DWS-ESD 61APP
Rev. 07/2014

State of Utah
Department of Workforce Services

APPLICATION FOR FOOD STAMPS, FINANCIAL ASSISTANCE, CHILD CARE, AND MEDICAL ASSISTANCE

Esta solicitud también se encuentra disponible en Español

For faster automated service, you can apply online at jobs.utah.gov

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Check The Services You Are Applying For:

☐ Food Stamps ☐ Cash/Financial Assistance ☐ Child Care ☐ Medical

Do you want help paying for medical bills from the last 3 months? ..... ☐ Yes ☐ No

If yes, for who? _____ For which month(s)? _____

1. Your Information:

Name: _____
First Middle Last

Home Address: _____ City: _____ Zip: _____

Mailing Address (If different from Home Address): _____

City: _____ Zip: _____

Phone #: _____ Other Phone #: _____

Birth Date: _____ Social Security # (optional): _____

Primary language spoken in your home? _____

Would you like to receive your notices in English or Spanish? ☐ English ☐ Spanish

Case # (optional): _____ Signature: _____

2. Do you have a Utah Horizon Card (Financial, Food Stamp and/or Child Care benefits)? ……..... ☐ Yes ☐ No
If you mark No, a new card will be mailed. Any other cards you have will no longer work.

3. Do ALL individuals who are applying for medical assistance need a medical card? .....……..... ☐ Yes ☐ No
If no, who needs a card*?* _____

If you want to apply for unemployment benefits, log on to jobs.utah.gov.

Your Rights:

- **IF YOU NEED HELP FILLING OUT THIS APPLICATION, WE ARE HAPPY TO HELP.**
- **YOU HAVE THE RIGHT TO AN INTERPRETER AT NO CHARGE.**
- Food Stamps and Medical:
  You can turn in an incomplete application with only your name, address and signature; however, before we can determine your eligibility for benefits, all questions will need to be answered. You can send in your application by: fax: 877-313-4717, mail: PO Box 143245, SLC, UT 84114-3245, email: imagingops@utah.gov or drop off at your local office
  - We will issue your assistance based on the date we receive your application. If your application is received outside business hours (Monday through Friday 8:00 a.m. to 5:00 p.m.) it will be effective the following business day.
- Financial and Child Care:
  - In order to file a Financial Assistance application you **must** complete questions **1 – 6 and 8 – 30, the Financial Section AND sign page 13**.
  - In order to file a Child Care Assistance application you **must** complete questions **1 – 6 and 8 – 23, the Child Care Section AND sign page 13**.
  - If you **do not** complete all of the required questions for Financial or Child Care, the application for Financial and/or Child Care will be considered incomplete and no action will be taken.
  - If eligible for Financial and/or Child Care, benefits are effective the date that we receive the completed application with the exception of the General Assistance financial program where benefits will be effective the first day of the month following the month an application is completed.

Food Stamp, Financial and Medicaid Information for Immigrants:

- You can apply for and receive Food Stamp, Financial and Medicaid benefits for eligible family members, even if your family includes other members who are not eligible because of immigration status. For example, immigrant parents may apply for Food Stamp benefits for their U.S. citizen or qualified immigrant children, even though the parents may not be eligible for benefits.
- You do not have to provide immigration status information, Social Security numbers, or documents for any family members who are not eligible for Food Stamp benefits because of immigrant status and who are not asking for Food Stamp benefits. Family members who are not eligible for Food Stamp, Financial or Medicaid benefits will still need to answer other questions about their name, relationship, income, assets, etc.
- Using Food Stamp, Medical and Financial benefits will not affect your immigration status or the immigration status of your family. Immigration information is private and confidential.
- Use of Medicaid benefits by you or your family members should not affect your ability to apply for permanent resident status unless you use Medicaid to pay for long-term care (nursing home or other institutionalized care). Use of Medicaid benefits will not affect your ability to apply for citizenship unless you committed fraud in getting those services.

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Medical Only Information

- Who do you need to include on this application?
  - Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage). The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.
- Affordable Private Health Insurance and Advanced Premium Tax Credits (APTC)
  - Information obtained from this application could also be used to determine your eligibility for affordable private health insurance plans and APTC, which could immediately help you pay your premiums for health coverage.
- Assets and Expenses (Questions 24 - 33)
  - You are only required to answer these questions if there is anyone in your household who is applying for Aged (65+), Blind or Disabled Medicaid, Spenddown Medicaid, Nursing Home, Waiver, Medicare Cost Sharing, and/or Refugee Medical.

Expedited Food Stamp Information

The following households are entitled to expedited services:

- Households whose combined monthly gross income and liquid resources are less than the household's monthly utilities and rent or mortgage.
- Households with less than $150 in monthly gross income and whose liquid resources (cash, savings, checking accounts, etc.) are no more than $100.
- Some migrant and seasonal farm worker households.

Let us know if you disagree with the decision made on your case about Expedited Food Stamps and a meeting will be scheduled for you within two (2) working days.

HOUSEHOLD AND GENERAL INFORMATION

4. List everyone who is living in your household and applying for benefits:

First and Last Name	Social Security #[1]	Birth Date	U.S. Citizen/ National[1] Yes/No	Gender M / F	Relationship	Utah Resident Yes/No	Utah Resident Since[2] (ex: 1/1/2013)	Race[3]	Ethnicity[4]	Marital Status[5]
					Self					

[1] Social Security Number and Citizenship information are only needed for the people applying for benefits. If someone wants help getting a Social Security Number, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

[2] Utah Resident Since is optional for all programs

[3] Race (optional): AI = American Indian or Alaska Native (**For medical applicants only, complete Attachment A**)
GC = Guamanian or Chamorro, ASI = Asian Indian, CH = Chinese, JA = Japanese, KO = Korean
OPI = Other Pacific Islander, FI = Filipino, VI = Vietnamese, AS = Asian, OA = Other Asian
BL = Black or African American, SA = Samoan, NH = Native Hawaiian, OT = Other, WH = White

[4] Ethnicity (optional): N = Not Hispanic , Latino or Spanish Origin, M = Mexican, MA = Mexican American, CH = Chicano/a
PR = Puerto Rican, CU = Cuban, AH: Another Hispanic, Latino or Spanish Origin, OT = Other

[5] Marital Status is not required for Food Stamps

5. Is there anyone living with you who is not applying for benefits? ..... ☐ Yes ☐ No

If yes, list below:

Name	Relationship to You	Do you purchase and prepare food with this person?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

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6. Has anyone moved into your home in the past three months? ..... ☐ Yes ☐ No

Name: _____ Date entered the home: _____

Name: _____ Date entered the home: _____

7. Answering this question is only required for medical assistance:
Do you plan to file a federal income tax return next year or will you be claimed as a dependent on someone's tax return next year? ..... ☐ Yes ☐ No

If yes, complete all columns below (if you are claiming more than 6 dependents, please make a copy of this page and attach it to your application). In addition to the questions below, please complete Attachment B of this application for all dependents that are NOT living with you but are claimed on your tax return.

1st ☐ Tax Filer -or- ☐ Tax Dependent	**Filing Jointly with Spouse** (applicable to Tax Filers only)	**Dependents listed on your Tax Return** (applicable to Tax Filers only)
First & Last Name: _____ Will you be claimed as a dependent on someone's tax return? … ☐ Yes ☐ No If yes, list name of tax filer and your relationship to the tax filer: Name:_____ Relationship:_____	Are you filing jointly with your spouse? ☐ Yes ☐ No If yes, name of spouse: _____	Name: _____ Living with tax filer: ☐ Yes ☐ No Name: _____ Living with tax filer: ☐ Yes ☐ No Name: _____ Living with tax filer: ☐ Yes ☐ No Name: _____ Living with tax filer: ☐ Yes ☐ No Name: _____ Living with tax filer: ☐ Yes ☐ No Name: _____ Living with tax filer: ☐ Yes ☐ No
2nd ☐ Tax Filer -or- ☐ Tax Dependent	**Filing Jointly with Spouse** (applicable to Tax Filers only)	**Dependents listed on your Tax Return** (applicable to Tax Filers only)
First & Last Name: _____ Will you be claimed as a dependent on someone's tax return? … ☐ Yes ☐ No If yes, list name of tax filer and your relationship to the tax filer: Name:_____ Relationship:_____	Are you filing jointly with your spouse? ☐ Yes ☐ No If yes, name of spouse: _____	Name: _____ Living with tax filer: ☐ Yes ☐ No Name: _____ Living with tax filer: ☐ Yes ☐ No Name: _____ Living with tax filer: ☐ Yes ☐ No Name: _____ Living with tax filer: ☐ Yes ☐ No Name: _____ Living with tax filer: ☐ Yes ☐ No Name: _____ Living with tax filer: ☐ Yes ☐ No

8. This question is not required for Food Stamps:
Is anyone in your household currently pregnant or has anyone been pregnant in the past 3 months? ..... ☐ Yes ☐ No

If yes, who?_____

Due date (if still pregnant): _____

If yes, how many babies are expected during this pregnancy? _____

Has she smoked or used tobacco in the past 6 months? ..... ☐ Yes ☐ No
(This question is for survey purposes only and does not affect eligibility)

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9. Is anyone in your household living in an institution? ..... ☐ Yes ☐ No
If yes, check which applies:
☐ Hospital/Medical Facility ☐ Shelter ☐ Drug/Rehab Center
☐ Group Home ☐ Nursing Home
☐ Jail - If yes, on work release? ..... ☐ Yes ☐ No

Who? _____ Name of institution: _____ Date entered the institution: _____

10. Does anyone in your household have a disability (a physical, mental or emotional health condition that causes limitations in activities like bathing, dressing, daily chores, etc.)? ..... ☐ Yes ☐ No

If yes, who? _____ Start date of disability:_____

Is the disability permanent or temporary? _____ If temporary, how long is it expected to last? _____

Disability/Incapacity determined by:
☐ SSA Disability Recipient ☐ SSI Recipient ☐ (VA) Veterans Affairs ☐ Medical Statement
☐ Railroad Retirement Board ☐ State Medical Disability Office ☐ Other: _____

If the disabled person is the parent(s), is he/she able to care for their children? ..... ☐ Yes ☐ No

Is the disabled person a child? ..... ☐ Yes ☐ No

11. This question is not required for medical assistance:
Has anyone in your household ever applied for or received Food Stamp, Financial or Medical Benefits in Utah or any other state? ..... ☐ Yes ☐ No

Name	Type of Assistance	Where? (list all states)	When?	Date Ended?

12. Answer the following question only for individuals who are applying for benefits:
If anyone in your household is not a U.S. Citizen or U.S. National, do they have eligible immigration status? ..... ☐ Yes ☐ No

If yes, complete all columns:

Name	Alien Registration Number	Immigration Document Type	Document ID Number (if different from A#)	Have you lived in the U.S. since 1996?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

This part of the question is not required for Food Stamps or Child Care:
Is anyone listed in question #11 a Veteran, an active-duty member of the U.S. Military or has a spouse or parent who is a Veteran or an active-duty member of the U.S. Military?..... ☐ Yes ☐ No

If yes, who? _____

13. Is anyone in your household attending school? ..... ☐ Yes ☐ No

If yes, complete all columns:

Name of Student	School Name / Type	Full Time / Part Time	Expected Graduation Date (If Over 16 Years Old)

14. This question is not required for Food Stamps:
Has anyone in your household applied for, received, or been denied Social Security income, Veterans Benefits, Unemployment or Workers' Compensation? ..... ☐ Yes ☐ No

If yes, who? _____ Benefit type: _____

15. This question is not required for medical assistance**:**
Is anyone in your household a fleeing felon? (Hiding or running from the law to avoid prosecution, being taken into custody, or going to jail, for a felony crime or attempted felony crime) ..... ☐ Yes ☐ No

If yes, who? _____

16. This question is not required for medical assistance:
Is anyone in your household violating a condition of parole or probation for a felony or misdemeanor?..... ☐ Yes ☐ No

If yes, who? _____

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INCOME

17. Does anyone in your household have earned income? ..... ☐ Yes ☐ No

If yes, complete all columns:

Employed Person	Employer Name	Date of Hire	Hours Worked Weekly	Hourly Rate or Monthly Salary (ex: $900/mo, $8/hr)	Additional Income (ex: Tips, Bonus, Commission)	How Often Paid (ex: weekly, monthly)

18. Is anyone in your household self-employed? ..... ☐ Yes ☐ No

If yes, complete all columns:

Self - Employed Person	Company Name	Business Start Date	% Owned	Type of Business (ex: LLC, S-Corp, 1099, etc.)	Hours Worked Monthly	Gross Monthly Income

Are there any self-employment expenses? ..... ☐ Yes ☐ No

Answering this question is only required for medical assistance: How much net income (profits once business expenses are paid) will you get from this self-employment this month? _____

19. Does anyone in your household expect any changes in earnings or in the number of hours worked? ☐ Yes ☐ No

If yes, who? _____ Explain change(s):_____

20. Has anyone in your household left a job or reduced work hours in the last 30 days? ..... ☐ Yes ☐ No

If yes, complete the following information:

If left a job:

Name: _____ Name of employer: _____

Last day worked: _____ Date of last pay check: _____

Reason the job ended: _____

If reduced work hours:

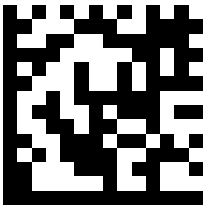
Name: _____ Name of employer: _____

Hours reduced from: _____ to: _____ Date of first pay check with reduced hours: _____

Reason hours reduced: _____

21. In the past year, did anyone in your household change jobs, stop working or start working fewer hours? …….. ☐ Yes ☐ No

If yes, who? _____ Explain change(s): _____



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22. Does anyone in your household receive the following types of educational income? ..... ☐ Yes ☐ No

If yes, complete all columns:

	Type	Recipient's Name	Amount Received	Number of Months Intended to Cover	Date Income Started
☐	Montgomery GI Bill				
☐	Stipend - Living Expenses				
☐	Veterans Educational				
☐	Work Study (Not Title IV)				

Are there any educational expenses? .... ☐ Yes ☐ No

If yes, complete all columns. Some examples of educational expenses are tuition, books, mandatory fees, transportation or the rental or purchase of equipment, materials and supplies.

Type	Amount	Who Pays This	How Often Paid	Date Expense Started

23. Does anyone in your household have any of the following types of income? ..... ☐ Yes ☐ No

If yes, complete all columns:

	Type	Recipient's Name	Amount Received	How Often Paid (ex: weekly, monthly)	Date Income Started
☐	Social Security				
☐	SSI				
☐	Child Support received directly from parent or another state				
☐	Child Support received through ORS				
☐	Unemployment State:				
☐	Money received from family, friends or church From who?				
☐	Retirement				
☐	Pension				
☐	Alimony				
☐	Veteran's Benefits				
☐	Workers Compensation				
☐	Tribal Income				
☐	Lump Sum Payments				
☐	Other income (Ex: Adoption, Mineral Rights, Rental, Royalty, Child and Adult Care Food Program payments etc.): _____				

Other than taxes, are any deductions being withheld from anyone's income listed? ……..... ☐ Yes ☐ No

If yes, complete the following information:

Name: _____ Type of deduction? _____ Deduction amount: $_____

Name: _____ Type of deduction? _____ Deduction amount: $_____

ASSETS*

* If applying for Medical Assistance - you are only required to answer these questions if there is anyone in your household who is applying for Aged (65+), Blind or Disabled Medicaid, Spenddown Medicaid, Nursing Home, Waiver, Medicare Cost Sharing, and/or Refugee Medical.

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24. Does anyone in your household have cash on hand? ……..…. ☐ Yes ☐ No

If yes, who? _____ Amount: $_____

25. Does anyone in your household have financial accounts? ..... ☐ Yes ☐ No

If yes, list all accounts owned by you or anyone applying with you. Some examples of financial accounts are Checking, Savings, 401K*, IRA*, Annuities, Money Market, Stocks/Bonds/Mutual Funds, etc.

** Not Required for Food Stamps*

Type	Account Owner(s)	Bank Name	Account Balance	Date Opened

26. Does anyone in your household have any vehicles? ..... ☐ Yes ☐ No

If yes, complete all columns. Some examples of vehicles are cars, trucks, boats or water craft, motorcycles, snowmobiles, motor homes, ATV's, etc.

Registered Owner(s)	Make	Model	Year	Licensed Yes/No	State	Amount Owed	Vehicle Use	Date of Purchase

27. Does anyone in your household have any of the following property assets? ..... ☐ Yes ☐ No

If yes, complete all columns:

	Type	Who Owns This?	Fair Market Value	Amount Owed	Date Acquired
☐	Home you live in				
☐	Land				
☐	Rental Home				
☐	Vacation Home/Time Share				
☐	Equipment/Tools				
☐	Machinery				
☐	Trailers				
☐	Livestock				
☐	Mineral/Other Rights				
☐	Other:				

28. Does anyone in your household have any of the following other assets? ..... ☐ Yes ☐ No

Mark all that apply: ☐ Life Insurance ☐ Trust ☐ Burial plot ☐ Burial Plan/Contract

If yes, who? _____

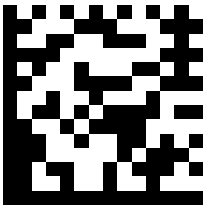
29. This question is not required for medical assistance**:**

Has anyone in your household sold, traded, or given away any assets in the last three months? ..... ☐ Yes ☐ No

If yes, explain: _____

_____

EXPENSES*



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* If applying for Medical Assistance - you are only required to answer these questions if there is anyone in your household who is applying for Aged (65+), Blind or Disabled Medicaid, Spenddown Medicaid, Nursing Home, Waiver, Medicare Cost Sharing, and/or Refugee Medical.

30. Does anyone in your household pay alimony, child support or daycare expenses? ..... ☐ Yes ☐ No

If yes, complete all columns:

	Type	Person Paying This Expense	Who For?	Amount Paid	How Often Paid?	Date This Started
☐	Alimony* Court ordered? ☐Yes ☐No **Not required for Food Stamps*					
☐	Child Support Court ordered? ☐Yes ☐No					
☐	Out-of-Pocket Daycare Name of daycare provider: _____ I need child care so I can: ☐ Accept/Continue Employment ☐ Seek Employment ☐ Attend School ☐ Attend Training ☐ Other:					

31. Is anyone in your household responsible to pay any of the following expenses? ……..…… ☐ Yes ☐ No

If yes, complete all columns:

	Type	Amount Paid	Who pays this expense?	Does this person live in your home? Yes/No	How often is this expense paid?	Date This Started
☐	Rent, Subsidized Rent, Rental Insurance					
☐	Mortgage, Second Mortgage, Home Equity Loan, Property Taxes					
☐	Home Owners Insurance, HOA, Condo Fees					
☐	Trailer/Lot Space					

32. Is anyone in your household responsible to pay any of the following utility expenses separately from rent and/or mortgage? ..... ☐ Yes ☐ No

If yes, mark all that apply:

☐	Gas or electricity for heating and/or cooling my home	☐	I received HEAT assistance in the last 12 months
☐	Telephone	☐	I am homeless. However, I pay some monthly heating/cooling expenses
☐	Electricity, Water, Sewer, Garbage		

33. Does anyone in your household who is at least 60 years old or disabled have any medical expenses? ☐ Yes ☐ No

(Expenses must be reported and some expenses must be verified by your household to receive a deduction.)

If yes, complete all columns:

	Type	Who For?	Person Paying This Expense	Amount Paid	How Often Paid?	Date This Started
☐	Dental Care, Dentures					
☐	Medical / Medicare Insurance					
☐	Hearing Aids					
☐	Home Health Care					
☐	Hospitalization or Outpatient Care					
☐	Medical Services					
☐	Mental Health Services					
☐	Nursing Home Care					
☐	Prescription Drugs					
☐	Prescription Eye Glasses					
☐	Service Animal (ex: Food, Veterinary bills, etc.)					
☐	Other:					

FINANCIAL ASSISTANCE SECTION

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34. Has anyone in your household been disqualified in any state from the TANF (Financial) program for a program violation? ..... ☐ Yes ☐ No

If yes, who? _____ State: _____

35. Has anyone in your household received out-of-state TANF months? …… ☐ Yes ☐ No

If yes, who? _____ State(s):_____ Number of months: _____

36. Are any children in your household home-schooled? ..... ☐ Yes ☐ No

If yes, who? _____ Is this school district approved? ..... ☐ Yes ☐ No

37. Do you have rent that is subsidized by any federal, state, or local government agency, including a private social service agency? ..... ☐ Yes ☐ No

If yes, select one: ☐ Public Housing Agency ☐ Other Agency

38. Is anyone in your household a Veteran? ……..……... ☐ Yes ☐ No

If yes, who? _____

39. Do you have child(ren) living in the home? ..... ☐ Yes ☐ No

If yes, are you willing to cooperate with the Office of Recovery Services (ORS) regarding establishment or collection of Child Support from an absent parent? ..... ☐ Yes ☐ No

List the name of the absent parent(s) and the name of the child(ren) of the absent parent.

Absent Parent Name: _____ Child(ren) of Absent Parent: _____

Reason for Absence:

☐ Single Parent Adoption ☐ Divorced ☐ Separated ☐ Legally Separated

☐ Death ☐ Incarceration ☐ Other: _____

Absent Parent Name: _____ Child(ren) of Absent Parent: _____

Reason for Absence:

☐ Single Parent Adoption ☐ Divorced ☐ Separated ☐ Legally Separated

☐ Death ☐ Incarceration ☐ Other: _____

CHILD CARE SECTION

40. Has anyone in your household been disqualified in any state from the Child Care program for a program violation? ..... ☐ Yes ☐ No

If yes, who? _____ State: _____

41. Does anyone in your household pay any of the following expenses? ..... ☐ Yes ☐ No

If yes, complete all columns:

	Type	Person Paying This	Who For?	Amount Paid	How Often Paid?	Date This Started
☐	Court-Ordered Alimony					
☐	Court-Ordered Child Support					

42. List the parents' work schedule. Enter the days and hours for the most recent work schedule, even if your schedule varies. (ex: Mon 8:00 a.m. to 5:00 p.m.)

Name	Employer	Sun	Mon	Tue	Wed	Thu	Fri	Sat

Is child care needed for every day worked? ..……..... ☐ Yes ☐ No

If no, what day(s) is care needed? _____

43. Is any parent in school or training? ..... ☐ Yes ☐ No

If yes, list school/training schedule(s). (ex: Mon 8:00 a.m. to 5:00 p.m.)

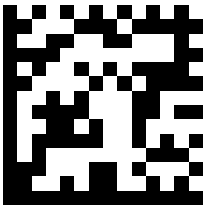
Name	School Name	Type of degree or certificate	Sun	Mon	Tue	Wed	Thu	Fri	Sat

Is child care needed on all days attending training? ..... ☐ Yes ☐ No

If no, what day(s) is care needed? _____

44. Do you have a Child Care provider? ..... ☐ Yes ☐ No

Name of Provider	Is this Child Care provider related to your child(ren)? Yes / No	Relation to Child(ren)



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45. For the children who need child care, do they have a disability or have a need for specialized care? (ex: needs special equipment, assistance with feeding, etc.)?..... ☐ Yes ☐ No

FOOD STAMP SECTION

46. Has anyone in your household been disqualified in any state from the Food Stamp program for a program violation? ..... ☐ Yes ☐ No

If yes, who? _____ State: _____

47. Has anyone in your household been sanctioned from the Food Stamp program due to non-participation in Employment and Training requirements? ..... ☐ Yes ☐ No

If yes, who? _____

If yes, does this person agree to participate? ..... ☐ Yes ☐ No

48. Are there any adults in your household who do not have a high school diploma or GED? ..... ☐ Yes ☐ No

If yes, who? _____

49. Is anyone in your household responsible for the care of a child under six? ..... ☐ Yes ☐ No

If yes, who is caring for the child? _____ Name of child: _____

50. Would it be a problem to obtain child care in order to participate in Employment and Training activities? ..... ☐ Yes ☐ No

If yes, explain: _____

51. Is anyone in your household responsible to care for a disabled person for 20 hours or more per week? ..... ☐ Yes ☐ No

If yes, who? _____

52. Has anyone in your household been unemployed in the last six months? ..... ☐ Yes ☐ No

If yes, who? _____

53. Has anyone in your household been temporarily laid off? ..... ☐ Yes ☐ No

If yes, explain: _____

54. Is anyone in your household on strike? ..... ☐ Yes ☐ No

If yes, who? _____

55. Is anyone in your household currently on probation or parole? ..... ☐ Yes ☐ No

If yes, are they required to complete court ordered activities (Ex: work release or drug court)? ... ☐ Yes ☐ No

Who? _____ What activities are required? _____

56. Is anyone in your household participating in a drug/alcohol treatment program? ..... ☐ Yes ☐ No

If yes, who? _____ Which program? _____

57. Is anyone in your household participating in any of the following programs: Vocational Rehabilitation, Older American programs, Easter Seals, Forestry program or Choose to Work? ..... ☐ Yes ☐ No

If yes, who? _____ Which program? _____

58. Is anyone in your household participating in refugee employment services? ..... ☐ Yes ☐ No

If yes, who? _____

59. Is anyone in your household experiencing domestic violence? ..... ☐ Yes ☐ No

If yes, who? _____

60. Is anyone in your household unable to access any type of public or private transportation? ..... ☐ Yes ☐ No

If yes, explain: _____

61. Does your household live more than 35 miles away from a DWS employment center? ..... ☐ Yes ☐ No

62. Are you homeless? ..... ☐ Yes ☐ No

63. Is anyone in your household receiving Food Stamps from another state? .... ☐ Yes ☐ No
If yes, who? _____ State: _____

64. Is anyone in your household a boarder? ..... ☐ Yes ☐ No
If yes, explain: _____

65. Is anyone in your household a foster child or foster adult? ..... ☐ Yes ☐ No
If yes, who? _____

66. Is anyone in your household a migrant or seasonal farm worker? ..... ☐ Yes ☐ No
If yes, who? _____

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67. Have you or anyone in your household been convicted of any of the following after September 22, 1996:

- Fraudulently receiving duplicate Food Stamp benefits in any state ..... ☐ Yes ☐ No
  If yes, who? _____ State: _____
- Buying or selling Food Stamp benefits over $500 ..... ☐ Yes ☐ No
  If yes, who? _____
- Trading Food Stamps for guns, ammunitions, or explosives ..... ☐ Yes ☐ No
  If yes, who? _____
- Trading Food Stamp benefits for drugs ..... ☐ Yes ☐ No
  If yes, who? _____

MEDICAL SECTION

68. Do you have child(ren) living in the home? ..... ☐ Yes ☐ No

If yes, are you willing to cooperate with the Office of Recovery Services (ORS) regarding establishment of medical support from an absent parent(s)? ..... ☐ Yes ☐ No

69. Is anyone in your household enrolled in or eligible for COBRA coverage or continued health insurance through an employer? ..... ☐ Yes ☐ No

70. Does anyone in your household currently have health insurance (including VA Health Care System benefits, Tricare or Peace Corps), have insurance available but not enrolled, or has had insurance in the past 6 months?.. ☐ Yes ☐ No

If yes, please complete the information below. *(Do not list Medicaid, Medicare, CHIP or PCN)*

Insurance 1: ☐ Enrolled

☐ Not Enrolled, but available (Complete Attachment C)

Date Ended: _____

Name(s) of individual(s) covered: _____

Name of insurance company: _____ Phone #: _____

Address of insurance company: _____ Group #: _____

Policyholder name: _____ Policy #: _____

Policyholder birth date: _____ Policyholder SS#: _____

If insurance is through an employer, list employer's name and phone #:

_____

Premium cost: $_____ Date due: _____ How often: _____

Type of Insurance: ☐ Medical ☐ Dental Start date: _____ Coverage: ☐ Limited ☐ Comprehensive

Is this a retiree health plan? ..... ☐ Yes ☐ No

Insurance 2: ☐ Enrolled

☐ Not Enrolled, but available (Complete Attachment C)

Date Ended: _____

D13314900001229

Name(s) of individual(s) covered: _____

Name of insurance company: _____ Phone #: _____

Address of insurance company: _____ Group #: _____

Policyholder name: _____ Policy #: _____

Policyholder birth date: _____ Policyholder SS#: _____

If insurance is through an employer, list employer's name and phone #:

_____

Premium cost: $_____ Date due: _____ How often: _____

Type of Insurance: ☐ Medical ☐ Dental Start date: _____ Coverage: ☐ Limited ☐ Comprehensive

Is this a retiree health plan? ..... ☐ Yes ☐ No

71. Does anyone in your household currently have Medicaid, CHIP or Medicare? If yes, check the type of coverage and write the person(s) name(s) next to the coverage they have.

☐ Medicaid: _____

☐ CHIP: _____

☐ Medicare: _____

72. Has anyone in your household been injured in an accident or been a victim of assault in the last 12 months? ..... ☐ Yes ☐ No

73. Is someone outside of your household required to pay for your household's medical services? ……. ☐ Yes ☐ No

74. Does anyone in your household have a major medical need? ..... ☐ Yes ☐ No
(This includes pregnancy/cancer/kidney disease, etc. Answering this question may get you extra help.)
If yes, who? _____ What is the medical need? _____

75. Does anyone help you pay mortgage/rent, food, or utility bills? ……,,….. ☐ Yes ☐ No

76. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? ..... ☐ Yes ☐ No

77. Has anyone in the household been in foster care at age 18 or older? ..... ☐ Yes ☐ No
If yes, who? _____

78. Deductions: Check all that apply, provide the amount, who received it and how often it's received. If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. **Note:** You should not include a cost that you already considered in your answer to net self-employment (question 18).

☐ Student loan interest: $_____ Who? _____ How often? _____

☐ Other deductions: $_____ Who? _____ How often? _____

79. Other income: Check all that apply, give the amount and how often you get it.

☐ Net farming/fishing: $_____ Who? _____ How often? _____

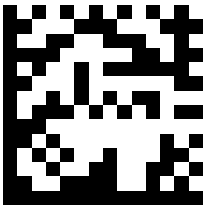
☐ Net rent/royalty: $_____ Who? _____ How often? _____

80. Yearly Income: Complete only if your income changes from month to month. If you do not expect changes to your monthly income, skip to the next question.

Total income THIS year: $_____ Total income NEXT year: $_____

81. What is your email address? _____

SIGNATURE SECTION



D13314900001329

I (print name) _____, read or had read to me the statements on the following pages, Rights and Responsibilities, and understand those statements. Under penalty of perjury, I certify that the information/answers I have given on this application are complete and correct to the best of my knowledge. I also certify that the citizenship and alien status information I provided is correct. I understand I can be penalized by law if I commit perjury by purposely giving false information on this application or fail to report changes. I am the person represented by the signature on this document.

Your Social Security number and all other information you give will be subject to verification by federal, state, and local agencies. The collection of this information is authorized under the Food and Nutrition Act of 2008 (formerly the Food Stamp Act). By signing this application, you are authorizing a release of information to conduct computer matches, program reviews, and audits with U.S. Citizenship and Immigration Services (formerly INS), coordination of services and other federal and state agencies. The submitted information received from USCIS may affect the household's eligibility and level of benefits. Your Social Security number may be disclosed to other Federal and State agencies for official examination, law enforcement officials for the purpose of apprehending persons fleeing to avoid the law, and private claims collection agencies. This also includes inquiries to any other organizations or individuals who may have eligibility information regarding you and other household members.

_____ _____

SIGNATURE (check one) ☐ Applicant ☐ Authorized Representative Date

_____

Birth Date of Authorized Representative (Food Stamps only)

Food Stamp, Financial and Child Care Representatives

You may choose an authorized representative to act on your behalf to assist you in the application, review, and/or change reporting process. Your designated authorized representative may assist you in obtaining and using your Food Stamp benefits. You may need to sign an additional Release of Information form to complete this process.

I would like to have an authorized representative: ..... ☐ Yes ☐ No

Name(s) of authorized representative: _____

Phone Number: _____ Address: _____

Type of Representative: ☐ Advocate ☐ Agency Representative ☐ ARC ☐ Relative ☐ Other

Does someone have legal power of attorney for anyone in your household? ..... ☐ Yes ☐ No

If yes, who? _____

Medical Representatives

Would you like to grant an authorized representative access to your case? ..... ☐ Yes ☐ No

If Yes, complete Attachment D

Complete the following information if you are a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

Application start date (mm/dd/yyyy): _____

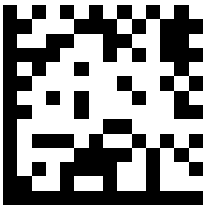
First name, Middle name, Last name, & Suffix: _____

Organization name: _____

ID number (if applicable): _____

Voter Registration Information

If you are not registered to vote where you live now, would you like to apply to register to vote here today? ..... ☐ Yes ☐ No



D13314900001429

- IF YOU DO NOT CHECK EITHER OF THESE BOXES, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

- If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided.

- 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 or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with Lt. Governor, State of Utah, 203 State Capitol Building, Salt Lake City, UT, 84114.

Medical Only

Renewal of Coverage in Future Years

To make it easier 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. I also agree to allow the Department of Workforce Services, the Department of Human Services and the Department of Health to use information from tax returns. I can opt out at any time. The Marketplace will send me a notice and let me make any changes.

Yes, renew my eligibility automatically for the next:

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☐ Do not use information from tax returns to renew my coverage.

ATTACHMENT A
AMERICAN INDIAN/ALASKA NATIVE HOUSEHOLD MEMBER INFORMATION

(Required only for Medical Assistance)

D13314900001529

Case Name: _____ Case#: _____

Complete this form if you or family members are American Indian or Alaska Native.
Submit this with your application for medical assistance.

Tell us about your American Indian or Alaska Native family member(s):
American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special month enrollment periods.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	**AI/AN PERSON 2**
1. Name (First name, Middle name, Last name	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes ☐ No **If yes**, tribe name: _____	☐ Yes ☐ No **If yes**, tribe name: _____
3. Has this person ever gotten a service from the 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 this person eligible to get services from the Indian Health Service, tribal health programs, urban Indian health programs or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, urban Indian health programs or through a referral from one of these programs? ☐ Yes ☐ No
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties. • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of the Interior (including reservations and former reservations). • Money from selling things that have cultural significance.	$ _____ How often? _____	$ _____ How often? _____

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DWS-ESD 741
10/2013

ATTACHMENT B
TAX DEPENDENTS NOT LIVING WITH YOU

(Required only for Medical Assistance)

D13314900001729

Case Name: _____ Case #: _____

Complete for dependents listed on your tax returns but NOT living in your household (if you have multiple dependents, please make copies of this page and attach it to your application).

1. Name: _____
First Middle Last

2. Relationship to you? _____ **3.** Date of Birth: _____

4. Sex: ☐ Male ☐ Female **5.** Social Security # (optional): _____

6. Is your dependent pregnant? …….. ☐ Yes ☐ No
If yes, how many babies are expected during this pregnancy? _____

7. Does your dependent have earned income? ..... ☐ Yes ☐ No
If yes, complete all columns:

Employer Name	Employer address and phone #	Date of Hire	Hours Worked Weekly	Hourly Rate or Monthly Salary (Ex: $900/mo, $8/hr)	Additional Income (Ex: Tips, Bonus, Commission)	How Often Paid (Ex: weekly, monthly)

8. In the past year, did your dependent change jobs, stop working or start working fewer hours? ..... ☐ Yes ☐ No

9. Does your dependent have self-employment income? ..... ☐ Yes ☐ No
If yes, complete all columns:

Company Name	Business Start Date	% Owned	Type of Business (Ex: LLC, S-Corp, 1099, etc.)	Hours Worked Monthly	Gross Monthly Income	Net income this month (profit once business expenses are paid)

Are there any self-employment expenses? ..... ☐ Yes ☐ No

10. Does your dependent receive any of the following unearned income? …….. ☐ Yes ☐ No
If yes, complete all that apply.

Type	Amount	How Often	Type	Amount	How Often
☐ Unemployment	$		☐ Alimony received	$	
☐ Pensions	$		☐ Other income Type:	$	
☐ Social Security	$		☐ None		
☐ Retirement accounts	$				

11. Deductions: Check all that apply, give the amount and how often your dependent gets it. If they pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.
Note: You should not include a cost that you already considered in your answer to net self-employment (question 9).

☐ Alimony paid	$	How often?	
☐ Student loan interest	$	How often?	
☐ Other deductions	$	How often?	

12. Other income: Check all that apply, give the amount and how often your dependent gets it.

☐ Net farming/fishing	$	How often?	
☐ Net rent/royalty	$	How often?	

13. Yearly Income: Complete only if your dependent's income changes from month to month.

Total income THIS year: $ _____ Total income NEXT year: $ _____

D13314900001829

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DOH Form 116M
05/2014

ATTACHMENT C
EMPLOYER'S HEALTH INSURANCE INFORMATION

D13314900001929

Case Name: _____ Case #: _____

You will need your employer or company's Human Resources representative to complete this form. Complete this form for each employed household member. You may copy this form. If you need more time to finish this form, please send us the rest of the application so that we can look at your application as soon as possible. However, in some situations, we will need the information from this form to help determine your eligibility. If you have questions regarding this form, please call 1-866-435-7414.

A. General Information

Employee Information

Employee Name: _____ Employee SSN#: _____
First M.I. Last

Employer Information

Employer Name: _____

EIN#: _____ Phone #: _____

Address: _____
Street Apt.# City State Zip

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

Contact Name _____

Phone #: _____ Email address: _____

☐ Yes ☐ No 1. Does your company offer health insurance? If no, skip to section D. Sign and return the form.

☐ Yes ☐ No 2. Is your health insurance a state employee benefit plan?

☐ Yes ☐ No 3. Is your health insurance offered through Avenue H?

☐ Yes ☐ No 4. Is the employee eligible to enroll in any insurance plan offered?
If no, please explain: _____
If yes, when is/was the employee eligible to enroll? (mm/dd/yy) _____

☐ Yes ☐ No 5. Is the employee or any family member enrolled in any insurance plan offered?
If yes, name(s) of persons enrolled: _____
_____
_____

☐ Yes ☐ No 6. Has this employee or any family member dropped/changed coverage in the last six months?
If yes, name(s): _____
If yes, when did coverage end/change? (mm/dd/yy) _____

☐ Yes ☐ No 7. Does the employer offer a health plan that meets the *minimum value standard?

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

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

b. How often? ☐ weekly ☐ every 2 weeks ☐ twice a month ☐ quarterly ☐ yearly

☐ Yes ☐ No 9. Do you know what change the employer will make for the new plan year?
If yes, complete the following:
☐ Employer won't offer health insurance
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the *minimum value standard. (Premium should not reflect the discount for wellness programs. See question 8.

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

b. How often? ☐ weekly ☐ every 2 weeks ☐ twice a month ☐ quarterly ☐ yearly

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

B. Employer's Least Expensive Plan or Avenue H Default Plan

D13314900002029

Questions below refer to the **employer's least expensive** plan or the **Avenue H Default Plan**.

☐ Yes ☐ No 1. Does the employee have to enroll in order to add their dependent(s)?

2. When will/did coverage begin? (mm/dd/yy) _____
3. When does the company's next open enrollment begin? (mm/dd/yy) _____
4. Complete the chart below. **Do not** include the cost of dental, vision or other coverage if it is separate.

Monthly Premium		
	Employee's Portion	**Company's Portion**
Employee	$	$
Employee + spouse	$	
Employee + child	$	
Family	$	

Yearly Health Plan Deductible	
Individual amount	$
Family amount	$

C. Employee's Health Plan Choice

Questions below refer to the plan that the employee has selected. Questions 3-7 refer to "in-network" benefits.

1. Insurance company and plan name: _____
2. Policy number, if known: _____

☐ Yes ☐ No 3. Is the deductible $2,500 or less per individual?

☐ Yes ☐ No 4. Is the lifetime maximum benefit $1,000,000 or more?

☐ Yes ☐ No 5. Does the plan pay at least 70% of an inpatient stay (after the deductible)?

6. What benefits are covered under this plan? (Check all that apply.)
   ☐ Physician visits ☐ Hospital inpatient services ☐ Pharmacy/Rx

☐ Yes ☐ No 7. Does the plan cover abortion services? If yes, under what circumstances:
   ☐ Only in the case where the life of the mother would be endangered if the fetus were carried to term or in the case of incest or rape.
   ☐ Other, please describe: _____

8. Complete this chart only if it is different from the chart in section B.
   Do not include the cost of dental, vision or other coverage if it is separate.

Monthly Premium		
	Employee's Portion	**Company's Portion**
Employee	$	$
Employee + spouse	$	
Employee + child	$	
Family	$	

Yearly Health Plan Deductible	
Individual amount	$
Family amount	$

☐ Yes ☐ No 9. Are the employee's children currently enrolled or do they plan to enroll in your company's dental plan? If yes, name(s): _____

D. Signature

I certify that I am a representative of the Human Resource Department, or that I am the health insurance contact person. The information on this form is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Name (please print): _____

Title: _____ Phone: _____

Please return completed form to:

Department of Workforce Services, PO Box 143245, SLC, UT 84114-3245
Fax: 1-801-526-9500 Toll-free Fax: 1-877-313-4717

Equal Opportunity Employer Program

Auxiliary aids and services are available upon request to individuals with disabilities by calling (801) 526-9240. Individuals with speech and/or hearing impairments may call Relay Utah by dialing 711. Spanish Relay Utah: 1-888-346-3162

DWS-ESD 114AR
Rev. 07/2013

ATTACHMENT D
AUTHORIZATION TO DISCLOSE MEDICAL ELIGIBILITY INFORMATION

D13314900002129

Customer Name	Social Security #	Case #	Date of Birth
_____	_____	_____	____/____/____

I _____hereby give
(Customer or Authorized Representative)

_____ the authority to:
(Name of Individual or Organization)

(check only one box)

☐ Receive Medicaid, CHIP, UPP, PCN or Buyout eligibility information regarding my current application, ongoing case or a recent case denial or closure. This authorization is effective from the date this form is signed to whichever of the following occurs first:

- **The following date: _____; or**
- **The medical application is denied*; or**
- **30 days from the month the medical program is closed*.**

*If the application is denied or the case is closed, information disclosure will continue throughout the fair hearing process.

☐ Speak or act on my behalf as an authorized representative, which includes receiving Medicaid, CHIP, UPP, PCN or Buyout eligibility information regarding my current application, ongoing case or a recent case denial or closure. This authorization is effective from the date this form is signed until a written notification to revoke the authorization is received by the Department of Workforce Services.

_____
Address and Phone Number of Authorized Representative

I understand that I may revoke this authorization at any time by sending a written notification to the Department of Workforce Services (DWS). I understand that a revocation is not effective to the extent that the Utah Department of Health, through its Division of Medicaid and Health Financing (DMHF) or the DWS has relied on the disclosed health information.

I understand my rights and responsibilities described in the Notice of Privacy Practices. For a duplicate Notice of Privacy Practices, access the following URL - http://health.utah.gov/hipaa/privacy.htm.

I understand that I may refuse to sign this authorization. I also understand that the DWS cannot deny eligibility for benefits if I refuse to sign this authorization.

I understand that giving an individual authorized representative power allows them to act on my behalf, which includes making changes to my medical case and any changes that they make, I may be liable for if an overpayment is incurred.

I understand that, once information is disclosed pursuant to this authorization, it is possible that it will no longer be protected by medical privacy laws and could be disclosed by the person or agency that receives it.
Note: DMHF and DWS will not disclose controlled documents without the consent of their Legal Departments.

By signing this form, I acknowledge I have been provided a copy of this signed authorization.

_____/_____
Signature of Customer, Legal Guardian or Authorized Representative Date

If signed by other than the customer; description of authority to serve: _____

_____

D13314900002229

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Important Application and Program Information
(Keep this information for your records)

D13314900002329

General Information

Application Processing
A decision about the program(s) you applied for will be made no later than 30 days from the date of application. Some medical benefit decisions may take longer.

Managing Your Application
You can manage your case information by using *my*Case at jobs.utah.gov.

- *my*Case can help answer questions about your case; you can access forms, view your notices, and keep track of your application.

You can send in your verifications by:

- Fax: 877-313-4717
- Mail: PO Box 143245, SLC, UT 84114-3245
- Email: imagingops@utah.gov
- Drop off at your local office

You may contact us by phone toll free 1-866-435-7414 or Salt Lake Valley 801-526-0950.

Interviews
Each program has different interviewing requirements. If you are required to complete an interview, you will receive a notice.

Paperwork and Verifications
To prevent delays in processing your case, turn in ALL requested verifications as soon as possible.

- Paperwork is imaged within 48 business hours after it is received and usually processed within 14 days in the order received.
- Your *my*Case account will show what verifications we have received and what is still missing. You can also use *my*Case to view decisions made on programs you have applied for.
- Ensure your case number is included on each page you provide.
- Your benefits may be prorated if the items and forms are not returned by the 30th day following the date of application.

If You Are Approved
You will receive your Financial, Food Stamp, and/or Child Care benefits on a Utah Horizon Card.
Your Medical card(s) will be mailed at initial program approval, upon request and every 36 months.

Utah Horizon Card EBT Basic Instructions
Call the Utah Horizon Card Helpdesk to activate your card and select your personal identification number (PIN). This telephone number will be located on the back of your card.

- Keep your Utah Horizon Card even if your case closes. This will save you time if you apply again for benefits in the future.
- If you are homeless or have no mailing address, your card will be sent to a post office near you marked for General Delivery.
- Keep your PIN secret and do not write it down on the card or card sleeve.
    - If you give the card and PIN to anyone, you will be responsible for any withdrawals made from the card.
    - If you lose the card or if it is stolen, report it immediately.

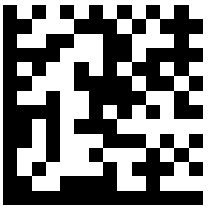
Utah Horizon Card Customer Service is available 24 hours a day, 7 days a week. Call the Helpdesk at (800) 997-4444 if:

- You need to check your balance.
- You need a replacement card because the card has been lost, stolen or is no longer working.
    - The replacement card will be mailed to you.
- You need to change your PIN for any reason.
- You have questions on how to use your card.
- The ATM does not give you the correct amount.

If you are eligible for Expedited Food Stamps and have not received your card within 7 days of your application, contact your local employment center. In all other cases where you did not receive your card, or if you did not receive your card due to an address change, call 801-526-0950 or 1-866-435-7414.

Our Programs
Financial, Medical, Child Care, and Food Stamp are temporary programs to assist you as you work towards increasing your family's income through employment, child support, and/or disability payments. DWS offers a wide range of employment preparation services in our offices to help as you look for work, including job referrals, workshops, mock interviews, resumes, Work Readiness Evaluations, and other services with a skilled DWS Employment Counselor. For more information on the services available or to connect with an Employment Counselor, contact your local DWS employment center.

Food Stamp Program



D13314900002429

When Food Stamps are Available

Food Stamp benefits are automatically added to your Food Stamp EBT account if your application is approved. For every month that you receive Food Stamp benefits, your benefits will be automatically deposited into your EBT account based on the first letter of your last name. Food Stamp benefits will be available on your assigned day even if it's a holiday or weekend.

Last Name Starts With	Date Available
A - G	5th
H - O	11th
P - Z	15th

Using your EBT Card for Food Stamps

You can use your EBT card like a debit card at most stores that sell food.

- Once the cashier has totaled the items you can buy with the EBT card, you will pass your EBT card through a point-of-sale (POS) machine in the checkout line and enter your PIN.
- The cost of the items you buy will be subtracted from the amount in your Food Stamp EBT account.
- Sales tax cannot be charged on items bought with Food Stamp benefits.

Keep your receipt to show the amount of your purchase and the amount of money left in your EBT account and for your records in case there are questions or problems with your account.

Households **CAN** use Food Stamps to buy:

- Unprepared food
- Breads and cereals
- Fruits and vegetables
- Meats, fish and poultry
- Dairy products
- Plants and seeds to grow food

Households **CANNOT** use Food Stamps to buy:

- Prepared items (Hot foods and food that can be eaten in the store)
- Beer, wine, liquor, cigarettes or tobacco
- Nonfood items:
    - Pet food
    - Soap
    - Paper products
    - Cleaning supplies
    - Vitamins and medicines
    - Personal hygiene items such as shampoo, deodorant, toothpaste, cosmetics

Reporting Changes

For Food Stamps, you must report changes in your income within 10 days of the change if it exceeds the income limit. If you are an Able-Bodied Adult without Dependents, you must also report if you are no longer working 20 hours per week at your job.

Participation in Food Stamp Employment & Training Activities

Once you are approved, you may be required to participate in employment and training activities to keep getting Food Stamp benefits. You may be required to:

- Register for work
- Complete required workshops
- Complete job search activities

If you are required to participate in additional activities, you will receive a notice.

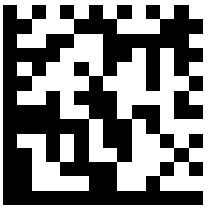
Participation in Able-Bodied Adults without Dependents Activities

Able-bodied adults are those who are healthy and have not had a doctor diagnose a disability and who do not have dependent children living in their home. The Food Stamp program allows able-bodied adults without dependent children to receive Food Stamp benefits for 3 months in a period of 36 months without participating in an able-bodied employment or training activity. After the initial three months, an able-bodied adult is required to participate in these activities unless they are exempt from participation. You may be required to:

- Register for work
- Meet with an Employment Counselor
- Complete worksite learning activities
- Complete job search activities

If you are required to participate in additional activities, you will receive a notice.

Financial Programs



D13314900002529

Financial Information

Financial assistance programs are temporary cash assistance aimed towards increasing income by focusing on employment, child support and/or disability payments.

All financial programs have time limits for the length of time you can receive benefits from the program.

- The time limits will vary depending on the program type.

Financial Participation

You WILL be required to participate in employment activities. You will need to meet with an employment counselor in creating an employment plan and goals that will help increase your household income.

- The employment plan will be based on your individual needs and goals.
- If you have children, you may be eligible for help to pay for child care while you participate in employment activities.
- A notice will be sent to you explaining how to contact an employment counselor.

You WILL be required to apply for all other financial benefits that you might be eligible for, such as:

- Social Security benefits
- Unemployment Compensation
- Veteran's benefits
- Workman's Compensation
- Insurance settlements
- Financial assistance programs from American Indian Tribes

How To Use Your Financial Benefits

For ALL financial programs, participation is required before payment is authorized.

- Most financial benefits are available on the first of the month.
- Payments for some programs are issued on the 5th and 20th of the month. Your employment counselor will let you know when you will receive your benefits.

Purchasing Items

You may use your card to buy the things you need at stores that accept EBT cards. You can also withdraw your cash benefits at most ATM's and store point-of-sale (POS) machines.

- A small transaction fee may be charged to your account.
- Stores may limit the amount of cash you can get back with a purchase.

If financial benefits are issued to your Utah Horizon Card account that you are not eligible to receive, the funds may be removed and returned to the State of Utah without prior notification to you of the removal. You will receive notification after the financial benefits have been removed.

Financial – Families with Children

You will be required to provide verification of your relationship to other family members in your home.

- Children between the ages of 6 and 18 are required to attend school full time.
- Children between the ages of 16 and 18 who are not in school must participate with an employment counselor.

Family Programs & Child Support

Child Support is an important element in increasing your family's income. When families receive adequate child support, they move further toward self-support.

- If you do receive child support for a child in your home, you will be required to turn your child support over to the State of Utah through the Office of Recovery Services (ORS).
- If you do not receive child support for a child in the home, you will be required to cooperate with the Office of Recovery Services to establish and collect child support from an absent parent.

Financial – Without Children

General Assistance Program

You may be considered for this program if you have a medical impairment that prevents working in any occupation for 60 days or longer from the date of the application.

- DWS will provide you with a medical form to be completed by a doctor or licensed health care professional.

Refugee Cash Assistance

If you are not a U.S. Citizen but you have an immigration status of refugee or asylee and you received this status within the last 8 months, you may be eligible for this program.

- You will be required to provide verification of your immigration status.

Child Care Programs

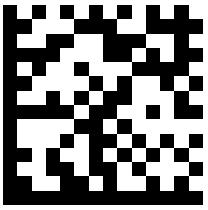
Child Care Information

Child Care assistance is a subsidy program that helps parents pay a provider for watching their children while the parent is at work or in school.

- You are responsible to pay all costs charged by the provider. If the child care subsidy is less than the amount charged, you are responsible for the difference.
- Once approved for Child Care, the payment will be available to pay your provider at the beginning of each month.

Eligibility for Child Care Assistance
Your household must include an eligible child under the age of 12 and/or a special needs child under the age of 18.

- A single parent must be working an average of 15 hours per week.
- In a two-parent family: one parent must work an average of 15 hours per week, and the other parent must work an average of 30 hours per week.
- Child Care may also be approved for training if the parent(s) meet the minimum work requirements and can complete the training within 24 months. Additional information will be required.



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Selecting a Child Care Provider
You have the right to select the type of child care provider which best meets your family needs.

- Go to careaboutchildcare.utah.gov to search online for providers in your area and learn more about child care and what to look for in a child care setting.
- You may also contact your local Care About Childcare agency for help finding a provider.
    - Call the Child Care Professional Development Institute toll free at 855-531-2468 to find your local Care About Childcare agency.

If you select an unlicensed provider such as a relative:

- Your provider must complete the following requirements to be approved as a provider for your child.
    - Your provider and their household members age 12 and older must pass a criminal background check completed by Child Care Licensing.
    - Your provider must complete all Health and Safety requirements administered by Child Care Licensing.
- If you select a provider who is not related, lives with you, or does not meet the relationship definition an exemption will need to be granted by a DWS Specialist.

Provider Payments
Payments to your child care provider will depend on what type of provider you select.

- If you select a **licensed provider**, the money will be deposited into a child care account on your Utah Horizon EBT Card. You can swipe the card at their point-of-sale machine or transfer funds to them over the phone.
    - For phone transfers, you will need to ask them for their EBT Merchant ID number, call the toll free number on the back of your EBT card, and follow the prompts to make a child care provider payment transfer.
    - For step by step instructions go to Transferring Child Care Benefits with Interactive Voice Response (IVR) located at http://jobs.utah.gov/customereducation/services/childcare/paying_provider.html.
- If you select a **family member, friend or neighbor** as your provider, you will receive a two-party check as payment.

NOTE: Always check *my*Case to see how much money has been authorized for your child care provider(s) before paying them. The child care subsidy should only be used to pay an approved provider for an approved month of service. Any unused child care money on your Utah Horizon Card should NOT be used to pay for unauthorized months of child care services or to an unapproved provider. Using funds this way may result in an overpayment to DWS.

Required Documents
After you have selected a child care provider you will need to complete and return the following child care forms:

- **Licensed Providers:** Form 980– Child Care Subsidy Worksheet
- **Family, Friend or Neighbor:** Form 980 – Child Care Subsidy Worksheet and Form PRO1– License Exempt Provider Registration

These forms will be mailed to you and are located in *my*Case to print at any time.

Other Information

UTA Discount Bus Passes
You can use the cash value on your Utah Horizon Card to purchase a discounted adult monthly pass.

- Available for use on the UTA system anywhere between Payson and Brigham City.
- The pass is good for unlimited travel on local buses and TRAX for one calendar month.
    - This discounted fare applies to passengers ages 18-64.
- Two children ages 5 and younger may accompany the adult passenger with a monthly pass.
- Additional fare will be required on express and premium services.

To find out where you can buy a discounted bus pass with the cash value on your Utah Horizon Card visit your *my*Case account and click on the UTA link.

Helpful Websites for Other Services
General

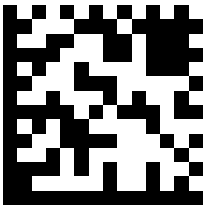
- Jobs.utah.gov: http://jobs.utah.gov
- 2-1-1 Information & Referral: www.uw.org/211
- Local Employment Center: http://jobs.utah.gov/regions/ec.html
- Unemployment Insurance: https://jobs.utah.gov/ui/ContinuedClaims/UIAccountHome.aspx
- Voter Registration: https://secure.utah.gov/voterreg/index.html
- Food Stamp, Financial and Child Care Policy: http://jobs.utah.gov/infosource/eligibilitymanual/eligibility_manual.htm

Food Assistance

- Food Stamps Brochure (#313): http://snap.ntis.gov/pdf/313E.pdf
- WIC: http://health.utah.gov/wic/
- Nutrition Education: http://extension.usu.edu/foodsense/

Financial

- ORS/Child Support: www.ors.utah.gov
- Adoption Assistance: http://jobs.utah.gov/customereducation/services/financialhelp/adoption/index.html



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Child Care

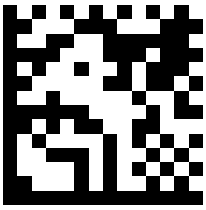
- For more information: jobs.utah.gov/occ/index.html
- Transferring Child Care Benefits with Interactive Voice Response (IVR): http://jobs.utah.gov/customereducation/services/childcare/paying_provider.html
- Search for quality child care: http://careaboutchildcare.utah.gov

RIGHTS AND RESPONSIBILITIES

YOUR RIGHTS

- You have the right to be treated fairly and with courtesy, dignity, and respect.
- You have the right to an interpreter.
- The U.S Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)
- If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.
- Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).
- For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call 1-866-526-3663 or 1-800-371-7897; found online at http://www.fns.usda.gov/snap/contact_info/hotlines.htm.
- USDA is an equal opportunity provider and employer.
- In accordance with Federal law and U.S. Department of Health and Human Services (DHHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. To file a complaint of discrimination, visit www.hhs.gov/ocr/office/file.
- Title VI of the Civil Rights Acts of 1964 allows us to ask for racial/ethnic information. You do not have to give us racial/ethnic information. If you do not want to give us this information, it will have no effect on your case. If you do not give us the information, the worker will enter an answer. This information is collected to ensure program benefits are issued without regard to race, color, or national origin.
- You have the right to apply or reapply any time for any of the assistance programs offered by the Department of Workforce Services (DWS). Applications for CHIP, the Primary Care Network program (PCN), and UPP are only accepted during open enrollment periods.
- You have the right to know if your application was approved or denied and the reasons for the decision.
  - For Food Stamps - benefits must be available to eligible household members no later than 30 days from the date of application.
  - For Medicaid, Financial and Child Care assistance, a decision will be provided within 30 days. If a disability decision is required for Medicaid approval may take up to 90 days.
  - For PCN/UPP/CHIP, a decision will be provided within 30 days.
  - Your application will be considered for all programs selected. You may receive separate approval and/or denial notices based on the individual program rules on your application.
- You have the right to know if your assistance is reduced or ended. For Food Stamp benefits, there is one important exception to this rule. You will not receive advance notice of a Food Stamp benefit decrease if approved for financial assistance.
- If you are in an institution and apply for Food Stamps and SSI at the same time, the filing date for Food Stamps will be the date of release from the institution.
- You have several options if you do not agree with the decisions made regarding your case, you may:
  - Talk to your worker to make sure you are not misunderstanding each other.

- Talk to your worker's supervisor.
- Call DWS Customer Relations at: 801-526-4390 or 800-331-4341.
- Request a Fair Hearing verbally or in writing with an impartial Hearing Officer. You must provide a written request for Fair Hearing for Medical assistance. You may choose to be represented at a Fair Hearing by legal counsel, a relative, friend, or other spokesperson.
- Free legal advice is available from Utah Legal Services, 801-328-8891 or toll free at 800-662-4245. A referral for legal advice is available from Salt Lake Lawyer Referral at 801-531-9075.



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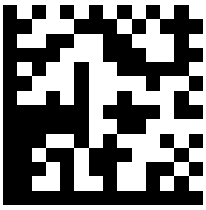
- You have the right to privacy in your home. DWS may not enter your home without your permission or use coercion or force to enter your home. DWS may not visit you after working hours without an appointment.
- The Department of Workforce Services may contact you, or have someone contact you, about the effectiveness of services you received.
- You have the right to access your case record information.
- You have the right to receive information regarding registering to vote and may request help to complete the voter registration form.
- The information you provide on your application may be disclosed to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law.
- When your income has increased enough that you no longer get financial assistance, you may continue to get medical assistance, Food Stamps, and Child Care if you meet certain requirements. Ask your employment counselor for more information.

YOUR RESPONSIBILITIES

- Medical assistance (Medicaid, CHIP, UPP, PCN) recipients are automatically enrolled in the Utah Clinical Health Information Exchange (cHIE). For more information or to opt out of cHIE participation, visit www.mychie.org or contact your health care provider.
- You must report changes that affect your eligibility for assistance programs. Your worker will provide you specific information on changes you must report when your application is approved.
- You must provide the Social Security number for each household member requesting assistance, with the exception of Child Care, CHIP and Emergency Medicaid. If you do not have a number, you must provide proof of applying for a number. You can receive assistance while you are waiting to receive a number.
- You must cooperate with any review of your case by Quality Control and/or DWS.
- You must provide the information necessary to prove you are eligible for assistance. If you do not understand what is required, or if you cannot give the necessary information, please let your worker know.
- You must report to us if you are fleeing the law to avoid prosecution, being taken in to custody, or going to jail for a felony crime, or violating conditions of probation or parole.
- If you are approved for financial assistance, you will need to sign over to the Office of Recovery Services any child support, medical support, or alimony you would have received on behalf of your household during the time you are getting assistance. Child support and alimony will be used to offset the costs of providing financial assistance for your household.
- If you receive medical assistance, you must tell DWS, if you have health insurance. You may be required to enroll in a medical health plan.
- Parents have the responsibility to support their minor children until they are emancipated by turning age 18, married, or otherwise directed by court order. Parents who receive financial or medical are required to cooperate with child and medical support orders and collections, unless you can provide good cause for not cooperating.
- If the Utah Department of Health (UDOH) pays for your medical care, you assign to it your rights to payments from any third party and to benefits for medical services. You will give to the UDOH any money you collect from an insurance policy, legal settlement or from someone required to pay for your medical expenses. You authorize payment directly to the UDOH or the Office of Recovery Services and will hold harmless any party making payment to them. You agree to cooperate with the State of Utah to pursue any third party responsible for medical expenses.
- You authorize any person or organization to release medical records or information about your health or the health of your dependents to the UDOH, Division of Health Care Financing or designee. The UDOH and the Department of Workforce Services may give health care providers information about your eligibility for medical assistance.
- In the event of my death and my spouse's death, the state has the right to recover from my estate all money spent to pay my medical bills if I receive PCN and/or Medicaid at any time while I am 55 years of age or older. The state does not have the right to recover from my estate those costs paid as a benefit of eligibility for a Medicare cost-sharing program (QMB, SLMB, or QI).
- You agree that the assistance you receive under any medical program is limited to that described in the Provider Manuals that the Utah Department of Health has written. You understand that the benefits you are eligible to receive may be changed without your knowledge or consent. You further agree to be responsible for any co-pays to providers at the time of medical service unless you are exempt from those co-pays.
- Children enrolled in Medicaid are automatically enrolled in the Utah Statewide Immunization Information System (USIIS). If you do not want your children enrolled in this system, you must call the USIIS HelpLine at 801-538-6872 or the Immunization Hotline at 1-800-275-0659.

- If you receive benefits for which you are not eligible, you must pay them back.
- If you choose a license-exempt child care provider, the State of Utah does not regulate or monitor the child care. We can give you more information about how to choose a quality child care provider.



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VERIFICATION OF INFORMATION

- For all those applying for benefits, your Social Security number, as well as other information you give us, will be subject to verification using the State Income and Eligibility Verification System. DWS will ensure that your household is eligible for Food Stamps and other federal assistance programs through electronic matches. Computer matching, program reviews and audits will be conducted with DWS, Department of Homeland Security, Social Security Administration and Internal Revenue Service records. It also includes inquiries to banking and loan institutions and any other organizations or individuals who may have eligibility information regarding you and other household members. Your application may be denied and you could be subject to criminal prosecution if you intentionally provide false information. The submitted information received from USCIS may affect the household's eligibility and level of benefits.
- Computer matches will be completed when you apply and after you receive assistance. Your Food Stamp, Financial, Child Care and Medical benefits may be reduced, denied or terminated because of information from these sources. Information provided on your application will be verified using Federal, State, and Local resources. Your application for Food Stamps may be denied and/or you could be subject to criminal prosecution if you intentionally provide false information.

OBEY PROGRAM RULES

- All the members of your household must obey the program rules and provide complete and accurate information. Do not provide false information in order to receive benefits. Do not give Food Stamp benefits to anyone who has no right to use them or purchase ineligible items. Do not use other individuals' Food Stamp benefits unless you are the authorized representative.
- Do not trade or sell an EBT card. Do not use Food Stamp benefits to buy nonfood items, such as alcohol, cigarettes, or to pay on credit accounts. Using Food Stamp benefits to purchase food on credit could result in a disqualification.
- **If you break any of these rules, you may be disqualified from receiving Food Stamp benefits, Child Care or Financial Assistance.**
  - **The first time you violate a rule, you may not be eligible for these benefits for 12 months.**
  - **The second rule violation may result in a 24 month disqualification.**
  - **The third time, you may be ineligible permanently for Food Stamp, Child Care or Financial program benefits. You may also be prosecuted under other laws.**
  - **There may also be a fine up to $250,000 or a jail sentence up to 20 years.**
  - **The court may also order an additional 18 months of Food Stamp ineligibility if convicted of a felony or misdemeanor related to inappropriate use of Food Stamp benefits.**
  - **If a court of law finds you guilty of using or receiving benefits in a transaction involving the sale of a controlled substance, you will not be eligible for benefits for two years for the first offense, and permanently for the second offense.**
  - **If a court of law finds you guilty of having used or received benefits in a transaction involving the sale of firearms, ammunition or explosives, you will be permanently ineligible to participate in the Program upon the first occasion of such violation.**
  - **If a court of law finds you guilty of having trafficked benefits for an aggregate amount of $500 or more, you will be permanently ineligible to participate in the Program upon the first occasion of such violation.**
  - **If you are found to have made a fraudulent statement or representation with respect to the identity or place of residence in order to receive multiple Food Stamp benefits simultaneously, you will be ineligible to participate in the Program for a period of 10 years.**
- Knowingly providing false information or fraudulent participation in any program may result in criminal or civil action and/or administrative claims.
- If you sell food you purchased with your Food Stamp benefits, you will be disqualified from the Food Stamp program for 12 months for the first offense, 24 months for the second offense, and permanently for any additional offenses.
- You will be disqualified for Food Stamps, Financial and Child Care programs for 10 years each for the first and second offenses if you make a fraudulent statement regarding your identity and residence to get multiple benefits. The third offense will result in permanent disqualification.
- An EBT card cannot be used to access cash benefits at a Point-of-Sale or ATM machine in an establishment that primarily sells liquor, allows gambling or gaming, or provides adult-oriented entertainment where performers disrobe or perform unclothed.
- A customer who access FEP cash benefits at one of the above establishments may be disqualified from Family Employment Programs for 12 months for an intentional program violation.