Arizona Department of Economic Security
Family Assistance Administration

Application for Benefits

Esta solicitud está disponible en línea o en su oficina local.

Here is a description of the benefits you may apply for using this application. Please tear off and keep all the information pages (A through E). These pages help you with the application process and help you understand your rights and responsibilities. Complete the application on pages 1 through 9. If you need help, please check the type of help you need on page 1 of the application.

The terms "us" or "we" refers to DES, its agents, and contractors throughout this application. The terms "you" and "your" include you and anyone you are applying for.

AHCCCS Health Insurance (MA) Gives medical services to families or individuals. Premiums or co-payments may apply. If you are responsible for the care of children who are not your own, they may be eligible for AHCCCS Health Insurance regardless of your income. (See pages B through C for information regarding covered medical services and available health plans)

If you do not have immigration documents, you may be eligible for emergency services only.

Cash Assistance/Temporary Assistance for Needy Families (CA/TANF) $ Gives temporary benefits to low income families. Parents or relatives of dependent children who are in their care may be eligible. Some families may qualify for a one-time lump sum cash assistance payment. We will determine if you qualify for this payment option.

Nutrition Assistance Benefits (NA) Helps low income families or individuals buy food for a healthier diet. Tell us if you think your family needs emergency Nutrition Assistance benefits and we will tell you if you qualify.

YOUR NUTRITION ASSISTANCE RIGHTS

You can file an application with only your name, address, and the signature of a responsible household member or your authorized representative. This will hold your date of application but eligibility for Nutrition Assistance benefits **cannot** be determined until you complete a full application and an interview.

Tuberculosis Control (TC) Gives cash support for individuals who are determined unable to work by the Department of Health Services as a result of communicable Tuberculosis.

Free School Lunch

If your children are eligible for Cash Assistance or Nutrition Assistance benefits, they are also eligible for the National School Lunch Program (NSLP). The NSLP gives nutritionally balanced, low cost or free lunches to children who qualify. This program operates in most public and non-profit private schools and in many child care institutions. Ask your children's school for more information and how to apply

The USDA is an equal opportunity provider and employer • DES/TANF/USDA Agencies are Equal Opportunity Employers/Programs

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

What services does AHCCCS Health Insurance (MA) cover?

Covered Medical Services		
Doctor's Visits	Immunizations (shots)	Transportation to Doctor*
Specialist Care	Physical Exams	Glasses*
Hospital Services	Family Planning	Vision Exams*
Emergency Care	Lab and X-rays	Dental Services*
Pregnancy Care	Prescriptions	Hearing Exams*
Podiatry Services	Dialysis	Hearing Aids*
Surgery	Annual Well Women Exams	Behavioral Health*

*Coverage of these services may be limited depending on your age or the program.

What does AHCCCS Health Insurance cost you?

Premiums

Most people do not have to pay a monthly premium for AHCCCS Health Insurance.

Some people with income too high to qualify for AHCCCS Health Insurance with no monthly premium may be able to get it by paying a monthly premium. If you have to pay a premium, the premium amounts are:

- $10 - $70 per household for all children.
- $10 - $ 35 per person for employed people with disabilities.

Co-payments

A co-payment is the amount you pay a health care provider when you receive a medical service. Your co-payment amount will vary depending on which AHCCCS program you are enrolled in. Co-payments for services are:

- Physician visits $0 to $1
- Non-emergency use of the Emergency Room $0 to $1

Native Americans and Alaskan Natives

Per federal law, Native Americans enrolled with a federally recognized tribe and certain Alaskan Natives do not have to pay a KidsCare premium. To get KidsCare at no cost, you must give us proof of tribal enrollment.

How does AHCCCS Health Insurance work?

If you are approved for AHCCCS Health Insurance, you will receive your health care from an AHCCCS Health Plan unless:

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

How Does a Health Plan Work?

- The health plan works with the health care providers (doctors, hospitals, pharmacies, etc.) to provide all AHCCCS covered services.
- The health plan will send you a member handbook once you are enrolled.
- You can call the health plan if you have any questions about your benefits or services or if you need an accommodation because of a disability or interpreter services. The phone number for your health plan's member or customer services can be found on your AHCCCS ID Card and in your Member Handbook.

Your Primary Doctor and Specialists

- You must choose your primary doctor or one will be assigned to you.
- Once enrolled, you will get a list of primary doctors in your area from the health plan.
- Your primary doctor will:
  - Take care of your health care.
  - Be the first person you go to for non-emergency medical care.
  - Be responsible for authorizing your non-emergency medical services.
  - Send you to a specialist when needed.
- You have the right to change your primary doctor at any time by calling your Health Plan's member or customer services.

How Can I Get Behavioral Health Services?

- You can go through your primary doctor, or
- Call the behavioral health telephone number on your AHCCCS ID Card.

What if I Have Medicare or Other Health Insurance?

- Be sure to tell your health plan that you have Medicare or any other health insurance.
- If your doctor does not contract with your AHCCCS health plan, your doctor must call the AHCCCS health plan to coordinate care or you may be responsible for any Medicare or other health insurance co-payments or deductibles.
- If you are in an HMO, you should pick a primary doctor who works with both your HMO and your AHCCCS health plan.
- If you have Medicare, your prescription coverage under AHCCCS is limited. If you have questions about prescriptions, call 1-800-MEDICARE (633-4227), or your AHCCCS health plan.

Your AHCCCS D Card

- Your AHCCCS ID Card has your unique AHCCCS ID number.
- Show the card when you get medical care (you may need to show a picture ID as well).
- Doctors, hospitals and pharmacists use your AHCCCS ID Card to obtain faster verification of your eligibility.
- Keep your AHCCCS ID Card with you at all times.
- Keep your AHCCCS ID Card in a safe place.
- Do not let anyone else use your AHCCCS ID Card or you may be prosecuted.

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YOU NEED TO CHOOSE A HEALTH PLAN THAT SERVES YOUR COUNTY.

- All AHCCCS health plans provide the same covered medical services.
- Review the health plans for your county listed below. Native Americans may choose American Indian Health Program or an AHCCCS Health Plan.
- Before choosing, check with your doctor, pharmacy or hospital, to see if they contract with (work with) the plan that you want. If you want more information about the doctors, specialists or hospitals that contract with a health plan that serves your county, call the number listed below for the health plan or ask your Eligibility Specialist for the health plan's list of health care providers.
- If you do not choose a health plan, one will be assigned to you. If you have been enrolled in an AHCCCS health plan within the past 90 days, you may be enrolled with your previous health plan.

APACHE COUNTY
Phoenix Health Plan 1-800-747-7997
Health Choice Arizona 1-800-322-8670
American Indian Health Program 928-729-8000
If your zip code is 85943, you must choose from among the health plans listed under Navajo County.

COCHISE COUNTY
University Family Care 1-800-582-8686
Mercy Care Plan 1-800-624-3879
American Indian Health Program 520-295-2479

COCONINO COUNTY
Phoenix Health Plan 1-800-747-7997
Health Choice Arizona 1-800-322-8670
American Indian Health Program 928-283-2501
If your zip code is 86336 or 86340, you must choose from among the health plans listed under Yavapai County.

GILA COUNTY
Phoenix Health Plan 1-800-747-7997
University Family Care 1-800-582-8686
American Indian Health Program 928-475-2371

GRAHAM COUNTY
University Family Care 1-800-582-8686
Mercy Care Plan 1-800-624-3879
American Indian Health Program 928-475-2686
If your zip code is 85643, you must choose from among the health plans listed under Cochise County.

GREENLEE COUNTY
University Family Care 1-800-582-8686
Mercy Care Plan 1-800-624-3879
American Indian Health Program 928-475-2371

LA PAZ COUNTY
Arizona Physicians, IPA 1-800-348-4058
Health Choice Arizona 1-800-322-8670
American Indian Health Program 928-669-2137

MARICOPA COUNTY
Phoenix Health Plan 1-800-747-7997
Care 1st 1-866-560-4042
Health Choice Arizona 1-800-322-8670
Arizona Physicians, IPA 1-800-348-4058
Mercy Care Plan 1-800-624-3879
Maricopa Health Plan 1-800-582-8686
American Indian Health Program 602-263-1200

MOHAVE COUNTY
Phoenix Health Plan 1-800-747-7997
Health Choice Arizona 1-800-322-8670
American Indian Health Program 928-769-2900

NAVAJO COUNTY
Phoenix Health Plan 1-800-747-7997
Health Choice Arizona 1-800-322-8670
American Indian Health Program 928-338-4911

PIMA COUNTY
Arizona Physicians, IPA 1-800-348-4058
Health Choice Arizona 1-800-322-8670
Mercy Care Plan 1-800-624-3879
Phoenix Health Plan 1-800-747-7997
University Family Care 1-800-582-8686
American Indian Health Program 520-295-2479
If your zip code is 85645, you must choose from among the health plans listed under Santa Cruz County.

PINAL COUNTY
Phoenix Health Plan 1-800-747-7997
University Family Care 1-800-582-8686
American Indian Health Program 520-562-3321
If your zip code is 85242 or 85220, you must choose from among the health plans listed under Maricopa County. If your zip code is 85292 you must choose from among the health plans listed under Gila County.

SANTA CRUZ COUNTY
University Family Care 1-800-582-8686
Health Choice Arizona 1-800-322-8670
Indian Health Service 520-295-2479

YAVAPAI COUNTY
Phoenix Health Plan 1-800-747-7997
Bridgeway 1-866-475-3129
Indian Health Service 602-263-1200
If your zip code is 85342, 85358 or 85390, you must choose from among the health plans listed under Maricopa County. If your zip code is 86351 you must choose from among the health plans listed under Coconino County.

YUMA COUNTY
Arizona Physicians, IPA 1-800-348-4058
Health Choice Arizona 1-800-322-8670
Indian Health Service 760-572-4100

IMPORTANT

When you have chosen a health plan you can either:

- Give your choice to your eligibility specialist, **OR**
- Call AHCCCS to pre-enroll. From area codes 480, 602 or 623 call (602) 417-7100 or from area codes 520 or 928 call 1-800-334-5283. When you call to pre-enroll, you will need to give the following information:
  - Name
  - Sex (male or female)
  - Date of birth, and
  - Social Security number of all the individuals for whom you applied.

If you have any questions about enrolling with an AHCCCS health plan, need an interpreter, or if you are visually or hearing impaired and need special accommodations to choose a health plan or to understand the information, from area codes 480, 602 or 623 call (602) 417-7100 or TDD (602) 417-4191 or from area codes 520 or 928 call toll free at 1-800-334-5283 or TDD 1-800-826-5140.

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1. How do I apply for benefits?

- You can apply online through the Health-e-Arizona website at www.healthearizona.org
- You can fill out the application and turn it in by mail, fax, or in person, to any Department of Economic Security/Family Assistance Administration (DES/FAA) or Tribal Temporary Assistance for Needy Families (TANF) office.
- You may apply in person at any DES/FAA Department of Economic Security/Family Assistance Administration (DES/FAA) local office. You can find a list of FAA local offices at www.azdes.gov/faa, or you can call our 24 hour Interactive Voice Response (IVR) system at 602-542-9935 (if calling from area code 602, 480, or 623) or 1-800-352-8401 (for all other area codes).
- You can ask us to mail or fax an application to you.

2. Application assistance

- You should fill out as much of the application as you can. If you need help filling out the application, please ask us for help. We cannot make a decision on your application until we have all of the information needed for the benefits you are asking for.
- If you need a language interpreter, or accommodations for a disability, please check the type of help you need on page 1 of the application.
- If you are applying for Cash Assistance only for children who are not your own, answer the Cash Assistance questions as they apply to you, the children you are applying for, your own children, your spouse, if you are married and your spouse's children.
- If you apply for AHCCCS Health Insurance only for children who are not your own, answer the questions as they apply only for the children you are applying for. For example, the questions about income, resources, etc., apply to the children and not to you.

3. Interview Information

- When AHCCCS Health Insurance is the only program you are applying for, we may not need to interview you before determining your eligibility.
- When applying for Cash Assistance and or Nutrition Assistance, we will schedule an interview for you or your representative.
- If you cannot come to the office for an interview, we may be able to set up a telephone or home interview for you.
- If an interview is needed, you or your representative must complete the interview in person or by phone.
- Please tell us if you need an interpreter or if you have special needs so this can be set up before the interview by completing the "Language/Accommodations for Disability" section on page 1 of the application.

4. Can someone else apply for me?

- For Nutrition Assistance benefits and AHCCCS Health Insurance you can assign a representative to apply for you. If an interview is needed, your representative can be interviewed on your behalf. Complete the Representative section on page 1 of the application. Be sure your representative knows your situation. You are responsible for any missing or wrong information given by your representative.

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

- You do not need to tell us about your citizenship or immigration status if you are not applying for benefits for yourself.
- You will still need to provide information on the citizenship and immigration status of any person in your family or household (such as a child) you are applying for.
- If you do not give us citizenship and immigration information because you are not applying for benefits, we will not try to find out this information from U.S. Citizenship and Immigration Services (USCIS).
- It is DES policy not to report you, a family, or household member to U.S. Immigration and Customs Enforcement (ICE), unless you inform us that you, your family or household member are in the U.S. illegally.
- You will still need to provide information on income, resources, or other information for yourself, or others, who have not given us citizenship or immigration status information to complete the application process.
- Only citizens and qualified non-citzens can get Cash Assistance, Nutrition Assistance, and Medical Assistance (AHCCCS). But you do not need to be a US citizen or qualified alien to get Federal Emergency Medical Services (FES).
- Giving us the citizenship and immigration status for all persons who are eligible for benefits allows us to give you the highest amount of benefits you are eligible to receive. When you do not give us this information it will not affect the eligibility of the people you are applying for that have provided verification of their citizenship or qualified non-citizen status. However, it will affect the amount of the benefits for these people.
- Under federal law, certain non-citizens (such as refugees or political asylees) may qualify for AHCCCS Health Insurance or Nutrition Assistance benefits. For those non-citizens, USCIS guidelines state that use of these benefits will not affect your ability to become a Lawful Permanent Resident.

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6. To receive benefits, do I have to give you my Social Security number?

Federal Law requires that you give a Social Security number for anyone who wants to get AHCCCS Health Insurance, Cash Assistance, or Nutrition Assistance benefits. [42 U.S.C. § 1320b-7; 42 U.S.C. § 405(c)(2)(C); and 7 U.S.C. §§ 2011-2036] We will not give any Social Security numbers to the United States Citizenship and Immigration Services (USCIS).

If you or anyone you are applying for does not have a Social Security number, we will refer you to the Social Security office to apply for one. Immigrants who are not legally able to get a Social Security number are not required to give one or apply for one. Any person you are applying for who is legally able to get a Social Security number, but does not have a Social Security number or does not apply for one will not be eligible for benefits.

If you are not applying for benefits for yourself, you do not have to give us your Social Security number. However, it may reduce the total amount of Nutrition Assistance and Cash Assistance benefits for the person you are applying for because we will not consider your needs when determining benefit amounts.

We will not use your Social Security number as your case number or AHCCCS identification number.

7. What do you do with my information?

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

- Verify identity.
- Verify income and assets.
- Verify other health insurance.
- Prevent duplicate benefits.
- Establish and enforce child support and medical support orders.
- Computer match with state and federal agencies and our other programs to verify information.
- Collect money we overpaid you in the form of benefits.
- Share with other government agencies and their contractors to assess Cash Assistance, Medical Assistance, or Nutrition Assistance program management and compliance.

We may give your information to law enforcement officials for the purpose of arresting persons fleeing to avoid the law.

The collection of this information, including the Social Security number of each person you are applying for, is authorized under the Nutrition Assistance Act of 1977, as amended, 7 U.S.C. §§ 2011-2036; 42 U.S.C. § 1320b-7 for Medical Assistance; 42 U.S.C. § 405(c)(2)(C) for Cash Assistance.

8. What is expected of me?

- For Cash Assistance and AHCCCS Health Insurance, you must give us information, if you have any, about an absent parent or request a Claim for Good Cause for not giving us information about an absent parent, including if giving us the information might put you, your family, or anyone you are applying for, in danger.
- All adult household members and minor parents who are eligible for Nutrition Assistance or Cash Assistance benefits must be fingerprint imaged. (*Exceptions may apply*.)
- If you are approved you will get a letter telling you what changes you must report. You will need to timely report and provide proof of the changes.

9. Am I eligible for Emergency Nutrition Assistance benefits?

- If you have little or no money, you may be eligible for emergency Nutrition Assistance benefits. Be sure to answer the Emergency Nutrition Assistance benefit questions on page 1 of the application.
- We will use the information given on the application and at the interview to see if you can get emergency Nutrition Assistance benefits.

10. What information do I need to give DES?

- The table below lists the items required for each program. It is best to turn in all items when you turn in your application.
- If applying online through our website at www.healthearizona.org, most documents can be faxed or uploaded to the application. We will need to see the original documents for some of the items listed below.
- If an in office interview is required you can bring these items with you at that time.
- If you can not turn in all items when you turn in your application, come to the interview anyway and we will help you. We may request more verification, depending on your situation.
- If we do not need to interview you, we will send you a letter asking you to fax, mail, or bring the information to the office. You must give us proof of the information we need to make a decision on your application.

Cash Assistance	**Nutrition Assistance benefits**	**AHCCCS Health Insurance**	**Items to bring:**
×	×	×	Identification(ID)
×	×	×	Proof of U.S. citizenship* **(Original is required for AHCCCS Health Insurance. Do not fax or mail when applying for AHCCCS)**
×	×	×	Immigration registration documents for non-U.S. citizens*
×	×	×	Social Security numbers, or proof that a number has been applied for*
×		×	Proof of relationship
×		×	A statement verifying your address and the names of everyone living with you. The statement must be made by a non-relative who does not live with you, and must be signed, dated and include their address and telephone number.
×	×	×	Proof of all money your household received last month and this month
×	×	×	Proof that your employment ended and the last date paid
×			Registration or titles for all vehicles
×	×	×	Most recent bank or credit union complete statement (savings or checking)
×	×		Proof of savings bonds, securities, retirement plans and life insurance
		×	Proof of pregnancy, including the estimated date of delivery
×	×		Proof of rent **or** mortgage, home owner association (HOA) and utility bills for the most recent month
×	×	×	Proof of dependent care (child or adult) expenses for the most recent month
	×		Proof of all medical expenses (including transportation costs for medical treatment) for those who are age 60 or disabled
		×	Proof of any medical insurance other than AHCCCS

*You do not have to provide this information for any person who is not asking for benefits. See page D section 5. "Do I have to give you information about my Citizenship and Immigration Status" and Page E, Section 6, "To receive benefits, do I have to give you my Social Security number".

11. How will I know if I am eligible?

- If approved, we will send you a letter explaining benefits you are eligible for and the amount of benefits you will receive.
- If denied, we will send you a letter explaining the reason for the denial.
- Before your benefits end, we will tell you that it is time to reapply so your benefits can continue without interruption.

12. How long does it take to find out if I qualify for benefits after you receive my application?

- For AHCCCS Health Insurance we will make a decision within **45** days, or within **20** days, if you are pregnant.
- For Cash Assistance we will make a decision within **45** days. If you are a relative or legal guardian applying only for children who are not your own, we must determine if the children qualify within **20** days.
- For Nutrition Assistance we will make a decision within **30** days.
- If you are eligible for emergency Nutrition Assistance benefits, we must issue Nutrition Assistance benefits on your Electronic Benefit Transfer (EBT) card within **seven (7)** days. See Section 14 "How can I get my benefits when my application is approved".

13. What if you do not make a decision on my application on time?

If we do not make a decision on your application within the time frames shown above, or you have questions, you can:

- Call your FAA local office during normal business hours.
- Call our 24 hour Interactive Voice Response (IVR) system at 602-542-9935 (if calling from area code 602, 480, or 623), or 1-800-352-8401 (for all other area codes).
- Get additional contact information via the internet at www.azdes.gov/faa.
- You may request a fair hearing at any FAA local office.

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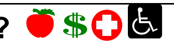
14. How can I get my benefits when my application is approved?? 

- An AHCCCS Health Insurance card is mailed to you for all members of your household who are approved for medical benefits.
- If you qualify for Cash Assistance or Nutrition Assistance benefits we mail you an Electronic Benefit Transfer (EBT) card. This card works like a debit card. We will give you at your interview or mail you a pamphlet with instructions on how to use your card.
- Your benefits are issued on your EBT card after approval; it can take up to 48 hours for the benefits to appear. You can call the Customer Service number on the back of the card to check the balance of your benefits.
- If you qualify for Nutrition Assistance benefits, you can use the EBT card to purchase approved Nutrition Assistance items. If you qualify for Cash Assistance benefits, you can use your EBT card to get cash or pay for nonfood items at any participating store. You may also withdraw your Cash Assistance benefits at ATMs.

15. What are my rights?

You have the right to:

- Courteous and professional treatment.
- Talk about your case with your worker or a supervisor.
- Get a written letter before your benefits are reduced or stopped.
- Have the information you give us used only as authorized by law.
- Ask for a fair hearing, verbally or in writing, for any action or failure to take action by DES/FAA.
- Look at your file before a fair hearing.
- Bring an attorney or any other person to a fair hearing.
- Claim Good Cause for non-cooperation with Child Support Enforcement if establishing or enforcing support would bring harm to you or any child in your custody. You may claim Good Cause by telling your Cash Assistance or Child Support worker the facts justifying good cause and signing the Claim of Good Cause at any time you are applying for or receiving Cash Assistance.

In accordance with Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (DHHS) policy, DES is prohibited from discrimination in all of its programs and activities on the basis of:

- Race
- Color
- Age
- Disability
- Sex
- National Origin
- Religion
- Political Beliefs

To file a complaint of discrimination, contact USDA or DHHS. Write or call:

USDA, Director
Office of Civil Rights
Room 326-W, Whitten Building
1400 Independence Ave., S.W.
Washington, D.C. 20250-9410

1-202-720-5964 (voice and TDD)

Attention: Regional Manager
U.S. Department of Health and Human Services
Office for Civil Rights/Region IX
50 United Nations Plaza, Room 322
San Francisco, CA 94102

1-800-368-1019 (voice)
1-415-437-8311 (TDD)

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16. What are the Rules and Penalties?

If you, your representative, or any household member hides information or gives false information on purpose to get or continue to get AHCCCS Health Insurance, Cash Assistance or Nutrition Assistance benefits, that person will be subject to:

- Criminal prosecution
- Fines
- Imprisonment
- Other penalties provided for by the state and federal laws.

If you get AHCCCS Health Insurance, Cash Assistance or Nutrition Assistance benefits, you must follow the rules below:

- Do not make false statements or hide information. If you are not truthful, DES can take back money overpaid to you and you may be taken to court.
- Do not do anything dishonest to get benefits that you are not supposed to get.
- Do not give or sell your AHCCCS ID card to anyone.
- Do not buy, sell, trade, exchange, or otherwise transfer your or someone else's Nutrition Assistance benefits or EBT card.
- Do not alter an EBT card.
- Do not allow someone, other than an authorized user approved by DES, to use your EBT card.
- Do not use someone else's EBT card.
- Do not use your Nutrition Assistance benefits to buy non-food items such as alcohol and tobacco.

If you knowingly break the rules and get Cash Assistance and/or Nutrition Assistance benefits, we will disqualify you from receiving Cash Assistance and /or Nutrition Assistance benefits for:

- 12 months for the **first** violation.
- 24 months for the **second** violation.
- Permanently for the **third** or any other violations.

The following additional penalties apply to the **Nutrition Assistance Program**:

- An additional disqualification, of up to 18 months, may be ordered by a court.
- Any participant or household member who makes false statements or hides information can be fined up to $250,000, imprisoned up to 20 years, or both.
- You and/or your household members may be subject to further prosecution under federal laws.

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

- Has been convicted of using or getting Nutrition Assistance benefits in a transaction involving the sale of firearms, ammunition or explosives. This person can never get Nutrition Assistance benefits again.
- Is a fleeing felon, or probation/parole violator.
- Has been found guilty of having used or received Nutrition Assistance benefits in the sale of a controlled substance. This person is not eligible to participate for 2 years for the first violation and permanently for the second violation.
- Has committed and was convicted of a federal or state felony on or after 8/23/96 for the possession, use, or distribution of a controlled substance.
- Has been found by a court of law to have given false identification or residence information in order to get benefits in more than one case. This person is not eligible to get benefits for 10 years.
- An entire household is not eligible for Cash Assistance if any mandatory adult household member refuses to sign and comply with the Personal Responsibility Agreement (PRA). We give you the PRA during the interview process.
- Is an adult recipient (18 years or older) of Cash Assistance when any of the following apply:
  1. The recipient does not return the completed Illegal Drug Use Statement (A002). We send the A002 via U.S. mail after Cash Assistance has been approved.
  2. The recipient fails to take a required drug test; or
  3. The recipient fails the drug test.

The following additional penalties apply to the **AHCCCS Health Insurance Program:**

- If you or your representative knowingly gives false information, you or your representative will be subject to criminal prosecution that could result in fines, imprisonment, and other penalties under state or federal laws. We may require you to pay for AHCCCS Health Insurance you received while you were not eligible.

- If you do not cooperate with the Division of Child Support Enforcement, we may stop or reduce your Cash Assistance. We may also disqualify you from AHCCCS Health Insurance. We will not disqualify your children from AHCCCS Health Insurance if you do not cooperate.

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

Tear off and keep this page

Arizona Department of Economic Security • Family Assistance Administration

Application for Benefits

Language / Accommodations for Disability **Please print in black or blue ink**

I need:
- ☐ **A language interpreter** What language? ____________
- ☐ Braille ☐ American Sign Language
- ☐ **Help reading/understanding this application** ☐ **Help filling out this form**
- **Accommodations with:** ☐ Hearing ☐ Walking ☐ Seeing ☐ Speaking ☐ Writing ☐ Other:

Agency Use Only

Case Number:

W1

Referral Source:

I am applying for the following programs: (Check one or more boxes)
- ☐ AHCCCS Health Insurance
- ☐ Nutrition Assistance benefits
- ☐ Cash Assistance/TANF
- ☐ I do not want AHCCCS Health Insurance
- ☐ Tuberculosis Control

Date Stamp

Personal Information

Name (Last, First, M.I.) (Include Maiden, Alias and other names)	Soc. Sec. No.	Date of Birth
Home Address (If rural, give directions to where you live)		
Mailing Address (No., Street, Apt. #, City, State, ZIP) (If different)		
Phone Number	Message Phone Number	E-mail address

If you are not registered to vote where you live, would you like to register to vote?
☐ Already registered ☐ Yes ☐ No **(If 'Yes', see the last page for necessary information)**

Interview Information

1. ☐ Yes ☐ No Are you or your representative able to come into the office for an interview? If 'No', explain:
2. ☐ Yes ☐ No Do you need a special appointment? If 'Yes', write the days and times that are best for you:

Emergency Benefits: AHCCCS Health Insurance, Cash Assistance, and Nutrition Assistance

To help us determine your emergency needs, answer the following questions for you and everyone you are applying for:

3. The total amount of income, before deductions, you expect to receive this month. $ ________
4. The total amount of cash on hand, and money in your checking and savings accounts. $ ________
5. The total monthly housing costs (rent or mortgage, taxes, homeowner/rental insurance, etc.). $ ________
6. The total monthly utility costs (gas, electric, phone, water, etc.). $ ________
7. ☐ Yes ☐ No Does anyone receive Tribal Food Distribution?
8. ☐ Yes ☐ No Is anyone a Migrant or Seasonal Farm Worker?
9. ☐ Yes ☐ No Do you live in a shelter? If 'Yes', what type? ________
10. ☐ Yes ☐ No Has anyone received Nutrition Assistance benefits in any other state? If 'Yes', which state?
State: ________ When? ________ Who? ________
11. ☐ Yes ☐ No Is anyone pregnant? If 'Yes', who? ________
☐ Yes ☐ No Due Date ________ Number of babies expected? ________
12. ☐ Yes ☐ No Are you applying for children who are not your own?

If you want to allow someone else to represent you, complete the following section:
Representative's Name: ________ Is your representative your legal guardian? ☐ Yes ☐ No
Phone Number: ________ Message Phone Number: ________
Mailing Address (No., Street, Apt. #, City, State, ZIP) (If different):

By signing below, I:
- Give permission for my representative to complete and sign my application.
- Give permission for my representative to give DES any documents requested, including personal information.
- Give permission to my representative to sign on my behalf to permit other people, businesses, or agencies to give personal information about me to AHCCCS and DES.
- Give permission for AHCCCS or DES to tell my representative about my eligibility.
- Agree that I am legally responsible for all statements and information my representative makes to DES.

Signature of Applicant/Representative
(not needed if the applicant has a legal guardian or is unable to sign due to being incapacitated): ________ Date: ________

If you are applying for **Nutrition Assistance benefits** **and/or Cash or TC** $ and you want to allow someone else to have access to your benefits in your **EBT account**, complete the following section:

EBT Representative's Name: ____________ EBT Representative's Date of Birth ____________

Phone No.: ____________ Message No.: ____________ Address: ____________

Complete the following for everyone living in your home even if they do not want benefits:
(You do not need to give us the Social Security number, citizenship, immigration status, or place of birth for people, including you, who do not want benefits)

Information about you (Household member #1)

Full Name (Last, First, M.I.):	Relationship to you: **Self**	Date of Birth:	Place of Birth (State/Country): ☐ Choose not to answer
What health plan would you like for your family?	Sex ☐M ☐F	**U.S. Citizen ☐ Y ☐ N ☐ Choose not to answer	If no, what number is on your immigration card? ☐ NA ID No.: **A**
In School ☐ Y ☐ N ☐ Full time ☐ Part time			
Applying for: ☐ None ☐ Nutrition Assistance	☐ AHCCCS Health Insurance ☐ I do not want AHCCCS Health Insurance	☐ Cash Assistance ☐ Tuberculosis Control	
*Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino	*Race, check all that apply: ☐ White ☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Hawaiian/Pacific Islander Native		
Enrolled tribal member: ☐ Y ☐ N Tribal Census No.:	Living on a tribal reservation: ☐ Y ☐ N Reservation name:		

Household member #2

Full Name (Last, First, M.I.):	Soc. Sec. No.:	Date of Birth:	Place of Birth (State/Country): ☐ Choose not to answer
Relationship to you:	Sex ☐M ☐F	**U.S. Citizen ☐ Y ☐ N ☐ Choose not to answer	If no, what number is on your immigration card? ☐ NA ID No.: **A**
In School ☐ Y ☐ N ☐ Full time ☐ Part time	Shots current ☐ Y ☐ N		
Applying for: ☐ None ☐ Nutrition Assistance	☐ AHCCCS Health Insurance ☐ This person does not want AHCCCS Health Insurance	☐ Cash Assistance ☐ Tuberculosis Control	
*Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino	*Race, check all that apply: ☐ White ☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Hawaiian/Pacific Islander Native		
Enrolled tribal member: ☐ Y ☐ N Tribal Census No.:	Living on a tribal reservation: ☐ Y ☐ N Reservation name:		

Household member #3

Full Name (Last, First, M.I.):	Soc. Sec. No.:	Date of Birth:	Place of Birth (State/Country): ☐ Choose not to answer
Relationship to you:	Sex ☐M ☐F	**U.S. Citizen ☐ Y ☐ N ☐ Choose not to answer	If no, what number is on your immigration card? ☐ NA ID No.: **A**
In School ☐ Y ☐ N ☐ Full time ☐ Part time	Shots current ☐ Y ☐ N		
Applying for: ☐ None ☐ Nutrition Assistance	☐ AHCCCS Health Insurance ☐ This person does not want AHCCCS Health Insurance	☐ Cash Assistance ☐ Tuberculosis Control	
*Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino	*Race, check all that apply: ☐ White ☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Hawaiian/Pacific Islander Native		
Enrolled tribal member: ☐ Y ☐ N Tribal Census No.:	Living on a tribal reservation: ☐ Y ☐ N Reservation name:		

Household member #4

Full Name (Last, First, M.I.):	Soc. Sec. No.:	Date of Birth:	Place of Birth (State/Country): ☐ Choose not to answer
Relationship to you:	Sex ☐M ☐F	**U.S. Citizen ☐ Y ☐ N ☐ Choose not to answer	If no, what number is on your immigration card? ☐ NA ID No.: **A**
In School ☐ Y ☐ N ☐ Full time ☐ Part time	Shots current ☐ Y ☐ N		
Applying for: ☐ None ☐ Nutrition Assistance	☐ AHCCCS Health Insurance ☐ This person does not want AHCCCS Health Insurance	☐ Cash Assistance ☐ Tuberculosis Control	
*Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino	*Race, check all that apply: ☐ White ☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Hawaiian/Pacific Islander Native		
Enrolled tribal member: ☐ Y ☐ N Tribal Census No.:	Living on a tribal reservation: ☐ Y ☐ N Reservation name:		

***Ethnicity and race categories are voluntary and will not affect your benefit .**See page D #5 for citizenship requirements.**

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

Please provide the information requested below:

Name of someone who knows you well	Relationship to you
Mailing Address	Daytime Telephone Numbers
Name of Landlord	
Mailing Address	Daytime Telephone Numbers

Answer the following questions for AHCCCS Health Insurance.

13. ☐ Yes ☐ No Is anyone hospitalized? If 'Yes', who? ____________
Name of hospital: ____________

14. ☐ Yes ☐ No Do you consider Arizona to be your permanent home state? If 'No', explain: ____________
____________ Tell us the date you moved to Arizona: ____________

15. ☐ Yes ☐ No Do you plan on staying in Arizona? If 'No', explain: ____________

16. ☐ Yes ☐ No Was anyone in Arizona's Foster Care or Young Adult Program on their 18th birthday? If 'Yes', who?
____

17. ☐ Yes ☐ No Does anyone have an injury or illness due to an accident or medical malpractice within the last three years? If 'Yes', who? ____________

18. ☐ Yes ☐ No Does anyone have a chronic illness (medical condition that requires frequent and ongoing treatment) and, that if not properly treated, will seriously affect the person's overall health? If 'Yes', who?
____

19. ☐ Yes ☐ No Does anyone have health insurance, other than AHCCCS? If 'Yes', who? ____________
Name of health insurance: ____________

20. ☐ Yes ☐ No If you are not eligible for free AHCCCS Health Insurance, are you willing to pay a monthly premium for coverage? If 'No', for who? ____________

21. ☐ Yes ☐ No Was anyone recently released from prison or jail?
If 'Yes', who? ____________ When? ____________

22. ☐ Yes ☐ No If anyone is not a U.S. citizen, did they enter the United States on or before August 22, 1996?
If 'Yes', who? ____________

23. ☐ Yes ☐ No Has any person on this application or their spouse or deceased spouse served in the military?

24. ☐ Yes ☐ No Is anyone on this application the child of a person who served in the military? You are applying for the spouse or child, or spouse of a deceased person who previously served in the military?
If you answered 'Yes' to #23 or #24 complete the following:
Name of person who served: ____________ Military ID No.: ____________
Branch of service: ____________ Dates of service: ____________

25. ☐ Yes ☐ No Is anyone unable to work because of a medical condition that has lasted or may last 12 months, or will result in death? If 'Yes', who? ____________

26. ☐ Yes ☐ No Has anyone applied for disability benefits (such as Social Security benefits, Veteran's benefits, or Worker's Compensation? If 'Yes', who? ____________

Answer the following questions for AHCCCS Health Insurance and/or Cash Assistance. $

27. ☐ Yes ☐ No Are you, or anyone you are applying for married?

28. ☐ Yes ☐ No Are **both** parents of all children you are applying for in the home?

If you answered 'No' to question 28, complete the following for **each** absent parent.

Absent parent's full name	Social Security number	Date of birth	Phone number	Relationship to you
Address (No., Street, Apt. #, City, State, ZIP)	Absent parent's medical insurance for children:			☐ Divorced ☐ Married ☐ Never married ☐ Separated ☐ Widowed
List **all** children of this absent parent				
Absent parent's full name	Social Security number	Date of birth	Phone number	Relationship to you
Address (No., Street, Apt. #, City, State, ZIP)	Absent parent's medical insurance for children:			☐ Divorced ☐ Married ☐ Never married ☐ Separated ☐ Widowed
List **all** children of this absent parent				

Answer the following questions for Nutrition Assistance benefits. and Cash Assistance benefits $.

29. ☐ Yes ☐ No Are you, or anyone you are applying for disabled?

Answer the following questions for Nutrition Assistance benefits.

30. ☐ Yes ☐ No Is anyone who is disabled or over age 60, have any medical expenses, to include paid or unpaid even if you have medical insurance (i.e. travel expenses to and from medical provider, doctor visits, prescriptions, lab work, etc.)?

31. ☐ Yes ☐ No Are you living in an assisted living facility or group home?

32. ☐ Yes ☐ No Is there anyone living with you who buys and prepares food on their own?

If 'Yes', complete the following for anyone living with you who buys and prepares food on their own.

Name	Age	Relationship to you	Does this person help pay expenses?	What expenses?
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

Answer the following questions for Nutrition Assistance and Cash Assistance benefits $.

You may still be eligible for benefits if you have a felony drug conviction.
(see 'What are the Rules and Penalties' section on page H.)

33. ☐ Yes ☐ No Have you or anyone you are applying for had a felony conviction for possession, use, or distribution of a controlled substance on or after August 23, 1996? If 'Yes', please provide name, date, city and state of conviction. ______

34. ☐ Yes ☐ No Have you or anyone you are applying for been found to have committed a Nutrition Assistance (NA), or Cash Assistance (CA) Intentional Program Violation in Arizona or any other state? If 'Yes', Which state?:

35. ☐ Yes ☐ No Are you or anyone you are applying for fleeing from law enforcement agencies on any charges, or are you in violation of probation or parole according to a court?

Complete the following questions for you and everyone you are applying for:

36. Do you, anyone in your family or anyone you are applying for, own or have their name on any of the following resources?

☐ Yes ☐ No Bank (checking or savings), credit union accounts, IRA, Keogh, 401K. Total amount: $ ______
If yes, who? ______ Name of Financial Institution: ______

☐ Yes ☐ No Stocks, bonds, money market accounts, CDs, trust funds, life insurance. Value: $ ______
If yes, who? ______ Name of Financial Institution: ______

☐ Yes ☐ No Real property (land or buildings) anywhere. Value: $ ______

☐ Yes ☐ No Vehicles (cars, trucks, boats, RVs, motorcycles, etc). How many? ______ Value: $ ______

☐ Yes ☐ No Other: ______ Value: $ ______

☐ Yes ☐ No Own, lease or maintain a home? Who? ______ Where? ______

37. ☐ Yes ☐ No Received benefits in any other state? If yes, which state? ______ Last received: ______

Answer the following questions for all programs.

38. Do you, your family or anyone you are applying for, receive or expect to receive money from any of the following:

Child Support	☐ Yes ☐ No	Social Security/SSI	☐ Yes ☐ No	Scholarships, grants/loans	☐ Yes ☐ No
Disability	☐ Yes ☐ No	Retirement/Pension	☐ Yes ☐ No	Veterans Administration	☐ Yes ☐ No
Foster Care	☐ Yes ☐ No	Unemployment	☐ Yes ☐ No	Worker's Comp/Industrial	☐ Yes ☐ No
Spousal Maintenance	☐ Yes ☐ No	Gift/loans	☐ Yes ☐ No	Bureau of Indian Affairs	☐ Yes ☐ No
Any Government check	☐ Yes ☐ No	Other:	☐ Yes ☐ No	Tribal money or benefits/GA	☐ Yes ☐ No

List all income **before** any deductions, such as Medicare premiums, taxes, insurance, or child support.

Name of person receiving income	Source	Amount before deductions	How often received
		$	
Name of person receiving income	Source	Amount before deductions	How often received
		$	
Name of person receiving income	Source	Amount before deductions	How often received
		$	

Answer the following questions for all programs.

39. ☐ Yes ☐ No Are you, anyone in your family or anyone you are applying for, working, self employed or receiving rental income? List all income, including any of the following:

Examples:
- full or part time employment
- salaries
- tips
- wages
- self employment
- commissions
- temporary/seasonal
- training
- odd jobs

If you answered 'Yes', list all income **before** any deductions, such as taxes, insurance, child support or union dues.

Name of person working or self employed	Name of employer or business		
Address of employer or business	Phone number of employer or business		
How often paid? ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Twice a month ☐ Other:		Hours per week	Hourly rate

Complete this section for anyone else in the home that is working or if the person listed above has a second job.

Name of person working or self employed	Name of employer or business		
Address of employer or business	Phone number of employer or business		
How often paid? ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Twice a month ☐ Other:		Hours per week	Hourly rate

Ask a DES worker for additional pages for employment, if necessary.

Answer the following questions for all programs.

Do you, anyone in your family and anyone you are applying for:

40. ☐ Yes ☐ No Expect to receive money from any other source? If 'Yes', who? ____________
From where? ____________

41. ☐ Yes ☐ No Work in exchange for food or rent? If 'Yes', who? ____________ From where? ____________

42. ☐ Yes ☐ No Pay for the care of a child or disabled adult in order to work, look for work, attend training, or school (e.g., travel to and from the provider, after school care, adult daycare)? If 'Yes', who pays?
____________ Amount? $ ____________

43. ☐ Yes ☐ No Pay court ordered child support? If 'Yes', who pays? ____________
Amount? $ ____________

44. ☐ Yes ☐ No Have monthly income, or cash and bank account balances to cover your monthly rent, mortgage, utility and child care payments?

45. Complete the following for anyone temporarily living outside your home who is expected to return.

Name (Last, First, M.I.)	Date Left	Expected Return Date	Temporary Address	Why are they out of the home?

Please read the following information for AHCCCS Health Insurance.

Assignment of rights to other coverage for Medical Care

By signing this application, I state that I understand if I or members of my family are approved for AHCCCS Health Insurance benefits, AHCCCS can collect payment from any other parties who may be responsible for paying for our health care costs. This includes, but is not limited to, the following:

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

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

Please read the following information for Cash Assistance. $

Assignment of support rights for Cash Assistance

Federal law and state law (at A.R.S. 46-407) provide that the legal rights to child support and spousal maintenance must be assigned to the State of Arizona for all persons receiving Cash Assistance. **I understand** the following by signing this application:

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

Please read the following information for Cash Assistance. $

Release of AHCCCS Health Insurance eligibility information to Jobs private contractors

Jobs private contractors assist qualified Cash Assistance applicants in moving from Cash Assistance to employment. By signing this application:

- I AGREE to give Jobs private contractors access to AHCCCS Health Insurance eligibility information contained on the same computer screens as my other benefit eligibility information for as long as I receive public benefits. I understand the AHCCCS eligibility information includes case notes made during interviews with eligibility workers and may contain personal medical information. I also understand that neither DES nor AHCCCS can deny me medical benefits based on whether I agree to allow the Jobs private contractors access to my AHCCCS application information. I understand that I may revoke this authorization at any time by calling 602-542-5472.
- By agreeing to allow the Jobs private contractor access to my medical information, if the Jobs private contractor discloses my medical information to another person, my medical information will not be protected by the federal privacy rules covering AHCCCS. State law and the contract between Jobs private contractors and DES require that medical information be kept private.

I can prevent the Jobs private contractors from seeing my medical information by initialing and dating here: ________ (Initials) _________ (Date) because I do NOT agree to authorize the release of information to the Jobs private contractors.

Please read the following information for all programs.

By signing this application

- I state I have received the What are the Rules and Penalties on Page H.
- I state I have read and understand the Assignment of Support Rights for Cash Assistance on page 6.
- I state I have read and understand the Assignment of Rights to Other Coverage for Medical Care on page 6.
- I state I have read and understand the Release of AHCCCS Health Insurance Eligibility Information to Jobs Private Contractors on page 6.
- I register certain Cash Assistance or Nutrition Assistance household members for work programs. I understand there may be exceptions. I can discuss this with you. I understand these members must look for and accept training and/or a job. If anyone does not, or will not, work or attend training, my benefits may be reduced or stopped.
- I authorize DES and its contractors to contact my current or past employers to get wage information, financial institutions to get asset and property information and other persons or institutions to get information relating to my eligibility. DES may treat a photocopy or facsimile (FAX) of my signature below as my original signature.
- I state I received the "Assistance Programs in Arizona, What You Need to Know" brochure, PAF-001-A. If I have any questions about this brochure, I can contact you.*
- I state I received the "Your Change Reporting Requirements" pamphlet, PAF-558 and was advised of my change reporting requirements.*
- I understand DES and its contractors will verify the immigration status of the non-citizen household members for whom I am applying. The information DES and its contractors get from the U.S. Citizenship and Immigration Service (USCIS) may affect these members' eligibility for benefits. If we cannot confirm citizenship and immigration status, the non-citizen household member may not get benefits. It may also impact timeliness for determining eligibility.
- I understand that DES and its contractors will use information available through an income and eligibility system (IEVS) to identify and verify any discrepancies. The information DES and its contractors get from the Income Eligibility Verification System (IEVS) may affect members' eligibility and benefit level.
- In the event DES or its agents engage in child support enforcement activities involving me, I understand the Assistant Attorneys General and Deputy County Attorneys handling the cases represent DES, and not me or my children.
- If my child support case goes to court, I understand certain personal information contained in this application or my DES records may be released to the court and other parties to the case and become a public record document.
- I also hereby agree to accept service of process by first class mail with regard to any paternity or child support proceeding initiated by DES and its agents.
- I understand that I must tell DES and provide proof to receive deductions, when applicable, for the following expenses: child support paid, court ordered child support, child/adult dependent care expenses, rent or mortgage payments, utility or other shelter costs, medical expenses, and transportation costs to and from the provider of medical care or daily care of a child/adult dependent.

AFFIDAVIT OF TRUTH

I swear under penalty of perjury that the statements, information, and documents provided about myself and persons in my home, including information about income, assets, property, citizenship and alien status, and all other information I have given DES and its contractors that relates to my eligibility for benefits is true and correct to the best of my knowledge, and that I have not withheld any information. I swear I have honestly reported for myself and on behalf of everyone for whom I am applying for benefits, intent to reside in Arizona, citizenship, and alien status.

***When an in-person interview is not required these pamphlets will be mailed to you.**

Signature of Applicant ______________________ Date __________

Signature of other adult household member (required for AHCCCS Health Insurance) ______________________ Date __________

Representative/Witness Signature ______________________ Date __________

Signature of DES or TANF agency employee who helped complete this application ______________________ Date __________

Signature of Interviewer ______________________ Date __________

Arizona Department of Economic Security
Family Assistance Administration

Authorization for Release of Information

I authorize the release of information requested by the Department of Economic Security (DES), its agents and contractors to verify my financial information, where I live, and members of my household. DES will only use the information in the administration of any public assistance programs for which I have applied. DES will not release this information to any other person or agency outside of DES, its agents and contractors.

Persons or organizations that may be contacted include, but are not limited to:

- local governments
- public assistance program contractors and grantees
- health care providers
- tax assessors
- financial institutions
- Native American corporations
- stock brokerage firms
- landlords
- employers
- school authorities
- private individuals
- vital records

This release of information remains in effect while I am an applicant or recipient of public assistance, and for any later investigation of my eligibility and receipt of benefits.

A copy of this release is as valid as the original

Your signature	Signature of Other Adult Household Member
Printed Name	Printed Name
Address (No., Street, Apt #, City, State, ZIP)	Address (No., Street, Apt #, City, State, ZIP)
Phone No.	Phone No.
Date	Date

Release of Information to Hospitals/Organizations/Agencies ❑ **Inpatient** ❑ **Treat & Release**		
Provide the information below if you wish to receive information about this applicant's eligibility. AHCCCS cannot share information about this applicant without the applicant's written permission.		
Hospital/Hospital's Agent/Organization/Agency	Contact Person	Telephone Number
Address (No., Street, Apt #, City, State, ZIP)		

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

- That I have applied for AHCCCS Health Insurance;
- The information or proof needed to see if I can get AHCCCS Health Insurance; and
- Whether I was approved or denied for AHCCCS Health Insurance and if denied, the reason.

Signature of Applicant	Date

NVRA-5

OFFER OF VOTER REGISTRATION

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

If you are not registered to vote where you live now, would you like to apply to register to vote today? ____Yes ____No

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

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

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

____

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

- -

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

State Election Director
Secretary of State's Office
1700 West Washington
Phoenix, Arizona 85007