DWS-ESD 61APP
Rev. 05/2020

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

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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 – 29, the Financial Section AND sign page 14**.
  - In order to file a Child Care assistance application you **must** complete questions **1, 4 – 5, 7 – 9, 11 – 22, 29, the Child Care Section AND sign page 14.**
  - 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 and Medicaid Information for Immigrants:

- You can apply for and receive SNAP, Financial and Medicaid benefits for eligible family members, even if your family includes other members who are not eligible because of immigration status. For example, immigrant parents may apply for 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 SNAP, Medicaid and Financial benefits may affect your immigration status or the immigration status of your family. Immigration information is private and confidential.
- In order to determine your eligibility for SNAP, complete questions 1, 4 – 5, 8 – 24, 26 – 32, 52 – 72 and sign page 14.
- 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 23 – 32)
  - 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)	Race[3, 6]	Ethnicity[4, 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. Social Security number is not required for Child Care.

[2] Utah Resident is optional for all programs

[3] Race (optional): AI = American Indian or Alaska Native (For medical applicants only, complete Attachment A to determine if you are exempt from Community Engagement)
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 case.

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:
Do you plan to file a federal income tax return next year or will you be claimed as a dependent on someone's tax return next year? ..... ☐ Yes ☐ No

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

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

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

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.)

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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? _____ If temporary, how long is it expected to last? _____
Disability/Incapacity determined by:
☐ SSA Disability Recipient ☐ VA (Veterans Affairs) ☐ SSI Recipient ☐ Medical Statement
☐ Railroad Retirement Board ☐ State Medical Disability Office ☐ Other: _____

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

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

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. Answer the following question only for individuals who are applying for benefits:
If anyone in your household has an eligible immigration status and is applying for benefits, complete the chart below:

Name	Alien Registration or I-94 Number	Immigration Document Type	Document ID Number (if different from A#)	Have you lived in the U.S. since 1996?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

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

If yes, who? _____

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. 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: _____

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14. 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? _____

15. 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

16. 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? _____

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

If yes, complete all columns:

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

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

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? $_____

18. 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): _____

19. 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: _____

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

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

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21. 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
	$			
	$			
	$			

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

If yes, complete all columns:

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

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

If yes, complete the following information:

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

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

ASSETS*

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* 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.

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

If yes, who? _____ Amount: $ _____

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

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

** Not Required for SNAP*

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

25. 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		$		

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

If yes, complete all columns:

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

27. 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? _____

28. 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.

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29. 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 School ☐ Attend Training ☐ Other:

30. 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: $ _____

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

If yes, mark all that apply:

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

32. 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:

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	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

33. 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: _____

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

If yes, who? _____State(s): _____Number of months: _____

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

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

36. 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:

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

If yes, who? _____

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: _____

CHILD CARE SECTION

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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

Parent Name: _____ School Name: _____

Type of Training/degree: _____

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

43. Do you share custody with an absent parent? …… ☐ Yes ☐ No

If yes, how many hours per week do you have physical custody of the child(ren) when care is needed? _____

44. If there is an absent parent, do they pay or are they responsible to pay any part of the child care expenses? …… ☐ Yes ☐ No

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

(If you have not selected a child care provider, you can go to *careaboutchildcare.utah.gov* to search online for licensed providers in your area.)

- 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 of agency: _____

SNAP SECTION

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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 requirement..... ☐ Yes ☐ No

If yes, who? _____

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

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

If yes, explain: _____

55. Has anyone in your household become unemployed in the last six months?..... ☐ Yes ☐ No

If yes, who?: _____

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

If yes, explain: _____

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

If yes, who? _____

58. 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? _____

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

If yes, who? _____ Which program? _____

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

If yes, who? _____

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

If yes, explain: _____

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

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

64. Is anyone in your household receiving SNAP from another state? ..... ☐ Yes ☐ No

If yes, who? _____ State: _____

65. Is anyone in your household a boarder? ..... ☐ Yes ☐ No

If yes, explain: _____

66. Is anyone in your household a foster child or foster adult? ..... ☐ Yes ☐ No

If yes, who? _____

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

If yes, who? _____

68. 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? _____

SNAP and MEDICAL SECTION

D13320900241234

Medical applicants only: Adults ages 19-59 who are applying for medical coverage may have to participate in employment activities. This includes registering for work, completing an online job assessment and training modules, and applying for 48 jobs. (For additional information, visit https://medicaid.utah.gov/community-engagement). If this requirement applies to you, you will receive a notice with more information. In order to help us decide if you or another adult in your household are exempt from employment activities, please answer the questions below (Do not answer for individuals who are aged, blind or disabled, living in a nursing home, applying for a Medicaid waiver program, former foster care youth, pregnant, a member of a federally recognized tribe or working 30 or more hours a week). These questions are optional, providing this information will help process your application more quickly.

69. 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: _____

70. Is anyone in your household responsible to care for a disabled person?.... ☐ Yes ☐ No

If yes, who? _____

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

If yes, who? _____ Which program? _____

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

If yes, who? _____

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

D13320900241334

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: _____

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, food, 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 17).

☐ 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

D13320900241434

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

_____

Birth Date of Authorized Representative (SNAP only)

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: _____

Phone number: _____ Address: _____

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

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

If yes, who? _____

Medical Representatives

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

If yes, complete Attachment D

D13320900241534

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

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

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

Organization name: _____

ID number (if applicable): _____

Voter Registration Information

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

- IF YOU DO NOT CHECK EITHER OF THESE BOXES, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.
- If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided.
- If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with Lt. Governor, State of Utah, 203 State Capitol Building, Salt Lake City, UT, 84114.

Medical Only

Renewal of Coverage in Future Years

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

Yes, renew my eligibility automatically for the next:

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

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

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

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ATTACHMENT A
AMERICAN INDIAN/ALASKA NATIVE HOUSEHOLD MEMBER INFORMATION
(Required only for Medical Assistance)

D13320900241734

Case Name: _____ Case #: _____

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

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

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

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

Equal Opportunity Employer/Program
Auxiliary aids 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)

D13320900241934

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: $ _____

Equal Opportunity Employer/Program
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ATTACHMENT C
EMPLOYER'S HEALTH INSURANCE INFORMATION

D13320900242134

Case Name: _____ Case #: _____

You will need your employer's Human Resources representative or department who manages employee benefits for each employed household member to complete this form. If you marked no to question 77, 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.

A. Employee Information

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

B. Employer Information

Employer Name: _____

EIN: _____ Phone #: _____

Address: _____
Street Apt.# City State Zip

Enter the information for the person or department who manages employee benefits and can provide information about benefits and coverage under the employer's health insurance plan. We may need to contact this person if more information is needed.

Contact Name: _____

Phone #: _____ Email address: _____

1. Does your company offer health insurance? If no, skip to section E. Sign and return the form..... ☐ Yes ☐ No
2. Is the employee or any family member enrolled in any insurance plan offered? ..... ☐ Yes ☐ No
   If yes, name(s) of persons enrolled: _____
   When did the coverage begin? (mm/dd/yyyy) _____
3. Has the employee had an opportunity to enroll in health coverage offered by this employer?..... ☐ Yes ☐ No
   If yes, when was the more recent open enrollment period for this employee? (mm/dd/yyyy) _____
4. Is this employee eligible to enroll? ..... ☐ Yes ☐ No
   If yes, when? (mm/dd/yyyy) _____
5. Is this health insurance a state employee benefit plan?..... ☐ Yes ☐ No
6. 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/yyyy): _____

C. Employer's Least Expensive Plan

Complete the chart below for the employer's least expensive plan. Do not include the cost of dental, vision or other coverage if it is separate.

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

Yearly Health Plan Deductible	
Individual amount	$
Family amount	$

D. Employee's Health Plan Choice

D13320900242234

Questions below refer to the plan that the employee has selected or are enrolled in.
Questions 3 - 6 refer to "in-network" benefits.

1. Insurance company and plan name: _____
2. Policy and group number, if known: _____
3. Is the lifetime maximum benefit $1,000,000 or more? ..... ☐ Yes ☐ No
4. Does the plan pay at least 70% of an inpatient stay (after the deductible)? ☐ Yes ☐ No
5. What benefits are covered under this plan? (Check all that apply)
   ☐ Physician visits ☐ Hospital inpatient services ☐ Pharmacy/Rx ☐ Well Child Exams ☐ Child Immunizations
6. Does the plan cover abortion services? ..... ☐ Yes ☐ No
   If yes, check one:
   ☐ 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. (Federal definition)
   ☐ 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 or the mother's health would be irreversibly endangered. (State definition)
   ☐ Other, please describe: _____
7. Does the employer offer dental coverage that the employee or their dependents are enrolled in or plan to enroll in? ..... ☐ Yes ☐ No
   If yes, who? _____
   What date will/did coverage begin? (mm/dd/yyyy) _____

Complete this chart for the plan the employee has/will enroll in. **Do not** include the cost of dental, vision or other coverage if it is separate.

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

Yearly Health Plan Deductible	
Individual amount	$
Family amount	$

E. Signature

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

Signature: _____ Date: _____
Name (please print): _____
Title: _____ Phone: _____

Please return completed form to:

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

Equal Opportunity Employer/Program
Auxiliary aids and services are available upon request to individuals with disabilities by calling 801-526-9240. Individuals 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. 04/2019

ATTACHMENT D
AUTHORIZATION TO DISCLOSE MEDICAL ELIGIBILITY INFORMATION

D13320900242334

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, through its Division of Medicaid and Health Financing (DMHF) or the DWS has relied on the disclosed health information.

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

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

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

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

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

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

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

_____

Equal Opportunity Employer/Program
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D13320900242434

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

D13320900242534

General Information

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

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

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

You can send in your 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 account 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
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.

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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 will 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.
- 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

You have the right to select the type of child care provider which best meets your family needs. The provider you chose must comply with certain health and safety requirements to be eligible.

- Careaboutchildcare.utah.gov 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. A short video titled Assisting Parents to Find High-quality Child Care is available at *jobs.utah.gov/occ/about/index.html*
- To find out more information on the provider you have chosen, including verified research based-quality indicators, search for your provider at careaboutchildcare.utah.gov. You will see a link to their Department of Health Child Care Licensing record to find information about their health and safety requirements including regulatory requirements. Their licensing record will show the date the provider was last inspected and any history of violations of these requirements.
- You may call the Utah Registry for Professional Development toll free at 855-531-2468 if you need assistance in locating an approved provider or have questions about the provider you have selected.
- To file a complaint on a provider, you may submit a complaint form online at childcarelicensing.utah.gov or call Child Care Licensing at 801-273-2895.
- 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 childcarelicensing.utah.gov or call 800-883-9375 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 FFN Approved, make sure your provider contacts CCL 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.

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 change providers, or the amount your provider charges you for care changes. Always check *my*Case 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.

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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

Early detection of developmental delays is important for your child's well-being. Developmental screenings of young children can identify potential delays in a child's development and identify resources to offer additional support. If you want to learn more about typical development of children your child's age, or if you are concerned about your child's development, visit *http://helpmegrowutah.org*. Information on developmental screening is available online or by phone by a Help Me Grow staff member. If you are approved for child care assistance, DWS will share your case name, children's names ages 0 - 5 years, mailing address, phone number and email (if provided) with Help Me Grow. This agency will contact parents to provide resource information about child development and offer free developmental screenings for children in your home 0 - 5 years.

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: *www.uw.org/211*
- 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*

Food Assistance

- SNAP Brochure (#313): *https://fns-prod.azureedge.net/sites/default/files/snap/SNAP_313-e.pdf*
- WIC: *https://wic.utah.gov/*
- Nutrition Education: *http://extension.usu.edu/foodsense/*

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: *http://careaboutchildcare.utah.gov*

RIGHTS AND RESPONSIBILITIES

YOUR RIGHTS

- You have the right to an interpreter. Free language assistance services are available to you. Please call 801-526-0950 or see below:
    - **Spanish**: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 801-526-0950.
    - **Chinese:** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 801-526-0950。
    - **Vietnamese:** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 801-526-0950.
    - **Korean:** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 801-526-0950 번으로 전화해 주십시오

- **Navajo:** Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hólǫ, kojį' hódíílnih 801-526-0950.
- **Nepali:** ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 801-526-0950 ।
- **Tongan:** FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea teke lava 'o ma'u ia. Telefoni mai 801-526-0950.
- **Serbo-Croatian:** OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 801-526-0950.
- **Tagalog:** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 801-526-0950.
- **German:** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 801-526-0950.
- **Russian:** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 801-526-0950.
- **Cambodian:** ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 801-526-0950។
- **French:** ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 801-526-0950.
- **Japanese:** 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。801-526-0950。
- **Arabic:**

لحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 801- 526-0950

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- 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 UDOH 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 *http://www.fns.usda.gov/snap/contact_info/hotlines.htm.*
- USDA is an equal opportunity provider and employer.
- In accordance with Federal law and U.S. Department of Health and Human Services (DHHS) regulations, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. To file a complaint of discrimination, visit *www.hhs.gov/ocr/office/file* or contact the DHHS Office for Civil Rights at 999 18th Street, South Terrace, Suite 417, Denver, Colorado, 80202 or 303-844-2024, 303-844-3439 (TDD).
- 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). Applications for CHIP and UPP are only accepted during open enrollment periods.
- You have the right to know if your application was approved or denied and the reasons for the decision.
  - For 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.

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- 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, 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.
- 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.
- To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: h*ttps://www.ascr.usda.gov/sites/default/files/Complain_combined_6_8_12_508_0.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: U.S. Department of Agriculture
      Office of the Assistant Secretary for Civil Rights
      1400 Independence Avenue, SW
      Washington, D.C. 20250-9410
    - Fax: 202-690-7442; or
    - Email: program.intake@usda.gov.
- This institution is an equal opportunity provider.

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

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- 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
- 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.
- Individuals who are 19-59 may have to participate in Community Engagement activities. This includes registering for work, complete an online job assessment and training modules, and applying for 48 jobs. These activities must be completed within a 3-month period. You will be notified if you are required to participate. Individuals who meet one of the following reasons will be exempt from participation requirement. If the Department can determine you meet an exemption with information we already have, you will not be asked to provide additional proof.
  - Age 60 or older,
  - Pregnant or within the 60-day post-partum period,
  - Physically or mentally unable to meet the participation requirements as determined by a medical professional,
  - Responsible for the care of a dependent child under the age of six (only one parent per child),
  - Responsible for the care of a person with a disability as defined by the ADA (only one parent per disabled person),
  - A member of a federally recognized tribe,
  - Currently receiving unemployment insurance benefits, or awaiting an eligibility determination for those benefits.
  - Participating regularly in a drug or alcohol treatment program, including intensive outpatient treatment,
  - Enrolled at least half time in any school (including, but not limited to, college or university) or vocational training or apprenticeship program,
  - Participating in refugee employment services offered by the state, which include vocational training and apprenticeship programs, case management, and employment planning,
  - FEP recipients who are working with an employment counselor,
  - A beneficiary in compliance with or who is exempt from SNAP and/or FEP employment requirements,
  - Working at least 30 hours a week or working and earning at least what would equal the federal minimum wage earned working 30 hours a week.
- You must participate with community engagement activities unless you are found to be exempt or meet good cause criteria and that if you don't participate, you may not be eligible for Medicaid until you do participate, meet an exemption or good cause criteria.
- Individuals who do not qualify for an exemption may qualify for 'good cause' to not participate in the Community Engagement activities. If one of the following apply to you, good cause may be granted:
  - Have a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and was unable to meet the requirement for reasons related to that disability; or has an immediate family member in the home with a disability under federal disability rights laws and was unable to meet the requirement for reasons related to the disability of that family member; or the beneficiary or immediate family member, who was living in the home with the beneficiary, experiences a hospitalization or serious illness;
  - Experience the birth, or death, of a family member living with you;
  - Experience severe inclement weather (including natural disaster) and therefore was unable to meet the requirement;
  - Have a family emergency or other life-changing event (e.g. divorce or domestic violence);
  - Have no access to internet or transportation to a place where the requirements can be completed, such as a job center or library, to complete the requirements;

- There are fewer than 48 employers in your geographic area that potentially could offer employment to you or from where you reasonably could be expected to accept an offer of employment (including considerations related to, for example, your ability to obtain transportation to the employment site); in this case, the number of required employer contacts shall be reduced to an appropriate level so you are not required to make applications for employment that are likely to be futile; or
- Are the primary caretaker of a child age 6 or older and was unable to meet the requirement due to child care responsibilities.
- If you feel you may have a good cause reason not listed above, please contact your DWS worker at 801-526-0950 or toll free at 866-435-7414.

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- For more information about Community Engagement, visit: https://medicaid.utah.gov/community-engagement
- 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 (UDOH) pays for your medical care, you assign to it your rights to payments from any third party and to benefits for medical services. You will give to the UDOH any money you collect from an insurance policy, legal settlement or from someone required to pay for your medical expenses. You authorize payment directly to the UDOH or the Office of Recovery Services and will hold harmless any party making payment to them. You agree to cooperate with the State of Utah to pursue any third party responsible for medical expenses.
- You authorize any person or organization to release medical records or information about your health or the health of your dependents to the UDOH, Division of Health Care Financing or designee. The UDOH and the Department of Workforce Services may give health care providers information about your eligibility for medical assistance.
- In the event of my death and my spouse's death, the state has the right to recover from my estate all money spent to pay my medical bills if I receive 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 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.

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.

Equal Opportunity Employer/Program
Auxiliary aids 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.