIZENSHIP STATUS?

Some family members of applicants may choose not to apply for Health and Welfare services. In that case, they do not have to provide a SSN or citizenship or immigration status. Benefits to applicants will not be delayed or denied because some family members do not apply.

Anyone who applies for services, except child care, must have a SSN or apply for one. If you want Emergency Medicaid only or you are a victim of domestic violence, you may not have to give a SSN or immigration status. You only have to give us citizenship or immigration status information for persons who want help, except when applying for child care.

We can help you apply for a SSN, and benefits will not be denied or delayed while the application is being processed. We need the SSN to help you establish paternity, get Child Support, and change or enforce Child Support orders, including medical insurance coverage for a child. SSNs will not be given to the U.S. Citizen and Immigration Services.

## IS THERE EQUAL OPPORTUNITY FOR APPLICANTS?

In accordance with federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, the Department of Health and Welfare is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs.

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

- USDA, Director, Office of Civil Rights  
1400 Independence Avenue, SW  
Washington, D.C. 20250-9410  
  
(800) 795.3272 (Voice)  
(202) 720.6382 (TTY)

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

USDA & HHS are equal opportunity providers and employers.

## IDAHO MEDICAID PLAN CHOICE

If you are eligible for Medicaid, you have the right to choose the plan that is based on your health needs. Idaho Medicaid offers the Medicaid Basic Plan and the Medicaid Enhanced Plan to meet different health needs.

- **The Medicaid Basic Plan** is for low-income children and working-age adults with average health needs. This plan provides complete health, prevention, and wellness benefits for children and adults who don't have special health needs.
- **The Medicaid Enhanced Plan** is for individuals with disabilities or special health needs. This plan includes all benefits in the Basic Plan, plus additional benefits.

You may choose NOT to enroll in the plan that meets your health needs. You may choose to enroll in Standard Medicaid instead. Standard Medicaid does not include prescription drugs, certain prevention and wellness benefits, therapies, dental services, vision services, and other services. If you do not want to enroll in the benefit plan that meets your health needs, you must inform your Self-Reliance worker.

# Tell Us About Your Living Situation and Expenses

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

Your Food Stamps may increase if you have expenses such as adult care costs, housing costs, medical costs (including prescriptions) for people with disabilities or who are over 60, and utility costs. However, if you do not report or verify any of these expenses, it will mean that you do not want a deduction for the unreported or unverified expenses. See the back of page 4 for more information.

List the monthly housing costs for your household:

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

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

List your monthly medical costs:

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

Does your spouse live with you?  No  Yes

If "No," where does your spouse live?

Own Home  Apartment  With relative providing medical care

In a facility providing medical care Name of Facility: \_\_\_\_\_



- If you want **health coverage or cash assistance for the elderly, blind, or disabled**, you are done giving us information. **Go to pages 12 and 13 to sign the application.** See the back side of page 5 for more information about these programs.
- If you want **assistance buying food**, then **proceed to the next section.**

# Tell Us Some More About Your Household

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

If applying for Cash Assistance, has anyone in your household been convicted of a felony involving drugs?  No  Yes

If Yes, who: \_\_\_\_\_ Year: \_\_\_\_\_

Is anyone fleeing to avoid felony prosecution or jail time?  No  Yes Who: \_\_\_\_\_

Is anyone currently violating conditions of probation or parole?  No  Yes Who: \_\_\_\_\_

Has anyone been disqualified from public assistance due to an intentional program violation?  No  Yes

If Yes, who: \_\_\_\_\_ When/Where: \_\_\_\_\_

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

Heating  Cooling  Water  Sewer  Trash  Telephone  
 Electrical  Other: \_\_\_\_\_  Other: \_\_\_\_\_



- If you want **assistance buying food**, you are done providing us the information we need. **Go to pages 12 and 13 to sign the application.** See the back side of page 4 for more information about getting food assistance.
- If you want **county medical assistance**, then **proceed to the next page.**

# COUNTY MEDICAL ASSISTANCE

A face-to-face county interview is required before you receive county medical assistance. In rare cases you may have a telephone interview. You will be required to provide proof of all information shown on your application. If you have any questions about this, ask your County Assistance Office.

**DOCUMENTATION:** To establish eligibility for county medical assistance, you must provide the County Assistance Office with all of the following that apply:

Proof of identity, like photo identification card, driver's license, or immigration cards.

Proof of application or award letters for Social Security, SSI, Medicaid, Medicare, Worker's Compensation, or Crime Victims showing current benefit amount.

Proof of application for other forms of public assistance including:

- Food Stamps
- Rental/Energy Assistance
- Housing
- TAFI
- AABD

Proof of all household income from all sources for the last six (6) months including:

- Wage Stubs
- Employer Earning Statements
- Scholarships
- Alimony
- Stipends
- Social Security
- Veterans Benefits
- Settlements
- Grants
- Student Loans
- Rental/Escrow
- Child Support
- Unemployment
- Interest

A complete copy of the most recent federal and state income tax returns with schedules and W-2s.

If self-employed, the year-to-date bookkeeping records including sales and expense records.

The last six (6) months of bank statements including checking, savings, escrow, and credit union accounts.

Proof of value and balances owed for all real property.

Proof of value and balances owed for all personal property including:

- Household Goods (including art, jewelry, coins, guns, collections, electronic equipment, musical instruments, tools of trade, etc.)
- Motor Vehicles
- Certificates of Deposit
- Livestock
- Trailers
- IRAs
- Other Vehicles
- Trusts
- Mining Claims
- Campers
- Stocks
- Motorcycles
- Inheritance
- Farm Equipment
- RVs
- Bonds
- Snowmobiles
- Annuities
- Timber
- 401Ks

Proof of monthly expenses for the last six (6) months, for example:

- Utility Bills
- Current Month's Rent
- Child Support
- Alimony
- Space Rent
- Medical Expenses
- Land/House Payment
- Child Care
- All Insurance
- Balances Owed

Proof of health insurance and life insurance.

Proof of Veteran's status (DD214, military discharge papers).

**Provide all medical bills (immediately, upon receipt) to the county for which assistance is requested.**

# County Medical Assistance Information

## Tell Us About the Patient

First Name	Middle Initial	Last Name	Date of Birth	Former Names, if any
If Minor, Parent/Guardian Name				
If Legal Alien, Sponsor Name				
List medical condition(s) and procedure(s) for which you are requesting assistance:				
Are you registered to vote? <input type="checkbox"/> No <input type="checkbox"/> Yes		Are you licensed to drive? <input type="checkbox"/> No <input type="checkbox"/> Yes		
If yes, what State/County?		If yes, what State?		
Are you a Veteran? <input type="checkbox"/> No <input type="checkbox"/> Yes		If yes, what is your VA ID#?		Type of Discharge:

## Tell Us About the Patient's Spouse/Significant Other (Provide if outside household)

First Name	Middle Initial	Last Name	Date of Birth	Former Names, if any
<input type="checkbox"/> U.S. Citizen SSN :		<input type="checkbox"/> Legal Alien If Legal Alien, Sponsor Name:		
<input type="checkbox"/> Other				
Physical Address	City	State	Zip Code	County
Daytime Phone Number (work, home, or cell)		If none, where can we leave a message?		Phone:
Is your spouse registered to vote? <input type="checkbox"/> No <input type="checkbox"/> Yes		Is your spouse licensed to drive? <input type="checkbox"/> No <input type="checkbox"/> Yes		
If yes, what state/county?		If yes, what state?		
Is patient's spouse a Veteran? <input type="checkbox"/> No <input type="checkbox"/> Yes		If yes, VA ID#?		Type of Discharge:

Provide the following information about a person **outside** your household who is aware of your circumstances.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

County Use Only:

Date Application Received: \_\_\_\_\_

Lien Instrument #: \_\_\_\_\_

Filing Date: \_\_\_\_\_

UCC Filing Date: \_\_\_\_\_

Type of application:

Emergency 31-Day

Non-emergency 10-Day Prior

Additional Request

180-Day Delayed\*

\*Justification must be attached



## Tell Us About Medical Providers

List each medical provider to be considered for payment. (Idaho Code §§ 31-3508; 31-3505(C); 31-3505(E); and 31-3519)

PROVIDER NAME, ADDRESS, AND PHONE	DATES OF SERVICE	TYPE OF SERVICE	AMOUNT
	From: To:		
	From: To:		
	From: To:		
	From: To:		
	From: To:		
	From: To:		
	From: To:		
	From: To:		
	From: To:		

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

## Tell Us About Health Insurance/Other Assistance

- Did you or anyone in your household have health insurance in the last 60 days?  No  Yes
- Did anyone in your household have a job in the last 90 days, but is now unemployed?  No  Yes
- If unemployed, were COBRA benefits available?  No  Yes
- Date employment ended \_\_\_\_\_ Have you received COBRA forms?  No  Yes
- Do you or anyone in your household have insurance available through school?  No  Yes
- Has a court ordered anyone to pay medical expenses or provide health insurance for anyone in your household?  No  Yes

If you answered "Yes" to any of the above, provide the following information:

ELIGIBLE PERSONS	SUBSCRIBER	INSURANCE OR COMPANY NAME	POLICY NUMBER

Are you or anyone in your household an enrolled member of a Native American Tribe?  No  Yes

If yes, who? \_\_\_\_\_ Name of Tribe \_\_\_\_\_

Do you or anyone in your household have actions pending from which money may be received, such as lawsuits, inheritance, accident claims, insurance settlements, etc?  No  Yes



**Tell Us About Residency** List any residences you've had during the past five (5) years\* If you need to provide more information, please attach extra sheets

ADDRESS STREET, CITY, STATE, COUNTY	DATES	LANDLORD NAME AND PHONE NUMBER
	From: To:	
	From: To:	
	From: To:	
	From: To:	
	From: To:	
	From: To:	

**Tell Us About Income**

**Earned Income** List any employment information.

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

PATIENT/APPLICANT			SPOUSE/SIGNIFICANT OTHER		
Current Employer:			Current Employer:		
Phone:			Phone:		
Address (street, city, state, zip):			Address (street, city, state, zip):		
Hours per Week:	Hourly Rate:	Monthly Gross:	Hours per Week:	Hourly Rate:	Monthly Gross:
List Dates of Employment:			List Dates of Employment:		
Previous Employer:			Previous Employer:		
Address (street, city, state, zip):			Address (street, city, state, zip):		
Hours per Week:	Hourly Rate:	Monthly Gross:	Hours per Week:	Hourly Rate:	Monthly Gross:
List Dates of Employment:			List Dates of Employment:		

**Unearned Income** Are you or anyone in your household receiving income from the following sources? Check all that apply.

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Worker's Compensation                   | <input type="checkbox"/> Veteran's Benefits    | <input type="checkbox"/> Rental/Escrow         | <input type="checkbox"/> Alimony            |
| <input type="checkbox"/> Retirement                              | <input type="checkbox"/> Tribal/BIA Assistance | <input type="checkbox"/> Commodities           | <input type="checkbox"/> Interest/Dividends |
| <input type="checkbox"/> Inheritance/Trust                       | <input type="checkbox"/> Energy Assistance     | <input type="checkbox"/> Insurance Settlements | <input type="checkbox"/> Church             |
| <input type="checkbox"/> Income Tax Refunds/Earned Income Credit |  | <input type="checkbox"/> Other                 |   |

If you answered yes to any, list the following:

SOURCE OF UNEARNED INCOME	PERSON RECEIVING INCOME	AMOUNT



## Tell Us About Resources

**Financial Assets** List any items that you or your spouse/significant other have or on which both of your names appear.

TYPE OF ACCOUNT	NAMES ON ACCOUNT	NAME OF BANK OR INSTITUTION	ACCOUNT NUMBER	\$ VALUE

## Real/Personal Property

REAL/PERSONAL PROPERTY	DESCRIPTION	MARKET VALUE	AMOUNT OWED	EQUITY
<input type="checkbox"/> Home Residence				
<input type="checkbox"/> Manufactured Home Year, Make Model				
<input type="checkbox"/> Land				
<input type="checkbox"/> Rental Property				
<input type="checkbox"/> Livestock				
<input type="checkbox"/> Tools of Trade				
<input type="checkbox"/> Other				

Have you or your spouse/significant other sold, traded, given away, or put into a trust any money or resources within the last year?  No  Yes

If yes, provide the following:

DESCRIPTION	WHEN SOLD	AMOUNT RECEIVED

## Tell Us About Current Monthly Household Expenses

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

DESCRIPTION	MONTHLY AMOUNT	PAST DUE	BALANCE DUE	COUNTY USE ONLY
Rent/Mortgage				
Utilities				
Food				
Non-Food (Cleaning Products, Diapers, Paper Products)				
Health/Accident/Life Insurance				
Home/Renters Insurance				
Auto Insurance				
Car Payment, to:				
Fuel/Maintenance				
Payroll Taxes				
Property Taxes				
Child Support				
Contract/Credit Card Payments				
Other:				
Total Expenses				



# Rights and Responsibilities

## For Food Assistance, Health Coverage Assistance, Cash Assistance, and Child Care Assistance

By initialing the following provisions, I understand that . . .

- \_\_\_\_\_ I could be sanctioned and required to return any Medicaid benefits I receive if my information is not true. Sanctions may include administrative, civil or criminal actions against me, including prosecution.
- \_\_\_\_\_ I consent to the gathering, use, and disclosure of my information by the Idaho Department of Health and Welfare. I understand the information is needed for the purpose of providing benefits or services, obtaining payment for my benefits or services, and for normal business operations of the Department.
- \_\_\_\_\_ I have the right to revoke this consent, in writing, at any time except to the extent the Department has already used and disclosed my information in reliance on this consent. If I revoke this consent, the Department may not provide me further benefits or services.
- \_\_\_\_\_ I understand that I will be notified of the right to appeal Department decisions and I can contact the Department for information on the appeal process.
- \_\_\_\_\_ My signature indicates I have received a copy of the Department Privacy Practices.
- \_\_\_\_\_ I have read and understand the plan choices and that I might be responsible for paying part of the cost of my health plan.
- \_\_\_\_\_ By applying for benefits for a minor child, a medical support case must be opened, when applicable. If I am receiving benefits for myself, failure to cooperate with Child Support Services may result in a loss or decrease of my benefits.
- \_\_\_\_\_ If a third party is responsible for my disease or injury, I give to Medicaid any rights I may have, or may acquire in the future to be compensated by that responsible party for any Medicaid benefits I receive.
- \_\_\_\_\_ My signature or the signature of my representative authorizes State offices to communicate with insurance companies related to my medical assistance.
- \_\_\_\_\_ I have the right to choose my Healthy Connections Primary Care Doctor, to request referrals for services, and to change my doctor/clinic if my circumstances change.
- \_\_\_\_\_ If I receive Medicaid after age 55, my estate may be subject to recovery of medical expenses paid on my behalf, and that any transfer of assets may be set aside by a court if I do not receive adequate value.
- \_\_\_\_\_ If I receive Medicaid/Cash Assistance, I am required to report changes in my circumstances including income, assets and living situation within ten (10) days of the change.
- \_\_\_\_\_ If I am determined eligible for Medicaid, I choose the plan that is based on my health needs, unless I tell my Self-Reliance worker otherwise.
- \_\_\_\_\_ If I receive a Child Support payment in error, Child Support Services will withhold future payments to recover the amount unless I submit written instructions to the contrary.
- \_\_\_\_\_ My signature certifies that the citizenship / immigration status marked on page 2 is correct for each person applying.

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

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Other Adult in the Household

\_\_\_\_\_  
Date

**PERSONAL/AUTHORIZED REPRESENTATIVE:** You may authorize someone else to apply for benefits for you and to use your Food Stamp benefits to buy food for you. If you want to authorize someone, enter his/her name, phone, and address below. **NOTE:** If your authorized representative gives us incorrect information that causes us to give you benefits you are not entitled to receive, you will have to repay the extra benefits to us.

\_\_\_\_\_  
Name of Authorized Representative                      Phone Number                      Address                      City                      State                      Zip

\_\_\_\_\_  
Signature of Authorized Representative/Guardian

\_\_\_\_\_  
Date



## Rights and Responsibilities for County Medical Assistance

By initialing the following provisions, I understand that . . .

- |   |  |
|---|--|
| <p>_____ An automatic county lien will attach to my real and personal property, insurance benefits, and any additional resources or assets I own.</p> <p>_____ I must complete the entire application within the timelines allowed by Law.</p> <p>_____ I must cooperate with the County's investigation of my application by providing documentation and submitting to an interview.</p> <p>_____ I am obligated to reimburse the County for any assistance requested and provided on my behalf.</p> <p>_____ I must notify the County if I receive resources after filing an application with the County.</p> <p>_____ To assist in determining my eligibility, I consent to the gathering, use, and disclosure of my personal and financial information by the County.</p> <p>_____ A provider may file an application on my behalf as a third party applicant.</p> <p>_____ I will be notified of the County's decision and that I may appeal an adverse decision of the Board of County Commissioners within 28 days of the date of determination.</p> | <p>_____ I may seek judicial review of the Board's final determination denying my application.</p> <p>_____ If I fail to cooperate with the County, make a material misstatement or material omission, my application will be denied and I will be ineligible for non-emergency services for up to two (2) years.</p> <p>_____ If I do not provide required material information or if I divest myself of resources within one (1) year prior to filing an application in order to become eligible for County assistance, my application will be denied.</p> <p>_____ If I am sanctioned by federal or state authorities and lose medical benefits, I will be ineligible for County assistance for the period of the sanction.</p> <p>_____ If I give false or misleading information to a hospital, county or its agent, or to any person in order to receive County assistance, or fail to disclose resources or benefits available to me as payment or reimbursement, I will be guilty of a misdemeanor and punishable under the law.</p> |
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Under penalty of perjury, I swear or affirm that the information I provide is true and complete.

Signature of Applicant	Date
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Signature of Spouse/Significant Other	Date
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If by a Third Party Applicant on behalf of the Applicant:

Name of Third Party	Phone Number	Name of Facility
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Signature of Third Party	Date
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**STATE OF IDAHO**

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):SS.

County of )

On this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, personally appeared before me and proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to this instrument and acknowledged to me that he/she/they executed the same.

Subscribed and sworn before me:

(SEAL)

Notary Public for the State of Idaho  
Residing at:

My commission expires on: \_\_\_\_\_



**AUTHORIZATION FOR RELEASE OF INFORMATION/RECORDS  
(Including Information from Federally Protected Assistance Programs)**

I/WE \_\_\_\_\_ (name of applicant and spouse), authorize each and every relative, bank, credit union, hospital, physician, doctor, health care provider/entity, and any other person, entity, employer, agency, board, utility, law enforcement, court, or county, including but not limited to the Department of Health and Welfare, State of Idaho, Social Security Administration, Public Health Districts, Veterans Administration, Crime Victims Compensation Program, Idaho Industrial Commission, and Department of Labor to release, exchange, communicate with, copy, and disclose records and information of a personal nature to representatives of the Department of Health and Welfare, State of Idaho, representatives of the Administrator of the Board of the Catastrophic Health Care Cost Program, and \_\_\_\_\_ County. The records and information are pertinent to my application for financial assistance and the investigation and eligibility determination for Medicaid and county financial assistance, pursuant to Title, 31, Chapter 35, Idaho Code. In accordance with Title XIX of the Social Security Act (Medicaid), Title XXI of the Social Security Act, and Idaho Code Sections 31-3503E and 31-3504, I specifically acknowledge, understand, request and give my permission for an open exchange of records and information of a personal nature concerning me/us to, by, among, or between, any provider, agency, board, or county named in this authorization.

I have read this authorization/had this authorization read/explained to me and I acknowledge an understanding of the purpose for the release of personal records and information. I am signing this authorization of my own free will. I understand that this authorization will assist any agency, board, or county named in this authorization to determine whether or not I am eligible for Medicaid or county financial assistance under Title 31, Chapter 35, Idaho Code. I understand that this information may include records or information that is otherwise confidential. I also understand that I may revoke this authorization at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization expires automatically one (1) year from the date of my signature. I understand that my ability to obtain Medicaid and/or county financial assistance may be contingent upon the execution of this authorization, but that medically necessary treatment will not be withheld based upon a refusal to sign this authorization.

\_\_\_\_\_  
Signature of Applicant or Authorized Representative

\_\_\_\_\_  
Title of Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Spouse/Significant Other or Authorized Representative

\_\_\_\_\_  
Title of Authorized Representative

\_\_\_\_\_  
Date

**STATE OF IDAHO**

) {PRIVATE}

) :ss.

County of \_\_\_\_\_

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On this \_\_\_\_ day of \_\_\_\_\_, 20\_\_ before me, the undersigned, a notary public in and for said county and state, personally appeared, \_\_\_\_\_ and \_\_\_\_\_, known or identified to me to be the person(s) whose name(s) is/are subscribed to the within instrument, and acknowledged to me that executed the same.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal the day and year in this certificate first above written.

(SEAL)

\_\_\_\_\_  
Notary Public for the State of Idaho  
Residing at:

Commision expires: \_\_\_\_\_



**Authorization for Release of Medical Information/Records  
(Including Information from Federally Protected Assistance Programs)**

I \_\_\_\_\_ (name of patient), authorize each and every hospital, physician, doctor, and health care provider/entity that has provided services to me ("providers") to release, exchange, communicate with, copy, and disclose my medical records and information (as defined in the provider's policy as belonging to the medical record set including any and all office notes, radiographs, and reports) to representatives of the Department of Health and Welfare, State of Idaho, representatives of the Administrator of the Board of the Catastrophic Health Care Cost Program, and \_\_\_\_\_ County. My medical records and information are pertinent to my application for financial assistance and the investigation and eligibility determination for Medicaid and county financial assistance, pursuant to Title, 31, Chapter 35, Idaho Code. In accordance with Title XIX of the Social Security Act (Medicaid), Title XXI of the Social Security Act, and Idaho Code Sections 31-3503E and 31-3504, I specifically acknowledge, understand, request and give my permission for an open exchange of my medical records and information to, by, among, or between, any provider, agency, board, or county named in this authorization.

I understand that this authorization, unless expressly limited by me in writing, will extend to all aspects of my treatment including medical information and records regarding alcohol abuse, substance abuse, mental health conditions, and venereal diseases (I.C. 39-601) including, but not limited to, acquired immunodeficiency syndrome (AIDS), AIDS related complexes (ARC), other manifestations of human immunodeficiency virus (HIV) infection, chancroids, and hepatitis B virus (HBV).

I have read this authorization/had this authorization read/explained to me and I acknowledge an understanding of the purpose for the release of medical records and information. I am signing this authorization of my own free will. I understand that this authorization will assist any agency, board, or county named in this authorization to determine whether or not I am eligible for Medicaid or county financial assistance under Title 31, Chapter 35, Idaho Code. I understand that this information may include material protected under federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 & 164. I also understand that I may revoke this authorization at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization expires automatically one (1) year from the date of my signature. I understand that my ability to obtain Medicaid and/or county financial assistance may be contingent upon the execution of this authorization, but that medically necessary treatment will not be withheld based upon a refusal to sign this authorization.

\_\_\_\_\_  
Signature of Applicant or Authorized Representative

\_\_\_\_\_  
Title of Authorized Representative

\_\_\_\_\_  
Date

**STATE OF IDAHO**

) {PRIVATE}

) :ss.

County of \_\_\_\_\_

)

On this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ before me, the undersigned, a notary public in and for said county and state, personally appeared, \_\_\_\_\_ and \_\_\_\_\_, known or identified to me to be the person(s) whose name(s) is/are subscribed to the within instrument, and acknowledged to me that executed the same.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal the day and year in this certificate first above written.

(SEAL)

Notary Public for the State of Idaho  
Residing at: \_\_\_\_\_

Commision expires: \_\_\_\_\_

