Application for Benefits

Tear off and keep pages A through H for your records.

What is this application for?

Use this application to see if you and members of your household qualify for:

- Free or low-cost insurance from AHCCCS
- Help with your Medicare costs
- Nutrition Assistance
- Cash Assistance/Temporary Assistance for Needy Families (TANF)
- Tuberculosis Control
- A new tax credit that can help pay your health insurance premiums

See page B for a description of each program.

Who can use this application?

An application may be completed by you or anyone you choose who knows or can get the information needed to complete the application for you and your household members. You can use this application to apply for anyone in your household, even if they already have benefits, including health insurance.

Your household includes:

- Your spouse, if married
- Your children under age 22 who live with you
- Your partner who lives with you (but only if you have a child together who needs health insurance or Cash Assistance)
- People you claim on your income tax return even if they do not live with you
- Relatives in your care who are under the age of 19 and live with you
- People who you live with that purchase and prepare food with you

If you want to select a representative to complete your application, complete the Authorized Representative form on page 1 of the application.

Where else can I apply?

You can apply faster online at www.healthearizonaplus.gov.

You can also apply in person at any local Department of Economic Security (DES)/Family Assistance Administration (FAA) office. You can find a list of local FAA offices at www.azdes.gov/faa, or can call our 24 hour Interactive Voice Response system at 1-855-HEA-PLUS (432-7587).

What information do I need to complete this application?

For everyone in your household, you may need:

- Birth dates
- Social Security numbers
- Employer and income information for everyone in your household
- Resources (e.g., bank account, cash, property)
- Expenses
- Information for any current health insurance
- Information about any job-related health insurance available to members of your household
- Other information needed to complete your application

Note: 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 cannot be determined until you complete a full application and an interview, if needed.

Why do we ask for so much information?

We ask about income and other information to make sure you and members of your household get the correct benefits for your household.

We will keep all information you provide private, as required by law.

What happens next?

Send your completed, signed application to the address on page 21 or take it to your local DES office. If you do not have all of the information available, you can still submit your application and we will help you get the rest of the information.

What if I need help?

If you need help filling out this application, please tell us. If you need a language interpreter or accommodations for a disability, please check the kind of help you need on page 1 of the application.

Online: www.healthearizonaplus.gov
Phone: 1-855-HEA-PLUS (432-7587)
In person: Visit www.azdes.gov/faa to find the office closest to you.
Program Information:

You can use this application to apply for one or more programs. Each program has a symbol. On the application, look for the symbol for the program(s) you want to apply for and answer those questions. These are the symbols you will see on this application:

- = AHCCCS Medical Assistance and/or help with Medicare costs
- = Nutrition Assistance
$ = Cash Assistance
$ = Tuberculosis Control

What is AHCCCS Medical Assistance?

AHCCCS stands for Arizona Health Care Cost Containment System, and it is the State of Arizona’s Medicaid program. AHCCCS can provide medical benefits and help with Medicare costs to Arizona residents who meet certain income and other eligibility standards.

AHCCCS Medical Assistance covers the following medical services:
- Prescription Medication*  
- Doctor’s Office Visits**  
- Laboratory and X-ray Services  
- Hospital Services  
- Dialysis  
- Medical Supplies  
- Medically Necessary Transportation  
- Medically Necessary Specialist Care  
- Behavioral Health Care  
- Immunizations (shots)  
- Chemotherapy  
- Emergency Medical Care  
- Rehabilitation Services  
- 90 days of nursing care services

* AHCCCS prescription coverage is limited for people who have Medicare.
** Wellness visits for people age 21 and over are not covered.

What is Medicare Savings Program?

Medicare Savings Program may pay:
- Medicare Part A premium  
- Medicare Part B premium  
- Medicare deductibles and copayments  
- Automatic Extra Help for Medicare Part D prescription expenses

What are Nutrition Assistance benefits?

Nutrition Assistance benefits help low-income families or individuals buy food for a healthier diet. If you have little or no money, you may be eligible for Emergency Nutrition Assistance benefits. Be sure to answer the Emergency Nutrition Assistance benefits questions on page 2 of this application.

What is Cash Assistance?

Cash Assistance gives temporary cash benefits to low income families. Parents or relatives of dependent children who are in their care may be eligible. Some families may qualify for a one-time lump sum cash assistance payment. We will determine if you qualify for this payment option.

What is Tuberculosis Control?

Tuberculosis Control gives cash support to individuals who are determined unable to work by the Department of Health Services as a result of communicable Tuberculosis.

What if I am not eligible for AHCCCS Medical Assistance?

If you are not eligible for AHCCCS Medical Assistance, you may be eligible for federal tax credits to help with your health insurance premiums. If you are not eligible for any programs through AHCCCS, we will send your information to the federal Health Insurance Marketplace to see about health insurance tax credits.
How does AHCCCS Medical Assistance work?

If you are approved for AHCCCS Medical Assistance, you will receive your health care from an AHCCCS health plan unless:

- You are American Indian 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 Savings Programs (QMB), AHCCCS may pay your Medicare premiums and Medicare coinsurance and deductibles.
- AHCCCS can only pay for your emergency services because of your status with United States Citizenship and Immigration Services (USCIS). If you are approved for emergency services only, you may receive medical services from any provider (doctor, hospital, etc.) that has an agreement to bill AHCCCS for covered emergency services.

How much does AHCCCS Medical Assistance cost?

**Premiums:**

- Most people do not have to pay a monthly premium for AHCCCS Medical Assistance.
- Some people with income too high to qualify for AHCCCS Medical Assistance with no monthly premium may be able to get it by paying a monthly premium. If you have to pay a premium, the premium amounts are $10 to $35 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 and the services you need. For some AHCCCS programs, the provider can deny services if the co-payments are not made. Co-payments for services are:

- $2.30 to $10.00 for prescriptions
- $0 to $30.00 for non-emergency use of an emergency room
- $3.40 to $5.00 for outpatient visits for evaluation and management services including doctor’s office visits
- $2.30 to $3.00 for physical, occupational or speech therapy

Remember to report any changes in income because this may change your co-payment amount.

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

- Children under age 19
- People determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services
- Individuals through age 20 eligible to receive services from the Children’s Rehabilitative Services (CRS) program
- People who are temporarily residing in nursing homes or residential facilities such as an Assisted Living Home and only when the acute care member’s medical condition would otherwise require hospitalization. The exemption from co-payments is limited to 90 days in a contract year
- People who receive hospice care

Co-payments are never charged for the following services for anyone:

- Hospitalizations
- Services paid on a fee-for-service basis
- Emergency services
- Pregnancy related health care including tobacco cessation for pregnant women
- Family planning services
Do I need a Social Security number?


- 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 one or does not apply for one will not be eligible for benefits.
- If you are not applying for benefits for yourself, you do not have to give us your Social Security number. However, it may reduce the total amount of Nutrition Assistance and/or Cash Assistance benefits for the person you are applying for because we will not include you in the benefit amount.
- We will not use your SSN as your DES or AHCCCS identification number.
- We will not give any Social Security numbers to the United States Citizenship and Immigration Services (USCIS).

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

- Verify identity
- Verify citizenship and immigration status
- Verify income and resources
- Prevent duplicate benefits
- Establish and enforce child support
- Computer match with state, local 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 Nutrition Assistance and/or Cash 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

If we are not able to find proof of the information you have given us through the sources available to us, then you must provide proof of the information for us to decide if you are eligible.

DES and/or AHCCCS will keep your information for at least 7 years.

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

- To get the most help, you need to give us information about citizenship and immigration status for each person who is applying for help.
- Giving us the citizenship and immigration status for all people who are eligible for benefits allows us to include them in the Nutrition Assistance and/or Cash Assistance benefit amount. When you do not give us this information, it will not affect the eligibility of the people you are applying for who have given us verification of their citizenship or qualified non-citizen status, but it may affect the amount of the benefits for these people.
- If you choose not to give us information regarding immigration status but still want AHCCCS Medical Assistance, you may only be eligible for emergency medical services.
- You do not need to give us information about citizenship and immigration status for any person who is not applying.
- You do need to give us information on income, resources, or other information for those who have not given us citizenship or immigration status information to complete the application process.
- Under federal law, certain non-citizens such as refugees or political asylees may qualify for Medical Assistance, Nutrition Assistance, and/or Cash Assistance. For those non-citizens, United States Citizenship and Immigration Services (USCIS) guidelines state that use of these benefits will not affect your ability to become a Lawful Permanent Resident.
- If you are not applying for any benefits or if you chose not to provide citizenship or immigration information, we will not try to find out this information from USCIS.
- We will not report you, a family, or a household member to U.S. Immigration and Customs Enforcement (ICE) unless you inform us that you, your family or a household member is in the U.S. illegally.
Will I have to do an interview?

When applying for AHCCCS Medical Assistance and/or help with Medicare costs, an interview is not needed. When applying for Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control you or your representative must complete an interview in person or by phone. If you need special accommodations for an interview, please tell us on page 1 of the application so we can be ready for your interview.

How long does it take to find out if I am eligible for benefits after you receive my application?

For AHCCCS Medical Assistance and/or help with Medicare costs, we will make a decision within 45 days.
- If you are pregnant, we will make a decision within 20 days.
- If you need a disability determination report, we will make a decision within 90 days.

For Nutrition Assistance, we will make a decision within 30 days.
- If you are eligible for Emergency Nutrition Assistance, we will make a decision within 7 days.

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 will determine if the children qualify within 20 days.

How will I know if I am eligible?

- If you are approved for benefits, you will receive a letter explaining the benefits you are eligible for and the amount of benefits you will get.
- If you are denied, we will send you a letter explaining the reason for our decision.

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

If you are approved for AHCCCS Medical Assistance and/or help with Medicare costs, you will get an approval letter. You will get your AHCCCS ID card from your enrollment plan 10 to 14 business days after you get your approval letter. If you need medical services before you get your AHCCCS ID card, contact your enrollment plan.

If you are approved for Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control:
- You will get an Electronic Benefit Transfer (EBT) card. This card works like a debit card. You will get a pamphlet with instructions on how to use your card.
- Your benefits are put on your EBT card after approval. It can take up to 48 hours for the benefits to be available. You can call the Customer Service number on the back of the card to check the balance of your benefits.
- If you are eligible for Emergency Nutrition Assistance, you may get an EBT card at your local DES/FAA office.
- If you qualify for Nutrition Assistance benefits, you can use the EBT card to buy approved food items. If you qualify for Cash Assistance benefits, you can use your EBT card to get cash or buy non-food items at any store where EBT cards are accepted. You may also withdraw your Cash Assistance benefits at ATMs, but there may be a fee.
What is expected of me?

**For all programs:**
- You must provide DES and/or AHCCCS with the needed information to correctly determine your eligibility and authorize DES and/or AHCCCS to investigate and contact any sources necessary to confirm the accuracy of the information for your eligibility.
- If you are approved for benefits, you will get a letter telling you what changes you must report. You MUST report your changes timely and give us proof of the changes.

**Program-specific expectations:**
If applying for help with AHCCCS Medical Assistance, help with Medicare costs, and/or Cash Assistance, you must take necessary steps to obtain any annuities, pensions, retirement and disability benefits to which you may be entitled, including, but not limited to, Social Security benefits, Railroad retirement, Veterans benefits and unemployment compensation.

For AHCCCS Medical Assistance and/or Cash Assistance, you must give us any information you have about an absent parent. If you have reason for not providing this information (such as adoption pending, abuse, incest, neglect, etc.) you may claim good cause. You must cooperate with the Division of Child Support Services (DCSS) to establish paternity, unless you can prove good cause.

All adult household members and minor parents who are eligible for Nutrition Assistance and/or Cash Assistance benefits must be fingerprint imaged. Exceptions may apply.

What are my rights?

**You have the RIGHT to:**
- Courteous and professional treatment.
- Be treated fairly and equally regardless of race, color, religion, national origin, sex, age, disability, or political beliefs.
- Apply for benefits and be given a letter that tells you if you are eligible or not, and/or get a letter before your benefits are reduced or stopped.
- Review DES and AHCCCS policy manuals that show the rules and regulations of AHCCCS Medical Assistance, Medicare Savings Program, Nutrition Assistance, Cash Assistance, and Tuberculosis Control if you want to know the reason for our decision.
- Talk about your case with a worker or supervisor.
- Have all information you give regarding your eligibility kept private according to state and federal law.
- Ask for a fair hearing if you disagree with your application being denied, your benefits ended, or are being reduced, or if a decision is not made on your application within the allowable number of days and the delay is due to DES or AHCCCS.
- Look at your file before a fair hearing.
- Bring an attorney or any other person to a fair hearing.

To file a discrimination complaint, contact:

USDA, Director
Office of Civil Rights
Room 326-W, Whitten Building
1400 Independence Avenue, 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)
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 Nutrition Assistance and/or Cash Assistance benefits that you are not entitled to, that person will be subject to:
- Criminal Prosecution
- Fines
- Imprisonment
- Other penalties provided for by state and federal laws

If you get Nutrition Assistance and/or Cash Assistance, you must follow the rules below:
- Do not make false statements or hide information. If you are not truthful, you may have to pay back DES for benefits you receive and you may be taken to court.
- Do not do anything dishonest to get benefits that you are not supposed to get.
- Do not buy, sell, trade, exchange or otherwise transfer your or someone else’s Nutrition Assistance benefits or EBT card.
- Do not buy containers with deposits for the purpose of discarding the product and returning the containers to get cash refund deposits.
- Do not sell products bought with Nutrition Assistance benefits to exchange them for cash or items other than eligible food.
- Do not buy products originally bought with Nutrition Assistance benefits to exchange those products for cash or items other than eligible food.
- Do not steal Nutrition Assistance or Cash Assistance benefits.
- Do not use your Nutrition Assistance benefits to buy non-food items such as alcohol and tobacco.
- Do not alter an EBT card.
- Do not use someone else’s EBT card unless you are an authorized user approved by DES.

If you knowingly break the rules and get Nutrition Assistance and/or Cash Assistance benefits, we will disqualify you from getting benefits for:
- 12 months for the first violation
- 24 months for the second violation
- Permanently for the third violation

You or a household member will not be eligible to get Nutrition Assistance and/or Cash Assistance benefits if you or the household member:
- Is a fleeing felon or probation/parole violator.
- 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.
- Has been found guilty of using or getting Nutrition Assistance benefits in a transaction involving the sale of a controlled substance. This person is not eligible to get Nutrition Assistance benefits for 2 years for the first violation and permanently for the second violation.
- Has committed and was convicted of a federal or state felony on or after August 23, 1996 for the possession, use or distribution of a controlled substance.
- 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.
- 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:
  - The recipient does not return the completed Illegal Drug Use Statement. We send the Illegal Drug Use Statement by U.S. Mail after Cash Assistance has been approved.
  - The recipient fails to take a required drug test.
  - The recipient fails the drug test.

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

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 $250,000.00, imprisoned for up to 20 years, or both.
- You and/or your household members may be subject to further prosecution under federal laws.
How to Choose an AHCCCS Health Care Plan:

You need to choose a health plan that services your county.
- All AHCCCS health plans provide the same covered medical services.
- Review the health plans for your county listed below. American Indians may choose American Indian Health Program or an AHCCCS health plan.
- Before you choose a plan, check with your doctor, pharmacy, or hospital to see if they work with the plan that you want. If you want more information about the doctors, specialists, or hospitals that work with a health plan that serves your county, call the number listed below for the health plan.

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.

Enter the health plan choice on this application.

### APACHE COUNTY
UnitedHealthcare Community Plan................. 1-800-348-4058  
Health Choice Arizona................................. 1-800-322-8670  
American Indian Health Program..................... 928-729-8000

If your zip code is 85943, you must choose from the health plans listed under Navajo County.

### COCHISE COUNTY
University Family Care ..................... 1-800-582-8686  
UnitedHealthcare Community Plan............. 1-800-348-4058  
American Indian Health Program.............. 520-295-2479

If your zip code is 86336 or 86340, you must choose from the health plans listed under Yavapai County.

### GILA COUNTY
Health Choice Arizona............... 1-800-322-8670  
University Family Care ................... 1-800-582-8686  
American Indian Health Program........ 928-475-2371

### MOHAVE COUNTY
UnitedHealthcare Community Plan........ 1-800-348-4058  
Health Choice Arizona...................... 1-800-322-8670  
American Indian Health Program........ 928-769-2900

If your zip code is 86434, you must choose from the health plans listed under Yavapai County.

### COCONINO COUNTY
UnitedHealthcare Community Plan........ 1-800-348-4058  
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 the health plans listed under Yavapai County.

### GILA COUNTY
Health Choice Arizona............... 1-800-322-8670  
University Family Care ................... 1-800-582-8686  
American Indian Health Program........ 928-475-2371

### NAVAH COUNTY
University Family Care .................. 1-800-624-3879  
American Indian Health Program........ 520-295-2479

If your zip code is 85645, you must choose from the health plans listed under Gila County.

### GRAHAM COUNTY
University Family Care .................. 1-800-582-8686  
UnitedHealthcare Community Plan........ 1-800-348-4058  
American Indian Health Program........ 928-475-2686

If your zip code is 85643, you must choose from the health plans listed under Cochise County.

### PINAL COUNTY
Health Choice Arizona............... 1-800-322-8670  
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 the health plans listed under Maricopa County.

If your zip code is 85292 you must choose from the health plans listed under Gila County.

### GREENLEE COUNTY
University Family Care .................. 1-800-582-8686  
UnitedHealthcare Community Plan........ 1-800-348-4058  
American Indian Health Program........ 928-475-2371

### SANTA CRUZ COUNTY
University Family Care .................. 1-800-582-8686  
UnitedHealthcare Community Plan........ 1-800-348-4058  
American Indian Health Program........ 520-295-2479

### LA PAZ COUNTY
UnitedHealthcare Community Plan........ 1-800-348-4058  
University Family Care ................... 1-800-582-8686  
American Indian Health Program........ 928-669-2137

If your zip code is 85342, 85358 or 85390, you must choose from the health plans listed under Maricopa County.

### MARICOPA COUNTY
Health Net of Arizona ............. 1-888-788-4408  
Health Choice Arizona................ 1-866-560-4042  
Health Choice Arizona.............. 1-800-624-3879  
American Indian Health Program........ 602-263-1200

### YAVAPAI COUNTY
UnitedHealthcare Community Plan........ 1-800-348-4058  
University Family Care ................... 1-800-582-8686  
American Indian Health Program........ 602-263-1200

If your zip code is 86336 or 86340, you must choose from the health plans listed under Yavapai County.

### YUMA COUNTY
UnitedHealthcare Community Plan........ 1-800-348-4058  
University Family Care ................... 1-800-582-8686  
American Indian Health Program........ 760-572-4100
Application for Benefits

Contact Information:

Tell us how we can contact an adult member of your household.

Name (First, Middle, Last):

Home Address: ___________________________ Apt.: ___ City: ___________ State: ___ Zip Code: ___

Mailing Address (if different): ___________________________ Apt.: ___ City: ___________ State: ___ Zip Code: ___

Do you live in a shelter? Yes No If ‘Yes,’ what kind of shelter?

Phone Number: _______ This number is: Home Cell Work Message Other: ___

Other Phone Number: _______ This number is: Home Cell Work Message Other: ___

What is the preferred SPOKEN household language? English Spanish Other:

What is the preferred WRITTEN household language? English Spanish Other:

I would like to get information about this application by:

Email: Yes No Email address: ___________________________

Text: Yes No Number to text (standard text rates apply): _____________

This section is OPTIONAL. You may authorize someone else to represent you in the application process. DES and/or AHCCCS cannot release any information about your eligibility without your written consent.

Authorized Representative:

This section is OPTIONAL. You may authorize someone else to represent you in the application process. DES and/or AHCCCS cannot release any information about your eligibility without your written consent.

Representative’s Name: ___________________________ Is representative your legal guardian? Yes No

Representative’s Mailing Address: ___________________________ City: ___________ State: ___ Zip Code: ___

Representative’s Phone Number: _______ This number is: Home Cell Work Message Other: ___

Representative’s Other Phone Number: _______ This number is: Home Cell Work Message Other: ___

What is the representative’s preferred SPOKEN language? English Spanish Other:

What is the representative’s preferred WRITTEN language? English Spanish Other:

My representative would like to get information about this application by:

Email: Yes No Email address: ___________________________

Text: Yes No Number to text (standard text rates apply): _____________

By signing below I, the customer, give permission for the person listed above as my representative to act on my behalf in the process of qualifying me for AHCCCS Medical Assistance, help with Medicare costs, Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control. I, therefore,

• Give permission for my representative to complete and sign my application.
• Give permission for my representative to provide any documents requested, including personal information.
• Give permission for my representative to sign on my behalf to permit other people, businesses, or agencies to give personal information about me to DES and/or AHCCCS, including protected health information needed to determine if I am disabled.
• Agree to give information about my personal circumstances to my representative.
• Agree to allow my representative to assign all my rights to medical reimbursement claims to AHCCCS on my behalf.

By signing below I, the representative, agree to act on the customer’s behalf. I also agree to:

• Provide only truthful and complete information under penalty of perjury.
• Fill in and sign agreed forms.
• Obtain and give to DES and/or AHCCCS all information needed to determine if the customer can qualify for help with healthcare costs, help with Medicare costs, Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control, such as the customer’s Social Security number, income, assets, citizenship, residency, medical insurance, and information about the customer’s spouse, minor children, and parents (if the customer is a minor child).
• Tell DES and/or AHCCCS right away if the customer:
  o Has an increase or decrease in income;
  o Has an increase or decrease in assets;
  o Changes ownership of assets, including opening or closing financial accounts;
  o Has a change in address; or
  o Has a change in health insurance or the amount of premiums paid.

If I am determined eligible, this authorization will stay in effect until I or my representative tells you to stop it. This authorization will expire when my application for assistance is withdrawn or denied, or when my eligibility ends. However, this authorization will continue during any time while I am contesting my eligibility in an administrative hearing or court proceeding.

Signature of Applicant: ___________________________ Date: __________________

Signature of Representative: ___________________________ Date: __________________
Release of Information to Hospitals/Hospital Agents/Organizations/Agencies:

You may give permission to DES and AHCCCS to release information about applicant eligibility. AHCCCS and DES cannot share any information about applicants without the applicant’s written permission. This section is OPTIONAL.

Name of Hospital/Hospital’s Agent/Organization/Agency: _______________________________________________________
Contact Person: __________________________________________ Phone Number: ____________________________
Mailing Address: __________________________________________ City: __________________________ State: __________ Zip Code: __________

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

- That I have applied for AHCCCS Medical Assistance;
- The information or proof needed to see if I can get AHCCCS Medical Assistance; and
- If approved for AHCCCS Medical Assistance, the effective date of my eligibility, the redetermination due date, and the category of assistance for which I was approved. If denied for AHCCCS Medical Assistance, the reason I was denied.

Signature of Applicant: __________________________________________________________ Date: __________

Access to Electronic Benefit Transfer (EBT) Account:

This section is OPTIONAL. If you are applying for Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control You may choose a person, called an Alternate Cardholder, to get your benefits for you. If you need an Alternate Cardholder, choose a person you trust. Remember, lost or stolen benefits will not be replaced.

EBT Representative’s Name: ______________________________________________________
EBT Representative’s Mailing Address: __________________________________________
City: ______________ State: _______ Zip Code: __________
EBT Representative’s Phone Number: ______________
☐ Home ☑ Cell ☐ Work ☐ Message ☐ Other: ______________________
EBT Representative’s Other Phone Number: ______________________
☐ Home ☑ Cell ☐ Work ☐ Message ☐ Other: ______________________

Signature of Applicant: __________________________________________ Date: __________

Someone Who Knows You Well:

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

Name of someone who knows you well: __________________________________________
Relationship to you: __________________________________________________________
Mailing Address: __________________________________________ City: ______________ State: _______ Zip Code: __________
Daytime Phone Number: ______________________

Name of Landlord: __________________________________________
Relationship to you: __________________________________________________________
Mailing Address: __________________________________________ City: ______________ State: _______ Zip Code: __________
Daytime Phone Number: ______________________

Emergency Nutrition Assistance:

Is anyone in your household applying for Emergency Nutrition Assistance? If YES: fill out this section. If NO: go to page 3.

What is the total amount of income, before deductions, you expect to get this month? $ ________
What is the total amount of cash on hand and money in your checking and savings account? $ ________
What are the total monthly housing costs (rent or mortgage, taxes, homeowner/rental insurance, etc.)? $ ________
What are the total monthly utility costs (gas, electric, phone, water, etc.)? $ ________
Does anyone receive Tribal Food Distribution? ☐ Yes ☑ No
Is anyone a migrant or seasonal farm worker? ☐ Yes ☑ No
Did anyone get Nutrition Assistance benefits from any other state? ☐ Yes ☑ No

If ‘Yes,’ who received? __________________________________________ When? ________ State: ________

Go to the next page to tell us about PERSON 1.
PERSON 1:

Tell us about each person in your household, starting with you. See page A for a definition of who you must include. If you are a representative, tell us about the first person in the household applying.

**Personal Information:**

- **Name (First, Middle, Last):**
- **Social Security Number (optional if not applying):**
- **Gender:** □ Male □ Female
- **Date of Birth:**
- **Marital Status:** □ Never Married □ Divorced □ Widowed □ Married
- **Is PERSON 1 attending school?** □ Yes □ No
  - **Name of School:**
  - **Grade Level:**
  - **Full Time** □ Part Time □

**Citizenship/Residency:** Tell us about PERSON 1’s citizenship/residency. You may need to provide proof of citizenship/residency.

- **Is PERSON 1 a U.S. citizen or U.S. national?** □ Yes □ No □ Choose not to answer
- **If PERSON 1 is NOT a U.S. citizen, what is his/her immigration status?**
  - □ Lawful Permanent Resident (LPR)
  - □ Lawful Temporary Resident
  - □ Non-Immigrant Status
  - □ Asylee
  - □ Refugee
  - □ Conditional Entrant granted before 1980
  - □ Other
  - □ I do not want to provide

- **Battered Spouse, Child or Parent** □
- **Removal/Suspension of Deportation** □
- **Registry Applicants** □
- **Special Immigrant Juvenile Status Applicant** □
- **Temporary Protection Status (TPS)** □
- **Victim of Trafficking** □
- **Applicant for Asylum, LPR, TPS, or Withholding Deportation** □
- **I do not want to provide** □

**What immigration document does PERSON 1 have?**

- □ Permanent Resident card
- □ I-94
- □ Visa
- □ Foreign Passport
- □ None
- □ Other:

**If PERSON 1 has an Arizona resident?** □ Yes □ No

- **Did PERSON 1 move to Arizona in the last 4 months?** □ Yes □ No
  - **If ‘Yes,’ date moved:**

**Race (optional), select one or more:**

- □ Asian
- □ Hawaiian or other Pacific Islander
- □ Black or African American
- □ American Indian/Alaska Native
- □ Other:

**Ethnicity (optional):**

- □ White
- □ Hispanic/Latino
- □ Non-Hispanic/Non-Latino

**If PERSON 1 is American Indian or Alaska Native:**

- **Is he/she enrolled in a federally recognized tribe?** □ Yes □ No
  - **If ‘Yes,’ name of tribe:**
  - **Tribal Census Number:**

- **Is he/she living on a reservation?** □ Yes □ No
  - **If ‘Yes,’ name of reservation:**

- **Has he/she ever gotten services from Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?** □ Yes □ No

**If PERSON 1 is applying for any benefits:**

- □ AHCCCS Medical Assistance
- □ Help with Medicare costs
- □ Need help paying for medical bills from the last 3 months
- □ Nutrition Assistance
- □ Cash Assistance
- □ Tuberculosis Control

**If PERSON 1 is attending school:**

- □ Yes □ No

**If PERSON 1 is applying for help with Medicare costs:**

- □ Yes □ No

**If PERSON 1 is attending school:**

- □ Yes □ No

**If PERSON 1 is an Arizona resident:**

- □ Yes □ No

**If PERSON 1 is applying for any benefits:**

- □ Yes □ No

Go to the next page to tell us more about PERSON 1.
PERSON 1:

This section asks specific questions for each type of benefit. If PERSON 1 is not applying for any benefits, go to page 5. If PERSON 1 is applying for benefits, complete each applicable section.

Questions for All Applicants: Answer the following questions if PERSON 1 is applying for benefits.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>If 'Yes,' number of babies due:</th>
<th>If 'Yes,' expected due date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is PERSON 1 physically or mentally disabled?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IS PERSON 1 in jail or prison?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was PERSON 1 released from jail or prison in the last 4 months?</td>
<td>Yes</td>
<td>No</td>
<td>If 'Yes,' release date:</td>
<td></td>
</tr>
</tbody>
</table>

AHCCCS Medical Assistance, Help with Medicare Costs, and Cash Assistance Questions:

Complete this section if PERSON 1 is applying for help AHCCCS Medical Assistance and/or help with Medicare costs, and/or Cash Assistance.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>If 'Yes,' number of babies due:</th>
<th>If 'Yes,' expected due date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is PERSON 1 pregnant?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If PERSON 1 is under age 19, are both of his/her parents living in the home?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent's Name (First, Last):</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mailing Address:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone Number:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If 'No,' complete the information below:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent's Name (First, Last):</td>
<td></td>
<td></td>
<td>Date of Birth:</td>
<td></td>
</tr>
<tr>
<td>Mailing Address:</td>
<td></td>
<td></td>
<td>City:</td>
<td>State:</td>
</tr>
<tr>
<td>Phone Number:</td>
<td></td>
<td></td>
<td>Reason parent is absent:</td>
<td>Deceased</td>
</tr>
</tbody>
</table>

AHCCCS Medical Assistance and Help with Medicare Costs Questions:

Answer these questions if PERSON 1 is applying for AHCCCS Medical Assistance and/or help with Medicare costs.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If PERSON 1 is under the age of 65, does he/she have a mental or physical disability that has kept or will keep him/her from working for at least 12 months?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If PERSON 1 works and is under the age of 65, does he/she have a disability that is expected to last at least 12 months?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Does PERSON 1 need help with activities of daily living (bathing, dressing, etc.) through personal assistance, services, nursing home, or other medical facility?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Does PERSON 1 live with at least one child under age 19 and is the main care taker of the child?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Has PERSON 1 ever received Supplemental Security Income (SSI Cash)?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Nutrition Assistance and Cash Assistance Questions:

Answer these questions if PERSON 1 is applying for Nutrition Assistance and/or Cash Assistance. PERSON 1 may still be able to get benefits if he/she has a felony drug conviction. See page G for more information.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has PERSON 1 had a felony conviction for possession, use, or distribution of a controlled substance on or after August 23, 1996?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Has PERSON 1 been found to have committed a Nutrition Assistance and/or Cash Assistance Intentional Program Violation in Arizona or any other state?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Is PERSON 1 fleeing from law enforcement agencies on any charges, or is PERSON 1 in violation of probation or parole according to a court?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Nutrition Assistance Questions:

Answer these questions if PERSON 1 is applying for Nutrition Assistance.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If PERSON 1 is disabled or over age 60, does he/she have any paid or unpaid medical expenses, even if he/she has medical insurance (example: travel expenses to and from medical provider, doctor visits, prescriptions, lab work, etc.)?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Is PERSON 1 living in an assisted living facility or group home?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Go to the next page to tell us more about PERSON 1.
PERSON 1:

Tell us about PERSON 1’s income, potential benefits and expected tax filing status. Complete this page even if PERSON 1 is not applying for any benefits.

Employment: Tell us about PERSON 1’s employment, including self-employment and rental income. You may need to provide proof of income. If self-employed, please attach the most current federal tax forms: 1040, SE, and applicable schedules such as C, C-EZ, E, F and K1. If you do not have tax forms, attach proof of business income and expenses for the last and current calendar month.

Does PERSON 1 work?    ☐ Yes    ☐ No     If yes, give employment information below:

<table>
<thead>
<tr>
<th>Employer’s Name and Phone Number:</th>
<th>Gross Earnings (before deductions):</th>
<th>How often paid?</th>
<th>How many hours worked per week?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is PERSON 1 self-employed?</td>
<td>☐ Yes     ☐ No</td>
<td>If ‘Yes,’ type of work: ____________________________</td>
<td></td>
</tr>
<tr>
<td>If ‘Yes,’ has PERSON 1 been in this business for 12 months?</td>
<td>☐ Yes ☐ No</td>
<td>If ‘Yes,’ annual net (after deductions) amount: ________</td>
<td></td>
</tr>
<tr>
<td>Does PERSON 1’s income change because of contract or seasonal employment?</td>
<td>☐ Yes ☐ No</td>
<td>If yes, how much income does PERSON 1 expect to make over the next 12 months?</td>
<td></td>
</tr>
<tr>
<td>Does PERSON 1 work in exchange for food or rent?</td>
<td>☐ Yes ☐ No</td>
<td>If ‘Yes,’ where? ____________________________</td>
<td></td>
</tr>
</tbody>
</table>

Other Income: Tell us about other income PERSON 1 receives. You may need to provide proof of income.

<table>
<thead>
<tr>
<th>Type of Income:</th>
<th>Amount:</th>
<th>How often received?</th>
<th>Who pays the income?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security benefits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplemental Security Income (SSI Cash)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retirement/pension</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability/worker’s compensation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child support</td>
<td>☐ Court ordered ☐ Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alimony</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veterans benefits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gifts or loans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tribal money</td>
<td>☐ Gaming ☐ Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per capita payments from natural resources, usage rights, leases or royalties</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Money from selling things that have cultural significance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Check here if this person does not have income ☐

Potential Benefits: Tell us about PERSON 1 to help determine if he/she may be eligible for additional benefits.

Has PERSON 1 or his/her spouse (living or deceased) ever worked for a government agency or an employer with a pension plan? ☐ Yes ☐ No If ‘Yes,’ employer name: ________________________

Has PERSON 1 or his/her spouse (living or deceased) served in the military? ☐ Yes ☐ No If ‘Yes,’ branch of service: ________________________

If PERSON 1 is under age 19, has his/her parent (living or deceased) served in the military? ☐ Yes ☐ No If ‘Yes,’ branch of service: ________________________

Federal Income Tax Filing: Tell us how PERSON 1 will file income taxes NEXT YEAR.

Will PERSON 1 file taxes NEXT YEAR? ☐ Yes ☐ No

If ‘Yes,’ will PERSON 1 file jointly with a spouse? ☐ Yes ☐ No If ‘Yes,’ name of spouse: ________________________

Will PERSON 1 claim dependents on his/her tax return? ☐ Yes ☐ No If ‘Yes,’ name of dependent(s): ________________________

Will PERSON 1 be claimed as a dependent on someone else’s tax return? ☐ Yes ☐ No If ‘Yes,’ name of tax filer: ________________________

Does PERSON 1 pay any expenses that may be deducted on the federal income tax return? ☐ Alimony Amount paid: ________ How often? ________________________

Do not include self-employment expenses.

Check all that apply.

Describe deductions:

Is there anyone else in PERSON 1’s household? If YES, go to the next page to tell us about PERSON 2. If NO, go to page 18.
PERSON 2:

Tell us about the other people in your household. See page A for a definition of who you must include.

**Personal Information:**

<table>
<thead>
<tr>
<th>Name (First, Middle, Last): ____________________________</th>
<th>Gender: □ Male □ Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth: ____________</td>
<td>Social Security Number (optional if not applying): ____________</td>
</tr>
<tr>
<td>Relationship to Person 1: □ Spouse □ Child/Step Child □ Parent □ Other: ____________</td>
<td></td>
</tr>
<tr>
<td>□ Spouse □ Grandchild □ Child/Step Child □ Parent □ Other: ____________</td>
<td></td>
</tr>
<tr>
<td>Marital Status: □ Never Married □ Divorced □ Widowed □ Married-name of spouse: ____________</td>
<td></td>
</tr>
<tr>
<td>Does PERSON 2 live at the same address as Person 1? □ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No If 'Yes,' what is PERSON 2's home address? ____________</td>
<td></td>
</tr>
<tr>
<td>Is PERSON 2 attending school? □ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No If 'Yes,' is PERSON 2 attending school: □ Full Time □ Part Time</td>
<td></td>
</tr>
<tr>
<td>Name of school: __________________________________________</td>
<td></td>
</tr>
<tr>
<td>Grade Level: ____________________________________________</td>
<td></td>
</tr>
</tbody>
</table>

If PERSON 2 is applying for any benefits: continue answering the questions below.

If PERSON 2 is **NOT** applying for any benefits: go to page 8 to tell us about PERSON 2’s income.

---

**Citizenship/Residency:** Tell us about PERSON 2’s citizenship/residency. You may need to provide proof of citizenship/residency.

<table>
<thead>
<tr>
<th>Is PERSON 2 a U.S. citizen or U.S. national? See page D for more information. □ Yes □ No □ Choose not to answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>If PERSON 2 is NOT a U.S. citizen, what is his/her immigration status?</td>
</tr>
<tr>
<td>□ Lawful Permanent Resident (LPR) □ Batteried Spouse, Child and Parent □ Removal/Suspension of Deportation</td>
</tr>
<tr>
<td>□ Lawful Temporary Resident □ Cuban-Haitian Entrant □ Registry Applicants</td>
</tr>
<tr>
<td>□ Non-Immigrant Status □ Deferred Action Status □ Special Immigrant Juvenile Status Applicant</td>
</tr>
<tr>
<td>□ Asylee □ Deferred Enforced Departure □ Temporary Protection Status (TPS)</td>
</tr>
<tr>
<td>□ Refugee □ Legalization under LIFE Act □ Victim of Trafficking</td>
</tr>
<tr>
<td>□ Conditional Entrant Granted before 1980 □ Legalization under IRCA Applicant □ Witholding of Deportation</td>
</tr>
<tr>
<td>□ Other □ Order of Supervision □ Applicant for Asylum, LPR, TPS, or Witholding Deportation</td>
</tr>
<tr>
<td>□ I do not want to provide □ Paroled into United States</td>
</tr>
</tbody>
</table>

What immigration document does PERSON 2 have? □ Permanent Resident card □ I-94 □ Visa □ None □ Other: ____________

<table>
<thead>
<tr>
<th>Immigration Document Number: ____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did PERSON 2 move to Arizona in the last 4 months? □ Yes □ No</td>
</tr>
<tr>
<td>If 'Yes,' date moved: ____________________________</td>
</tr>
</tbody>
</table>

Race (optional), select one or more:

<table>
<thead>
<tr>
<th>□ Asian □ Hawaiian or other Pacific Islander □ White</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Black or African American □ American Indian/Alaska Native □ Other: ____________</td>
</tr>
<tr>
<td>If PERSON 2 is American Indian or Alaska Native:</td>
</tr>
<tr>
<td>□ Is he/she enrolled in a federally recognized tribe? □ Yes □ No</td>
</tr>
<tr>
<td>□ If ‘Yes,’ name of tribe: ____________________________</td>
</tr>
<tr>
<td>□ Tribal Census Number: ____________________________</td>
</tr>
<tr>
<td>□ Is he/she living on a reservation? □ Yes □ No</td>
</tr>
<tr>
<td>□ If ‘Yes,’ name of reservation: ____________________________</td>
</tr>
<tr>
<td>□ Has he/she ever gotten services from Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? □ Yes □ No</td>
</tr>
<tr>
<td>□ If ‘No,’ is he/she eligible? □ Yes □ No</td>
</tr>
</tbody>
</table>

Go to the next page to tell us more about PERSON 2.
PERSON 2:

This section asks specific questions for each type of benefit. If PERSON 2 is not applying for any benefits, go to page 8. If PERSON 2 is applying for benefits, complete each applicable section.

Questions for All Applicants: Answer the following questions if PERSON 2 is applying for benefits.

- Is PERSON 2 physically or mentally disabled?  
- IS PERSON 2 in jail or prison?  
- Was PERSON 2 released from jail or prison in the last 4 months?

AHCCCS Medical Assistance, Help with Medicare Costs, and Cash Assistance Questions:

Complete this section if PERSON 2 is applying for AHCCCS Medical Assistance and/or help with Medicare costs, and/or Cash Assistance.

- Is PERSON 2 pregnant?
- If PERSON 2 is under age 19, are both of his/her parents living in the home?

AHCCCS Medical Assistance and Help with Medicare Costs Questions: Answer these questions if PERSON 2 is applying for AHCCCS Medical Assistance and/or help with Medicare costs.

- If PERSON 2 is under the age of 65, does he/she have a mental or physical disability that has kept or will keep him/her from working for at least 12 months?
- If PERSON 2 works and is under the age of 65, does he/she have a disability that is expected to last at least 12 months?
- Does PERSON 2 need help with activities of daily living (bathing, dressing, etc.) through personal assistance, services, nursing home, or other medical facility?
- Does PERSON 2 live with at least one child under age 19 and is the main care taker of the child?
- Has PERSON 2 ever received Supplemental Security Income (SSI Cash)?

Nutrition Assistance and Cash Assistance Questions: Answer these questions if PERSON 2 is applying for Nutrition Assistance and/or Cash Assistance. PERSON 2 may still be able to get benefits if he/she has a felony drug conviction. See page G for more information.

- Has PERSON 2 had a felony conviction for possession, use, or distribution of a controlled substance on or after August 23, 1996?
- Has PERSON 2 been found to have committed a Nutrition Assistance and/or Cash Assistance Intentional Program Violation in Arizona or any other state?
- Is PERSON 2 fleeing from law enforcement agencies on any charges, or is PERSON 2 in violation of probation or parole according to a court?

Nutrition Assistance Questions: Answer these questions if PERSON 2 is applying for Nutrition Assistance.

- If PERSON 2 is disabled or over age 60, does he/she have any paid or unpaid medical expenses, even if he/she has medical insurance (example: travel expenses to and from medical provider, doctor visits, prescriptions, lab work, etc.)?

Cash Assistance Questions: Answer this question if PERSON 2 is under age 19 and applying for Cash Assistance.

- If PERSON 2 is under age 19 and is living with his/her parents, are his/her shots current?
PERSON 2:

Tell us about PERSON 2’s income, potential benefits and expected tax filing status. Complete this page even if PERSON 2 is not applying for any benefits.

Employment: Tell us about PERSON 2’s employment, including self-employment and rental income. You may need to provide proof of income. If self-employed, please attach the most current federal tax forms: 1040, SE, and applicable schedules such as C, C-EZ, E, F and K1. If you do not have tax forms, attach proof of business income and expenses for the last and current calendar month.

<table>
<thead>
<tr>
<th>Does PERSON 2 work?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer’s Name and Phone Number:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gross Earnings (before deductions):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often paid?</td>
<td>How many hours worked per week?</td>
<td></td>
</tr>
<tr>
<td>Is PERSON 2 self-employed?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If ‘Yes,’ type of work:</td>
<td>If ‘Yes,’ annual net (after deductions) amount:</td>
<td></td>
</tr>
<tr>
<td>If ‘No,’ date business started:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does PERSON 2’s income change because of contract or seasonal employment?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If yes, how much income does PERSON 2 expect to make over the next 12 months?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does PERSON 2 work in exchange for food or rent?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If ‘Yes,’ where?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other Income: Tell us about other income PERSON 2 receives. You may need to provide proof of income.

<table>
<thead>
<tr>
<th>Type of Income:</th>
<th>Amount:</th>
<th>How often received?</th>
<th>Who pays the income?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security benefits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplemental Security Income (SSI Cash)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retirement/pension</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployment</td>
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</tr>
<tr>
<td>Disability/worker’s compensation</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Child support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Court ordered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alimony</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veterans benefits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gifts or loans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tribal money</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gaming</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per capita payments from natural resources, usage rights, leases or royalties</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Money from selling things that have cultural significance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Check here if this person does not have income □

Potential Benefits: Tell us about PERSON 2 to help determine if he/she may be eligible for additional benefits.

<table>
<thead>
<tr>
<th>Has PERSON 2 or his/her spouse (living or deceased) ever worked for a government agency or an employer with a pension plan?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has PERSON 2 or his/her spouse (living or deceased) served in the military?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If PERSON 2 is under age 19, has his/her parent (living or deceased) served in the military?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Federal Income Tax Filing: Tell us how PERSON 2 will file income taxes NEXT YEAR.

<table>
<thead>
<tr>
<th>Will PERSON 2 file taxes NEXT YEAR?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If ‘Yes,’ will PERSON 2 file jointly with a spouse?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Will PERSON 2 claim dependents on his/her tax return?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Will PERSON 2 be claimed as a dependent on someone else’s tax return?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Does PERSON 2 pay any expenses that may be deducted on the federal income tax return?</td>
<td>Alimony</td>
<td>Amount paid:</td>
</tr>
<tr>
<td>Do not include self-employment expenses.</td>
<td>Student loan interest</td>
<td>Amount paid:</td>
</tr>
<tr>
<td>Check all that apply.</td>
<td>Other deductions</td>
<td>Amount paid:</td>
</tr>
</tbody>
</table>

Is there anyone else in PERSON 1’s household? If YES, go to the next page to tell us about PERSON 3. If NO, go to page 18.
PERSON 3:

Tell us about the other people in your household. See page A for a definition of who you must include.

### Personal Information:

<table>
<thead>
<tr>
<th>Name (First, Middle, Last): ____________________________</th>
<th>Social Security Number (optional if not applying): ____________________________</th>
<th>Gender:</th>
<th>☐ Male</th>
<th>☐ Female</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Birth: ____________________________</th>
<th>Relationship to Person 1:</th>
<th>☐ Spouse</th>
<th>☐ Child/Step Child</th>
<th>☐ Parent</th>
<th>☐ Other: ____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Grandchild</td>
<td>☐ Niece/Nephew</td>
<td>☐ Legal Guardian</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital Status:</th>
<th>☐ Never Married</th>
<th>☐ Divorced</th>
<th>☐ Widowed</th>
<th>☐ Married-name of spouse: ____________________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Does PERSON 2 live at the same address as Person 1?</th>
<th>☐ Yes</th>
<th>☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If ‘No,’ what is PERSON 2’s home address: ____________________________________________________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is PERSON 3 attending school?</th>
<th>☐ Yes</th>
<th>☐ No</th>
<th>If ‘Yes,’ is PERSON 3 attending school: ☐ Full Time</th>
<th>☐ Part Time</th>
<th>Grade Level: ____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of School: ____________________________</td>
<td>____________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is PERSON 3 applying for AHCCCS Medical Assistance?</th>
<th>☐ Yes</th>
<th>☐ No</th>
<th>If ‘Yes,’ AHCCCS health plan choice: ____________________________</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Is PERSON 3 applying for help with Medicare costs?</th>
<th>☐ Yes</th>
<th>☐ No</th>
<th>If ‘Yes,’ Medicare claim number: ____________________________</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Does PERSON 3 need help paying for medical bills from the last 3 months?</th>
<th>☐ Yes</th>
<th>☐ No</th>
<th>If ‘Yes,’ what months? ____________________________</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Is PERSON 3 applying for Nutrition Assistance?</th>
<th>☐ Yes</th>
<th>☐ No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Is PERSON 3 applying for Cash Assistance?</th>
<th>☐ Yes</th>
<th>☐ No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Is PERSON 3 applying for Tuberculosis Control?</th>
<th>☐ Yes</th>
<th>☐ No</th>
</tr>
</thead>
</table>

If PERSON 3 is applying for any benefits: continue answering the questions below.

If PERSON 3 is NOT applying for any benefits: go to page 11 to tell us about PERSON 3’s income.

### Citizenship/Residency:

Tell us about PERSON 3’s citizenship/residency. You may need to provide proof of citizenship/residency.

<table>
<thead>
<tr>
<th>Is PERSON 3 a U.S. citizen or U.S. national?</th>
<th>☐ Yes</th>
<th>☐ No</th>
<th>☐ Choose not to answer</th>
</tr>
</thead>
</table>

If PERSON 3 is NOT a U.S. citizen, what is his/her immigration status?

<table>
<thead>
<tr>
<th>☐ Lawful Permanent Resident (LPR)</th>
<th>☐ Battered Spouse, Child or Parent</th>
<th>☐ Removal/Suspension of Deportation</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Lawful Temporary Resident</td>
<td>☐ Cuban-Haitian Entrant</td>
<td>☐ Registry Applicants</td>
</tr>
<tr>
<td>☐ Non-Immigrant Status</td>
<td>☐ Deferred Action Status</td>
<td>☐ Special Immigrant Juvenile Status Applicant</td>
</tr>
<tr>
<td>☐ Asylee</td>
<td>☐ Deferred Enforced Departure</td>
<td>☐ Temporary Protection Status (TPS)</td>
</tr>
<tr>
<td>☐ Refugee</td>
<td>☐ Legalization under LIFE Act</td>
<td>☐ Victim of Trafficking</td>
</tr>
<tr>
<td>☐ Conditional Entrant granted before 1980</td>
<td>☐ Legalization under IRCA Applicant</td>
<td>☐ Withholding Deportation</td>
</tr>
<tr>
<td>☐ Other</td>
<td>☐ Order of Supervision</td>
<td>☐ Applicant for Asylum, LPR, TPS, or Withholding Deportation</td>
</tr>
<tr>
<td>☐ I do not want to provide</td>
<td>☐ Paroled into United States</td>
<td></td>
</tr>
</tbody>
</table>

What immigration document does PERSON 3 have?

<table>
<thead>
<tr>
<th>☐ Permanent Resident card</th>
<th>☐ 1-94</th>
<th>☐ Visa</th>
<th>Has PERSON 3 lived in the U.S. since August 22, 1996?</th>
<th>☐ Yes</th>
<th>☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Foreign Passport</td>
<td>☐ None</td>
<td>☐ Other: ____________________________</td>
<td>Immigration Document Number: ____________________________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is PERSON 3 an Arizona resident?</th>
<th>☐ Yes</th>
<th>☐ No</th>
</tr>
</thead>
</table>

Did PERSON 3 move to Arizona in the last 4 months? | ☐ Yes | ☐ No | If ‘Yes,’ date moved: ____________________________ |

<table>
<thead>
<tr>
<th>Race (optional), select one or more:</th>
<th>☐ Asian</th>
<th>☐ Hawaiian or other Pacific Islander</th>
<th>☐ White</th>
<th>☐ Non-Hispanic/Non-Latino</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Black or African American</td>
<td>☐ American Indian/Alaska Native</td>
<td>☐ Other: ____________________________</td>
<td>☐ Hispanic/Latino</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity (optional):</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Non-Hispanic/Non-Latino</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If PERSON 3 is American Indian or Alaska Native:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Is he/she enrolled in a federally recognized tribe?</td>
</tr>
<tr>
<td>Tribal Census Number: ____________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is he/she living on a reservation?</th>
<th>☐ Yes</th>
<th>☐ No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Has he/she ever gotten services from Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?</th>
<th>☐ Yes</th>
<th>☐ No</th>
<th>If ‘No,’ is he/she eligible?</th>
<th>☐ Yes</th>
<th>☐ No</th>
</tr>
</thead>
</table>
PERSON 3:

This section asks specific questions for each type of benefit. If PERSON 3 is not applying for any benefits, go to page 11. If PERSON 3 is applying for benefits, complete each applicable section.

Questions for All Applicants: Answer the following questions if PERSON 3 is applying for benefits.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is PERSON 3 physically or mentally disabled?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is PERSON 3 in jail or prison?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was PERSON 3 released from jail or prison in the last 4 months?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

AHCCCS Medical Assistance, Help with Medicare Costs, and Cash Assistance Questions: Complete this section if PERSON 3 is applying for AHCCCS Medical Assistance and/or help with Medicare costs, and/or Cash Assistance.

- Is PERSON 3 pregnant?  
  - Yes  
  - No
- If PERSON 3 is under age 19, are both of his/her parents living in the home?  
  - Yes  
  - No
  - If 'No,' complete the information below:
    - Parent's Name (First, Last):  
    - Social Security Number:  
    - Date of Birth:  
    - Mailing Address:  
    - City:  
    - State:  
    - Zip Code:  
    - Phone Number:  
    - Reason parent is absent:  
      - Deceased  
      - Out of home
    - Parent's Name (First, Last):  
    - Social Security Number:  
    - Date of Birth:  
    - Mailing Address:  
    - City:  
    - State:  
    - Zip Code:  
    - Phone Number:  
    - Reason parent is absent:  
      - Deceased  
      - Out of home

AHCCCS Medical Assistance and Help with Medicare Costs Questions: Answer these questions if PERSON 3 is applying for AHCCCS Medical Assistance and/or help with Medicare costs.

- If PERSON 3 is under the age of 65, does he/she have a mental or physical disability that has kept or will keep him/her from working for at least 12 months?  
  - Yes  
  - No
- If PERSON 3 works and is under the age of 65, does he/she have a disability that is expected to last at least 12 months?  
  - Yes  
  - No
- Does PERSON 3 need help with activities of daily living (bathing, dressing, etc.) through personal assistance, services, nursing home, or other medical facility?  
  - Yes  
  - No
- Does PERSON 3 live with at least one child under age 19 and is the main care taker of the child?  
  - Yes  
  - No
- Has PERSON 3 ever received Supplemental Security Income (SSI Cash)?  
  - Yes  
  - No

Nutrition Assistance and Cash Assistance Questions: Answer these questions if PERSON 3 is applying for Nutrition Assistance and/or Cash Assistance. PERSON 3 may still be able to get benefits if he/she has a felony drug conviction. See page G for more information.

- Has PERSON 3 had a felony conviction for possession, use, or distribution of a controlled substance on or after August 23, 1996?  
  - Yes  
  - No
- Has PERSON 3 been found to have committed a Nutrition Assistance and/or Cash Assistance Intentional Program Violation in Arizona or any other state?  
  - Yes  
  - No
- Is PERSON 3 fleeing from law enforcement agencies on any charges, or is PERSON 3 in violation of probation or parole according to a court?  
  - Yes  
  - No

Nutrition Assistance Questions: Answer these questions if PERSON 3 is applying for Nutrition Assistance.

- If PERSON 3 is disabled or over age 60, does he/she have any paid or unpaid medical expenses, even if he/she has medical insurance (example: travel expenses to and from medical provider, doctor visits, prescriptions, lab work, etc.)?  
  - Yes  
  - No
- Is PERSON 3 living in an assisted living facility or group home?  
  - Yes  
  - No

Cash Assistance Questions: Answer this question if PERSON 3 is under age 19 and applying for Cash Assistance.

- If PERSON 3 is under age 19 and is living with his/her parents, are his/her shots current?  
  - Yes  
  - No

Go to the next page to tell us more about PERSON 3.
PERSON 3:

Tell us about PERSON 3’s income, potential benefits and expected tax filing status. Complete this page even if PERSON 3 is not applying for any benefits.

Employment: Tell us about PERSON 3’s employment, including self-employment and rental income. You may need to provide proof of income. If self-employed, please attach the most current federal tax forms: 1040, SE, and applicable schedules such as C, C-EZ, E, F and K1. If you do not have tax forms, attach proof of business income and expenses for the last and current calendar month.

<table>
<thead>
<tr>
<th>Employer’s Name and Phone Number</th>
<th>Gross Earnings (before deductions):</th>
<th>How often paid?</th>
<th>How many hours worked per week?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Is PERSON 3 self-employed?  
[ ] Yes  [ ] No  
If ‘Yes,’ type of work: ________________________  
If ‘Yes,’ annual net (after deductions) amount: ______

If ‘Yes,’ has PERSON 3 been in this business for 12 months?  
[ ] Yes  [ ] No  
If ‘No,’ date business started: ___________________

Does PERSON 3’s income change because of contract or seasonal employment?  
[ ] Yes  [ ] No  
If yes, how much income does PERSON 3 expect to make over the next 12 months? ________

Does PERSON 3 work in exchange for food or rent?  
[ ] Yes  [ ] No  
If ‘Yes,’ where? ____________________________

Other Income: Tell us about other income PERSON 3 receives. You may need to provide proof of income.

<table>
<thead>
<tr>
<th>Type of Income</th>
<th>Amount</th>
<th>How often received?</th>
<th>Who pays the income?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security benefits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplemental Security Income (SSI Cash)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retirement/pension</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability/worker’s compensation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Court ordered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other: ______________________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alimony</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veterans benefits</td>
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<tr>
<td>Gaming</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other: ______________________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per capita payments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>from natural resources, usage rights, leases or royalties</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Money from selling things that have cultural significance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other: ______________________</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Check here if this person does not have income  
[ ]

Potential Benefits: Tell us about PERSON 3 to help determine if he/she may be eligible for additional benefits.

Has PERSON 3 or his/her spouse (living or deceased) ever worked for a government agency or an employer with a pension plan?  
[ ] Yes  [ ] No  
If ‘Yes,’ employer name: ________________________  
If ‘Yes,’ dates of employment: ___________________

Has PERSON 3 or his/her spouse (living or deceased) served in the military?  
[ ] Yes  [ ] No  
If ‘Yes,’ branch of service: _____________________  
If ‘Yes,’ dates of service: _______________________

If PERSON 3 is under age 19, has his/her parent (living or deceased) served in the military?  
[ ] Yes  [ ] No  
If ‘Yes,’ branch of service: _____________________  
If ‘Yes,’ dates of service: _______________________

Federal Income Tax Filing: Tell us how PERSON 3 will file income taxes NEXT YEAR.

Will PERSON 3 file taxes NEXT YEAR?  
[ ] Yes  [ ] No  
If ‘Yes,’ will PERSON 3 file jointly with a spouse?  
[ ] Yes  [ ] No  
If ‘Yes,’ name of spouse: _______________________

Will PERSON 3 claim dependents on his/her tax return?  
[ ] Yes  [ ] No  
If ‘Yes,’ name of dependent(s): __________________

Will PERSON 3 be claimed as a dependent on someone else’s tax return?  
[ ] Yes  [ ] No  
If ‘Yes,’ name of tax filer: _____________________  
Relationship to tax filer: ______________________

Does PERSON 3 pay any expenses that may be deducted on the federal income tax return?  
[ ] Yes  [ ] No  
Alimony: Amount paid: ________  How often? ________

Student loan interest: Amount paid: ________  How often? ________

Other deductions: Amount paid: ________  How often? ________

Describe deductions: ____________________________

Is there anyone else in PERSON 1’s household?  
If YES, go to the next page to tell us about PERSON 4.  
If NO, go to page 18.
### PERSON 4:

Tell us about the other people in your household. See page A for a definition of who you must include.

#### Personal Information:

<table>
<thead>
<tr>
<th>Name (First, Middle, Last):</th>
<th>Social Security Number (optional if not applying):</th>
<th>Gender: □ Male  □ Female</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Birth:</th>
<th>Relationship to Person 1:</th>
<th>Marital Status:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Spouse  □ Child/Step Child  □ Parent  □ Other:</td>
<td>□ Never Married  □ Divorced  □ Widowed  □ Married-name of spouse:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Does PERSON 2 live at the same address as Person 1?</th>
<th>Is PERSON 4 attending school?</th>
<th>If ‘Yes,’ is PERSON 4 attending school:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes  □ No</td>
<td>□ Yes  □ No</td>
<td>□ Full Time  □ Part Time</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If PERSON 4 is applying for AHCCCS Medical Assistance?</th>
<th>Is PERSON 4 applying for help with Medicare costs?</th>
<th>Does PERSON 4 need help paying for medical bills from the last 3 months?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes  □ No</td>
<td>□ Yes  □ No</td>
<td>□ Yes  □ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is PERSON 4 applying for Nutrition Assistance?</th>
<th>Is PERSON 4 applying for Cash Assistance?</th>
<th>Is PERSON 4 applying for Tuberculosis Control?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes  □ No</td>
<td>□ Yes  □ No</td>
<td>□ Yes  □ No</td>
</tr>
</tbody>
</table>

If PERSON 4 is applying for any benefits: continue answering the questions below.  
If PERSON 4 is NOT applying for any benefits: go to page 14 to tell us about PERSON 4’s income.

#### Citizenship/Residency:

Tell us about PERSON 4’s citizenship/residency. You may need to provide proof of citizenship/residency.

<table>
<thead>
<tr>
<th>Is PERSON 4 a U.S. citizen or U.S. national?</th>
<th>Choose not to answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes  □ No</td>
<td>□ Choose not to answer</td>
</tr>
</tbody>
</table>

If PERSON 4 is NOT a U.S. citizen, what is his/her immigration status?

<table>
<thead>
<tr>
<th>□ Lawful Permanent Resident (LPR)</th>
<th>□ Lawful Temporary Resident</th>
<th>□ Non-Immigrant Status</th>
<th>□ Asylee</th>
<th>□ Refugee</th>
<th>□ Conditional Entrant granted before 1980</th>
<th>□ Other</th>
<th>□ I do not want to provide</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Battered Spouse, Child or Parent</td>
<td>□ Cuban-Haitian Entrant</td>
<td>□ Deferred Action Status</td>
<td>□ Deferred Enforced Departure</td>
<td>□ Legalization under LIFE Act</td>
<td>□ Legalization under IRCA Applicant</td>
<td>□ Order of Supervision</td>
<td>□ Paroled into United States</td>
</tr>
</tbody>
</table>

Immigration Document Number:  
Has PERSON 4 lived in the U.S. since August 22, 1996? □ Yes  □ No

<table>
<thead>
<tr>
<th>□ Permanent Resident Card</th>
<th>□ I-94</th>
<th>□ Visa</th>
<th>Foreign Passport</th>
<th>□ None</th>
<th>□ Other:</th>
</tr>
</thead>
</table>

Did PERSON 4 move to Arizona in the last 4 months? □ Yes  □ No

If ‘Yes,’ date moved: ________________  

What immigration document does PERSON 4 have?

<table>
<thead>
<tr>
<th>□ Black or African American</th>
<th>□ Hawaiian or other Pacific Islander</th>
<th>□ White</th>
<th>□ American Indian/Alaska Native</th>
<th>□ Other:</th>
</tr>
</thead>
</table>

If PERSON 4 is American Indian or Alaska Native:  
If he/she enrolled in a federally recognized tribe? □ Yes  □ No

Tribal Census Number: ________________

<table>
<thead>
<tr>
<th>□ Asian</th>
<th>□ Hispanic/Latino</th>
<th>□ Non-Hispanic/Non-Latino</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>□ If PERSON 4 is living on a reservation?</th>
<th>□ Yes  □ No</th>
<th>□ If ‘Yes,’ name of reservation:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>□ Has he/she ever gotten services from Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?</th>
<th>□ Yes  □ No</th>
<th>□ If ‘No,’ is he/she eligible?</th>
</tr>
</thead>
</table>

Go to the next page to tell us more about PERSON 4.
PERSON 4:

This section asks specific questions for each type of benefit. If PERSON 4 is not applying for any benefits, go to page 14. If PERSON 4 is applying for benefits, complete each applicable section.

Questions for All Applicants: Answer the following questions if PERSON 4 is applying for benefits.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is PERSON 4 physically or mentally disabled?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is PERSON 4 in jail or prison?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was PERSON 4 released from jail or prison in the last 4 months?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Ahcccs Medical Assistance, Help with Medicare Costs, and Cash Assistance Questions:
Complete this section if PERSON 4 is applying for AHCCCS Medical Assistance and/or help with Medicare costs, and/or Cash Assistance.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is PERSON 4 pregnant?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If PERSON 4 is under age 19, are both of his/her parents living in the home?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent's Name (First, Last):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mailing Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone Number:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent's Name (First, Last):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mailing Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone Number:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Ahcccs Medical Assistance and Help with Medicare Costs Questions: Answer these questions if PERSON 4 is applying for AHCCCS Medical Assistance and/or help with Medicare costs.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If PERSON 4 is under the age of 65, does he/she have a mental or physical disability that has kept or will keep him/her from working for at least 12 months?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If PERSON 4 works and is under the age of 65, does he/she have a disability that is expected to last at least 12 months?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does PERSON 4 need help with activities of daily living (bathing, dressing, etc.) through personal assistance, services, nursing home, or other medical facility?</td>
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<td></td>
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<tr>
<td>Does PERSON 4 live with at least one child under age 19 and is the main care taker of the child?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has PERSON 4 ever received Supplemental Security Income (SSI Cash)?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Nutrition Assistance and Cash Assistance Questions: Answer these questions if PERSON 4 is applying for Nutrition Assistance and/or Cash Assistance. PERSON 4 may still be able to get benefits if he/she has a felony drug conviction. See page G for more information.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has PERSON 4 had a felony conviction for possession, use, or distribution of a controlled substance on or after August 23, 1996?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has PERSON 4 been found to have committed a Nutrition Assistance and/or Cash Assistance Intentional Program Violation in Arizona or any other state?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is PERSON 4 fleeing from law enforcement agencies on any charges, or is PERSON 4 in violation of probation or parole according to a court?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Nutrition Assistance Questions: Answer these questions if PERSON 4 is applying for Nutrition Assistance.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If PERSON 4 is disabled or over age 60, does he/she have any paid or unpaid medical expenses, even if he/she has medical insurance (example: travel expenses to and from medical provider, doctor visits, prescriptions, lab work, etc.)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is PERSON 4 living in an assisted living facility or group home?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Cash Assistance Questions: Answer this question if PERSON 4 is under age 19 and applying for Cash Assistance.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If PERSON 4 is under age 19 and is living with his/her parents, are his/her shots current?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Go to the next page to tell us more about PERSON 4.
PERSON 4:

Tell us about PERSON 4’s income, potential benefits and expected tax filing status. Complete this page even if PERSON 4 is not applying for any benefits.

Employment: Tell us about PERSON 4’s employment, including self-employment and rental income. You may need to provide proof of income. If self-employed, please attach the most current federal tax forms: 1040, SE, and applicable schedules such as C, C-EZ, E, F and K1. If you do not have tax forms, attach proof of business income and expenses for the last and current calendar month.

<table>
<thead>
<tr>
<th>Does PERSON 4 work?</th>
<th>☐ Yes</th>
<th>☐ No</th>
<th>If yes, give employment information below:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer’s Name and Phone Number:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gross Earnings (before deductions):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How many hours worked per week?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is PERSON 4 self-employed?</th>
<th>☐ Yes</th>
<th>☐ No</th>
<th>If ‘Yes,’ type of work: __________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>If ‘Yes,’ have PERSON 4 been in this business for 12 months?</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>If ‘No,’ date business started: ________________</td>
</tr>
<tr>
<td>If ‘Yes,’ does PERSON 4 expect to make over the next 12 months?</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>If ‘Yes,’ annual net (after deductions) amount: __________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Does PERSON 4 work in exchange for food or rent?</th>
<th>☐ Yes</th>
<th>☐ No</th>
<th>If ‘Yes,’ where? ______________________________</th>
</tr>
</thead>
</table>

Other Income: Tell us about other income PERSON 4 receives. You may need to provide proof of income.

<table>
<thead>
<tr>
<th>Type of Income:</th>
<th>Amount</th>
<th>How often received?</th>
<th>Who pays the income?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security benefits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplemental Security Income (SSI Cash)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retirement/pension</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability/worker’s compensation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child support</td>
<td>☐ Court ordered</td>
<td>☐ Other: __________</td>
<td></td>
</tr>
<tr>
<td>Alimony</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veterans benefits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gifts or loans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tribal money</td>
<td>☐ Gaming</td>
<td>☐ Other: __________</td>
<td></td>
</tr>
<tr>
<td>Per capita payments from natural resources, usage rights, leases or royalties</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Money from selling things that have cultural significance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other: __________</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Check here if this person does not have income ☐

Potential Benefits: Tell us about PERSON 4 to help determine if he/she may be eligible for additional benefits.

<table>
<thead>
<tr>
<th>Has PERSON 4 or his/her spouse (living or deceased) ever worked for a government agency or an employer with a pension plan?</th>
<th>☐ Yes</th>
<th>☐ No</th>
<th>If ‘Yes,’ employer name: ________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has PERSON 4 or his/her spouse (living or deceased) ever served in the military?</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>If ‘Yes,’ branch of service: ___________________</td>
</tr>
<tr>
<td>If PERSON 4 is under age 19, has his/her parent (living or deceased) served in the military?</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>If ‘Yes,’ branch of service: ___________________</td>
</tr>
</tbody>
</table>

Federal Income Tax Filing: Tell us how PERSON 4 will file income taxes NEXT YEAR.

<table>
<thead>
<tr>
<th>Will PERSON 4 file taxes NEXT YEAR?</th>
<th>☐ Yes</th>
<th>☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If ‘Yes,’ will PERSON 4 file jointly with a spouse?</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Will PERSON 4 claim dependents on his/her tax return?</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Will PERSON 4 be claimed as a dependent on someone else’s tax return?</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Does PERSON 4 pay any expenses that may be deducted on the federal income tax return?</td>
<td>☐ Alimony</td>
<td></td>
</tr>
<tr>
<td>☐ Student loan interest</td>
<td>Amount paid: __________</td>
<td>How often?</td>
</tr>
<tr>
<td>☐ Other deductions</td>
<td>Amount paid: __________</td>
<td>How often?</td>
</tr>
</tbody>
</table>

Describe deductions: __________________________________________

Is there anyone else in PERSON 1’s household? If YES, go to the next page to tell us about PERSON 5. If NO, go to page 18.
PERSON 5:

If there are more than 5 people in your household, make a copy of pages 15, 16 and 17, then tell us about the other people in your household. See page A for a definition of who you must include. Attach copied pages to this application.

**Personal Information:**

<table>
<thead>
<tr>
<th>Name (First, Middle, Last): __________________________________________</th>
<th>Gender: □ Male □ Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth: ____________________________________________</td>
<td>Social Security Number (optional if not applying):</td>
</tr>
<tr>
<td>Relationship to Person 1: □ Spouse □ Child/Step Child □ Parent □ Other:</td>
<td></td>
</tr>
<tr>
<td>Marital Status: □ Never Married □ Divorced □ Widowed □ Married-name of spouse:</td>
<td></td>
</tr>
<tr>
<td>Does PERSON 2 live at the same address as Person 1? □ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>Is PERSON 5 attending school? □ Yes □ No</td>
<td>If ‘Yes,’ is PERSON 5 attending school: □ Full Time □ Part Time</td>
</tr>
<tr>
<td>Name of School: __________________________________________</td>
<td>Grade Level:</td>
</tr>
</tbody>
</table>

**Is PERSON 5 applying for AHCCCS Medical Assistance?**

**Is PERSON 5 applying for help with Medicare costs?**

**Does PERSON 5 need help paying for medical bills from the last 3 months?**

**Is PERSON 5 applying for Nutrition Assistance?**

**Is PERSON 5 applying for Cash Assistance?**

**Is PERSON 5 applying for Tuberculosis Control?**

If PERSON 5 is applying for any benefits: continue answering the questions below.

If PERSON 5 is NOT applying for any benefits: go to page 17 to tell us about PERSON 5’s income.

**Citizenship/Residency:** Tell us about PERSON 5’s citizenship/residency. You may need to provide proof of citizenship/residency.

Is PERSON 5 a U.S. citizen or U.S. national? See page D for more information. □ Yes □ No □ Choose not to answer

If PERSON 5 is NOT a U.S. citizen, what is his/her immigration status?

<table>
<thead>
<tr>
<th>Lawful Permanent Resident (LPR)</th>
<th>Battered Spouse, Child or Parent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lawful Temporary Resident</td>
<td>Cuban-Haitian Entrant</td>
</tr>
<tr>
<td>Non-Immigrant Status</td>
<td>Deferred Action Status</td>
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<td>Asylee</td>
<td>Deferred Enforced Departure</td>
</tr>
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<td>Refugee</td>
<td>Legalization under LIFE Act</td>
</tr>
<tr>
<td>Conditional Entrant granted before 1980</td>
<td>Legalization under IRCA Applicant</td>
</tr>
<tr>
<td>Other</td>
<td>Order of Supersvision</td>
</tr>
<tr>
<td>I do not want to provide</td>
<td>Paroled into United States</td>
</tr>
</tbody>
</table>

What immigration document does PERSON 5 have?

<table>
<thead>
<tr>
<th>Permanent Resident card □</th>
<th>I-94 □</th>
<th>Visa □</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreign Passport □</td>
<td>None □</td>
<td>Other:</td>
</tr>
</tbody>
</table>

Is PERSON 5 an Arizona resident? □ Yes □ No

Did PERSON 5 move to Arizona in the last 4 months? □ Yes □ No

If ‘Yes,’ date moved: ____________________________

Race (optional), select one or more:

<table>
<thead>
<tr>
<th>Asian □</th>
<th>Hawaiian or other Pacific Islander □</th>
<th>White □</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black or African American □</td>
<td>American Indian/Alaska Native □</td>
<td>Other:</td>
</tr>
</tbody>
</table>

If PERSON 5 is American Indian or Alaska Native:

Is he/she enrolled in a federally recognized tribe? □ Yes □ No

If ‘Yes,’ name of tribe: ____________________________

Tribal Census Number: ____________________________

Is he/she living on a reservation? □ Yes □ No

If ‘Yes,’ name of reservation: ____________________________

Has he/she ever gotten services from Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? □ Yes □ No

If ‘No,’ is he/she eligible? □ Yes □ No

Go to the next page to tell us more about PERSON 5.
PERSON 5:
This section asks specific questions for each type of benefit. If PERSON 5 is not applying for any benefits, go to page 17. If PERSON 5 is applying for benefits, complete each applicable section.

**Questions for All Applicants:** Answer the following questions if PERSON 5 is applying for benefits.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is PERSON 5 physically or mentally disabled?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IS PERSON 5 in jail or prison?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was PERSON 5 released from jail or prison in the last 4 months?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**AHCCCS Medical Assistance, Help with Medicare Costs, and Cash Assistance Questions:** Complete this section if PERSON 5 is applying for AHCCCS Medical Assistance and/or help with Medicare costs, and/or Cash Assistance.

<table>
<thead>
<tr>
<th>Question</th>
<th>Social Security Number</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is PERSON 5 pregnant?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If PERSON 5 is under age 19, are both of his/her parents living in the home?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**AHCCCS Medical Assistance and Help with Medicare Costs Questions:** Answer these questions if PERSON 5 is applying for AHCCCS Medical Assistance and/or help with Medicare costs.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If PERSON 5 is under the age of 65, does he/she have a mental or physical disability that has kept or will keep him/her from working for at least 12 months?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If PERSON 5 works and is under the age of 65, does he/she have a disability that is expected to last at least 12 months?</td>
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<td></td>
</tr>
<tr>
<td>Does PERSON 5 need help with activities of daily living (bathing, dressing, etc.) through personal assistance, services, nursing home, or other medical facility?</td>
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</tr>
<tr>
<td>Does PERSON 5 live with at least one child under age 19 and is the main care taker of the child?</td>
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<td></td>
</tr>
<tr>
<td>Has PERSON 5 ever received Supplemental Security Income (SSI Cash)?</td>
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<td></td>
</tr>
</tbody>
</table>

**Nutrition Assistance and Cash Assistance Questions:** Answer these questions if PERSON 5 is applying for Nutrition Assistance and/or Cash Assistance. PERSON 5 may still be able to get benefits if he/she has a felony drug conviction. See page G for more information.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has PERSON 5 had a felony conviction for possession, use, or distribution of a controlled substance on or after August 23, 1996?</td>
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<td></td>
</tr>
<tr>
<td>Has PERSON 5 been found to have committed a Nutrition Assistance and/or Cash Assistance Intentional Program Violation in Arizona or any other state?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Nutrition Assistance Questions** Answer these questions if PERSON 5 is applying for Nutrition Assistance.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If PERSON 5 is disabled or over age 60, does he/she have any paid or unpaid medical expenses, even if he/she has medical insurance (example: travel expenses to and from medical provider, doctor visits, prescriptions, lab work, etc.)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is PERSON 5 living in an assisted living facility or group home?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Cash Assistance Questions:** Answer this question if PERSON 5 is under age 19 and applying for Cash Assistance.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If PERSON 5 is under age 19 and is living with his/her parents, are his/her shots current?</td>
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<td></td>
</tr>
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Go to the next page to tell us more about PERSON 5.
PERSON 5:

Tell us about PERSON 5’s income, potential benefits and expected tax filing status. Complete this page even if PERSON 5 is not applying for any benefits.

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Does PERSON 5 work?  
Yes  
No  
If yes, give employment information below:

<table>
<thead>
<tr>
<th>Employer’s Name and Phone Number</th>
<th>Gross Earnings (before deductions)</th>
<th>How often paid?</th>
<th>How many hours worked per week?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

Is PERSON 5 self-employed?  
Yes  
No  
If ‘Yes,’ type of work:  
If ‘Yes,’ annual net (after deductions) amount: ___________

If ‘Yes,’ has PERSON 5 been in this business for 12 months?  
Yes  
No  
If ‘Yes,’ date business started: ___________

Does PERSON 5’s income change because of contract or seasonal employment?  
Yes  
No  
If yes, how much income does PERSON 5 expect to make over the next 12 months? ___________

Does PERSON 5 work in exchange for food or rent?  
Yes  
No  
If ‘Yes,’ where? ___________

Other Income: Tell us about other income PERSON 5 receives. You may need to provide proof of income.

<table>
<thead>
<tr>
<th>Type of Income</th>
<th>Amount</th>
<th>How often received?</th>
<th>Who pays the income?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security benefits</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Supplemental Security Income (SSI Cash)</td>
<td></td>
<td></td>
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<tr>
<td>Retirement/pension</td>
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<tr>
<td>Unemployment</td>
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<tr>
<td>Disability/worker’s compensation</td>
<td></td>
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</tr>
<tr>
<td>Child support</td>
<td>Court ordered</td>
<td>Other: __________</td>
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</tr>
<tr>
<td>Alimony</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Veterans benefits</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Gifts or loans</td>
<td></td>
<td></td>
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<tr>
<td>Tribal money</td>
<td>Gaming</td>
<td>Other: __________</td>
<td></td>
</tr>
<tr>
<td>Per capita payments from natural resources, usage rights, leases or royalties</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land</td>
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<tr>
<td>Money from selling things that have cultural significance</td>
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<tr>
<td>Other: __________</td>
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</tbody>
</table>

Check here if this person does not have income  

Potential Benefits: Tell us about PERSON 5 to help determine if he/she may be eligible for additional benefits.

Has PERSON 5 or his/her spouse (living or deceased) ever worked for a government agency or an employer with a pension plan?  
Yes  
No  
If ‘Yes,’ employer name:  
If ‘Yes,’ dates of employment: ___________

Has PERSON 5 or his/her spouse (living or deceased) served in the military?  
Yes  
No  
If ‘Yes,’ branch of service:  
If ‘Yes,’ dates of service: ___________

If PERSON 5 is under age 19, has his/her parent (living or deceased) served in the military?  
Yes  
No  
If ‘Yes,’ branch of service:  
If ‘Yes,’ dates of service: ___________

Federal Income Tax Filing: Tell us how PERSON 5 will file income taxes NEXT YEAR.

Will PERSON 5 file taxes NEXT YEAR?  
Yes  
No  
If ‘Yes,’ will PERSON 5 file jointly with a spouse?  
Yes  
No  
If ‘Yes,’ name of spouse: ___________

Will PERSON 5 claim dependents on his/her tax return?  
Yes  
No  
If ‘Yes,’ name of dependent(s): ___________

Will PERSON 5 be claimed as a dependent on someone else’s tax return?  
Yes  
No  
If ‘Yes,’ name of tax filer: ___________

Does PERSON 5 pay any expenses that may be deducted on the federal income tax return?  
Alimony | Amount paid: ________ | How often? ________ |
Student loan interest | Amount paid: ________ | How often? ________ |
Other deductions | Amount paid: ________ | How often? ________ |

Describe deductions: __________________________________________

Is there anyone else in PERSON 1’s household?  
If YES, attach extra pages to tell us about the other people.  
If NO, go to page 18.
# Nutrition Assistance, Cash Assistance and Tuberculosis Control Questions:

Is anyone in your household applying for Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control?

If **YES**: answer the questions below. If **NO**: go to the next page.

## Temporary Absence:
Tell us about any people who are temporarily living outside of your home that are expected to return.

<table>
<thead>
<tr>
<th>Name (First and Last):</th>
<th>Date Left:</th>
<th>Expected Return Date:</th>
<th>Temporary Address:</th>
<th>Why are they out of the home?</th>
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</thead>
<tbody>
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</tbody>
</table>

## Resources and Expenses:
Answer the following questions if anyone in your household is applying for Nutrition Assistance and/or Cash Assistance.

- **Do you or anyone in your household own or have their name on bank accounts (checking or savings), credit union accounts, IRAs, Keoghs, or 401Ks?**
  - Yes ☐  No ☐ If ‘Yes,’ total value: $ ______
  - Who owns? __________________________________
  - Name of financial institution: ________________

- **Do you or anyone in your household own or have their name on stocks, bonds, money market accounts, Certificates of Deposit (CD’s), trust funds, or life insurance?**
  - Yes ☐  No ☐ If ‘Yes,’ total value: $ ______
  - Who owns? __________________________________
  - Name of financial institution: ________________

- **Do you or anyone in your household own real property (land or buildings)?**
  - Yes ☐  No ☐ If ‘Yes,’ total value: $ ______
  - Who owns? __________________________________
  - Where? _____________________________________

- **Do you or anyone in your household own vehicles (cars, trucks, boats, RVs, motorcycles, etc.)?**
  - Yes ☐  No ☐ If ‘Yes,’ total value: $ ______
  - How many vehicles? ___________________________

- **Do you or anyone in your household own other resources?**
  - Yes ☐  No ☐ If ‘Yes,’ total value: $ ______
  - Describe resources: __________________________
  - Who owns? __________________________________

- **Did you or anyone in your household ever apply for or get benefits from any other state?**
  - Yes ☐  No ☐ If ‘Yes,’ who? ____________________
  - What type of benefits? _________________________
  - When did benefits stop? _______________________
  - Name of state/county: _________________________

- **Do you or anyone in your household pay for the care of a child or disabled adult in order to work, look for work, attend training, or attend school?**
  - Yes ☐  No ☐ If ‘Yes,’ who pays? ______________
  - Amount paid for care: $ ______________________
  - How often is care paid for? ________________

- **Do you or anyone in your household have transportation costs to travel to/from the person or agency that provides provider, after school care or adult daycare?**
  - Yes ☐  No ☐ If ‘Yes,’ amount: $ ____________

- **Do you or anyone in your household pay court-ordered child support?**
  - Yes ☐  No ☐ If ‘Yes,’ who pays? ______________
  - Amount paid: ______________________________
  - How often paid: ____________________________

- **Does your household have enough monthly income, cash and/or bank account balances to cover your monthly rent/mortgage, utility and child care payments?**
  - Yes ☐  No ☐ If ‘No,’ how are you paying your bills? __________________________

## Food Preparation:
If anyone in your household is applying for Nutrition Assistance, tell us how your household buys and prepares food.

- Does anyone in your household buy and prepare his/her own food separate from others in the household?
  - Yes ☐  No ☐

  If ‘Yes,’ tell us about the people who buy and prepare their own food:

<table>
<thead>
<tr>
<th>Name (First &amp; Last):</th>
<th>Age:</th>
<th>Relationship to PERSON 1:</th>
<th>Does this person pay expenses?</th>
<th>What expenses?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>Yes ☐  No ☐</td>
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<td>Yes ☐  No ☐</td>
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<td>Yes ☐  No ☐</td>
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<td>Yes ☐  No ☐</td>
<td></td>
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</tbody>
</table>

Is anyone in your household applying for AHCCCS Medical Assistance, help with Medicare costs, and/or Cash Assistance?

If **YES**: Go to the next page. If **NO**: go to page 20.
### Health Insurance:

**Health Insurance Coverage:** Answer the following questions if anyone in your household is applying for AHCCCS Medical Assistance, help with Medicare costs, and/or Cash Assistance.

<table>
<thead>
<tr>
<th>Name of Insured:</th>
<th>Name of Insurance Provider:</th>
<th>Policy Number:</th>
<th>Coverage Effective Date:</th>
</tr>
</thead>
<tbody>
<tr>
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Do any applicants have health insurance other than AHCCCS or Medicare?  □ Yes  □ No

If ‘Yes,’ give the following information:

**Health Insurance Tax Credits:**

If you are not eligible for you AHCCCS Medical Assistance, you may be eligible for federal tax credits to help with your health insurance premiums. If you are not eligible for any programs through AHCCCS, we will send your information to the federal Health Insurance Marketplace to see about health insurance tax credits.

**Insurance from Jobs:** Tell us about health insurance that may be offered through a job.

If anyone in your household is applying for AHCCCS Medical Assistance and/or help with Medicare costs.

Are any applicants currently admitted to a hospital?  □ Yes  □ No  □ I do not know

Answer the following questions if anyone in your household is applying for AHCCCS Medical Assistance and/or help with Medicare costs.

Do any applicants have an injury or illness due to an accident or medical malpractice?  □ Yes  □ No  □ If ‘Yes,’ who?

What changes will the employer make for the new plan year (if known)?

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

- How much will the employee have to pay in premiums for that plan? $ _______  □ Yes  □ No  □ I do not know

- How often will the employee have to pay the premium?

  - □ Weekly
  - □ Twice a month
  - □ Every 2 Weeks
  - □ Monthly
  - □ Quarterly
  - □ Yearly
  - □ I do not know
  - □ Other: ______

What changes will the employer make for the new plan year (if known)?

- Employer will not offer health coverage
- Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard*

  - How much will the employee have to pay in premiums for that plan? $ _______  □ Yes  □ No  □ I do not know

  - How often will the employee have to pay the premium?

    - □ Weekly
    - □ Twice a month
    - □ Every 2 Weeks
    - □ Monthly
    - □ Quarterly
    - □ Yearly
    - □ I do not know
    - □ Other: ______

- I do not know

**Renewal of Tax Credit Coverage in Future Years:**

To make it easier for the Federal Facilitated Marketplace to determine my eligibility for help paying for health coverage in future years, I agree to allow the Marketplace to use income data, including information from tax returns. The Marketplace will send me a notice, let me make changes, and I can opt out at any time.

- Yes, renew my eligibility for the next:  □ 5 years  □ 4 years  □ 3 years  □ 2 years  □ 1 year
- No, do not use information from tax returns to renew my coverage  □

*An employer-sponsored health plan meets “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60% of such costs.

Go to the next page to sign the application.
Sign the Application:

The application is not valid until it is signed. All unrelated adults without a child in common must sign the application. Otherwise, the application must be signed by one of the following:
- The applicant or the applicant's designee (we must have documentation showing this person is authorized to act on the applicant’s behalf); or
- The applicant's spouse, if married and living within the same household; or
- The parent/legal guardian of a minor child.

Penalty Warning

The information provided on this form may be verified by federal, state, and local officials. If any information is inaccurate, you may be denied benefits.
- You must not knowingly withhold or give false information with the intent to receive or to continue receiving DES and/or AHCCCS benefits to which you are not entitled.
- You will be required to pay back to DES and/or AHCCCS any benefits you receive as a result of withholding or giving false information and you will be subject to criminal prosecution.
- It is fraud for any person to knowingly withhold information with the intent to receive or continue to receive benefits to which he/she is not eligible. Any person found guilty of fraud may be subject to fines, criminal prosecution, imprisonment or other penalties as provided for by applicable State and Federal laws.

Release of Information

I authorize DES and/or AHCCCS to investigate and contact any sources necessary to establish eligibility and the accuracy of financial information that pertains to AHCCCS eligibility.

Assignment of Rights to Other Benefits for Medical Care

I understand that if I am or members of my household are approved for DES and/or AHCCCS benefits, DES and/or AHCCCS can collect payment from any other parties who may be responsible for paying for my/our health costs. This includes:
- Private or employer-sponsored health insurance (not including Medicare)
- Persons, such as an absent spouse or parent, who are legally responsible for providing medical support
- Private or employer-sponsored disability insurance
- Private or employer-sponsored accident insurance
- Insurance claims, jury awards, or legal settlements resulting from injuries

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

I understand that DES and/or AHCCCS and/or their contractors will release information to DES/Division of Child Support Services (DCSS), for a parent of a child who does not live in the home and the child has AHCCCS or private health insurance. DCSS may use this information to get a medical support order.

Assignment of Rights to Other Benefits for Cash Assistance

State and federal law (A.R.S. 46-407) provide that the legal rights to child support and spousal maintenance must be assigned to the State of Arizona for all persons receiving Cash Assistance. I understand:
- While receiving Cash Assistance, the State has the right to keep child support or spousal maintenance collections, including support or spousal maintenance that was owed while Cash Assistance was paid.
- When Cash Assistance stops, current support payments will be paid to me. The state may continue to collect any assigned back payments for support (assigned arrears) owed before and during the time I received Cash Assistance.
- Child support payments will be used to pay back the state for Cash Assistance paid to me or anyone on my application.
- The State will not keep more from my collected current support or assigned arrears than the total amount of Cash Assistance I received.
- Also the State will not keep any arrears that are more than the total amount of Cash Assistance I received.

Statement of Truth

By signing this application:
- I agree I have read and understand the rules and penalties on page G. I have read and understand my rights and responsibilities, and provided Social Security numbers for each applicant that has a Social Security number.
- I agree I have read and understand the assignment or rights to other benefits for Medical Care above.
- I agree I have read and understand the assignment of support rights for Cash Assistance above.
- I agree that certain Nutrition Assistance and/or Cash Assistance household members will cooperate with the work programs, which includes looking for work and accepting training and/or a job. If anyone does not, or will not, look for work, attend training, or accept a job, my benefits may be reduced or stopped.
- I agree to cooperate with Arizona or Federal personnel in the completion of a quality control review on my eligibility for benefits.
- In the event DES or its agents engage in child support enforcement activities involving me, I understand the Assistant Attorneys General and Deputy County Attorneys handling the cases represent DES, and not me or my children.
- If my child support case goes to court, I understand certain personal information contained in this application or my DES records may be released to the court and other parties to the case and becomes public record document.
- I also hereby agree to accept service of process by first class mail with regard to any paternity or child support proceeding initiated by DES and its agents.
- I understand that my records will be kept confidential and will only be released for purposes authorized by federal and state law.

I swear under penalty of perjury that the statements and documents provided about myself and persons in my home, 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 under penalty of perjury that any photocopied information I have provided are the same as the original documents.

Signature of Applicant: ________________________________ Date: ________________________
Signature of Spouse: ________________________________ Date: ________________________
Signature of Other Adult in Household: ________________________________ Date: ________________________
Signature of Authorized Representative: ________________________________ Date: ________________________
Signature of Witness (if signed with mark): ________________________________ Date: ________________________
Voter Registration:

Tell us if any person over the age of 18 listed on this application would like to register to vote. If ‘Yes,’ we will mail a voter registration form.

You may also access a voter registration form at www.azsos.gov/election/voterinformation.htm. If you would like help filling out the voter registration application form, we will help you. You may fill out the application form in private. Your answer to this question will not impact the programs you are eligible for.

Would any person on this application over the age of 18 like to register to vote?  ☐ Yes  ☐ No  ☐ Already registered to vote

If YES is not checked, all persons over the age of 18 on this application will be considered to have decided not to register to vote at this time.

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

State Election Director
Secretary of State’s Office
1700 West Washington
Phoenix, AZ 85007
602-542-8683

Submit the Application:

Submit your completed and signed application along with any supporting documents to your local DES/FAA office.

If any additional information is needed, you will be contacted.
You will be notified of our decision.

Thank you for applying!