Table of Contents

State/Territory Name: Idaho

State Plan Amendment (SPA) #: 13-0021-MM

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Seattle Regional Office
2201 Sixth Avenue, Mail Stop 43
Seattle, Washington 98121

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

Richard Armstrong, Director
Department of Health and Welfare
Towers Building-Tenth Floor
Post Office Box 83720
Boise, Idaho 83720-0036

NOV 0 6 2013

RE: Idaho State Plan Amendment (SPA) Transmittal Number 13-0021-MM

Dear Mr. Armstrong:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of State Plan Amendment (SPA) Transmittal Number 13-0021-MM. This transmittal incorporates the Modified Adjusted Gross Income (MAGI)-Based eligibility process requirements, including the single streamlined application, into the Medicaid State Plan in accordance with the Affordable Care Act.

This SPA is approved effective October 1, 2013.

The approval of SPA 13-0021-MM includes full approval of your state's alternative application used to apply for multiple human service programs. By January 1, 2014, the state will implement a single streamlined paper application for health coverage only. Until July 31, 2014, the state is using an interim alternative single streamlined online application and will submit a revised alternative single streamlined online application that will address CMS concerns outlined in the companion letter issued with this SPA approval.

The new state plan pages and attachments should be incorporated within a separate section at the end of Idaho's approved state plan:

- Pages S94-1 and S94-2 include the attachments noted below:
    - Idaho Department of Health & Welfare Application for Assistance (multi-benefit application) Form HW2000, Rev. 11/26/2013.
    - Statement of use with respect to the alternative single streamlined paper application.
    - Statement of use with respect to the alternative single streamlined online application.

CMS appreciates the significant amount of work your staff dedicated to preparing this SPA. If you have any additional questions or require any further assistance, please contact me or have your staff contact Janice Adams at (206) 615-2541 or janice.adams@cms.hhs.gov.

Sincerely,

/s/

Associate Regional Administrator
Division of Medicaid and Children 's Health Operations

cc:
Denise Chuckovich, Deputy Administrator
Paul Leary, Medicaid Benefits Administrator

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Seattle Regional Office
2201 Sixth Avenue, Mail Stop 43
Seattle, Washington 98121

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

CENTERS FOR MEDICARE & MEDICAID SERVICES

Richard Armstrong, Director
Department of Health and Welfare
Towers Building-Tenth Floor
Post Office Box 83720
Boise, Idaho 83720-0036

NOV 06 2013

Dear Mr. Armstrong:

This letter is being sent as a companion to the Centers for Medicare & Medicaid Services (CMS) approval of State Plan Amendment (SPA) Transmittal Number 13-0021-MM. CMS is granting approval for Form S94-Eligibility Process, which was submitted to CMS on October 8, 2013. Our review of this submission included a review of the alternative application used to apply for multiple human service programs developed by the state and a review of the timeline for completion of both the online single streamlined application and the single streamlined paper application for health coverage only.

Until January 31, 2014, the state is using an interim alternative single streamlined paper application and until July 31, 2014, the state is using an interim alternative single streamlined online application. Both of these applications must be revised to meet the standards as outlined in 42 CFR 435.907 and the guidance on alternative applications released by CMS on June 19, 2013.

Please submit the single streamlined paper application for health coverage only to CMS for review no later than January 1, 2014, to ensure approval by January 31, 2014. Please also submit a revised alternative single streamlined online application to CMS for review no later than July 1, 2014, to ensure approval by July 31, 2014. We continue to be available to provide technical assistance. If you have any questions about this letter, please contact Dena Greenblum at (410) 786-8684 or dena.greenblum@cms.hhs.gov or contact Janice Adams at (206) 615-2541 or janice.adams@cms.hhs.gov.

Sincerely,

/s/

Associate Regional Administrator
Division of Medicaid and Children's Health
Operations

cc:
Denise Chuckovich, Deputy Administrator
Paul Leary, Medicaid Benefits Administrator

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: **Idaho**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

ID-13-0021

Proposed Effective Date

10/01/2013 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

42 CFR 435, subpart J and subpart M

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$ 0.00
Second Year	2015	$ 0.00

Subject of Amendment

ACA XIX SPA action 2, SPA group Eligibility Process.

Governor's Office Review

Governor's office reported no comment

Comments of Governor's office received

Describe:

No reply received within 45 days of submittal

Other, as specified

Describe:

Signature of State Agency Official

Submitted By:	**Rachel Strutton**
Last Revision Date:	**Dec 10, 2013**
Submit Date:	**Oct 8, 2013**

Transmittal Number:	Approval Date:	Effective Date:
13-0021	November 6, 2013	October 1, 2013

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

General Eligibility Requirements Eligibility Process	S94

42 CFR 435, Subpart J and Subpart M

Eligibility Process

☑ The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

☐ The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

☒ An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

☒ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

☒ The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

☐ An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

◉ Yes ○ No

Indicate the other electronic means below:

	Name of Method	Description	
+	Fax	agency provides fax number for workers to send applications to centralized mail unit for routing and processing	x
+	e-mail	individual may complete the fillable pdf and send by e-mail to designated department e-mail address	x

☑ The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Redetermination Processing

☑ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:

■ Once every 12 months

■ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency

■ If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

■ Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

☒ Once every 12 months

☐ Once every 6 months

☐ Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

☑ The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION	
☒Paper Application ☐Online Application	
TRANSMITTAL NUMBER: 13-0021-MM	**STATE:** Idaho
Through January 31, 2014, the state is using an interim paper alternative single streamlined application. After January 31, 2014, the state will use revised paper application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.	

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION ☐ Paper Application ☒ Online Application	
TRANSMITTAL NUMBER: 13-0021-MM	**STATE:** Idaho
Through July 31, 2014, the state is using an interim online alternative single streamlined application. After July 31, 2014, the state will use a revised online single streamlined application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.	

IDAHO DEPARTMENT OF HEALTH & WELFARE

Application for Assistance

HW2000
Rev. 11/26/2013

Food Assistance

The Idaho Food Stamp Program is a supplemental nutrition assistance program that helps families buy food for good health. Eligible families get a debit like card to buy food items. You may be required to participate in work programs, and cooperate with Child Support Services.

Health Coverage Assistance

The Idaho Medicaid Program provides health coverage assistance according to individual needs. Eligible families may qualify for 1) free or low-cost coverage from Medicaid, 2) tax credits to help pay health coverage premiums, or 3) affordable private health insurance plans.

Cash Assistance

The Temporary Assistance for Families in Idaho Program provides cash assistance for: emergency situations, families with children, and the elderly, blind, or disabled. Eligible families receive a one-time or on-going payment, depending on the needs of the household.

Child Care Assistance

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

Who can use this application

Anyone may use this application to:

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

What you may need to apply

Sending or bringing proof of the items below will help speed up your application:

- Identity
- Income
- Household expenses
- Resources

Why we ask for this information

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

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

Equal opportunity for applicants

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

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

- 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 506F, 200 Independence Avenue, SW
  Washington, D.C. 20201
  ocrcomplain@hhs.gov
  (202) 619.0403 (Voice)
  (202) 619.3257 (TTY)

What happens next

Send your complete, signed application to the address below. We will tell you if you're eligible or not, or give you further instructions for completing your application.

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

Get help with this application

- **Online:** healthandwelfare.idaho.gov
- **Phone:** 1-877-456-1233
- **E-mail:** MyBenefits@dhw.idaho.gov
- **In person:** Visit our website or call 1-877-456-1233 to find a local office.
- **Language Interpreter:** Call 1-877-456-1233 or TDD 208-332-7205

Transmittal Number: ID-13-0021-MM Approval Date: November 6, 2013 Effective Date: October 1, 2013

Tell us about yourself (or another adult in the household who will be the primary contact for this application)

1. First Name	Middle Name	Last Name	Suffix	2. Date of birth	3. Former Names, if any

4. Physical Address	City	State	Zip Code	County

5. Mailing Address	City	State	Zip code	County

6. Daytime Phone	7. Phone type (choose one)	8. If none, where can we leave a message?	9. Email
	☐ Home ☐ Work ☐ Cell	Phone:	

10. Preferred language spoken (if not English):	11. Preferred language written/read (if not English):

12. Do you want an interpreter if you are interviewed? One will be provided at no cost to you. ☐ No ☐ Yes
¿Le gustaría un intérprete si a usted le están entrevistando? Uno estará disponible a ningún costo para usted.

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

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

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

15. Social Security Number	16. Birth Country	17. Birth State (if born in USA)	18. Sex	19. Marital Status
			☐ M ☐ F	☐ Married ☐ Not Married

20. Pregnant?	a. If yes, due date	b. How many due?	21. Race (Optional)			
☐ No ☐ Yes			☐ White	☐ Asian	☐ Black/African American	
			☐ American Indian/Alaska Native		☐ Native Hawaiian/Pacific Island	

22. Hispanic or Latino? (Optional) ☐ No ☐ Yes 23. U.S. citizen or national? (Skip #23 & 24 if not applying for assistance) ☐ No ☐ Yes

24. If not a U.S. citizen or national, does this person have eligible immigration status? ☐ Yes. Complete questions a through d.

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

c. Lived in the U.S. since 1996? ☐ No ☐ Yes d. A veteran or active-duty member of the U.S. military? ☐ No ☐ Yes

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

a. Filing jointly with a spouse? ☐ No ☐ Yes If yes, name of spouse: _____

b. Claiming dependents? ☐ No ☐ Yes If yes, names of dependents: _____

c. Claimed as a dependent on someone's tax return who does not live at the address listed on page 1 of this application? ☐ No ☐ Yes

26. Do you want telephone assistance for your household? ☐ **No.** Go to the next section. ☐ **Yes.** Complete the questions below.
The Idaho Telecommunications Service Assistance Program (ITSAP) helps pay monthly telephone service costs.

a. Name of phone company	b. Phone number	c. Name on bill

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

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

If you qualify, emergency Food Stamp benefits can begin within 7 days of the date on this application. You may start the Food Stamp application process immediately by filling out this page, signing it, and turning it in. You must complete the rest of the application and turn it in as soon as possible.

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

Tell us who lives in your household

Who you need to include on this application

- Regardless of the types of assistance you are applying for, we need information about ***everyone*** who lives at the physical address you wrote down in the "Tell Us About Yourself" section above.
- If applying for health coverage for anyone under 65 and not disabled, also tell us about everyone included on your federal tax return (if you file taxes), even if they don't live at the same address. You don't need to file taxes to get health coverage.

Information that is optional or not required

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

Attach another sheet if you need to provide more information than space allows.

Transmittal Number: ID-13-0021-MM Approval Date: November 6, 2013 Effective Date: October 1, 2013

Tell us about everyone else in your household

Tell us about each person who lives with you at the address you wrote down in the "Tell Us About Yourself" section on page 1. If applying for health coverage for anyone under 65 and not disabled, tell us about everyone included on your federal tax return. See page 1 for details.

Copy this page or attach another sheet if you need to provide more information than space allows.

Person 1

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

2. First Name	Middle Name	Last Name	Suffix	3. Former Names, if any	4. Relationship to you

5. Social Security Number	6. Date of birth	7. Birth Country	8. Birth State (if born in USA)	9. Sex	10. Marital Status
				☐ M ☐ F	☐ Married ☐ Not Married

11. Pregnant? ☐ No ☐ Yes a. If yes, due date b. How many due?

12. Race ☐ White ☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Island

13. Hispanic or Latino? (Optional) ☐ No ☐ Yes

14. U.S. citizen or national? (Skip #14 & 15 if not applying for assistance) ☐ No ☐ Yes

15. If not a U.S. citizen or national, does this person have eligible immigration status? ☐ Yes. Complete questions a through d.

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

c. Lived in the U.S. since 1996? ☐ No ☐ Yes d. A veteran or active-duty member of the U.S. military? ☐ No ☐ Yes

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

a. Filing jointly with a spouse? ☐ No ☐ Yes If yes, name of spouse: _____

b. Claiming dependents? ☐ No ☐ Yes If yes, names of dependents: _____

c. Claimed as a dependent on someone's tax return who does not live at the address listed on page 1 of this application? ☐ No ☐ Yes

Person 2

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

2. First Name	Middle Name	Last Name	Suffix	3. Former Names, if any	4. Relationship to you

5. Social Security Number	6. Date of birth	7. Birth Country	8. Birth State (if born in USA)	9. Sex	10. Marital Status
				☐ M ☐ F	☐ Married ☐ Not Married

11. Pregnant? ☐ No ☐ Yes a. If yes, due date b. How many due?

12. Race ☐ White ☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Island

13. Hispanic or Latino? (Optional) ☐ No ☐ Yes

14. U.S. citizen or national? (Skip #14 & 15 if not applying for assistance) ☐ No ☐ Yes

15. If not a U.S. citizen or national, does this person have eligible immigration status? ☐ Yes. Complete questions a through d.

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

c. Lived in the U.S. since 1996? ☐ No ☐ Yes d. A veteran or active-duty member of the U.S. military? ☐ No ☐ Yes

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

a. Filing jointly with a spouse? ☐ No ☐ Yes If yes, name of spouse: _____

b. Claiming dependents? ☐ No ☐ Yes If yes, names of dependents: _____

c. Claimed as a dependent on someone's tax return who does not live at the address listed on page 1 of this application? ☐ No ☐ Yes

Person 3

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

2. First Name	Middle Name	Last Name	Suffix	3. Former Names, if any	4. Relationship to you

5. Social Security Number	6. Date of birth	7. Birth Country	8. Birth State (if born in USA)	9. Sex	10. Marital Status
				☐ M ☐ F	☐ Married ☐ Not Married

11. Pregnant? ☐ No ☐ Yes a. If yes, due date b. How many due?

12. Race ☐ White ☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Island

13. Hispanic or Latino? (Optional) ☐ No ☐ Yes

14. U.S. citizen or national? (Skip #14 & 15 if not applying for assistance) ☐ No ☐ Yes

15. If not a U.S. citizen or national, does this person have eligible immigration status? ☐ Yes. Complete questions a through d.

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

c. Lived in the U.S. since 1996? ☐ No ☐ Yes d. A veteran or active-duty member of the U.S. military? ☐ No ☐ Yes

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

a. Filing jointly with a spouse? ☐ No ☐ Yes If yes, name of spouse: _____

b. Claiming dependents? ☐ No ☐ Yes If yes, names of dependents: _____

c. Claimed as a dependent on someone's tax return who does not live at the address listed on page 1 of this application? ☐ No ☐ Yes

Continue telling us about each person who lives with you. See page 1 for details.

Person 4 1. Type(s) of assistance requested for this person: ☐ Food ☐ Health Coverage ☐ Cash ☐ Child Care ☐ None

2. First Name	Middle Name	Last Name	Suffix	3. Former Names, if any	4. Relationship to you

5. Social Security Number	6. Date of birth	7. Birth Country	8. Birth State (if born in USA)	9. Sex	10. Marital Status
				☐ M ☐ F	☐ Married ☐ Not Married

11. Pregnant? ☐ No ☐ Yes a. If yes, due date b. How many due?

12. Race ☐ White ☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Island

13. Hispanic or Latino? (Optional) ☐ No ☐ Yes

14. U.S. citizen or national? (Skip #14 & 15 if not applying for assistance) ☐ No ☐ Yes

15. If not a U.S. citizen or national, does this person have eligible immigration status? ☐ Yes. Complete questions a through d.

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

c. Lived in the U.S. since 1996? ☐ No ☐ Yes d. A veteran or active-duty member of the U.S. military? ☐ No ☐ Yes

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

a. Filing jointly with a spouse? ☐ No ☐ Yes If yes, name of spouse: _____

b. Claiming dependents? ☐ No ☐ Yes If yes, names of dependents: _____

c. Claimed as a dependent on someone's tax return who does not live at the address listed on page 1 of this application? ☐ No ☐ Yes

Person 5 1. Type(s) of assistance requested for this person: ☐ Food ☐ Health Coverage ☐ Cash ☐ Child Care ☐ None

2. First Name	Middle Name	Last Name	Suffix	3. Former Names, if any	4. Relationship to you

5. Social Security Number	6. Date of birth	7. Birth Country	8. Birth State (if born in USA)	9. Sex	10. Marital Status
				☐ M ☐ F	☐ Married ☐ Not Married

11. Pregnant? ☐ No ☐ Yes a. If yes, due date b. How many due?

12. Race ☐ White ☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Island

13. Hispanic or Latino? (Optional) ☐ No ☐ Yes

14. U.S. citizen or national? (Skip #14 & 15 if not applying for assistance) ☐ No ☐ Yes

15. If not a U.S. citizen or national, does this person have eligible immigration status? ☐ Yes. Complete questions a through d.

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

c. Lived in the U.S. since 1996? ☐ No ☐ Yes d. A veteran or active-duty member of the U.S. military? ☐ No ☐ Yes

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

a. Filing jointly with a spouse? ☐ No ☐ Yes If yes, name of spouse: _____

b. Claiming dependents? ☐ No ☐ Yes If yes, names of dependents: _____

c. Claimed as a dependent on someone's tax return who does not live at the address listed on page 1 of this application? ☐ No ☐ Yes

Tell us about your household situation

1. Is anyone in your household American Indian or Alaska Native? ☐ No ☐ Yes. If yes, complete Appendix B with the application.

2. Is anyone in your household applying for or already receiving Tribal Commodities? ☐ No ☐ Yes

3. Is anyone in your household applying for or already receiving Foster Care or Adoption Assistance? ☐ No ☐ Yes

4. Was anyone in foster care when they turned 18? ☐ No ☐ Yes a. If yes, who?

5. Is anyone in your home currently receiving assistance from another State? ☐ No ☐ Yes. If yes, tell us when, where, and the type.

a. Date	b. City	State	County

c. Type of assistance received

6. Is anyone who is applying for assistance disabled? ☐ No ☐ Yes a. If yes, who:

7. Does anyone who is applying have a pending application for Social Security disability? ☐ No ☐ Yes

a. If yes, who:

8. Does anyone who is applying need medical services provided in the home? ☐ No ☐ Yes

a. If yes, who:

9. Does anyone who is applying live in a medical care facility? ☐ No ☐ Yes

a. If yes, who	b. Name of the facility	c. Facility phone

10. Is anyone listed on this application incarcerated? ☐ No ☐ Yes a. If yes, who: _____

Attach another sheet if you need to provide more information than space allows.

Transmittal Number: ID-13-0021-MM Approval Date: November 6, 2013 Effective Date: October 1, 2013

Tell us about your household situation

- If applying for multiple types of assistance, or all household members are over 65 or disabled, **complete this page.**
- If applying for health care only, and all household members are under 65 and not disabled, **skip to page 5.**

1. Has anyone in your household been disqualified from public assistance due to an intentional program violation? ☐ No ☐ Yes

   a. If yes, who: b. When: c. State:

2. Has anyone in your household been convicted of a felony involving drugs? ☐ No ☐ Yes

   a. If yes, who: b. When:

3. Is anyone fleeing to avoid felony prosecution or jail time? ☐ No ☐ Yes

   a. If yes, who:

4. Is anyone currently violating conditions of probation or parole? ☐ No ☐ Yes

   a. If yes, who:

5. Is anyone applying for assistance age 16 to 19 and going to high school? ☐ No ☐ Yes. If yes, use the table below to tell us who.

Name of student	Name of high school	Expected graduation date

6. Is anyone applying for assistance age 18 to 49 and going to college? ☐ No ☐ Yes. If yes, use the table below to tell us who.

Name of student	Name of college	Student status	Work study
		☐ Full time ☐ Part time	☐ No ☐ Yes
		☐ Full time ☐ Part time	☐ No ☐ Yes
		☐ Full time ☐ Part time	☐ No ☐ Yes

7. If you have children in the home, are they immunized? ☐ No ☐ Yes

8. If you have children in your home, do any of them have a parent NOT living with them? ☐ No ☐ Yes. If yes, tell us who they are.

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.

Child name	Absent parent name	Absent parent Social Security Number	Absent parent Date of birth

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

Tell us about all income your household receives. We want to know about the last 30 days, as well as any money received quarterly or annually. Income is money earned (wages or salary) from a job or self-employment, or unearned from sources such as Social Security, child support, unemployment benefits, gifts, rental income, retirement income, etc.

Copy this page or attach another sheet if you need to provide more information than space allows.

Income Source 1

1. Name of person with income:

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

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

5. Wages/tips (before taxes) $ _____ paid ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

6. Income expected to change (raise, hours changed, etc.) ☐ No ☐ Yes Why?

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

7. Name of business	a. Type of work	b. Years in business	c. Estimated net income this month

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

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

Income Source 2

1. Name of person with income:

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

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

5. Wages/tips (before taxes) $ _____ paid ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

6. Income expected to change (raise, hours changed, etc.) ☐ No ☐ Yes Why?

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

7. Name of business	a. Type of work	b. Years in business	c. Estimated net income this month

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

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

Income Source 3

1. Name of person with income:

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

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

5. Wages/tips (before taxes) $ _____ paid ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

6. Income expected to change (raise, hours changed, etc.) ☐ No ☐ Yes Why?

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

7. Name of business	a. Type of work	b. Years in business	c. Estimated net income this month

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

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

- If applying for multiple types of assistance, or all household members are over 65 or disabled, **complete this page.**
- If applying for health care only, and all household members are under 65 and not disabled, **skip to page 8.**

Tell us about your vehicles, resources, and property

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

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

2. Resources - Tell us about all resources your household owns, including cash on-hand, checking and savings accounts, stocks, bonds, mutual funds, 401Ks, IRAs, trusts, CDs, life insurance policies, burial funds, etc.

Name/owner of resource	Resource type	Name of financial institution	Account number	Current value

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

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

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

Name	Date of Transaction	What Assets	Amount Received	Fair Market Value

Attach another sheet if you need to provide more information than space allows.

Transmittal Number: ID-13-0021-MM Approval Date: November 6, 2013 Effective Date: October 1, 2013

- If applying for multiple types of assistance, or all household members are over 65 or disabled, **complete this page.**
- If applying for health care only, and all household members are under 65 and not disabled, **skip to page 8.**

Tell us about your household expenses

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.

1. Shelter Expenses - Tell us about your recurring expenses. When telling us the amount of each expense, include only the amount ***you*** pay. If your mortgage payments include other payments such as irrigation, property taxes, HOA fees, etc., break them out and record them separately below.

Rent per month	Mortgage per month	2nd Mortgage per month	Space rent per month
$	$	$	$
Irrigation	**Property tax**	**HOA fees**	**Homeowners Insurance**
$ per	$ per	$ per	$ per

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

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

Landlord's name | Landlord's contact number

2. Dependent Care Expenses - Use the space below to tell us about any child care, adult disabled care, or elderly care.

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

3. Individual Expenses - Use the space below to tell us about any individual expenses. Allowable expenses include child support paid and some medical expenses for household members who are disabled or over the age of 60. When telling us the amount of each expense, include only the amount ***you*** pay.

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

Tell us about your health coverage situation

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

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

a. If yes, tell us who

b. If yes, tell us your gross household income (income before taxes) received by your family in each of the last three months:

Last month	Two months ago	Three months ago

2. Is anyone on this application insured by any of the following?

☐ Medicaid ☐ No ☐ Yes Who? _____

☐ CHIP ☐ No ☐ Yes Who? _____

☐ Medicare ☐ No ☐ Yes Who? _____

☐ TRICARE ☐ No ☐ Yes Who? _____

☐ VA Health Care ☐ No ☐ Yes Who? _____

☐ Peace Corps ☐ No ☐ Yes Who? _____

☐ Employer Insurance ☐ No ☐ Yes Who? _____

Name of insurance: _____

Policy number: _____

Is this COBRA coverage? ☐ No ☐ Yes

Is this a retiree health plan? ☐ No ☐ Yes

What services are covered? Check all that apply.

☐ Inpatient/outpatient hospital services ☐ Lab services

☐ Physicians medical/surgical services ☐ X-ray services

☐ Other Insurance ☐ No ☐ Yes Who? _____

Name of insurance: _____

Policy number: _____

Monthly premium: _____

Is this a limited-benefit plan? ☐ No ☐ Yes

What services are covered? Check all that apply.

☐ Inpatient/outpatient hospital services ☐ Lab services

☐ Physicians medical/surgical services ☐ X-ray services

3. If not currently receiving coverage, does anyone have access to health insurance from a job? Check "yes" even if the coverage is from someone else's job such as a parent or a spouse.

☐ **No** ☐ **Yes.** Complete Appendix C.

Rights and Responsibilities

I understand that...

_____ My signature certifies that the information on this application is true and accurate. I could be sanctioned and required to return any benefit I receive if my information is not true. Sanctions may include administrative, civil or criminal actions against me, including prosecution.

_____ I consent to the gathering, use and disclosure of my information by the Idaho Department of Health and Welfare or its designees. I understand the information is needed for the purpose of providing benefits or services, obtaining payment for my benefits or services, and for normal business operations of the Department.

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

_____ I have the right to revoke this consent, in writing, at any time except to the extent the Department has already used and disclosed my information in reliance on this consent. If I revoke this consent, the Department may not provide further benefits or services.

_____ I will be notified of the right to appeal Department decisions and I can contact the Department for information on the appeal process.

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

_____ By applying for benefits for a minor child, a medical support case must be opened, when applicable. If I am receiving benefits for myself, failure to cooperate with Child Support Services may result in a loss or decrease of my benefits.

_____ If I receive a Child Support payment in error, Child Support Services will withhold future payments to recover the amount unless I submit written instructions to the contrary.

_____ By applying for heating and energy assistance, I authorize the Department to request information from and/or disclose necessary information to my utility companies for the purpose of determining my eligibility and providing benefits or services until I become ineligible or I request to end the benefits or services.

_____ If I am determined eligible for Medicaid, I choose the plan that is based on my health needs, unless I tell the Self Reliance worker otherwise.

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

_____ My signature or the signature of my representative authorizes State offices to communicate with insurance companies related to my/my child's medical assistance.

_____ I have the right to choose a Healthy Connections Primary Care Doctor, to request referrals for services, and to change the doctor/clinic if my circumstances change.

_____ If I receive Medicaid after age 55, my estate may be subject to recovery of medical expenses paid on my behalf, and that any transfer of assets may be set aside by a court if I do not receive adequate value.

_____ If a third party is responsible for my child's disease or injury, I give to Medicaid any rights I may have, or may acquire in the future, to be compensated by the responsible party for any medical benefits I receive for myself/my children.

_____ If I receive Medicaid/Cash Assistance, I am required to report changes in my circumstance, including income, assets, and living situation within ten (10) days of the change.

_____ I may be required to cooperate with state or federal reviewers who are making sure my benefits are correct. I may not be eligible to receive benefits if I do not cooperate.

_____ To receive Food Assistance, I may be required to participate in work programs. Failure to do so may result in a loss or decrease in benefits.

_____ It is illegal to give my Quest EBT card away or to trade the benefits on my card for cash, firearms, drugs, or other goods and services. Penalties include fines, imprisonment, and disqualification from future benefits.

_____ If I receive cash assistance (TAFI), I may not withdraw cash benefits, or use cash benefit funds to purchase products and services, in gambling establishments, liquor and tobacco stores, adult entertainment venues, other establishments prohibiting persons under the age of 18, or tattoo, body piercing, or other branding parlors.

Sign Your Signature (must be completed)

Under penalty of perjury, I swear or affirm the information I have provided is true and complete. My signature confirms that I have read and understand the Rights and Responsibilities listed on this page.

_____ _____

Signature of applicant/authorized representative — Date

_____ _____

Signature of applicant/authorized representative — Date

Appendix A

IDAHO DEPARTMENT OF HEALTH & WELFARE

Authorized Representative Form

You can name someone as an authorized representative.

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

If you ever need to cancel or change your authorized representative, contact the Department.

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

Tell us who you want to name as your authorized representative

First Name	Middle Name	Last Name

Address	Apartment or suite number

City	State	Zip Code	County

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

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

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

Signature of Applicant

Date

Appendix B

IDAHO DEPARTMENT OF HEALTH & WELFARE

American Indian or Alaska Native Family Member

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Assistance.

Tell us about your American Indian or Alaska Native family member(s).

American Indians (AI) and Alaska Natives (AN) can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more than three people to include, make a copy of this page and attach with your Application for Assistance.

Person 1

1. First Name | Middle Name | Last Name

2. Is this person a member of a federally recognized tribe? ☐ No ☐ Yes b. **If yes**, name of tribe:

3. Has this person ever received services from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? ☐ No ☐ Yes

   b. **If no**, is this person eligible to receive these services? ☐ No ☐ Yes

4. List any income (amount and how often) reported on the application that includes money from:
   - Per capita payments from a tribe that come from natural resources, usage rights, or royalties
   - Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
   - Money from selling things that have cultural significance

   Amount: $ _____

   Frequency: _____

Person 2

1. First Name | Middle Name | Last Name

2. Is this person a member of a federally recognized tribe? ☐ No ☐ Yes b. **If yes**, name of tribe:

3. Has this person ever received services from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? ☐ No ☐ Yes

   b. **If no**, is this person eligible to receive these services? ☐ No ☐ Yes

4. List any income (amount and how often) reported on the application that includes money from:
   - Per capita payments from a tribe that come from natural resources, usage rights, or royalties
   - Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
   - Money from selling things that have cultural significance

   Amount: $ _____

   Frequency: _____

Person 3

1. First Name | Middle Name | Last Name

2. Is this person a member of a federally recognized tribe? ☐ No ☐ Yes b. **If yes**, name of tribe:

3. Has this person ever received services from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? ☐ No ☐ Yes

   b. **If no**, is this person eligible to receive these services? ☐ No ☐ Yes

4. List any income (amount and how often) reported on the application that includes money from:
   - Per capita payments from a tribe that come from natural resources, usage rights, or royalties
   - Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
   - Money from selling things that have cultural significance

   Amount: $ _____

   Frequency: _____

Appendix C

IDAHO DEPARTMENT OF HEALTH & WELFARE

Health Coverage from Jobs

Tell us about the job that offers coverage

Complete the questions below if someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage. If you need help answering the questions about your employer's health plan, please contact your employer.

Employee Information

1. First Name	Middle Name	Last Name	2. Social Security Number

Employer Information

3. Name			4. Identification Number (EIN)
5. Address			6. Phone
7. City	8. State	9. Zip Code	

10. Who can we contact about employee health coverage at this job?

11. Phone	12. Email

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

☐ **No.** Stop here and submit this form with your application. ☐ **Yes.** Complete the rest of this form.

a. If you're in a waiting or probationary period, when can you enroll in coverage? _____

b. List everyone who is eligible for coverage from this job:

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard?* ☐ No ☐ Yes

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

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

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

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't 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.* (Premium should reflect the discount for wellness programs. See question 15.)

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

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

c. Date of change:

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

Table of Contents

State/Territory Name: Idaho

State Plan Amendment (SPA) #: 13-0021-MM

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Seattle Regional Office
701 Fifth Avenue, Suite 1600, MS/RX-200
Seattle, WA 98104

Division of Medicaid & Children's Health Operations

November 10, 2015

Richard Armstrong
Idaho Department of Health and Welfare
Towers Building – Tenth Floor
Post Office Box 83720
Boise, Idaho 83720-0036

RE: Idaho State Plan Amendment (SPA) Transmittal Number 13-0021-MM

Dear Mr. Armstrong:

On November 6, 2013, the Centers for Medicare & Medicaid Services (CMS) approved Idaho's State Plan Amendment (SPA) 13-0021-MM with an effective date of October 1, 2013. This SPA included approval for the state to use an interim alternative single, streamlined online application.

The CMS has reviewed the changes submitted with respect to Idaho's alternative single streamlined online application. The revised application addresses the concerns outlined in the companion letter that was issued with the SPA approval. This letter serves as official approval of Idaho's alternative single streamlined online application.

Enclosed is a copy of the approved alternative single streamlined online application. Please incorporate these pages into the State Plan following the attachment to S94 entitled "Use of the Alternative Single Streamlined Application."

If you have any additional questions or require any further assistance, please contact me or have your staff contact Janice Adams at Janice.Adams@cms.hhs.gov or (206) 615-2541.

Sincerely,

[redacted]

Digitally signed by David L. Meacham -S
DN: c=US, o=U.S. Government, ou=HHS, ou=CMS, ou=People, 0.9.2342.19200300.100.1.1=2000041858, cn=David L. Meacham -S
Date: 2015.11.10 14:23:16 -08'00'

David L. Meacham
Associate Regional Administrator

Enclosure

cc:
Denise Chuckovich, IDHW
Lisa Hettinger, IDHW

IDAHO DEPARTMENT OF HEALTH & WELFARE

Application for Assistance

HW2000
Rev. 12/01/2014 [Print]

Food Assistance

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

Health Coverage Assistance

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

Cash Assistance

The Temporary Assistance for Families in Idaho Program provides cash assistance for emergency situations, families with children, and the elderly, blind, or disabled. Eligible families receive a one-time or on-going payment, depending on the needs of the household.

Child Care Assistance

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

Who can use this application

Anyone may use this application to:

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

What you may need to apply

Sending or bringing proof of the items below will help speed up your application:

- Identity
- Income
- Household expenses
- Resources

Why we ask for this information

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

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

Equal opportunity for applicants

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

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

- 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 506F, 200 Independence Avenue, SW
  Washington, D.C. 20201
  ocrcomplain@hhs.gov
  (202) 619.0403 (Voice)
  (202) 619.3257 (TTY)

What happens next

Send your complete, signed application to the address below. We will tell you if you're eligible or not, or give you further instructions for completing your application.

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

Get help with this application

- **Online:** healthandwelfare.idaho.gov
- **Phone:** 1-877-456-1233
- **E-mail:** MyBenefits@dhw.idaho.gov
- **In person:** Visit our website or call 1-877-456-1233 to find a local office.
- **Language Interpreter:** Call 1-877-456-1233 or TTY 1-800-377-3529

Transmittal Number: ID 13-0021-MM Approval Date: 11/10/15 Effective Date: 10/01/13

Tell us about yourself You will be the primary contact person for this application.

1. First Name	Middle Name	Last Name	Suffix	2. Date of birth	3. Former Names, if any

4. Physical Address	City	State	Zip Code	County

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

6. Daytime Phone	7. Phone type (choose one)	8. If none, where can we leave a message?	9. Email
	☐ Home ☐ Work ☐ Cell	Phone:	

10. Preferred language spoken (if not English):	11. Preferred language written/read (if not English):

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

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

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

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

15. Social Security Number	16. Sex	17. Marital Status	18. Pregnant? a. If yes, due date b. How many due?
	☐ M ☐ F	☐ Married ☐ Not Married	☐ No ☐ Yes

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

20. Hispanic or Latino? ☐ No ☐ Yes 21. U.S. citizen or national? ☐ No ☐ Yes

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

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

c. Lived in the U.S. since 1996? ☐ No ☐ Yes d. A veteran or active-duty member of the U.S. military? ☐ No ☐ Yes

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

a. Do you plan to file jointly with a spouse? ☐ No ☐ Yes If yes, name of spouse: _____

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

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

24. Do you want telephone assistance for your household? ☐ **No.** Go to the next section. ☐ **Yes.** Complete the questions below.
The Idaho Telecommunications Service Assistance Program (ITSAP) helps pay monthly telephone service costs.

a. Name of phone company	b. Phone number	c. Name on bill

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

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

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

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

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

Tell us who lives in your household

Who you need to include on this application

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

Information that is optional or not required

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

Attach another sheet if you need to provide more information than space allows.

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Tell us about everyone else in your household

Tell us about each person who lives with you at the address you wrote down in the "Tell Us About Yourself" section on page 1. If applying for health coverage assistance for anyone under 65 and not disabled, tell us about everyone included on your federal tax return. See page 1 for details.

Person 1

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

2. First Name | Middle Name | Last Name | Suffix | 3. Former Names, if any | 4. Relationship to you

5. Social Security Number | 6. Date of birth | 7. Sex ☐M ☐F | 8. Marital Status ☐Married ☐Not Married | 9. Pregnant? ☐No ☐Yes a. If yes, due date b. How many due?

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

11. Hispanic or Latino? ☐No ☐Yes | 12. U.S. citizen or national? ☐No ☐Yes

13. If not a U.S. citizen or national, does this person have eligible immigration status? ☐No ☐Yes. Complete questions a-d.

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

c. Lived in the U.S. since 1996? ☐No ☐Yes d. A veteran or active-duty member of the U.S. military? ☐No ☐Yes

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

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

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

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

Person 2

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

2. First Name | Middle Name | Last Name | Suffix | 3. Former Names, if any | 4. Relationship to you

5. Social Security Number | 6. Date of birth | 7. Sex ☐M ☐F | 8. Marital Status ☐Married ☐Not Married | 9. Pregnant? ☐No ☐Yes a. If yes, due date b. How many due?

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

11. Hispanic or Latino? ☐No ☐Yes | 12. U.S. citizen or national? ☐No ☐Yes

13. If not a U.S. citizen or national, does this person have eligible immigration status? ☐No ☐Yes. Complete questions a-d.

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

c. Lived in the U.S. since 1996? ☐No ☐Yes d. A veteran or active-duty member of the U.S. military? ☐No ☐Yes

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

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

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

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

Person 3

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

2. First Name | Middle Name | Last Name | Suffix | 3. Former Names, if any | 4. Relationship to you

5. Social Security Number | 6. Date of birth | 7. Sex ☐M ☐F | 8. Marital Status ☐Married ☐Not Married | 9. Pregnant? ☐No ☐Yes a. If yes, due date b. How many due?

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

11. Hispanic or Latino? ☐No ☐Yes | 12. U.S. citizen or national? ☐No ☐Yes

13. If not a U.S. citizen or national, does this person have eligible immigration status? ☐No ☐Yes. Complete questions a-d.

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

c. Lived in the U.S. since 1996? ☐No ☐Yes d. A veteran or active-duty member of the U.S. military? ☐No ☐Yes

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

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

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

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

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Continue telling us about each person who lives with you. See page 1 for details.

Person 4

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

2. First Name	Middle Name	Last Name	Suffix	3. Former Names, if any	4. Relationship to you

5. Social Security Number	6. Date of birth	7. Sex	8. Marital Status	9. Pregnant? a. If yes, due date b. How many due?
		☐ M ☐ F	☐ Married ☐ Not Married	☐ No ☐ Yes

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

11. Hispanic or Latino? ☐ No ☐ Yes

12. U.S. citizen or national? ☐ No ☐ Yes

13. If not a U.S. citizen or national, does this person have eligible immigration status? ☐ No ☐ Yes. Complete questions a-d.

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

c. Lived in the U.S. since 1996? ☐ No ☐ Yes d. A veteran or active-duty member of the U.S. military? ☐ No ☐ Yes

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

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

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

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

Person 5

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

2. First Name	Middle Name	Last Name	Suffix	3. Former Names, if any	4. Relationship to you

5. Social Security Number	6. Date of birth	7. Sex	8. Marital Status	9. Pregnant? a. If yes, due date b. How many due?
		☐ M ☐ F	☐ Married ☐ Not Married	☐ No ☐ Yes

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

11. Hispanic or Latino? ☐ No ☐ Yes

12. U.S. citizen or national? ☐ No ☐ Yes

13. If not a U.S. citizen or national, does this person have eligible immigration status? ☐ No ☐ Yes. Complete questions a-d.

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

c. Lived in the U.S. since 1996? ☐ No ☐ Yes d. A veteran or active-duty member of the U.S. military? ☐ No ☐ Yes

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

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

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

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

Tell us about your household situation

1. Is anyone in your household American Indian or Alaska Native? ☐ No ☐ Yes a. If yes, who?

2. Is anyone in your household applying for or already receiving Tribal Commodities? ☐ No ☐ Yes a. If yes, who?

3. Is anyone in your household applying for or already receiving Foster Care or Adoption Assistance? ☐ No ☐ Yes

a. If yes, who?

4. Was anyone in Idaho foster care when they turned 18? ☐ No ☐ Yes a. If yes, who?

5. Is anyone in your household currently receiving assistance from another State? ☐ No ☐ Yes If yes, tell us when, where, and the type.

a. Date (month/year) From: To:	b. City	State	County

c. Type of assistance received

6. Is anyone in your household 65 or over or disabled? ☐ No ☐ Yes a. If yes, who?

7. Does anyone who is applying have a pending application for Social Security disability? ☐ No ☐ Yes

a. If yes, who?

8. Does anyone who is applying need medical services provided in the home? ☐ No ☐ Yes

a. If yes, who?

9. Does anyone who is applying live in a medical care facility? ☐ No ☐ Yes

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

10. Is anyone listed on this application currently incarcerated? ☐ No ☐ Yes a. If yes, who?

Attach another sheet if you need to provide more information than space allows.

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Tell us about your household situation

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

1. Has anyone in your household been disqualified from public assistance due to an intentional program violation? ☐ No ☐ Yes

   a. If yes, who? b. When: c. State:

2. Has anyone in your household been convicted of a felony involving drugs? ☐ No ☐ Yes

   a. If yes, who? b. When:

3. Is anyone in your household fleeing to avoid felony prosecution or jail time? ☐ No ☐ Yes

   a. If yes, who?

4. Is anyone in your household currently violating conditions of probation or parole? ☐ No ☐ Yes

   a. If yes, who?

5. Use the table below to specify the names of any applicant between the ages of 16 and 19 that is attending high school.

Name of student	Name of high school	Expected graduation date

6. Use the table below to specify the names of any applicant between the ages of 18 and 49 that is attending college.

Name of student	Name of college	Student status	Work study
		☐ Full time ☐ Part time	☐ No ☐ Yes
		☐ Full time ☐ Part time	☐ No ☐ Yes
		☐ Full time ☐ Part time	☐ No ☐ Yes

7. If you have children in the home, are they immunized? ☐ No ☐ Yes

8. If you have children in your home, do any of them have a parent NOT living with them? ☐ No ☐ Yes. If yes, tell us who they are.

Note: *A medical support case must be opened for non-custodial parents on behalf of a minor child if one or more parents are not in the home. You must cooperate with Child Support Services unless you fear harm to yourself or your children as a result of the opening of the medical support case.*

Child name	Non-custodial parent name	Non-custodial parent Social Security Number	Non-custodial parent Date of birth

Attach another sheet if you need to provide more information than space allows.

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

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

Income 1

1. Name of person with income:

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

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

5. Wages/tips (before taxes) $ ____ paid ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

6. Income expected to change (raise, hours changed, etc.) ☐ No ☐ Yes Why?

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

7. Name of business | a. Type of work | b. Years in business | c. Estimated net income this month

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

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

Income 2

1. Name of person with income:

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

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

5. Wages/tips (before taxes) $ ____ paid ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

6. Income expected to change (raise, hours changed, etc.) ☐ No ☐ Yes Why?

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

7. Name of business | a. Type of work | b. Years in business | c. Estimated net income this month

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

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

Income 3

1. Name of person with income:

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

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

5. Wages/tips (before taxes) $ ____ paid ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

6. Income expected to change (raise, hours changed, etc.) ☐ No ☐ Yes Why?

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

7. Name of business | a. Type of work | b. Years in business | c. Estimated net income this month

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

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

Gross Income

If applying for health coverage assistance, provide us with your anticipated annual gross income (Jan. through Dec. of the current year). $ ____

(weekly amount before taxes x 4.3 x 12= annual gross income)

Copy this page or attach another sheet if you need to provide more information than space allows.

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If applying for health coverage only, and all household members are under 65 and not disabled, **skip to page 8.** Otherwise, complete this page.

Tell us about your vehicles, resources, and property

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

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

2. Resources - Tell us about all resources your household owns, including cash on-hand, checking and savings accounts, stocks, bonds, mutual funds, 401Ks, IRAs, trusts, CDs, life insurance policies, burial funds, etc.

Name/owner of resource	Resource type	Name of financial institution	Account number	Current value

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

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

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

Name	Date of Transaction	What Assets	Amount Received	Fair Market Value

Attach another sheet if you need to provide more information than space allows.

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If applying for health coverage only, and all household members are under 65 and not disabled, **skip to page 8.** Otherwise, complete this page.

Tell us about your household expenses

Your Food Stamps may increase if you have expenses such as child or adult care costs, child support paid for children not living with you, housing costs, medical costs (including prescriptions) for people with disabilities or who are over 65, and utility costs. However, if you do not report or verify any of these expenses, it will mean that you do not want a deduction for the unreported or unverified expenses.

1. Shelter Expenses - Tell us about your recurring expenses. When telling us the amount of each expense, include only the amount ***you*** pay. If your mortgage payments include other payments such as irrigation, property taxes, HOA fees, etc., break them out and record them separately below.

Rent per month	Mortgage per month	2nd Mortgage per month	Space rent per month
$	$	$	$
Irrigation	**Property tax**	**HOA fees**	**Homeowners Insurance**
$ per	$ per	$ per	$ per

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

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

Landlord's name | Landlord's contact number

2. Dependent Care Expenses - Use the space below to tell us about any child care, adult disabled care, or elderly care.

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

3. Individual Expenses - Use the space below to tell us about any individual expenses only for the individual in your household who is over 65 or disabled. Allowable expenses include child support paid, some medical expenses, and health insurance premiums.

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

Attach another sheet if you need to provide more information than space allows.

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Tell us about your health coverage situation

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

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

a. If yes, tell us who?

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

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

2. For any children (under the age of 19) who are applying, tell us if they are currently receiving health coverage and what services are covered by that health insurance. Check all that apply.

Child 1

Name of insured child

☐ Inpatient/outpatient hospital services ☐ Physicians medical/surgical service ☐ Lab services ☐ X-ray services ☐ None of the above

Child 2

Name of insured child

☐ Inpatient/outpatient hospital services ☐ Physicians medical/surgical service ☐ Lab services ☐ X-ray services ☐ None of the above

Child 3

Name of insured child

☐ Inpatient/outpatient hospital services ☐ Physicians medical/surgical service ☐ Lab services ☐ X-ray services ☐ None of the above

Child 4

Name of insured child

☐ Inpatient/outpatient hospital services ☐ Physicians medical/surgical service ☐ Lab services ☐ X-ray services ☐ None of the above

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

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

☐ CHIP Who? _____

☐ Medicare Who? _____

☐ TRICARE Who? _____

☐ Employer Insurance Who? _____
(If selected, complete **Appendix B**)

☐ VA Health Care Who? _____

☐ Peace Corps Who? _____

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

☐ No ☐ Yes. Complete **Appendix B**.

Attach another sheet if you need to provide more information than space allows.

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Rights and Responsibilities

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

_____ My signature certifies that the information on this application is true and accurate. I could be sanctioned and required to return any benefit I receive if my information is not true. Sanctions may include administrative, civil or criminal actions against me, including prosecution.

_____ I consent to the gathering, use and disclosure of my information by the Idaho Department of Health and Welfare or its designees. I understand the information is needed for the purpose of providing benefits or services, obtaining payment for my benefits or services, and for normal business operations of the Department.

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

_____ I have the right to revoke this consent, in writing, at any time except to the extent the Department has already used and disclosed my information in reliance on this consent. If I revoke this consent, the Department may not provide further benefits or services.

_____ I will be notified of the right to appeal Department decisions and I can contact the Department for information on the appeal process.

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

_____ By applying for benefits for a minor child, a medical support case must be opened, when applicable. If I am receiving benefits for myself, failure to cooperate with Child Support Services may result in a loss or decrease of my benefits.

_____ If I receive a Child Support payment in error, Child Support Services will withhold future payments to recover the amount unless I submit written instructions to the contrary.

_____ By applying for heating and energy assistance, I authorize the Department to request information from and/or disclose necessary information to my utility companies for the purpose of determining my eligibility and providing benefits or services until I become ineligible or I request to end the benefits or services.

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

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

_____ My signature or the signature of my representative authorizes State offices to communicate with insurance companies related to my/my child's medical assistance.

_____ I have the right to choose a Healthy Connections Primary Care Doctor, to request referrals for services, and to change the doctor/clinic if my circumstances change.

_____ If I receive Medicaid after age 55, my estate may be subject to recovery of medical expenses paid on my behalf, and that any transfer of assets may be set aside by a court if I do not receive adequate value.

_____ If a third party is responsible for my child's disease or injury, I give to Medicaid any rights I may have, or may acquire in the future, to be compensated by the responsible party for any medical benefits I receive for myself/my children.

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

_____ I may be required to cooperate with state or federal reviewers who are making sure my benefits are correct. I may not be eligible to receive benefits if I do not cooperate.

_____ To receive Food Assistance, I may be required to participate in work programs. Failure to do so may result in a loss or decrease in benefits.

_____ It is illegal to give my Quest EBT card away or to trade the benefits on my card for cash, firearms, drugs, or other goods and services. Penalties include fines, imprisonment, and disqualification from future benefits.

_____ If I receive cash assistance (TAFI), I may not withdraw cash benefits, or use cash benefit funds to purchase products and services, in gambling establishments, liquor and tobacco stores, adult entertainment venues, other establishments prohibiting persons under the age of 18, or tattoo, body piercing, or other branding parlors.

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

Before you complete this application, ensure that:

- **If you want someone to be your Authorized Representative, complete Appendix A.**
- **If anyone in your household has access to health insurance from a job, even if the coverage is from someone else's job such as a parent or a spouse, or if you currently have health insurance from a job, you MUST complete Appendix B.**

Signature (must be completed)

Under penalty of perjury, I swear or affirm the information I have provided is true and complete. My signature confirms that I have read and understand the Rights and Responsibilities listed on this page and understand my reporting requirements.

_____ _____

Signature of applicant/authorized representative — Date

_____ _____

Signature of applicant/authorized representative — Date

Appendix A

IDAHO DEPARTMENT OF HEALTH & WELFARE

Authorized Representative Form

You can name someone as an authorized representative.

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

If you ever need to cancel or change your authorized representative, contact the Department.

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

Tell us who you want to name as your authorized representative

First Name	Middle Name	Last Name

Address	Apartment or suite number

City	State	Zip Code	County

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

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

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

Signature of Applicant

Date

Appendix B

IDAHO DEPARTMENT OF HEALTH & WELFARE

Health Coverage from Jobs

Complete this appendix if someone in the household has access to or is currently covered by health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage

If you need help answering the questions about your employer's health plan, please contact your employer.

Employee Information

1. First Name	Middle Name	Last Name	2. Social Security Number

Employer Information

3. Name			4. Identification Number (EIN)
5. Address			6. Phone
7. City	8. State	9. Zip Code	

10. Who can we contact about employee health coverage at this job?

11. Phone	12. Email

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

☐ **No.** Stop here and submit this form with your application. ☐ **Yes.** Complete the rest of this form.

a. If you're in a waiting or probationary period, when can you enroll in coverage? _____

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

We will assume that the coverage that is offered by your employer meets the minimum value standard* and you will not be considered for the tax credit to purchase a qualified health plan. If you don't believe that your plan meets this standard, please have your employer fill out the remainder of this page and return it to the Idaho Department of Health and Welfare.

Tell us about the **health plan** offered by this employer

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

15. Does the plan meet minimum essential coverage?** ☐ Yes ☐ No

16. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

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

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

17. What change will the employer make for the new plan year (if known)?

☐ Employer won't 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.* (Premium should reflect the discount for wellness programs. See question 14.)

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

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

c. Date of change: _____

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

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