

# Application for Assistance



## Food Assistance

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



## 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:

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>• U.S. Department of Agriculture<br/>Office of the Assistant Secretary for Civil Rights<br/>1400 Independence Avenue, SW<br/>Washington, D.C. 20250-9410<br/>Fax: (202) 690.7442<br/>Email: <a href="mailto:program.intake@usda.gov">program.intake@usda.gov</a></li> </ul> | <ul style="list-style-type: none"> <li>• U.S. Department of Health &amp; Human Services<br/>Room 506F, 200 Independence Avenue, SW<br/>Washington, D.C. 20201<br/>Email: <a href="mailto:ocrcomplain@hhs.gov">ocrcomplain@hhs.gov</a><br/>(202) 619.0403 (Voice)<br/>(202) 619.3257 (TTY)</li> </ul> |
|--|--|

## What happens next

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

### Self Reliance Programs - Statewide Application Team

PO Box 83720  
Boise, ID 83720-0026  
Fax: 1-866-434-8278  
E-mail: [MyBenefits@dhw.idaho.gov](mailto:MyBenefits@dhw.idaho.gov)

## Get help with this application

- **Online:** [healthandwelfare.idaho.gov](http://healthandwelfare.idaho.gov)
- **Phone:** 1-877-456-1233
- **E-mail:** [MyBenefits@dhw.idaho.gov](mailto: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

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

If applying for Food Assistance only, you do not need to answer question 23 on this page.

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) <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		8. If none, where can we leave a message? Phone:		9. Email
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)? ¿Quiere usted un intérprete si usted sea entrevistado (se le proporcionara uno sin costo alguno)?					<input type="checkbox"/> No <input type="checkbox"/> Yes
13. Would you like to name someone as your authorized representative? <input type="checkbox"/> No <input type="checkbox"/> Yes. Complete <b>Appendix A</b> . 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: <input type="checkbox"/> Food <input type="checkbox"/> Health Coverage <input type="checkbox"/> Cash <input type="checkbox"/> Child Care <input type="checkbox"/> None					
15. Social Security Number	16. Sex <input type="checkbox"/> M <input type="checkbox"/> F	17. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Not Married		18. Pregnant? a. If yes, due date b. How many due? <input type="checkbox"/> No <input type="checkbox"/> Yes	
19. Race <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Island, Name of Tribe: _____ <input type="checkbox"/> American Indian/Alaska Native, Name of Tribe: _____					
20. Hispanic or Latino? <input type="checkbox"/> No <input type="checkbox"/> Yes		21. U.S. citizen or national? <input type="checkbox"/> No <input type="checkbox"/> Yes			
22. If not a U.S. citizen or national, do you have eligible immigration status? <input type="checkbox"/> No <input type="checkbox"/> Yes. Complete questions a-b. a. Immigration document type: _____ b. Document ID number: _____ <small>Alien status is subject to verification by submission of information on your application to USCIS. The response from USCIS may affect your household's eligibility and benefit amount.</small>					
23. Do you plan to file a federal tax return for the CURRENT YEAR? <input type="checkbox"/> No. Skip to question c. <input type="checkbox"/> Yes. Complete questions a-c. a. Do you plan to file jointly with a spouse? <input type="checkbox"/> No <input type="checkbox"/> Yes. Complete parts i and ii. i. Name of spouse: _____ <i>If your household is approved for Advance Payment of Premium Tax Credit (APTC), and you decide to purchase insurance through Your Health Idaho (YHI), one adult tax filer will be assigned as the primary account holder for your household. Choose which spouse you wish to be assigned as the primary account holder for your household.</i> ii. Name of preferred primary account holder: _____ b. Do you plan to claim dependents? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, names of dependents: _____ c. Will you be claimed as a dependent on someone else's tax return? <input type="checkbox"/> No <input type="checkbox"/> Yes <b>If yes</b> , name of tax filer: _____					
24. Do you want telephone assistance for your household? <input type="checkbox"/> <b>No</b> . Go to the next section. <input type="checkbox"/> <b>Yes</b> . 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. Your filing date is the date we receive an application with your name, address, and signature.

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

## 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. If applying for Food Assistance only, you do not need to answer question 14 in the following section.

**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? a. If yes, due date b. How many due?  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-b.

a. Immigration document type: \_\_\_\_\_ b. Document ID number: \_\_\_\_\_

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

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? a. If yes, due date b. How many due?  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-b.

a. Immigration document type: \_\_\_\_\_ b. Document ID number: \_\_\_\_\_

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

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? a. If yes, due date b. How many due?  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-b.

a. Immigration document type: \_\_\_\_\_ b. Document ID number: \_\_\_\_\_

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

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 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  M  F 8. Marital Status  Married  Not Married 9. Pregnant? a. If yes, due date b. How many due?  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-b.  
a. Immigration document type: \_\_\_\_\_ b. Document ID number: \_\_\_\_\_  
Alien status is subject to verification by submission of information on your application to USCIS. The response from USCIS may affect your household's eligibility and benefit amount.

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  M  F 8. Marital Status  Married  Not Married 9. Pregnant? a. If yes, due date b. How many due?  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-b.  
a. Immigration document type: \_\_\_\_\_ b. Document ID number: \_\_\_\_\_  
Alien status is subject to verification by submission of information on your application to USCIS. The response from USCIS may affect your household's eligibility and benefit amount.

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 qualifying life event



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

## Tell us about your household situation If applying for Food Assistance only, skip question 8 in this section.

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) b. City State County  
From: \_\_\_\_\_ To: \_\_\_\_\_  
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? \_\_\_\_\_

## Continue telling 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 section. If applying for Food Assistance only, you do not need to complete question 10 of this section.

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. Has anyone in your household been convicted of trading Food Stamp benefits for guns, ammunitions, or explosives?  No  Yes  
a. If yes, who? \_\_\_\_\_
5. Has anyone in your household been convicted of buying or selling Food Stamp benefits over \$500?  No  Yes  
a. If yes, who? \_\_\_\_\_
6. Has anyone in your household been convicted of receiving duplicate Food Stamp benefits in any state?  No  Yes  
a. If yes, who? \_\_\_\_\_
7. Is anyone in your household currently violating conditions of probation or parole?  No  Yes  
a. If yes, who? \_\_\_\_\_
8. 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

9. 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
		<input type="checkbox"/> Full time <input type="checkbox"/> Part time	<input type="checkbox"/> No <input type="checkbox"/> Yes
		<input type="checkbox"/> Full time <input type="checkbox"/> Part time	<input type="checkbox"/> No <input type="checkbox"/> Yes
		<input type="checkbox"/> Full time <input type="checkbox"/> Part time	<input type="checkbox"/> No <input type="checkbox"/> Yes

10. If you have children in the home, are they immunized?  No  Yes
11. 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.  Check this box if you fear harm to yourself or your children as a result of opening a medical support case.

Child name	Non-custodial parent name	Non-custodial parent Social Security Number	Non-custodial 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, 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	<input type="checkbox"/> Hourly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Yearly	6. Income expected to change (raise, hours changed, etc.) <input type="checkbox"/> No <input type="checkbox"/> 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
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**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
_____	_____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> 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	<input type="checkbox"/> Hourly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Yearly	6. Income expected to change (raise, hours changed, etc.) <input type="checkbox"/> No <input type="checkbox"/> 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
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**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
_____	_____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> 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	<input type="checkbox"/> Hourly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Yearly	6. Income expected to change (raise, hours changed, etc.) <input type="checkbox"/> No <input type="checkbox"/> 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
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**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
_____	_____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly

## Anticipated Annual Income

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



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)
			<input type="checkbox"/> Business <input type="checkbox"/> Get to work <input type="checkbox"/> Work search <input type="checkbox"/> Medical <input type="checkbox"/> Recreational <input type="checkbox"/> Residence <input type="checkbox"/> Income producing <input type="checkbox"/> Personal (other)
			<input type="checkbox"/> Business <input type="checkbox"/> Get to work <input type="checkbox"/> Work search <input type="checkbox"/> Medical <input type="checkbox"/> Recreational <input type="checkbox"/> Residence <input type="checkbox"/> Income producing <input type="checkbox"/> Personal (other)
			<input type="checkbox"/> Business <input type="checkbox"/> Get to work <input type="checkbox"/> Work search <input type="checkbox"/> Medical <input type="checkbox"/> Recreational <input type="checkbox"/> Residence <input type="checkbox"/> Income producing <input type="checkbox"/> 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)
				<input type="checkbox"/> Home <input type="checkbox"/> Rental income <input type="checkbox"/> Business/Self-employment <input type="checkbox"/> Other:
				<input type="checkbox"/> Home <input type="checkbox"/> Rental income <input type="checkbox"/> Business/Self-employment <input type="checkbox"/> Other:
				<input type="checkbox"/> Home <input type="checkbox"/> Rental income <input type="checkbox"/> Business/Self-employment <input type="checkbox"/> 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



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 \$ _____ per _____	Property tax \$ _____ per _____	HOA fees \$ _____ per _____	Homeowners Insurance \$ _____ 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. Child Support Expense** - Use the space below to tell us about any court ordered child support expense or arrears you pay to someone who is not in your household.

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

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

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

# Tell us about your health coverage situation

If applying for Food Assistance only, skip this section.

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? \_\_\_\_\_

Employer Insurance Who? \_\_\_\_\_

Medicare Who? \_\_\_\_\_

(If selected, complete **Appendix B**)

VA Health Care Who? \_\_\_\_\_

TRICARE 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**.

# Rights and Responsibilities

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Before you complete this application:

- If you want someone to be your Authorized Representative, complete [Appendix A](#).
- If anyone in your household has access to health insurance from a job, even if the coverage is from someone else's job such as a parent or a spouse, or if you currently have health insurance from a job, you **MUST** complete [Appendix B](#).
- If anyone in your household is applying for health coverage, complete [Appendices C and D](#).

### 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

## 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) <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		Email		
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

## Health Coverage from Jobs

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

### Employee Information

First Name	Middle Name	Last Name	SSN	
Address		City	State	Zip Code
Phone Number	Email Address			

List everyone who is eligible for coverage from this job: \_\_\_\_\_

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

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

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

### Health plan information (must be completed by employer)

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

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

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

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

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

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

### Employer Information

Employer Name	Phone Number	Email Address
Name of Person Completing Form	Who may we contact about employee health coverage at this job (if different)?	

### Signature (must be completed)

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

Signature of Employer \_\_\_\_\_

Date \_\_\_\_\_

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

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

# Appendix C

## Qualifying Life Event

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

**Full name of primary tax filer for the household:** \_\_\_\_\_

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

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

1. Did any member of your household recently lose or expect to lose health insurance coverage within the next 60 days?  
 No  Yes. If yes, when did (or will) the event occur? \_\_\_\_\_
2. Did any member of your household recently become a citizen or lawful immigrant in the U.S.?  
 No  Yes. If yes, when did the event occur? \_\_\_\_\_
3. Did any person move into or leave your household?  No  Yes. If yes, complete the following:  
When did the event occur? \_\_\_\_\_  
Why did someone enter or leave your household?  Had a baby  Got married  Had a divorce  
 Adopted or is fostering a child  Other
4. Did any existing tax filer in your household recently gain a new Tax Dependent?  
 No  Yes. If yes, when did the event occur? \_\_\_\_\_
5. Did your household recently move to Idaho?  
 No  Yes. If yes, when did the event occur? \_\_\_\_\_
6. Did your household recently move within Idaho?  
 No  Yes. If yes, when did the event occur? \_\_\_\_\_
7. Did your household's income recently change?  No  Yes. If yes, complete the following:  
When did the event occur? \_\_\_\_\_  
Did the household income increase or decrease?  Increase  Decrease

\*Refer to question 14 on pages 2-3 of this application. If you checked "yes" for more than one person, and the additional person(s) is not a spouse filing jointly or a dependent, you may have more than one tax household.

# Appendix D



## Anticipated Annual Income Worksheet

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

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

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

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

### Earned Income

Earned income is money earned, such as wages, tips, or salary from a job, or income from self-employment. Use the tables below to enter gross earned income (income before taxes) for all members of your household for each month of the current year. Enter any self-employment income as net (instead of gross) income. Include the name of the source of income, like an employer name, for each entry. Ask for or make a copy of this worksheet if you have more than three household members with earned income.

#### Name of Person 1:

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

#### Name of Person 2:

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

#### Name of Person 3:

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

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

## Unearned Income

### Social Security Income

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

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

### Other Unearned Income

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

#### Name of Person 1:

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

#### Name of Person 2:

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

### Anticipated Annual Income (AAI) as a single figure

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

\$ \_\_\_\_\_