DWS-ESD 61APP
Rev. 03/2025

State of Utah
Department of Workforce Services

APPLICATION FOR SNAP, 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/mycase

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Check the services you are applying for:

☐ SNAP (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): _____

Do you speak English? ☐ Yes ☐ No If no, what is your primary language? _____

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 and SNAP 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 benefits have a Utah Medicaid medical card? ..... ☐ Yes ☐ No
If no, who needs a card*?* _____

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

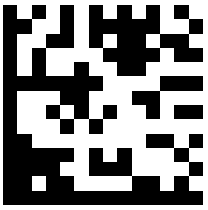
Your Rights:

- **IF YOU NEED HELP FILLING OUT THIS APPLICATION, WE ARE HAPPY TO HELP.**
- **YOU HAVE THE RIGHT TO AN INTERPRETER AT NO CHARGE.**
- Translation services are available if you require additional assistance during the application process.
- SNAP 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 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, 4 – 5, 7 – 10, 12 - 30, the Financial Section AND sign page 13**.
  - In order to file a Child Care assistance application, you **must** complete questions **1, 4 – 5, 7 – 9, 12, 14 – 23, 30, 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.

SNAP, Financial, Child Care and Medicaid Information for Immigrants:

- You can apply for and receive SNAP, Financial, Child Care 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 SNAP 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 SNAP benefits because of immigrant status and who are not asking for SNAP benefits. Family members who are not eligible for SNAP, Financial or Medicaid benefits will still need to answer other questions about their name, relationship, income, assets, etc.

- Using Medicaid and Financial benefits may affect your immigration status or the immigration status of your family. Immigration information is private and confidential.
- Using Child Care benefits will not be considered in public charge determinations. Immigration is private and confidential.
- Using SNAP benefits does not affect your immigration status or the immigration status of your family. Being a SNAP applicant or recipient will not affect your ability to remain in the United States, get a green card or lawful permanent resident status, or become a U.S. citizen.
- In order to determine your eligibility for SNAP, complete questions 1, 4 – 5, 8 – 25, 27 - 33, the SNAP section and sign page 13.
- Use of Medical benefits by you or your family members should not affect your ability to apply or 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?
  - For adults who need coverage, include, even if they are not applying for coverage, the following individuals: spouse, children/stepchildren under age 21 and anyone else you claim on your federal tax return. You do not need to file a tax return to receive medical coverage.
  - For children under age 21 who need coverage, include, even if they are not applying for coverage, the following individuals: spouse, parents/stepparents, siblings that live with you and any children/stepchildren.
- Marketplace: Information obtained from this application could also be used to determine your eligibility for comprehensive health insurance through the marketplace as well as Advanced Premium Tax Credits (APTC). An APTC is a tax credit that can help pay your premiums for health coverage. For more information, visit www.healthcare.gov
- 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 SNAP 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 SNAP 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/ Eligible Non-Citizen Yes/No	Gender M / F	Relationship	Utah Resident Yes/No	Utah Resident Since[2] (ex: 07/14/13)	Ethnicity[4, 6]	Race[3,6]	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 800-772-1213 or visit socialsecurity.gov. TTY users should call 800-325-0778. A Social Security number is not required for Child Care. Eligibility for Child Care will not be denied due to not providing a Social Security Number.

[2] Utah Resident 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 SNAP

[6] For SNAP and Medicaid: 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 SNAP and Medical. For Financial: This is required information for the application.

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? (applicable to SNAP only)
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

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6. Answering this question is only required for medical assistance: Please have each adult answer the following questions to help us select the correct program for your household. 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.

Adult 1:

a. Do you plan to file a Federal income tax return next year? …… ☐ Yes ☐ No
If yes, answer questions b – d. If no, skip to question d.
You can still apply for coverage even if you don't file a Federal income tax return.

b. Will you file jointly with a spouse? …….. ☐ Yes ☐ No
If yes, write spouses name: _____

c. Will you claim any dependents on your tax return?..... ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

_____

d. Will you be claimed as a dependent on someone's tax return? …….. ☐ Yes ☐ No
If yes, list the name of the tax filer: _____
How are you related to this tax filer? _____

Adult 2 (do not complete if Married Filing Jointly with the person above):

a. Do you plan to file a Federal income tax return next year?…… ☐ Yes ☐ No
If yes, answer questions b – d. If no, skip to question d.
You can still apply for coverage even if you don't file a Federal income tax return.

b. Will you file jointly with a spouse? …….. ☐ Yes ☐ No
If yes, write spouses name: _____

c. Will you claim any dependents on your tax return?..... ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

_____

d. Will you be claimed as a dependent on someone's tax return? …… ☐ Yes ☐ No
If yes, list the name of the tax filer: _____
How are you related to this tax filer? _____

7. This question is not required for SNAP:
Is anyone who is applying for benefits currently pregnant or has anyone been pregnant in the last 3 months? ..... ☐ Yes ☐ No

If yes, who? _____
Due date (if still pregnant): _____
How many babies are expected during this pregnancy? _____

Has the pregnant woman smoked or used tobacco in the past 6 months?..... ☐ Yes ☐ No
(Information about tobacco use among pregnant women is needed only to determine potential eligibility for tobacco programs. Response to this question is optional.)

8. Is anyone who is applying for benefits 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: _____ Anticipated release date (if known): _____

9. Does anyone who is applying for benefits 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? ☐ Permanent ☐ Temporary

If temporary, how long is it expected to last? _____

Disability/Incapacity determined by:

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

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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

For Financial only: Does the disability prevent the individual from working for 60 days or longer in any occupation?..... ☐ Yes ☐ No

10. This question is not required for Medical assistance or Child Care:
Has anyone in your household ever applied for or received SNAP, Financial or Medical benefits in Utah or any other state? ..... ☐ Yes ☐ No

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

11. If anyone in your household has an eligible immigration status and is applying for benefits, complete the chart below:

Name	Alien Registration, A number/USCIS #, or I-94 Number	Immigration Document Type	Sponsored Non-citizen Yes/No	Have you lived in the U.S. since 1996?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

This question is not required for SNAP:
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? _____

12. 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)

13. This question is not required for Medical or Child Care assistance:
Is anyone in your household a Veteran? ..... ☐ Yes ☐ No

If yes, who? _____

14. 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? _____

INCOME

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

If yes, complete all columns:

Employed Person	Employer Name and/or Payroll Company	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)
				$		
				$		
				$		

This question is only for Child Care assistance:
If your job began in the last 30 days, what is the date and amount you expect to receive on your first check? _____

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

If yes, complete all columns. (Self-employment also includes income from DoorDash, Uber, Instacart, SudShare, etc.)

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

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

This question is only required for medical and Child Care assistance:
If yes, 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): _____

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

If yes, complete all columns:

	Type	Recipient's Name	Gross (before deductions) 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 receive any of the following types of income? ☐ Yes ☐ No

If yes, complete all columns:

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	Type	Recipient's Name	Gross Amount (before deductions) 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 you or anyone applying for coverage is aged, blind, or disabled, living in a nursing home, applying for a Medicaid waiver program or if you are over the income for the other Medicaid programs. While these questions are optional to answer upfront for medical, providing this information now will help us to process your application more quickly.

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, Electronic Payment Apps such as Apple Cash, PayPal, Venmo, etc. ** Not Required for SNAP*

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	State	Amount Owed	Vehicle Use	Date of Purchase
				☐ Yes ☐ No		$		
				☐ Yes ☐ No		$		
				☐ Yes ☐ No		$		

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		$	$	
☐	Other property (ex: land, rental home, vacation home/time share, mineral/other rights, etc.): _____		$	$	
☐	Trailers		$	$	
☐	Other (ex: equipment/tools, machinery, livestock, etc.): _____		$	$	

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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*

* If applying for Medical Assistance, you are only required to answer these questions if you or anyone applying for coverage is aged, blind, or disabled, living in a nursing home, applying for a Medicaid waiver program or if you are over the income for the other Medicaid programs. While these questions are optional to answer upfront for medical, providing this information now will help us to process your application more quickly.

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

If yes, complete all columns:

	Type	Who Pays This Expense?	Who is This Expense For?	Amount Paid	How Often Paid?	Date This Started
☐	Alimony* Court ordered?... ☐Yes ☐No **Not required for SNAP*			$		
☐	Child Support Court ordered?... ☐Yes ☐No			$		
☐	Child Care			$		
	Is someone else helping you pay this expense (family member, organization, state agency, etc.)?... ☐ Yes ☐ No If yes, who? _____ Monthly Amount: $ _____ Name of child care provider: _____ I need child care so I can: ☐ Accept/Continue Employment ☐ Seek Employment ☐ Attend Training ☐ Attend School ☐ Other: _____					

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

If yes, complete all columns:

	Type	Amount Paid	Your Portion	Who Pays This Expense?	Does This Person Live in Your Home?	How Often Paid?	Date This Started
☐	Rent, Subsidized Rent, Rental Insurance	$	$		☐ Yes ☐ No		
☐	Mortgage, Second Mortgage, Home Equity Loan, Property Taxes	$	$		☐ Yes ☐ No		
☐	Home Owners Insurance, HOA, Condo Fees	$	$		☐ Yes ☐ No		
☐	Trailer/Lot Space	$	$		☐ Yes ☐ No		

Is someone else helping you pay this expense (family member, organization, state agency, etc.)?... ☐ Yes ☐ No

If yes, who? _____ Monthly Amount: $ _____

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 ☐ Telephone

☐ I received HEAT assistance in the last 12 months ☐ I am homeless

☐ Electricity, Water, Sewer, Garbage

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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 is This Expense For?	Who Pays 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

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. Does any child who is applying for coverage have a parent living outside 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

☐ Incarceration ☐ Death ☐ Other: _____

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

Reason for Absence:

☐ Single Parent Adoption ☐ Divorced ☐ Separated ☐ Legally Separated

☐ Incarceration ☐ Death ☐ Other: _____

39. If you are a specified relative, do you want to be included in the financial grant with the relative child? ..... ☐ Yes ☐ No

40. Do you or anyone in your household currently live in a treatment or substance abuse facility? (i.e. mental or drug) ……. ☐ Yes ☐ No

If yes, who? _____ Name of Facility: _____

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CHILD CARE SECTION

41. Is child care needed when a parent works?..... ☐ Yes ☐ No

If yes, how many hours per week of child care do you need while you work?

Parent Name: _____ Weekly Hours: _____

Parent Name: _____ Weekly Hours: _____

For two-parent households, how many weekly hours of child care do you need while you work and neither parent is available to care for your children? _____

42. Is child care needed when a parent attends training/school?..... ☐ Yes ☐ No

If yes, how many hours per week of child care do you need while in training/school?

Parent Name: _____ Weekly Hours: _____

Parent Name: _____ Weekly Hours: _____

For two-parent households, how many weekly hours of child care do you need while you attend school/training and neither parent is available to care for your children? _____

Parent Name: _____ School Name: _____

Type of Training/degree: _____

Will this parent complete the training within 24 months?..... ☐ Yes ☐ No

Is this schooling/training funded by WIOA (Workforce Innovation & Opportunity Act) or TANF Non-FEP? ☐ Yes ☐ No

Parent Name: _____ School Name: _____

Type of Training/degree: _____

Will this parent complete the training within 24 months?..... ☐ Yes ☐ No

Is this schooling/training funded by WIOA (Workforce Innovation & Opportunity Act) or TANF Non-FEP? ☐ Yes ☐ No

43. Do you share custody or visitation of any of the children with an absent parent? ……..…… ☐ Yes ☐ No

If yes, provide the following information:

Name of absent parent _____

Names of child(ren) shared with absent parent _____

Explain your current custody/visitation schedule _____

_____

44. Does any child needing child care have an absent parent paying any part of the child care expense? ☐ Yes ☐ No

If yes, does the absent parent pay any part of the child care expenses? …… ☐ Yes ☐ No

If yes, provide the following information:

Name of absent parent _____Amount paid monthly? _____

Who is the amount listed above paid directly to? ☐ Provider ☐ Parent/Caretaker/Relative

Comments _____

45. Have you selected a provider? ……..……..……..…… ☐ Yes ☐ No

(If you have not selected a child care provider, you can go to *https://jobs.utah.gov/jsp/cac/welcome* to search online for licensed providers in your area.)

If yes, has your selected provider agreed to care for your child(ren)? …….. ☐ Yes ☐ No

- If yes, complete the information below on the child care provider.
- If no, contact your provider to obtain the information.

Name of Provider and Phone Number	Are They a Family, Friend, or Neighbor Provider*?	List the Child(ren) Being Cared for by This Provider	Date Child(ren) Began Being Cared For By This Provider
	☐ Yes ☐ No		
	☐ Yes ☐ No		

**Read the Child Care Customer Education section if selecting a Family, Friend, or Neighbor provider.*

46. Do your total assets exceed one million dollars? ……..…… ☐ Yes ☐ No

47. Is anyone applying for Child Care assistance an active-duty member of the U.S. military? ….…… ☐ Yes ☐ No

48. Is anyone applying for Child Care assistance a member of either a National Guard unit or a Military Reserve Unit? ……..…… ☐ Yes ☐ No

49. Do you consider yourself homeless? ……... ☐ Yes ☐ No

(Some examples of homelessness are: living in a motel, hotel, camping grounds, or not having a fixed, regular, and adequate nighttime residence.)

50. Does your child have a disability? …… ☐ Yes ☐ No
(a) Does your child have a specialized need for care? ..... ☐ Yes ☐ No
If yes, who? _____

51. Do you receive tribal child care benefits? …… ☐ Yes ☐ No
If yes, which tribe or agency: _____

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SNAP SECTION

52. Has anyone in your household been disqualified in any state from SNAP for a program violation? ☐ Yes ☐ No
If yes, who? _____ State: _____

53. Has anyone in your household been sanctioned from SNAP due to non-participation in Employment and Training requirements..... ☐ Yes ☐ No
If yes, who? _____
If yes, does this person agree to participate? ..... ☐ Yes ☐ No

54. 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: _____

55. Would it be a problem to obtain child care in order to participate in Employment and Training activities?..... ☐ Yes ☐ No
If yes, explain: _____

56. Is anyone in your household responsible to care for an incapacitated person? …… ☐ Yes ☐ No
If yes, who? _____

57. Has anyone in your household left a job or reduced work hours in the last 30 days? ..... ☐ Yes ☐ No
If yes, who? _____

58. Has anyone in your household been temporarily laid off from their current job? …..... ☐ Yes ☐ No
If yes, explain: _____

59. Is anyone in your household on strike? ..... ☐ Yes ☐ No
If yes, who? _____

60. 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? _____

61. Is anyone in your household participating in a drug/alcohol treatment program other than AA? ..... ☐ Yes ☐ No
If yes, who? _____ Which program? _____

62. Is anyone in your household participating in a partner program which is case managed such as Vocational Rehabilitation, or involved in Title V programs such as Older American programs, Easter Seals or Forestry program, or are you participating in Choose to Work program? ..... ☐ Yes ☐ No
If yes, who? _____ Which program? _____

63. Is anyone in your household participating in refugee employment services? …… ☐ Yes ☐ No
If yes, who? _____

64. Is anyone in your household experiencing domestic violence? ..... ☐ Yes ☐ No
If yes, who? _____

65. Is anyone in your household unable to access any type of public or private transportation? ……. ☐ Yes ☐ No
If yes, explain: _____

66. Does your household live more than 35 miles (56 km) away from a DWS employment center? ..... ☐ Yes ☐ No

67. Are you homeless or do not have a fixed address?..... ☐ Yes ☐ No

68. Is anyone in your household receiving SNAP in another household or state? ……..… ☐ Yes ☐ No
If yes, who? _____ State (if applicable): _____

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

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

71. Is anyone in your household a migrant or seasonal farmworker? ..... ☐ Yes ☐ No
If yes, who? _____

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

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

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MEDICAL SECTION

73. Does any child who is applying for coverage have a parent living outside the home? ..... ☐ Yes ☐ No
If yes, are you willing to cooperate with the Office of Recovery Services (ORS) to establish medical support from an absent parent(s)? ……..……..……..…..... ☐ Yes ☐ No

74. Is anyone who is applying for coverage enrolled in or eligible for COBRA coverage or continued health insurance through an employer? ..... ☐ Yes ☐ No
If yes complete question 76 below (Do not list Medicaid, Medicare, or CHIP)

75. Do you want help paying for COBRA or your employer's health insurance plan? ..... ☐ Yes ☐ No

76. Does anyone in your household currently have health insurance (Veterans, 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, or CHIP).* If you marked no, you do not need to complete Attachment C.

Insurance 1: ☐ Enrolled
☐ Not Enrolled, but available (If you checked that your insurance status is "Not enrolled, but available" and this insurance is offered through your job or someone else's job such as a parent or spouse, 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 #: _____
Type of Coverage: ☐ Limited ☐ Comprehensive
Is this insurance through the Marketplace? ..... ☐ Yes ☐ No

Insurance 2: ☐ 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 #: _____
Type of Coverage: ☐ Limited ☐ Comprehensive
Is this insurance through the Marketplace?..... ☐ Yes ☐ No

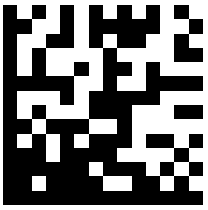
77. Does whoever is applying for coverage, currently have Medicaid, CHIP or Medicare? ..... ☐ Yes ☐ No

If yes, check the type of coverage and write the person(s) name(s) next to the coverage they have.

☐ Medicaid: _____

☐ CHIP: _____

☐ Medicare: _____



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78. Has anyone who is applying for coverage been injured in an accident or been a victim of assault in the last 12 months? ..... ☐ Yes ☐ No

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

80. Does anyone who is applying for coverage 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? _____

81. Does anyone help you pay mortgage/rent or utility bills? ..... ☐ Yes ☐ No

82. Are you the primary person taking care of a child living in your home that is under age 19? ..... ☐ Yes ☐ No

83. Was anyone who is applying for coverage in foster care on or after his/her 18th birthday? ..... ☐ Yes ☐ No

If yes, who? _____

Did they receive Medicaid at any time during the foster care period in which they turned 18 or older? ☐ Yes ☐ No

84. Deductions: Check all that apply, provide the amount, who pays it and how often it's paid. 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).

☐ Alimony: $ _____ Who? _____ How often? _____

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

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

85. 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? _____

86. Deductions: Do you have pre-tax deductions taken out of your paycheck such as health insurance premiums and 401K contributions? ..... ☐ Yes ☐ No

If yes complete the section below:

☐ Health Insurance Premium: $ _____ Who? _____ How often? _____

☐ 401K Contribution: $ _____ Who? _____ How often? _____

☐ Other Pre-tax Deductions Type: $ _____ Who? _____ How often? _____

87. 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: $ _____

88. What is your email address? _____

SIGNATURE SECTION

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I 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 non-citizen 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. Providing a Social Security number and information pertaining to immigration or non-citizen status is voluntary; however, any person who wants assistance but does not provide such information may not be eligible for benefits. Failure to provide this information will not subject the applicant to criminal charges.

Social Security number(s) and all other information you give for those who are applying for benefits will be subject to verification by federal, state, and local agencies to determine if such information is factual; that if any information is incorrect, SNAP may be denied to the applicant; and that the applicant may be subject to criminal prosecution for knowingly providing incorrect information. 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. Social Security number(s) for those who are applying for benefits 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 the applicant and other household members.

VERIFICATION OF INFORMATION

- **DWS will ensure that your household is eligible for SNAP 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.**
- **Computer matches will be completed when you apply and after you receive assistance. Your SNAP, 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 SNAP may be denied and/or you could be subject to criminal prosecution if you intentionally provide false information.**

_____ _____

SIGNATURE (check one) ☐ Applicant ☐ Authorized Representative Date

_____

Print Name

SNAP, 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 SNAP 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: _____

Address: _____

Phone number: _____ Birthdate (SNAP only): _____

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

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

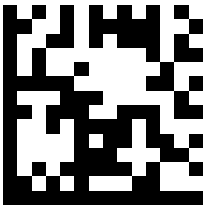
If yes, who? _____

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.



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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

- 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 and the Department of Health and Human Services 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.

State of Utah
Department of Workforce Services

D08725900551536

EXPEDITED SNAP SERVICES

You may be eligible to receive expedited services or receive Supplemental Nutrition Assistance Program (SNAP) benefits within seven (7) calendar days. You may turn in an incomplete application as long as it has your name, address and signature. However, the entire application must be completed in order for your eligibility for SNAP to be determined.

You will need an interview to complete your SNAP application. You can complete the interview on the phone at your local employment center, at your convenience from home, or you can request to schedule an in-person interview.

To determine if your household is eligible for expedited SNAP, please answer the following questions below:

1. How much is your household's total cash on hand and in a bank account or cash account? $_____
(Electronic Payment Apps such as Apple Cash, PayPal, Venmo, etc.)

2. How much money will your household earn or receive this month? $_____

3. How much is your household's shelter expense?
(mortgage, rent, lot space rent, list property taxes and property insurance when you pay them separately, homeowners association fees)

Type of Expense	Who pays this Expense?	Amount Paid	How Often

4. How much is your household's utility expense?
(electricity, gas, propane, wood, water, trash, sewer, telephone, etc.)

Type of Expense	Who pays this Expense?	Amount Paid	How Often

5. How do you heat (central heating, stove, fireplace) or cool (air conditioning, evaporative cooler) your home?
_____

6. Is anyone in your household a migrant or seasonal farmworker? ☐ Yes ☐ No

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WORKFORCE SERVICES
ELIGIBILITY

D08725900551736

The Application Process

I applied. What happens next?

The following steps will help you understand the application process for Medicaid, CHIP, SNAP, Child Care, and Financial assistance. Each step explains what to expect. Keep this information for your records.

Step 1 The Department of Workforce Services (DWS) will review your application.

- DWS will review your application in 7-10 days and may contact you by phone or mail to discuss your application.
- Check the status of your application at jobs.utah.gov/mycase or call DWS at 801- 526-0950 or 1-866-435-7414 Monday - Friday, 8 am - 5 pm.
- Watch for DWS notices sent by mail or if you receive paperless notices, you may log on to jobs.utah.gov/myCase and review the documents tab.
- If you applied for the SNAP program, a telephone interview is required. Call 801- 526-0950 or 866- 435-7414 to complete the interview. We encourage you to complete your interview within 7 days.

Step 2 DWS needs to gather your verification.

- Verification is the paperwork, like bank statements or pay stubs, required to verify the information you report to us. The information you provide will help us determine your eligibility.
- If verification is required, DWS will send you a notice. The notice will list what is required and a date the information is due.
- If you need help gathering the requested verification or need more time, call DWS before the due date.
- Once you turn in the requested documents, DWS will review them within 14 days to determine your eligibility. If they need additional information or documentation, they will contact you.

How do I get DWS the verification they need?

Online: You can upload verification documents at jobs.utah.gov/mycase

By fax: You can fax them to 1-877-313-4717 or 801-526-9500.

By mail: You can mail documents to:
Department of Workforce Services • Imaging Operations • PO BOX 143245 •Salt Lake City, UT 84114-3245

In person: You can drop off documents at any DWS Employment Center M – F, 8 am - 5 pm.

Step 3 DWS makes a decision.

- DWS will determine your eligibility for benefits within 30 days of your application (90 days for medical applications, if you claim a disability). But, if you return verifications within 30 days after an application has been denied, DWS will use the verification received and you may not have to complete a new application.
- Once your eligibility has been determined, DWS will send you a notice of decision explaining the outcome of your application. The notice lists your appeal rights if you do not agree with the decision.
- If you are approved for a Medicaid program with a cost-sharing requirement such as a spenddown, premium, or cost of care, a separate notice will be sent to you explaining the options, costs, due dates, and ways to make payments, if needed.
- New Medicaid members will receive a wallet sized Medicaid card. If you have received one in the past, a new one will not be mailed unless you request it. For SNAP and Financial programs, an EBT card may be mailed when your application is submitted. If you have an active EBT card another will not be mailed to you.
- Contact DWS at 801-526-0950 or 1-866-435-7414, Monday - Friday, 8 am - 5 pm to request a replacement Medicaid card or to report changes like your income, address, or household.
- Medicaid and CHIP members will get a welcome letter with instructions to enroll in a health plan.

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ATTACHMENT A
AMERICAN INDIAN/ALASKA NATIVE HOUSEHOLD MEMBER INFORMATION

(Required only for Medical Assistance)

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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 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 received 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 shall not be counted for Medicaid or the Children's Health Insurance Program (CHIP). Check any income reported in the income section above 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.	Amount $ _____ How often? _____	Amount $ _____ How often? _____

Equal Opportunity Employer/Program
Auxiliary aids (accommodations) and services are available upon request to individuals with disabilities by calling 801-526-9240. Individuals who are deaf, hard of hearing, or have speech impairments may call Relay Utah by dialing 711. Spanish Relay Utah: 1-888-346-3162.

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DWS-ESD 741
10/2013

ATTACHMENT B
TAX DEPENDENTS NOT LIVING WITH YOU
(Required only for Medical Assistance)

D08725900552136

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 Number	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: $ _____

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DHHS116M
02/2021

ATTACHMENT C
EMPLOYER'S HEALTH INSURANCE INFORMATION

D08725900552336

Complete this form for each employed household member. Your employers Human Resources representative or department who manages employee benefits must complete it. If you marked no to question 76, you do not need to complete this attachment. You may copy this form. In some situations, we will need the information from this form to help determine your eligibility for certain medical programs. If the form is not complete, it may delay the process. If you have questions regarding this form or medical programs, please call 801-526-0950 or 866-435-7414.

Employee's Name: _____ (First) _____ (MI) _____ (Last)

SSN (optional) or Date of Birth: _____ eREP Case #: _____

Employer Name: _____ EIN: _____

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

2. When does your company's enrollment period begin? (mm/dd/yy) _____

A. Access to a Qualified Health Plan

3. Does your company offer any health plan that meets all of the following?..... ☐ Yes ☐ No
   - The network deductible is $4,000 or less per person
   - The plan pays at least 70% of an inpatient stay after employee meets in-network deductible.
   - The plan covers physician's visits, inpatient and outpatient hospital care, prescription drugs, laboratory services, preventative and wellness services, pregnancy, and childbirth.
   - Employer pays at least 50% of the employee's premium.
   - Lifetime maximum benefit is $1,000,000 or more, or the plan has no maximum.

4. How do those plans cover abortion services? This can typically be found in the maternity/pregnancy or exclusion sections of your policy. (check one)
   - ☐ Does not cover abortion in any circumstances
   - ☐ Plan covers elective abortion
   - ☐ Covers abortion 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 (plan lists this exact language)
   - ☐ Other, or if multiple plans offer differing coverages, please describe: _____

B. Least Expensive Plan

Complete the chart below for the plan that would cost the employee the least. Do not include the cost of dental, vision or other coverage if it is not included in the medical insurance premium amount.

Monthly Premium		
	Employee's Portion	**Company's Portion**
Employee	$	$
Employee + Spouse	$	
Employee + Child	$	
Family	$	

Yearly Health Plan Deductible	
Individual Amount	$
Family Amount	$

5. Is this health insurance plan a state employee benefit plan? …… ☐ Yes ☐ No

If the employee is enrolled in health insurance skip to section D.

C. Employee Not Enrolled in Health Plan

6. Is the employee eligible to enroll in a health insurance plan?..... ☐ Yes ☐ No
   If no, why not? _____

7. Was the employee eligible to enroll in the last open enrollment period?..... ☐ Yes ☐ No

8. Has this employee or any family member dropped or reduced coverage in the last 90 days?..... ☐ Yes ☐ No
   If yes, name(s): _____
   If yes, when did coverage end/change? (mm/dd/yy) _____

D. Employee's Health Plan Information

D08725900552436

9. Is this employee or any family member enrolled in any insurance plan offered? ☐ Yes ☐ No
   If no, skip to section E
   If yes, name(s) of person(s) enrolled: _____
   When did coverage begin? (mm/dd/yy) _____
   Insurance company and plan name: _____
   Policy Number: _____ Group Number: _____
   What is the check date for the first premium deduction? _____
10. Does the employee's chosen health plan meet all of the following?..... ☐ Yes ☐ No
    - The network deductible is $4,000 or less per person.
    - The plan pays at least 70% of an inpatient stay after employee meets in-network deductible.
    - The plan covers physician's visits, inpatient and outpatient hospital care, prescription drugs, laboratory services, preventative and wellness services, pregnancy, and childbirth.
    - Employer pays at least 50% of the cost.
    - Lifetime maximum is $1,000,000 or more, or the plan has no maximum.
11. How does the plan cover abortion services? This can typically be found in the maternity/pregnancy or exclusion sections of your policy. (check one)
    ☐ Does not cover abortion in any circumstances
    ☐ Plan covers elective abortion
    ☐ Covers abortion 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 (plan lists this exact language)
    ☐ Other, please describe: _____
12. What is the monthly premium cost of this plan for just a single employee, not including any family members?

This plan's monthly premium cost for just a single employee	
Employee Cost	Employer Cost
$	$

13. Complete this chart for the benefits the employee is enrolled in. Fill out all applicable boxes.
    Premium deducted from this employee's check

How often is the premium deducted?
☐ Weekly ☐ Every 2 Weeks ☐ Twice a month ☐ Monthly ☐ Other (Specify:)

	Medical (required)	Dental (optional)	Vision (optional)
Employee	$	$	$
Employee + Spouse	$	$	$
Employee + Child	$	$	$
Family	$	$	$

Yearly Health Plan Deductible	
Individual Amount	$
Family Amount	$

14. Please list any children who have dental coverage? _____

E. Signature

Signature: _____ Date: _____
Name (please print): _____ Email Address: _____
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 (accommodations) and services are available upon request to individuals with disabilities by calling 801-526-9240. Individuals who are deaf, hard of hearing, or have speech impairments may call Relay Utah by dialing 711. Spanish Relay Utah: 1-888-346-3162.

DWS-ESD 114AR
Rev. 11/2022

ATTACHMENT D
AUTHORIZATION TO DISCLOSE MEDICAL ELIGIBILITY INFORMATION

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You can choose an authorized representative. You can give a trusted person permission to talk about your medical assistance case with us, see your information, and act on matters related to your case, including getting information about your case and signing forms on your behalf. This person is called an "authorized representative".

Customer Name	**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 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 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 and Human Services, through its Division of Integrated Healthcare (DIH) 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: DIH 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: _____

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

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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/myCase/*.

- *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 eligibility verifications by:

- Fax: 877-313-4717
- Mail: PO Box 143245, SLC, UT 84114-3245
- Drop off at your local employment center

You may contact us by phone: 801-526-0950 or 866-435-7414.

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 and/or SNAP benefits on a Utah Horizon Card.
- Your medical card(s) will be mailed at initial program approval, upon request and every 36 months.
- Child Care benefits will be paid directly to the provider(s) you have selected.

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.
- The retailer is required to provide you a receipt that will include retailer name, location, transaction type, transaction amount, and the remaining SNAP balance.
- There is no minimum dollar amount per transaction or maximum limit on the number of transactions. In addition, no transaction fees will be imposed on SNAP purchases.
- If you do not access your SNAP benefits for 274 days or Financial benefits for one year, your benefits will be removed from the card.
- You can view two months of your transaction history. You can access this through your myCase account at https://jobs.utah.gov/mycase.
- EBT account balances can be adjusted when there is a system error in processing a transaction. You will receive a notice about the adjustment. You may file a fair hearing if you disagree with the adjustment.

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

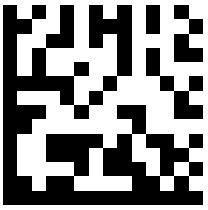
- You need to check your balance.
- You need a replacement card because the card has been lost, stolen or is no longer working.
  - The replacement card will be mailed to you.
- You need to change your PIN for any reason.
- You have questions on how to use your card.
- The ATM does not give you the correct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

If you are eligible for Expedited SNAP and have not received your card within 5 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 866-435-7414.

Our Programs

Financial, Medical, Child Care, and SNAP 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.

SNAP



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When SNAP benefits are Available

SNAP benefits are automatically added to your SNAP EBT account if your application is approved. For every month that you receive SNAP benefits, your benefits will be automatically deposited into your EBT account based on the first letter of your last name. SNAP 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 SNAP

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 SNAP EBT account.
- Sales tax cannot be charged on items bought with SNAP 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 SNAP 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 SNAP 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

Do not trade or sell your SNAP or EBT card.

- Trading or selling your SNAP or your card for cash, non-eligible items, or services is known as "trafficking" and is illegal.
- Selling or trading your SNAP or the EBT card could result in the loss of your benefits and criminal penalties.

Reporting Changes

For SNAP, you must report changes in your income by the 10th day of the month following 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.

Acceptable Verification

Item to be verified	***Acceptable verification***
Identity	Driver's License, Passport, State-issued ID cards, Birth Certificates
Residency	Rental or mortgage agreement, Utility bills, Statements from your landlord, family or friends
Social Security Numbers	Social security cards
Proof that non-citizens in your household applying for benefits are eligible	Social security cards, Passports

We may need proof of your status, if:	***Type of information***	***What are some types of materials you can bring us?***
You are an able-bodied person under the age of 50 with no dependents	Proof that you are working or in training at least 20 hours per week	Paystubs, statements from your employer, training enrollment forms

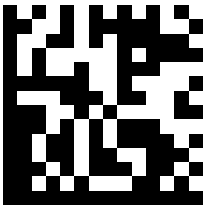
Financial Programs

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



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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
    - Temporary Assistance for Needy Families (TANF) program is available in Utah through the Navajo Nation Tribal TANF Program. If you are an enrolled member of one of these tribes or live within the boundaries of the tribal program, you may be eligible for financial benefits through the tribal TANF program.
    - The Bureau of Indian Affairs administers a General Assistance financial program that may be offered through a local Indian tribe.

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 an approved child care provider for watching their children while the parent is at work or in school. DWS has a maximum subsidy amount that can be covered per month.

- You may have to pay a co-payment based on your household size and income. DWS determines the amount of subsidy you are eligible for and the amount of your co-payment.
- Since providers may charge more than the subsidy rate, you may have additional out-of-pocket expenses you will owe to your provider above the co-payment. You are responsible to pay your provider the difference between what they charge you and what DWS pays.

- For example:
  - Your provider charges $530 per month for services.
  - DWS determines your Child Care payment at $510 minus a $77 co-payment. The subsidy amount DWS will pay to your provider is $433. ($510 – $77 = $433)
  - You will need to pay your co-payment of $77 plus an additional $20 charged by the provider. ($530 – $433 = $97)
  - The total cost you owe to your provider is $97.
- Households earning at or less than 100% of the federal poverty limit are not subject to the co-payment requirements. However, these families may still have out-of-pocket expenses that they are responsible to pay to their provider.
- If you are using more than one provider, there is no guarantee more than one provider will receive a payment.
- Once approved for Child Care, the payment will be paid directly to the provider you have selected.

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Eligibility for Child Care Assistance

Your household must include an eligible child under the age of 13 and/or a special needs child under the age of 18.

- Working parents must be earning minimum wage for the number of hours they work.
- 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. Post graduate work, or obtaining a second degree is not supported.
- The minimum work requirements may be waived for parent(s) attending a formal course of study to obtain their High School Diploma or equivalent General Education Diploma.
- Self-employed parents must have been self-employed for at least three months. Expenses can be deducted from the gross income. The net income must equal minimum wage for the number of hours working each month.
- Your child care provider has limited access to your payment information through the DWS Provider Portal. DWS may share general information with your child care provider needed to approve Child Care, including your case status, relevant dates, and subsidy or copayment amounts. Specific information will not be shared unless you agree to share it.
- Child Care benefits will be issued at the same benefit level for the 12-month certification period as long as there is a need for care. This includes fluctuations in employment and/or training hours.
  - Customer's experiencing permanent or temporary loss of employment such as maternity leave, other medical leave, or seasonal breaks of employment such as a teacher may be eligible for continued Child Care.

Selecting a Child Care Provider

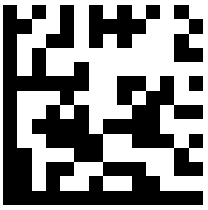
The Child Care assistance program supports families to have equal access to child care. You have the right to select the type of child care provider which best meets your family needs. The provider you have selected must comply with certain health and safety requirements to be eligible.

- Child Care Resource Agency at *https://jobs.utah.gov/occ/cac.html* provides information to parents about how to identify a quality child care setting and maintains a searchable child care provider database to find a provider in your area. There are tutorial videos in both English and Spanish to help you search for a provider at *https://jobs.utah.gov/occ/cac/search/.*
- To find out more information on the provider you have chosen, search for your provider at *https://jobs.utah.gov/occ/cac/search/.*
- You may call your local Child Care Resource Agency if you need assistance in locating an approved provider or have questions about the provider you have selected. Contact information for each Care About Childcare agency can be found at *https://jobs.utah.gov/occ/provider/cacmap.pdf*
- To file a complaint on a provider, you may submit a complaint form online at *https://dlbc.utah.gov/home/office-of-licensing/child-care/* or call Child Care Licensing at 801-707-4188.
- Report your selection of a child care provider if you have already met with the provider, have negotiated a start date and provider charge. There may be a delay in processing your application if you have not selected a child care provider at the time you apply.
- If you have not selected a child care provider, changes may be reported on *jobs.utah.gov/mycase* or by contacting the Eligibility Service Center, 801-526-0950 or 866-435-7414.

If you select a Family, Friend, or Neighbor (FFN) as your provider:

- They must apply with Child Care Licensing (CCL) to become a DWS-FFN approved provider prior to any Child Care assistance being approved.
- Your provider may submit an application online at *https://dlbc.utah.gov/home/office-of-licensing/child-care/* or call (888) 287-3704 to apply.
- If your FFN provider has not completed the application process, an information notice will be sent to you to give to your provider. Your Child Care application will start the day your FFN provider becomes approved.
- Your provider and their household members age 12 and older must pass a criminal background check and complete all Health and Safety requirements administered by Child Care Licensing.
- If you select a provider who lives with you an exemption will be considered only if a child in the home has special needs.

- If you have selected a provider who is currently DWS Family Friend Neighbor (FFN) Approved, make sure your provider contacts Child Care Licensing to report they will be providing care for your children. They will need your DWS case number. They are limited to the number of children they may provide care for. If they are over the limit, you may need to choose another provider.



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Provider Payments
Payments will be made directly to your chosen provider each month. Your provider will receive the Child Care payment by either direct deposit to a financial institution of their choice or by check. Your provider will need to contact the Office of Child Care at *occ@utah.gov* to set up an account in the DWS Provider Portal for direct deposit.

Note: It is important to report promptly when your provider is no longer caring for your child, you disenroll a child, change providers, or the amount your provider charges you for care changes. Always check *myCase* to see when the payment was issued and how much money has been authorized for your child care provider(s). It is your responsibility to ensure the Child Care payment was issued to the correct provider for the approved month of service. If you change providers after your current provider is paid for the month and they provide care, you will be responsible to pay your new provider for the month of change. DWS will not make the provider change until the following month.

Many providers require a two-week advance notice before changing providers. It is important to give your provider proper notice and to notify DWS as soon as you make this decision so that payment can be updated for the following month. This will help to prevent provider overpayments to be returned to DWS and will avoid unnecessary fees that you will owe your provider.

Developmental Screenings
Developmental screenings are an easy way to track milestones as your child grows! They can help you see your child's strengths and identify areas they could use a little practice. Completing a developmental screening can also lead you to activities, information, and resources to support your child's development. If you are interested in learning more or completing a free developmental screening, visit helpmegrowutah.org or call a Help Me Grow Utah staff member at 801-691-5322.

If you are approved for Child Care assistance, DWS will share your case name, children's names ages 0-71 months, mailing address, phone number, and email (if provided) with Help Me Grow Utah. Help Me Grow Utah will then contact parents to provide resource information about child development and offer free developmental screenings for children in your home 0-71 months.

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.

Helpful Websites for Other Services
General
- Jobs.utah.gov: *https://jobs.utah.gov*
- 2-1-1 Information & Referral: *https://211utah.org/*
- Local Employment Center: *https://jobs.utah.gov/jsp/officesearch/#/map*
- Unemployment Insurance: *https://jobs.utah.gov/ui/home/*
- Voter Registration: *https://secure.utah.gov/voterreg/index.html*
- SNAP, Financial and Child Care Policy: *http://jobs.utah.gov/Infosource/eligibilitymanual/Eligibility_Manual.htm*
- If you or someone you know is experiencing domestic violence, sexual assault, stalking or sexual harassment, there are resources available: *https://jobs.utah.gov/assistance/domviolence.pdf*

Food Assistance
- SNAP Brochure (#313): *https://fns-prod.azureedge.net/sites/default/files/resource-files/2019%20FNS%20313%20SNAP%20English%20for%20508.pdf*
- WIC: *https://wic.utah.gov/*
- Nutrition Education: *https://extension.usu.edu/createbetterhealth/*

Financial
- ORS/Child Support: *www.ors.utah.gov*
- Adoption Assistance: *https://jobs.utah.gov/customereducation/services/financialhelp/family/adoption.html*

Child Care
- For more information: *jobs.utah.gov/occ/index.html*
- Search for quality child care: *https://jobs.utah.gov/jsp/cac/welcome*

RIGHTS AND RESPONSIBILITIES

YOUR RIGHTS

Language Services

Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available for free. Call 801-526-0950 or 1-866-435-7414.

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Spanish
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-866-435-7414.

Chinese
中文 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提 供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-866-435-7414.

Ilocano
PANANGIKASO: No agsasaoka iti Ilocano, magun-odmo dagiti libre a serbisio ti tulong iti pagsasao. Libre met laeng a magun-odan dagiti maitutop a katulongan ken serbisio a mangipaay iti impormasion kadagiti ma-akses a pormat. Awagan ti 1- 866-435-7414.

Portuguese
Serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-866-435-7414.

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-866-435-7414.

Vietnamese
LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-866-435-7414.

Navajo
SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 1-866-435-7414.

Japanese
注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための 適切な補助支援やサービスも無料でご利用いただけます。1-866-435-7414.

Arabic
نبيه :إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية .كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانا .اتصل على الرق م 7414-435-866-1-

Greek
ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το 1-866-435-7414.

Serbo-Croatian
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Odgovarajuća pomoćna pomagala i usluge za pružanje informacija u dostupni formati su takođe besplatni. Nazovite 1-866-435-7414.

Russian
ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-866-435-7414.

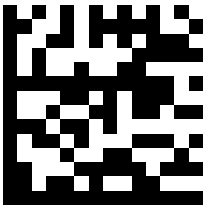
Tagalog
PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-866-435-7414.

Korean
주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-866-435-7414.

French
Des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-866-435-7414.

- You have the right to be treated fairly and with courtesy, dignity, and respect.
- Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA, DWS or Utah Department of Health and Human Services (DHHS) 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 866-526-3663 or 800-371-7897; found online at *https://www.fns.usda.gov/contact-us.*
- USDA is an equal opportunity provider and employer.
- In accordance with Federal law and U.S. Department of Health and Human Services regulations,
- this institution is prohibited from discriminating on the basis of race, color, national origin, sex,
- age, sexual orientation, gender identity (including gender expression), or disability. To file a
- complaint of discrimination, visit *www.hhs.gov/ocr/office/file* or contact the U.S. Department of Health and Human Services Office for Civil Rights at 999 18th Street, South Terrace, Suite 417, Denver, Colorado, 80202 or 303-844-2024, 303-844-3439 (TDD).



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- 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 of undeclared. 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).
- You have the right to know if your application was approved or denied and the reasons for the decision.
    - For SNAP, 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 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 SNAP benefits, there is one important exception to this rule. You will not receive advance notice of a SNAP benefit decrease if approved for Financial assistance.
- If you received payments under a long-term care partnership insurance plan, some assets may not count to decide your eligibility. In this case, the State will not recover medical costs from those assets after your death.
- If you are in an institution and apply for SNAP and SSI at the same time, the filing date for SNAP 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.
- 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. Our working hours are 7:00 a.m. to 6:00 p.m.
- 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, SNAP, and Child Care if you meet certain requirements. Ask your employment counselor for more information.
- In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA.
- Programs that receive federal financial assistance from the U.S. Department of Health and Human Services (HHS), such as Temporary Assistance for Needy Families (TANF), and programs HHS directly operates are also prohibited from discrimination under federal civil rights laws and HHS regulations.
- Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339. Additionally, program information may be made available in languages other than English.
- USDA provides federal financial assistance for many food security and hunger reduction programs such as the Supplemental Nutrition Assistance Program (SNAP), the Food Distribution Program on Indian Reservations (FDPIR) and others. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a

copy of the complaint form, call 866-632-9992. Submit your completed form or letter to USDA by:
    - Mail: Food and Nutrition Service, USDA
      1320 Braddock Place, Room 334, Alexandria, VA 22314; or
    - Fax: 833-256-1665, or 202-690-7442; or
    - Phone: 833-620-1071; or
    - Email: *fnscivilrightscomplaints@usda.gov.*
- For any other information regarding SNAP issues, persons should either contact the USDA SNAP hotline number at (800) 221-5689, which is also in Spanish, or call the state information/hotline numbers found online at https://www.fns.usda.gov/snap/state-directory.
- This institution is an equal opportunity provider.

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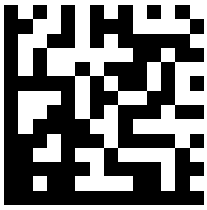
YOUR RESPONSIBILITIES

- Medical assistance (Medicaid, CHIP, UPP) 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.
- With certain exceptions, 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.
- Participation in SNAP Employment & Training Activities: Once you are approved, you may be required to participate in employment and training activities to keep getting SNAP 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.
- You are exempt from Employment & Training activities if you meet any of the following:
    - Age 60 or older
    - Younger than age 16
    - Age 16 or 17 attending school at least half time
    - Age 16 or 17 enrolled in school
    - Age 16 or 17 and not named as head of household
    - Physically or mentally unfit for employment
    - Receiving Financial for families with children
    - Receiving a Financial diversion payment
    - Responsible for the care of a dependent child under age 6
    - Responsible for the care of an incapacitated person
    - Receiving Unemployment Insurance or applying/awaiting a decision
    - Participating regularly in a drug and alcohol treatment program
        - Working at least 30 hours per week, or earning at least Federal Minimum wage times 30 hours per week.
    - Student enrolled at least half time and meet student eligibility requirements
    - Participating in refugee employment services
- If you fail to participate in Employment & Training activities, you will be disqualified from getting SNAP benefits for a minimum of one month for the first occurrence, three months for the second occurrence and six months for subsequent occurrences. You must serve your sanction period (one, three or six months) unless you meet an exemption or have good cause. Once your sanction period is over, you may be eligible for SNAP benefits if you agree to participate in Employment & Training activities or you are exempt from participation.
- You may be sanctioned from receiving SNAP benefits if you do any of the following within 30 days of your application or while receiving SNAP benefits:
    - Voluntarily quit a job working 30 hours or more per week while earning minimum wage
    - Voluntarily reducing your work hours
- The sanction period is one month for the first occurrence, three months for the second occurrence and six months for subsequent occurrences. You must serve your sanction period (one, three or six months) unless you meet an exemption or have good cause.
- Able-Bodied Adults Without Dependents: Able-bodied adults are healthy, have not had a doctor diagnose a disability and do not have dependent children living in their home. SNAP allows able bodied adults without dependent children to receive SNAP benefits for 3 months in a 36-month period without participating in an able-bodied employment or training activity. After the initial three months, an able-bodied adult must meet one of the following in order to remain SNAP eligible:
    - Work 20 hours a week.
    - Attend training at least part-time.
- For SNAP, you must always report substantial lottery or gambling winnings.
- 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.

- 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.
- To receive Financial assistance through the Family Employment Program, you must cooperate with Office of Recovery Services in obtaining child and/or medical support, unless you have "good cause" not to cooperate.
- You may be eligible to claim "good cause" NOT to cooperate with Office of Recovery Services. Good cause for not cooperating includes:
    - The child for whom support is sought was conceived as a result of incest or rape.
    - Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction, or a public or licensed private social agency is helping the individual resolve the issue of whether to keep or relinquish the child for adoption and the discussions have not gone on for more than three months.
    - Cooperation in establishing paternity or securing support is reasonably expected to result in physical or emotional harm to you or your child(ren). The source of physical or emotional harm may be from individuals other than the absent parent.
    - If you do not have evidence to support your good cause claim, you may request a fair hearing and your sworn testimony may be accepted as evidence to support good cause.
- If you do not cooperate with Office of Recovery Services or have good cause to not cooperate, your family will not be eligible for ongoing Financial assistance.
- 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 and Human Services (DHHS) 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 DHHS 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 DHHS 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 DHHS, Division of Integrated Healthcare (DIH) or designee. The DHHS 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 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). The state may place a lien on my property if I enter a nursing home.
- 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 and Human Services 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 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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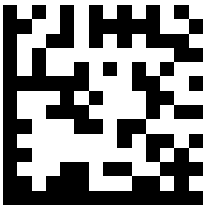
OBEY PROGRAM RULES

- 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 SNAP benefits to anyone who has no right to use them or purchase ineligible items. Do not use other individuals' SNAP benefits unless you are the authorized representative.
- Do not trade or sell an EBT card. Do not use SNAP benefits to buy non-food items, such as alcohol, cigarettes, or to pay on credit accounts. Using SNAP benefits to purchase food on credit could result in a disqualification.
- **If you break any of these rules, you may be disqualified from receiving SNAP 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 SNAP, 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 SNAP ineligibility if convicted of a felony or misdemeanor related to inappropriate use of SNAP 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 SNAP benefits simultaneously, you will be ineligible to participate in the Program for a period of 10 years.**



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- 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 SNAP benefits, you will be disqualified from SNAP for 12 months for the first offense, 24 months for the second offense, and permanently for any additional offenses.
- You will be disqualified for SNAP, Financial and Child Care programs for 10 years each for the first and second offenses if you make a fraudulent statement regarding your identity or 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.
- An EBT card cannot be used to purchase beer, intoxicating beverages, cigarettes, or tobacco products.
- A customer who accesses FEP cash benefits at one of the above establishments, or purchase any of the items listed above, may be disqualified from Family Employment Programs for 12 months for an intentional program violation.