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# **Table of Contents**

State/Territory Name: Arizona

State Plan Amendment (SPA) #: AZ-13-0002

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) SPA Summary Form
- 3) Approved SPA Pages

The complete title XXI state plan for Arizona consists of the most recent state plan posted on Medicaid.gov under CHIP and State Plan Amendments. The link is provided below. The following approved templates are in addition to, or replace sections of the state's posted current state plan. The attached approval letter(s) explain how these templates fit into that state plan.

Link to state title XXI state plans and amendments: XXI state plans and amendments: http://medicaid.gov/chip/state-program-information/chipstate-program-information.html

# DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services 7500 Security Boulevard, Mail Stop: S2-26-12

Baltimore, Maryland 21244-1850



# Children and Adults Health Program Group

NOV 0 7 2013

Melanie Norton, Assistant Director Arizona Health Care Cost Containment System (AHCCCS) 801 E. Jefferson MD 2600 Phoenix, AZ 85034

Dear Ms. Norton:

I am pleased to inform you that Arizona's Children's Health Insurance Program (CHIP) State Plan Amendment (SPA), AZ-13-0002, submitted on October 29, 2013, has been approved. This SPA incorporates the MAGI-based eligibility process requirements, including the single streamlined application, into Arizona's CHIP State Plan in accordance with the Affordable Care Act. The effective date of this SPA is October 1, 2013.

The approval of SPA AZ-13-0002, includes full approval of your alternative single streamlined application---both the paper and online versions.

Enclosed is a copy of the new state plan pages and attachments to be incorporated within Section 4 of Arizona's approved CHIP State Plan:

- CS24
- Alternative single, streamlined paper application
- An alternative paper application for mulitple human service programs, inclduing health insurance, SNAP, and TANF
- Healthe-Arizona Plus Medical Application Roadmap
- Health-e-Arizona Plus Online Flow Chart
- Key Differences between the Health-e-Arizona Plus online application and the CMS online application

This approval and the attachments supersede the following sections of the current CHIP State Plan:

- Section 4.3: Single, Streamlined Application Screen and Enroll Process
- Section 4.4: Renewals, Screening by Other Insurance Affordability Programs

This approval should not be read to address or resolve issues that may be raised by the HHS Office for Civil Rights (OCR) with respect to Arizona's Medicaid forms and procedures for processing Medicaid applications. Compliance with Federal civil rights laws is a condition of receipt of Medicaid funding, and is enforced by OCR. CMS sent comments to the state on behalf of OCR on August 09, 2013 and OCR officials met with Arizona State officials to discuss resolution of HHS OCR concerns on August 12, 2013. CMS is happy to provide technical assistance about Medicaid issues during the course of any subsequent discussions. Both CMS and OCR are committed to working together with Arizona to assist the State in presenting Marketplace options in a way that ensures that both Medicaid and civil rights issues are addressed.

CMS appreciates the significant amount of work your staff dedicated to preparing this State Plan Amendment. Your Title XXI project officer is Ms. Tonia Brown. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Brown's contact information is as follows:

Centers for Medicare & Medicaid Services Center for Medicaid & CHIP Services Mail Stop: S2-01-16 7500 Security Blvd. Baltimore, MD 21244-1850 Telephone: (410) 786-8613 Facsimile: (410) 786-5882

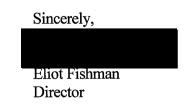
E-mail: Tonia.Brown@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Brown and to Ms. Gloria Nagle, Associate Regional Administrator (ARA) in our San Francisco Regional Office. Ms. Nagle's address is:

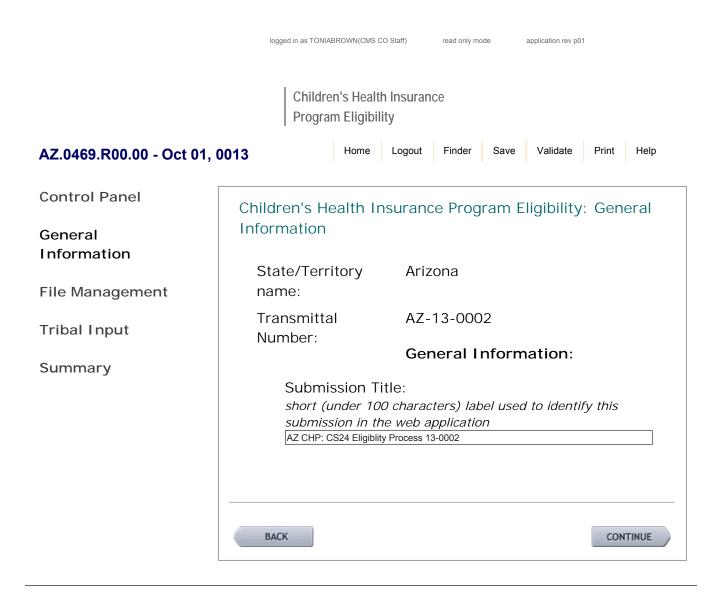
Centers for Medicare & Medicaid Services 90 7th Street, Suite 5-300 (5W) San Francisco, California 94103-6706

If you have additional questions, please contact Linda Nablo, Director, Division of State Coverage Programs at (410) 786-5143.

We look forward to continuing to work with you and your staff.



# Children's Health Insurance Program Eligibility: General Infor... Page 1 of 1



FAQs | Site Map | Contact | Medicaid.gov | CMS.gov



# **CHIP Eligibility**

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Separate Child Health Insurance Program General Eligibility - Eligibility Processing		S24
2102(b)(3) & 2107(e)(1)(O) of the SSA and 42 CFR 457, subpar	rt C	
The CHIP Agency meets all of the requirements of 42 CFR enrollment.	457, subpart C for application processing, eligibility screening and	× ,
Application Processing		
Indicate which application the agency uses for individuals apply modified adjusted gross income standard:	ring for coverage who may be eligible based on the applicable	
The single, streamlined application developed by the Se Care Act.	ecretary in accordance with section 1413(b)(1)(A) of the Affordable	
An alternative single, streamlined application developed section 1413(b)(1)(B) of the Affordable Care Act.	d by the state and approved by the Secretary in accordance with	
An attachn	nent is submitted.	
	aman service programs approved by the Secretary, provided that the e application used only for insurance affordability programs to ams.	
An attacl	hment is submitted.	
	d person acting on behalf of the individual, to submit an application via none, via mail, in person and other commonly available electronic mea	
The agency accepts applications in the following other elec-	tronic means.	
○ Other electronic means:		
Name of method	Description	
Fax	An individual can fax an application to the Medicaid or Human Services Agency	
Screen and Enroll Process		
application, periodic redeterminations, and follow-up eligib	nt screening procedures in place that are applied at time of initial bility determinations. The procedures ensure that only targeted low-liment is facilitated for applicants found to be potentially eligible for	
Procedures include:	·	



# **CHIP Eligibility**

			<del>~~~~~~~~</del>
	<b>SER</b> (	Screening of application to identify all individuals eligible or potentially eligible for CHIP or other insurance affordability programs; and	
		Income eligibility test, with calculation of household income consistent with 42 CFR 457.315 for individuals identified as potentially eligible for Medicaid or other insurance affordability programs based on household income; and	
		Screening process for individuals who may qualify for Medicaid on a basis other than having household income at or below applicable MAGI standard, based on information in the single streamlined application.	the
		e CHIP agency has entered into an arrangement with the Exchange to make eligibility determinations for advanced mium tax credits in accordance with section 1943(b)(2) of the SSA.	No
Rede	eter	mination Processing	
	<b>√</b>	Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 457.343:	<b>i</b>
		Once every 12 months.	
		Without requiring information from the individual if able to do so based on reliable information contained in the individual account or other more current information available to the agency.	dual's
		If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.	
Scre	eni	ng by Other Insurance Affordability Programs	
	<b>7</b>	The CHIP Agency provides assurance that it has adopted procedures to accept and process electronic accounts of individual screened as potentially eligible for CHIP by other insurance affordability programs in accordance with the requirements of CFR 457.348(b) and to determine eligibility in accordance with 42 CFR 457.340 in the same manner as if the application has been submitted directly to, and processed by the state.	42
		The CHIP Agency elects the option to accept CHIP eligibility decisions made by the Exchange or other agencies administer insurance affordability programs as provided in 42 CFR 457.348 and to furnish CHIP in accordance with requirements of 4 CFR 457.340 to the same extent and in the same manner as if the applicant had been determined by the state to be eligible for CHIP.	12
		e CHIP Agency has entered into an agreement with agencies administering other insurance affordability programs to fulfill the uirements of 457.348(b) and will provide this agreement to the Secretary upon request.	he

# PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130709

Approval Date: NOV 0 7 2013

Arizona Department of Economic Security/Family Assistance Administration (DES/FAA)
Arizona Health Care Cost Containment System (AHCCCS)

# **Application for Benefits**

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

# What is this application for?

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

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

See page B for a description of each program.

## Who can use this application?

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

### Your household includes:

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

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

### Where else can I apply?

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

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

## What information do I need to complete this application?

For everyone in your household, you may need:

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

Note: You can file an application with only your name, address, and the signature of a responsible household member or your authorized representative. This will hold your date of application but eligibility <u>cannot</u> be determined until you complete a full application and an interview, if needed.

### Why do we ask for so much information?

We ask about income and other information to make sure you and members of your household get the correct benefits for your household. We will keep all information you provide private, as required by law.

## What happens next?

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

### What if I need help?

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

Online: www.healthearizonaplus.gov Phone: 1-855-HEA-PLUS (432-7587)

In person: Visit www.azdes.gov/faa to find the office closest to you.

Transmittal Number: AZ 13-0005-MM Effective Date: October 1, 2013 Approval Date: September 30, 2013

# Program Information:

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



- = Health Insurance Costs (AHCCCS Medical Assistance, Medicare Savings Program, Tax Credits)
- = Nutrition Assistance
  - = Cash Assistance



= Tuberculosis Control

### What is AHCCCS Medical Assistance?



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

AHCCCS Medical Assistance covers the following medical services:

- Prescription Medication\*
- Doctor's Office Visits\*\*
- Laboratory and X-ray Services
- Hospital Services
- Dialysis

- Medical Supplies
- Medically Necessary Transportation
- Medically Necessary Specialist Care
- Behavioral Health Care
- Immunizations (shots)

- Chemotherapy
- Emergency Medical Care
- Rehabilitation Services
- 90 days of nursing care services

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

# What is Medicare Savings Program?



Medicare Savings Program may pay:

- Medicare Part A premium
- Medicare Part B premium
- Medicare deductibles and copayments
- Automatic Extra Help for Medicare Part D prescription expenses

### What are Nutrition Assistance benefits?



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

### What is Cash Assistance?



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

# What is Tuberculosis Control?



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

# What if I am not eligible for AHCCCS Medical Assistance?



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

Transmittal Number: AZ 13-0005-MM FA-001 (10/13) Arizona

Effective Date: October 1, 2013

### How does AHCCCS Medical Assistance work?



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

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

### How much does AHCCCS Medical Assistance cost?



### Premiums:

- Most people do not have to pay a monthly premium for AHCCCS Medical Assistance.
- Some people with income too high to qualify for AHCCCS Medical Assistance with no monthly premium may be able to get it by paying a monthly premium. If you have to pay a premium, the premium amounts are \$10 to \$35 per person for employed people with disabilities.

### Co-payments:

A co-payment is the amount you pay a health care provider when you receive a medical service. Your co-payment amount will vary depending on which AHCCCS program you are enrolled in and the services you need. For some AHCCCS programs, the provider can deny services if the co-payments are not made. Co-payments for services are:

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

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

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

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

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

- Hospitalizations
- Services paid on a fee-for-service basis
- · Emergency services

- Pregnancy related health care including tobacco cessation for pregnant women
- Family planning services

# Do I need a Social Security number?



Federal law requires you give a Social Security number (SSN) for anyone who wants to get AHCCCS Medical Assistance, help with Medicare costs, Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control (42 U.S.C. § 1320b-7; 42 U.S.C. § 405(c)(2)(C), 7 U.S.C. §§ 2011-2036, and Social Security Act (SSA) of 1935 (Section 1137) as amended by P.L. 98-369).

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

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

- · Verify identity
- · Verity citizenship and immigration status
- Verify income and resources
- · Prevent duplicate benefits
- · Establish and enforce child support
- Computer match with state, local and federal agencies and our other programs to verify information
- · Collect money we overpaid you in the form of benefits
- Share with other government agencies and their contractors to assess Nutrition Assistance and/or Cash Assistance program management and compliance
- We may give your information to law enforcement officials for the purpose of arresting persons fleeing to avoid the law

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

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

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



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

Effective Date: October 1, 2013

### Will I have to do an interview?



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

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

For AHCCCS Medical Assistance and/or help with Medicare costs, we will make a decision within 45 days.

- If you are pregnant, we will make a decision within 20 days.
- If you need a disability determination report, we will make a decision within 90 days.

For Nutrition Assistance, we will make a decision within 30 days.

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

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For Cash Assistance, we will make a decision within 45 days.

• If you are a relative or legal guardian applying only for children who are not your own, we will determine if the children qualify within 20 days.

# How will I know if I am eligible?



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

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



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



If you are approved for Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control:

Effective Date: October 1, 2013

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

## What is expected of me?

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#### For all programs

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

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### Program-specific expectations:

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



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



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

# What are my rights?



#### You have the RIGHT to:

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

Effective Date: October 1, 2013

- · Look at your file before a fair hearing.
- Bring an attorney or any other person to a fair hearing.

To file a discrimination complaint, contact:

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

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

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

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

### What are the Rules and Penalties?



If you, your representative, or any household member hides information or gives false information on purpose to get or continue to get Nutrition Assistance and/or Cash Assistance benefits that you are not entitled to, that person will be subject to:

- Criminal Prosecution
- Fines
- Imprisonment
- · Other penalties provided for by state and federal laws

If you get Nutrition Assistance and/or Cash Assistance, you must follow the rules below:

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

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

- 12 months for the first violation
- 24 months for the second violation
- · Permanently for the third violation

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

- Is a fleeing felon or probation/parole violator.
- Has been convicted of using or getting Nutrition Assistance benefits in a transaction involving the sale of firearms, ammunition or explosives. This person can never get Nutrition Assistance benefits again.
- Has been found guilty of using or getting Nutrition Assistance benefits in a transaction involving the sale of a controlled substance. This person is not eligible to get Nutrition Assistance benefits for 2 years for the first violation and permanently for the second violation.
- Has committed and was convicted of a federal or state felony on or after August 23, 1996 for the possession, use or distribution of a controlled substance.
- Has been found by a court of law to have given false identification or residence information in order to get benefits in more than one case. This person is not eligible to get benefits for 10 years.
- Refuses to sign and comply with the Personal Responsibility Agreement (PRA). We give you the PRA during the interview process.
- Is an adult recipient (18 years or older) of Cash Assistance when any of the following apply:
  - The recipient does not return the completed Illegal Drug Use Statement. We send the Illegal Drug Use Statement by U.S. Mail after Cash Assistance has been approved.
  - The recipient fails to take a required drug test.
  - The recipient fails the drug test.

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

The following additional penalties apply to the Nutrition Assistance Program:

- An additional disgualification, of up to 18 months, may be ordered by a court.
- Any participant or household member who makes false statements or hides information can be fined up to \$250,000.00, imprisoned for up to 20 years, or both.

# How to Choose an AHCCCS Health Care Plan:



## You need to choose a health plan that services your county.

All AHCCCS health plans provide the same covered medical services.

• Review the health plans for your county listed below. American Indians may choose American Indian Health Program or an AHCCCS health plan.

Before you choose a plan, check with your doctor, pharmacy, or hospital to see if they work with the plan that you
want. If you want more information about the doctors, specialists, or hospitals that work with a health plan that
serves your county, call the number listed below for the health plan.

If you do not choose a health plan, one will be assigned to you. If you have been enrolled in an AHCCCS health plan within the past 90 days, you may be enrolled with your previous health plan.

Enter the health plan choice on this application.

APACHE COUNTY UnitedHealthcare Community Plan
If your zip code is 85943, you must choose from the health plans listed under Navajo County.
COCHISE COUNTYUniversity Family Care1-800-582-8686UnitedHealthcare Community Plan1-800-348-4058American Indian Health Program520-295-2479
COCONINO COUNTYUnitedHealthcare Community Plan1-800-348-4058Health Choice Arizona1-800-322-8670American Indian Health Program928-283-2501
If your zip code is 86336 or 86340, you must choose from the health plans listed under Yavapai County.
GILA COUNTY Health Choice Arizona
GRAHAM COUNTYUniversity Family Care1-800-582-8686UnitedHealthcare Community Plan1-800-348-4058American Indian Health Program928-475-2686
If your zip code is 85643, you must choose from the health plans listed under Cochise County.
GREENLEE COUNTYUniversity Family Care1-800-582-8686UnitedHealthcare Community Plan1-800-348-4058American Indian Health Program928-475-2371
LA PAZ COUNTYUnitedHealthcare Community Plan1-800-348-4058University Family Care1-800-582-8686American Indian Health Program928-669-2137
MARICOPA COUNTY         Health Net of Arizona       1-888-788-4408         Care 1 <sup>st</sup> Arizona       1-866-560-4042         Health Choice Arizona       1-800-322-8670         UnitedHealthcare Community Plan       1-800-348-4058         Mercy Care Plan       1-800-624-3879         Maricopa Health Plan       1-800-582-8686         American Indian Health Program       602-263-1200

MOHAVE COUNTYUnitedHealthcare Community Plan1-800-348-4058Health Choice Arizona1-800-322-8670American Indian Health Program928-769-2900
If your zip code is 86434, you must choose from the health plans listed under Yavapai County.
NAVAJO COUNTY UnitedHealthcare Community Plan
PIMA COUNTY           UnitedHealthcare Community Plan         1-800-348-4058           Health Choice Arizona         1-800-322-8670           Care 1 <sup>st</sup> Arizona         1-866-560-4042           University Family Care         1-800-582-8686           Mercy Care Plan         1-800-624-3879           American Indian Health Program         520-295-2479
If your zip code is 85645, you must choose from the health plans listed under Santa Cruz County.

PINAL COUNTY	
Health Choice Arizona	1-800-322-8670
University Family Care	1-800-582-8686
American Indian Health Program	

If your zip code is 85242 or 85220, you must choose from the health plans listed under Maricopa County.

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

University Family Care	1-800-582-8686
UnitedHealthcare Community Plan	1-800-348-4058
American Indian Health Service	520-295-2479
UnitedHealthcare Community Plan	
University Family Care	
American Indian Health Program	602-263-1200

choose from the health plans listed under Maricopa County.

If your zip code is 86351 you must choose from the health plans listed under Coconino County.

YUMA COUNTY	
UnitedHealthcare Community Plan	1-800-348-4058
University Family Care	
American Indian Health Program	

Transmittal Number: AZ 13-0005-MM

Ellective Date: October 1, 2013

Approval Date: September 30, 2013

Page H

Do you need help with this application? Visit www.hea	attieanzonapids.gov of can 1-000-11271 200 (402 1001)
	A)
Contact Information:	
Tell us how we can contact an adult member of y	/our nousenoia.
Name (First, Middle, Last):	
Home Address: Apt.	#: City: State: Zip Code:
Mailing Address (if different): Apt.	#: City: State: Zip Code:
Do you live in a shelter?	of shelter?
Phone Number:This number is:	of shelter? Home
Other Phone Number:This number is:	Home U Cell U Work U Message U Other:
	□ Spanish □ Other:
What is the preferred WRITTEN household language?    Language Lang	n □ Spanish □ Other:
I would like to get information about this application by:	
Email:	
Text:  Yes No Number to text (standard text rates app	oly):application will be sent via U.S. Mail to the mailing address provided.
I need the following help with this application (check all that apply): ☐ Reading/understanding this application ☐ Filling out this a	
☐ American Sign Language ☐ Braille	□ Language Interpreter Language:
I need the following accommodations for this application (check all t	
☐ Hearing ☐ Speaking ☐ Seeing ☐ Writing	
Authorized Benrocontativo:	
Authorized Representative:	DEC and/or
This section is OPTIONAL. You may authorize AHCCCS cannot release any information about	e someone else to represent you in the application process. DES and/or
Representative's Name:	Is representative your legal guardian?   Yes  No
Representative's Mailing Address:	City: State: Zip Code:
	number is: 🔲 Home 🔲 Cell 🔲 Work 🔲 Message 🔲 Other:
	pumber is: □ Home □ Cell □ Work □ Message □ Other:
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What is the representative's preferred SPOKEN language? What is the representative's preferred WRITTEN language?	number is: ☐ Home ☐ Cell ☐ Work ☐ Message ☐ Other: ☐English ☐ Spanish ☐ Other: ☐ English ☐ Spanish ☐ Other:
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Approval Date: September 30, 2013 Effective Date: October 1, 2013

Transmittal Number: AZ 13-0005-MM FA-001 (10/13) Arizona

# Release of Information to Hospitals/Hospital Agents/Organizations/Agencies:

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

,	al/Hospital's Agent/Organization/Agen							
	E			Ph	one Numl	oer:		
Mailing Address	S:	City:		Sta	ate:	Zip	Code:	
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Signature of Ap	plicant:	····			Date:			
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Access to	o Electronic Benefit Tra	nster (EBT)	Accou	nt:				
<b>*</b> \$&	This section is OPTIONAL. If you armay choose a person, called an Alte choose a person you trust. Rememb	rnate Cardholder, to	get your be	nefits for	r you. If y			
EBT Represent	ative's Name:			_EBT R	epresenta	tive's Date of	Birth:	
EBT Represent	tative's Mailing Address:		City:	-		State:	_ Zip Cod	de:
EBT Represent	tative's Phone Number:		☐ Home	☐ Cell	☐ Work	☐ Message	Other:	
	tative's Other Phone Number:							
Signature of Ap	oplicant:			Da	ate:			
			***			**************		
Someone	Who Knows You Well:							
●\$&	We often need to contact people or or When we contact these people or org Economic Security (DES). We are provide contact information be	ganizations we tell the rohibited by law from	em your na	me, our f	title and th	nat we work fo	r the Depa	artment of
Name of someo	ne who knows you well:					o you:		
Mailing Address	Mumbon		City:			State:	Zip Code	•
Daytime Phone	Number:						20,000 o 10,000 (f)	
Name of Landlor Mailing Address	rd:	····	City	Rela	ationship t	o you: State:	Zin Code	y*
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Emergen	cy Nutrition Assistance							
	Is anyone in your household applying		rition Assist	ance? If	YES: fill o	out this section	n. If <b>NO</b> : (	go to page 3.
			•			***************************************		***************************************
	I amount of income, before deductions	<del></del>					\$	<del>/////////////////////////////////////</del>
	al amount of cash on hand and money tal monthly housing costs (rent or mon				e etc \?		\$ \$	
	tal monthly utility costs (gas, electric, p		michi cillai	mourant			\$	
	eceive Tribal Food Distribution?						☐ Yes	☐ No
Is anyone a mig	grant or seasonal farm worker?						☐ Yes	□ No
	Nutrition Assistance benefits from any		LA		GL-1		☐ Yes	□ No
If 'Yes,' who re	eceived?	e i podaleta i die di distribi	hen?	CONTRACTOR	State:	13-149-14-00 God G	网络多数电影 化	

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

# PERSON 1:

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

** * \$ & Personal Information:					
Name (First, Middle, Last):					Gender: 🛭 Male 🚨 Female
Date of Birth: Social Security Nur	nber (optio	nal if not	applying):		
Marital Status:		vorced	☐ Widowed	d 🗆 Ma	arried-name of spouse:
Is PERSON 1 attending school?		es,' is PEF		nding scho ade Level:	ol : □ Full Time □ Part Time
Is PERSON 1 applying for help with health	☐ Yes	□ No	If 'Yes,' Ah	ICCCS he	alth plan choice:e page H for enrollment plan choices.
insurance costs	☐ Yes	□ No			im number:
<ul> <li>Is PERSON 1 applying for help with Medicare costs?</li> <li>Does PERSON 1 need help paying for medical bills from the last 3 months?</li> </ul>	☐ Yes	□ No			??
Is PERSON 1 applying for Nutrition Assistance?	☐ Yes	□ No			
\$ Is PERSON 1 applying for Cash Assistance?	☐ Yes	□ No			
b. Is PERSON 1 applying for Tuberculosis Control?	☐ Yes	□ No			
If PERSON 1 is applying fo If PERSON 1 is <b>NOT</b> applying for	or any bene	fits: continu	e answering the	he question	s below.
IT PERSON T IS NOT applying for	any benefit	s. go to pag	e o to ten us a	IDUUL FERS	ON 13 income.
Citizenship/Residency: Tell us a citizenship/residency.	about PER	SON 1's c	itizenship/res	sidency. Y	ou may need to provide proof of
Is PERSON 1 a U.S. citizen or U.S. national? See page	D for more	information	on. 🔲 Y	es 🗆 N	No Choose not to answer
If PERSON 1 is NOT a U.S. citizen, what is his/her immig	ration stat	us?			
□ Lawful Permanent Resident (LPR) □ Batt □ Lawful Temporary Resident □ Cub □ Non-Immigrant Status □ Defe □ Asylee □ Defe □ Refugee □ Legs □ Conditional Entrant granted before 1980 □ Legs □ Other □ Orde	ered Spou an-Haitian erred Actio erred Enfol alization ul	se, Child of Entrant n Status rced Depa nder LIFE nder IRCA rvision	rture Act Applicant	Regist Specia Tempo Victim Withho	val/Suspension of Deportation ry Applicants al Immigrant Juvenile Status Applicant brary Protection Status (TPS) of Trafficking blding of Deportation ant for Asylum, LPR, TPS, or olding Deportation
What immigration document does PERSON 1 have? ☐ Permanent Resident card ☐ I-94 ☐ Visa ☐ Foreign Passport ☐ None ☐ Other:		mmigratio Has PERS	n Document ON 1 lived ir	Number: _ n the U.S. s	since August 22, 1996? ☐ Yes ☐ No
Is PERSON 1 an Arizona resident? ☐ Yes ☐ No		SON 1 mo		a in the las	t 4 months?
Race (optional), select one or more:					Ethnicity (optional):
☐ Asian ☐ Hawaiian or other Pa	acific Islan	der 🗆 W	hite		☐ Hispanic/Latino
☐ Black or African American ☐ American Indian/Ala	ska Native	<u> </u>	ther:		☐ Non-Hispanic/Non-Latino
If PERSON 1 is American Indian or Alaska Native: Is he/she enrolled in a federally recognized tribe?		ΩYe	es 🛭 No	If 'Yes,' I	name of tribe:
Has he/she ever gotten services from Indian Health Serv health program, or urban Indian health program, or throu from one of these programs?	ice, a triba gh a referr	al	ng kalawan ar uma		s he/she eligible?
\$\\$\\$\ \s\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		□Yı	es 🗆 No	If 'Yes,'	name of reservation:
Tribal Census Number:					

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

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

IS PERSON	1 physically or mentally disabled?		☐ Yes ☐	l No		4	
IS PERSON	1 in jail or prison?		☐ Yes ☐	l No			
Was PERSO	DN 1 released from jail or prison in the last 4 mon	ths?	☐ Yes □	l No	If 'Yes,' rele	ase date:	
<b>-</b> \$	AHCCCS Medical Assistance, Hel Complete this section if PERSON 1 is apply and/or Cash Assistance.	Ip with Medicar	re Costs, CS Medical	and C Assista	ash Assi	i <b>stance Qu</b> nelp with Medi	estions: care costs,
s PERSON	1 pregnant?		☐ Yes	□ No		umber of babie expected due o	
	1 is under age 19, are both of his/her parents living mplete the information below:	ng in the home?	☐ Yes	□ No			
Parent's Na	me (First, Last):	Social Secur	ity Number:			Date of Bir	th:
Mailing Add	ress:	City:		S	ate:	Zip Cod	ð:
Phone Num	ber:	Reason pare	nt is absent		Deceased	Out of ho	me
Parent's Na	me (First, Last):	Social Secur	ity Number:			Date of Bir	th:
√lailing Add	ress:	City:		S	ate:	Zip Cod	e:
Phone Num	ber:	Reason pare	nt is absent		Deceased	Out of ho	me
f PERSON will keep f f PERSON	AHCCCS Medical Assistance and questions if PERSON 1 is applying for AHC 1 is under the age of 65, does he/she have a menim/her from working for at least 12 months?  1 works and is under the age of 65, does he/she 2 months?	CCS Medical Assis	tance and/o bility that ha	r help v is kept	vith Medicar or 🔲		
f PERSON will keep f If PERSON at least 12 Does PERS assistance	questions if PERSON 1 is applying for AHC  1 is under the age of 65, does he/she have a mentim/her from working for at least 12 months?  1 works and is under the age of 65, does he/she months?  ON 1 need help with activities of daily living (bather, services, nursing home, or other medical facility	CCCS Medical Assis ntal or physical disa have a disability tha ning, dressing, etc.)	tance and/o bility that ha It is expecte through per	r help vas kept of to las	vith Medicar or □ .t □	re costs. Yes □ No Yes □ No Yes □ No	
will keep f If PERSON at least 12 Does PERS assistance Does PERS	questions if PERSON 1 is applying for AHC  1 is under the age of 65, does he/she have a menim/her from working for at least 12 months?  1 works and is under the age of 65, does he/she months?  2 months?  ON 1 need help with activities of daily living (bath	CCCS Medical Assis ntal or physical disa have a disability tha ning, dressing, etc.) y? d is the main care to	tance and/o bility that ha It is expecte through per	r help vas kept of to las	vith Medicar or	re costs. Yes □ No Yes □ No	
f PERSON will keep f f PERSON at least 12 Does PERS assistance Does PERS Has PERSO	questions if PERSON 1 is applying for AHC  1 is under the age of 65, does he/she have a menim/her from working for at least 12 months?  1 works and is under the age of 65, does he/she months?  1 months?  1 months?  1 months?  1 months?  2 months?  2 months?  3 months?  4 months?  4 months?  5 months?  5 months?  6 months?  6 months?  6 months?  6 months?  6 months a services, nursing home, or other medical facility  6 months must be months as a services.  7 months must be months as a service of the months and the months are a services.  8 months?  8 months?  8 months?  8 months?  9 month	CCCS Medical Assis ntal or physical disa have a disability that ning, dressing, etc.) y? d is the main care to e (SSI Cash)? ssistance Ques ance. PERSON 1 non.	tance and/o bility that ha it is expecte through per aker of the c stions: Ar nay still be a	r help vas kept do las sonal child?	vith Medicar or   it   it   inese questic get benefits	re costs. Yes □ No Ons if PERSON if he/she has a	N 1 is applyin a felony drug
f PERSON will keep If f PERSON at least 12 Does PERS assistance Does PERS Has PERSO	questions if PERSON 1 is applying for AHC  1 is under the age of 65, does he/she have a mentim/her from working for at least 12 months?  1 works and is under the age of 65, does he/she months?  1 months?  2 months?  2 months?  2 months?  2 months?  3 months?  3 months?  4 months?  5 months?  5 months?  6 months?  7 months?  7 months?  7 months?  7 months?  8 months?  8 months?  8 months?  9 mo	CCCS Medical Assis ntal or physical disa have a disability that ning, dressing, etc.) y? d is the main care to e (SSI Cash)? ssistance Ques ance. PERSON 1 non.	tance and/o bility that ha it is expecte through per aker of the o	r help vas kept do las sonal child?	vith Medicar or   it   it   inese questic get benefits  if 'Yes,' City/stat	re costs.  Yes □ No  Ons if PERSON	N 1 is applyin a felony drug tion:
f PERSON will keep if PERSON at least 12 Does PERS assistance Does PERS Has PERSO controlled	questions if PERSON 1 is applying for AHC  1 is under the age of 65, does he/she have a menim/her from working for at least 12 months?  1 works and is under the age of 65, does he/she months?  1 months?  1 months?  1 months?  1 months?  2 months?  2 months?  3 months?  4 months?  4 months?  5 months?  5 months?  5 months?  6 months?  7 months?  7 months?  7 months?  7 months?  7 months?  8 months?  9 mon	cCCS Medical Assis ntal or physical disa have a disability that hing, dressing, etc.)  y? d is the main care to e (SSI Cash)?  ssistance Questance. PERSON 1 non. or distribution of a	tance and/o bility that ha it is expecte through per aker of the c stions: Ar nay still be a	r help vas kept do las sonal shild?	vith Medicar or   it   mese questic get benefits  if 'Yes,' City/stat Type of if 'Yes,'	re costs. Yes □ No Ons if PERSON if he/she has a date of convicte te of conviction	N 1 is applyin a felony drug tion:
f PERSON will keep f f PERSON at least 12 Does PERS assistance Does PERS Has PERSO controlled Has PERSO Cash Ass s PERSON	questions if PERSON 1 is applying for AHC  1 is under the age of 65, does he/she have a mentim/her from working for at least 12 months?  1 works and is under the age of 65, does he/she months?  1 months?  2 months?  2 months?  2 months?  2 months?  2 months?  3 months?  3 months?  4 months?  5 months?  5 months?  6 mo	cCCS Medical Assis ntal or physical disa have a disability that hing, dressing, etc.)  or distribution of a sistance and/or or any other state?  charges, or is	tance and/o bility that ha it is expecte through per aker of the c stions: Ar nay still be a	r help vas kept of to lass sonal shild?	vith Medicar or   it   mese questic get benefits  if 'Yes,' City/stat Type of if 'Yes,'	re costs. Yes □ No Ons if PERSON if he/she has a date of conviction conviction:	N 1 is applyin a felony drug tion:
f PERSON will keep f f PERSON at least 12 Does PERS assistance Does PERS Has PERSO Controlled Has PERSO Cash Ass	questions if PERSON 1 is applying for AHC  1 is under the age of 65, does he/she have a mentim/her from working for at least 12 months?  1 works and is under the age of 65, does he/she months?  1 works and is under the age of 65, does he/she months?  1 months?  2	cCCS Medical Assis ntal or physical disa have a disability that hing, dressing, etc.)  of dis the main care to e (SSI Cash)?  ssistance Questance. PERSON 1 non.  or distribution of a sistance and/or any other state? charges, or is a court?	tance and/o bility that ha it is expecte through per aker of the c stions: Ar nay still be a	r help vas kept as kep	vith Medicar or   it   mese questic get benefits  if 'Yes,' City/stat Type of if 'Yes,'	re costs. Yes □ No Yes □ No Yes □ No Yes □ No Ons if PERSON if he/she has a date of conviction conviction: name of state	N 1 is applyin a felony drug tion: 
f PERSON will keep f if PERSON at least 12 Does PERS assistance Does PERS Has PERSO Controlled Has PERSO Cash Ass Is PERSON PERSON expenses	questions if PERSON 1 is applying for AHC  1 is under the age of 65, does he/she have a menim/her from working for at least 12 months?  1 works and is under the age of 65, does he/she months?  1 works and is under the age of 65, does he/she months?  1 months?  1 months?  1 months?  1 months?  2 months?  2 months?  2 months?  3 months?  3 months?  4 months?  4 months?  5 months?  6 m	cCCS Medical Assis ntal or physical disa have a disability that hing, dressing, etc.) or distribution of a sistance Questance. PERSON 1 mon. or distribution of a sistance and/or or any other state? charges, or is a court?  Answer these questancy paid or unpaid mone travel expenses to	tance and/o bility that ha It is expecte through per aker of the co stions: Ar nay still be a  "Yes "Yes "Yes "Yes "Yes	r help vas kept as kep	vith Medicar or   tt   mese questic get benefits  O If 'Yes,' City/stat Type of O If 'Yes,'	re costs. Yes □ No Yes □ No Yes □ No Yes □ No Ons if PERSON if he/she has a date of conviction conviction: name of state	N 1 is applyin a felony drug tion: 

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

# PERSON 1:

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

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

Does PERSON 1 work?	☐ Yes	□ No If y	yes, give employ	ment information below:
	s Earnings deductions	): Hov	v often paid?	How many hours worked per week?
Is PERSON 1 self-employed?	□ Ye	es 🗓 No	If 'Yes,' type o	f work: I net (after deductions) amount:
If 'Yes,' has PERSON 1 been in this business for 12 mor	nths? 🔲 Ye	es 🛚 No	If 'No,' date bu	usiness started:
Does PERSON 1's income change because of contract or	□ Ye	es 🛭 No		ch income does PERSON 1 expect to
seasonal employment?  Does PERSON 1 work in exchange for food or rent?	□ Ye	es 🛚 No	If 'Yes,' where	next 12 months?
Does PERSON I Work in exchange for food of fent?		=5 <b>LI</b> 110	ii ies, wiieie	
Other Income: Tell us about other in	come PERS	ON 1 receives	. You may need	I to provide proof of income.
Type of Income:	Amount:	How often	received?	Who pays the income?
Social Security benefits				
Supplemental Security Income (SSI Cash)				
Retirement/pension				
Unemployment				
Disability/worker's compensation				
Child support				
Alimony				
Veterans benefits				
Gifts or loans				
Tribal money		rangen and annound notice of a great		
Per capita payments from natural resources, usage rights, leases or royalties				
Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land				
Money from selling things that have cultural significance				
Other:				
Check here if this person does not have income				
Potential Benefits: Tell us about PE Has PERSON 1 or his/her spouse (living or deceased) eve for a government agency or an employer with a pension pla Has PERSON 1 or his/her spouse (living or deceased) serv military?	r worked an?	□ Yes □	No If 'Yes,' en If 'Yes,' da No If 'Yes,' br	nployer name:  ntes of employment: anch of service:
If PERSON 1 is under age 19, has his/her parent (living or served in the military?	deceased)	□ Yes □	No If 'Yes,' br	anch of service: tes of service:
Federal Income Tax Filing: Tell u	s how PERS	ON 1 will file i	ncome taxes NE	EXT YEAR.
Will PERSON 1 file taxes NEXT YEAR?	☐ Yes	□ No		
If 'Yes,' will PERSON 1 file jointly with a spouse?	☐ Yes	□ No	If 'Yes,' nam	ne of spouse:
Will PERSON 1 claim dependents on his/her tax return?	□ Yes	□ No		ne of dependent(s):
Will PERSON 1 be claimed as a dependent on someone else's tax return?	☐ Yes	□ No	If 'Yes,' nam Relationship	
Does PERSON 1 pay any expenses that may be deducted on the federal income tax return?  Do not include self-employment expenses.  Check all that apply.	☐ Other	ny nt loan interes deductions ribe deduction	Amount pai	d:How often?

Is there anyone else in PERSON 1's household? If **YES**, go to the next page to tell us about PERSON 2. If **NO**, go to page 18. Transmittal Number: AZ 13-0005-MM Effective Date: October 1, 2013 Approval Date: September 30, 2013

PERSON 2:							
Tell us about the other people in	your household. Se	ee page A for a c	lefinition o	of who you	must include.		
Personal Information:	-						
Name (First, Middle, Last):						_Gender: 🔲 Ma	le 🛚 Female
Date of Birth:	Social Security N					304	
Relationship to Person 1:	☐ Spouse ☐ Grandchild		ld/Step Cl ce/Nephe		☐ Parent☐ Legal Guar		140
Marital Status:   Never Ma					me of spouse: _		
Does PERSON 2 live at the same If 'No,' what is PERSON 2's ho							
Is PERSON 2 attending school?  Name of school:	☐ Yes ☐ No	If 'Ye	s,' is PER		ending school : Grade Level:	☐ Full Time ☐	Part Time
				<del></del>			
Is PERSON 2 applying for he	elp with health	☐ Yes	□ No	If 'Yes,'	AHCCCS health	plan choice: e H for enrollment pl	an choices
insurance costs? Is PERSON 2 applying for he	elp with Medicare	☐ Yes	□ No			umber:	
costs? Does PERSON 2 need help	paying for medical	☐ Yes	□ No	If 'Yes,' v	what months?		
bills from the last 3 months?  Is PERSON 2 applying for Nu	itrition Assistance?	☐ Yes	□ No				
Is PERSON 2 applying for Ca		☐ Yes	□ No				
Is PERSON 2 applying for Tu			□ No				
	r memocoli o transiti						
	f PERSON 2 is applyir ON 2 is <b>NOT</b> applying						
Citizenship	sidency.					may need to provi	
Is PERSON 2 a U.S. citizen or U				n. u	Yes □ No □	1 Choose not to a	IISWei
If PERSON 2 is NOT a U.S. citize  Lawful Permanent Resident (L  Lawful Temporary Resident  Non-Immigrant Status  Asylee  Refugee  Conditional Entrant Granted b  Other  I do not want to provide	PR)	Battered Spouse Cuban-Haitian En Deferred Action So Deferred Enforce Legalization unde Legalization unde Drder of Supervis Paroled into Unite	, Child and ntrant Status d Departu er LIFE Ad er IRCA A sion	ure ct	☐ Registry App ☐ Special Imm ☐ Temporary F ☐ Victim of Tra ☐ Withholding	igrant Juvenile St Protection Status ( afficking of Deportation r Asylum, LPR, TF	atus Applicant (TPS)
	s PERSON 2 have? I I-94	ln H	nmigration as PERSC	Documer ON 2 lived	nt Number: in the U.S. since	e August 22, 1996	? ☐ Yes ☐ N
Is PERSON 2 an Arizona resider	nt? 🗆 Yes 🗆 N	Did PERSO If 'Yes,' da			a in the last 4 mo	onths? 🛚 Yes	□ No
Race (optional), select one or mo					i	icity (optional):	
	<ul><li>Hawaiian or othe</li><li>American Indian/</li></ul>		· □ Whi		D No	spanic/Latino on-Hispanic/Non-l	
Is he/she enrolled in a federally r	ecognized tribe?			- D No	If 'Yes,' name	of tribo:	_atino
io morono ornonoa in a roadian, i	ecogrized tribe:		☐ Ye	s 🖵 No	ii ies, name	of tribe.	atino

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

Transmittal Number: AZ 13-0005-MM FA-001 (10/13) Arizona

Effective Date: October 1, 2013

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

	2 physically or mentally disabled?	☐ Yes	□ No		
	2 in jail or prison?	☐ Yes	□ No		
Was PERSO	N 2 released from jail or prison in the last 4 mont	ns?	□ No	If 'Yes,' rele	ease date:
\$	AHCCCS Medical Assistance, F Complete this section if PERSON 2 is ap Cash Assistance.	lelp with Medicare Cost plying for AHCCCS Medical A	ts, and ssistance	Cash As and/or help	sistance Questions o with Medicare costs, and
Is PERSON:		☐ Yes			umber of babies due: xpected due date:
	is under age 19, are both of his/her parents living aplete the information below:		□ No		
Parent's Nan	ne (First, Last):	Social Security Number:			Date of Birth:
Mailing Addr	988:	City:	Stat	e:	Zip Code:
Phone Numb	er:	Reason parent is absent	. 01	Deceased	☐ Out of home
Parent's Nan	ne (First, Last):	Social Security Number:			Date of Birth:
Mailing Addr	988:	City:	Stat	e:	Zip Code:
Phone Numb	er:	Reason parent is absent	: 🗆 [	Deceased	Out of home
	DN 2 need help with activities of daily living (bathi services, nursing home, or other medical facility)			ΥO	′es □ No
Does PERSO	ON 2 live with at least one child under age 19 and N 2 ever received Supplemental Security Income				
Does PERSO	-	(SSI Cash)? ssistance Questions: Ash Assistance. PERSON 2 ma	\nswer th	ese questic	res □, No ons if PERSON 2 is benefits if he/she has a
Does PERSO  Has PERSO  Has PERSO	N 2 ever received Supplemental Security Income  Nutrition Assistance and Cash A applying for Nutrition Assistance and/or Ca	(SSI Cash)?  ssistance Questions: Ash Assistance. PERSON 2 mare information.	\nswer th	ese questic able to get If 'Yes,' d City/state	res Q.No
Has PERSO controlled  Has PERSO cash Assis	N 2 ever received Supplemental Security Income  Nutrition Assistance and Cash A applying for Nutrition Assistance and/or Ca felony drug conviction. See page G for mo N 2 had a felony conviction for possession, use, of substance on or after August 23, 1996? N 2 been found to have committed a Nutrition Assistance Intentional Program Violation in Arizona or	(SSI Cash)?  ssistance Questions: A sh Assistance. PERSON 2 mare information. or distribution of a Yes sistance and/or Yes any other state?	Answer the ay still be No	ese questic able to get If 'Yes,' d City/state Type of c	ons if PERSON 2 is benefits if he/she has a ate of conviction:
Does PERSO Has PERSO controlled Has PERSO Cash Assis	N 2 ever received Supplemental Security Income  Nutrition Assistance and Cash A applying for Nutrition Assistance and/or Ca felony drug conviction. See page G for mo N 2 had a felony conviction for possession, use, of substance on or after August 23, 1996? N 2 been found to have committed a Nutrition Assistance.	ssistance Questions: Ash Assistance. PERSON 2 mare information. or distribution of a Yes sistance and/or yes any other state?	Answer the ay still be	ese questic able to get If 'Yes,' d City/state Type of c	ons if PERSON 2 is benefits if he/she has a late of conviction:
Does PERSO Has PERSO controlled Has PERSO Cash Assis	N 2 ever received Supplemental Security Income  Nutrition Assistance and Cash A applying for Nutrition Assistance and/or Ca felony drug conviction. See page G for mo N 2 had a felony conviction for possession, use, of substance on or after August 23, 1996?  N 2 been found to have committed a Nutrition Assistance Intentional Program Violation in Arizona or 2 fleeing from law enforcement agencies on any of	(SSI Cash)?  ssistance Questions: A sh Assistance. PERSON 2 mare information.  or distribution of a Yes sistance and/or any other state? charges, or is Yes court?	Answer the ay still be No No	ese questic able to get If 'Yes,' d City/state Type of c If 'Yes,' r	res □, No ons if PERSON 2 is benefits if he/she has a late of conviction: of conviction: conviction: name of state:
Has PERSO controlled Has PERSO Cash Assists PERSON PERSON STANDARD	Nutrition Assistance and Cash A applying for Nutrition Assistance and/or Ca felony drug conviction. See page G for mo N 2 had a felony conviction for possession, use, osubstance on or after August 23, 1996?  N 2 been found to have committed a Nutrition Assistance Intentional Program Violation in Arizona or 2 fleeing from law enforcement agencies on any of 2 in violation of probation or parole according to a	(SSI Cash)?  ssistance Questions: A sh Assistance. PERSON 2 mare information. or distribution of a Yes sistance and/or Yes any other state? Charges, or is Yes court?  Answer these questions if PER by paid or unpaid medical travel expenses to and from	Answer the ay still be No No	ese questic able to get If 'Yes,' d City/state Type of c If 'Yes,' r	ons if PERSON 2 is benefits if he/she has a late of conviction: co
Has PERSO controlled  Has PERSO Cash Assists PERSON PERSON  If PERSON expenses, medical pr	Nutrition Assistance and Cash A applying for Nutrition Assistance and/or Ca felony drug conviction. See page G for mo N 2 had a felony conviction for possession, use, osubstance on or after August 23, 1996?  N 2 been found to have committed a Nutrition Assistance Intentional Program Violation in Arizona or 2 fleeing from law enforcement agencies on any of 2 in violation of probation or parole according to a Nutrition Assistance Questions:  2 is disabled or over age 60, does he/she have ar even if he/she has medical insurance (example:	ssistance Questions: Ash Assistance. PERSON 2 mare information. or distribution of a Yes any other state? charges, or is Yes court?  Answer these questions if PER by paid or unpaid medical travel expenses to and from	Answer the ay still be No No	ese questic able to get If 'Yes,' d City/state Type of c If 'Yes,' r	res □ No  ons if PERSON 2 is benefits if he/she has a late of conviction: on of conviction: name of state:  or Nutrition Assistance.  res □ No
Has PERSO controlled  Has PERSO Cash Assists PERSON PERSON:	Nutrition Assistance and Cash A applying for Nutrition Assistance and/or Ca felony drug conviction. See page G for mo N 2 had a felony conviction for possession, use, osubstance on or after August 23, 1996?  N 2 been found to have committed a Nutrition Assistance Intentional Program Violation in Arizona or 2 fleeing from law enforcement agencies on any of 2 in violation of probation or parole according to a Nutrition Assistance Questions:  2 is disabled or over age 60, does he/she have an even if he/she has medical insurance (example: povider, doctor visits, prescriptions, lab work, etc.)	ssistance Questions: Ash Assistance. PERSON 2 mare information. or distribution of a Yes any other state? charges, or is Yes court?  Answer these questions if PER y paid or unpaid medical travel expenses to and from	Answer the ay still be No No No	ese questic able to get If 'Yes,' d City/state Type of c If 'Yes,' r	res □ No  ons if PERSON 2 is benefits if he/she has a late of conviction: of conviction: conviction: on Nutrition Assistance.  res □ No  res □ No

# PERSON 2:

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

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

the last and current calendar month.	, ou uo				1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Does PERSON 2 work?	☐ Yes	□ No	If yes,	give emp	ployment information below:
	s Earnings deductions)	): 	How of	ten paid	? How many hours worked per week?
Is PERSON 2 self-employed?	□ Ye	es 🗆 N	lf	'Yes,' ani	ne of work:nual net (after deductions) amount:
If 'Yes,' has PERSON 2 been in this business for 12 mor					business started:
Does PERSON 2's income change because of contract or seasonal employment?	□ Ye		m	ake over	much income does PERSON 2 expect to the next 12 months?
Does PERSON 2 work in exchange for food or rent?	□ Ye	es 🗆 N	No If	'Yes,' wh	ere?
Other Income: Tell us about other in		_	arrana and and		
Type of Income:	Amount:	How o	ften rec	eivea?	Who pays the income?
Social Security benefits					
Supplemental Security Income (SSI Cash)				r sign i destrui de autorio	
Retirement/pension					
Unemployment				100.7 KV. 2 VIOTA	
Disability/worker's compensation					
Child support			DOMESTIC CONTRACT	V 12 Mars 1 , 1 C 12	
Alimony			0.22		
Veterans benefits		E. J. BUSSIC on 1851	Taris A Constitution	vide Mediki Albi, ik	
Gifts or loans					
Tribal money Gaming Other:	1 3000000000000000000000000000000000000	METHOD OF THE AREA		Andreas version and a second	
Per capita payments from natural resources, usage rights, leases or royalties					
Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land					,
Money from selling things that have cultural significance					
Other:					
Check here if this person does not have income					
Potential Benefits: Tell us about Pl Has PERSON 2 or his/her spouse (living or deceased) eve		help dete			ay be eligible for additional benefits.
for a government agency or an employer with a pension pla				If 'Yes,	' dates of employment:
Has PERSON 2 or his/her spouse (living or deceased) ser	ved in the	☐ Yes	☐ No		' branch of service:
military?	ing the control of th	: :::::::::::::::::::::::::::::::::::	o reaching		' dates of service:
If PERSON 2 is under age 19, has his/her parent (living or	deceased)	LI Yes	U NO		' branch of service: ' dates of service:
served in the military?				II I ES,	uales of service.
Federal Income Tax Filing: Tell u	s how PERS	ON 2 wil	l file inco	me taxes	NEXT YEAR.
Will PERSON 2 file taxes NEXT YEAR?	☐ Yes	□ No			
If 'Yes,' will PERSON 2 file jointly with a spouse?	Yes	□ No		If 'Yes,'	name of spouse:
Will PERSON 2 claim dependents on his/her tax return?	☐ Yes	□ No	îsayî Marij	If 'Yes,'	name of dependent(s):
Will PERSON 2 be claimed as a dependent on someone else's tax return?	☐ Yes	□ No			name of tax filer:ship to tax filer:
Does PERSON 2 pay any expenses that may be	☐ Alimor	าง	anvika.		paid: How often?
deducted on the federal income tax return?		nt loan in	terest	Amount	paid: How often?
Do not include self-employment expenses. Check all that apply		deductio ribe dedu	194.44 4.47 1.396		paid: How often?

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

# PERSON 3:

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

Personal Information:				
Name (First, Middle, Last):				Gender: 🛭 Male 🚨 Female
Date of Birth: Social Security Nur	mber (optio	onal if not a	pplying): _	
Relationship to Person 1:	☐ Ch	ild/Step Cl	ild	□ Parent □ Other:
☐ Grandchild		ece/Nephe		Legal Guardian
Marital Status: ☐ Never Married ☐ Divorced ☐ Does PERSON 2 live at the same address as Person 1?	l Widowed □ Ye			of spouse:
If 'No,' what is PERSON 2's home address?				
Is PERSON 3 attending school?	If 'Ye	es,' is PER		nding school : 🔲 Full Time 🔲 Part Time Grade Level:
Is PERSON 3 applying for help with health insurance costs?	☐ Yes	□ No	OP	HCCCS health plan choice:
Is PERSON 3 applying for help with Medicare costs?		□ No		ledicare claim number:
Does PERSON 3 need help paying for medical bills from the last 3 months?	☐ Yes	□ No	If 'Yes,' w	hat months?
Is PERSON 3 applying for Nutrition Assistance?	☐ Yes	☐ No		
\$ Is PERSON 3 applying for Cash Assistance?	☐ Yes	□ No		
♣ Is PERSON 3 applying for Tuberculosis Control?	☐ Yes	□ No	,	
If PERSON 3 is applying fo				
If PERSON 3 is <b>NOT</b> applying for a	iny benefits	go to page	i i to tell us	about PERSON 3's income.
Citizenship/Residency: Tell us a citizenship/residency.	about PER	SON 3's c	tizenship/re	esidency. You may need to provide proof of
Is PERSON 3 a U.S. citizen or U.S. national? See page	D for more	informatio	n. 🗆 `	res ☐ No ☐ Choose not to answer
If PERSON 3 is NOT a U.S. citizen, what is his/her immig				
	ered Spou an-Haitian	se, Child o	r Parent	<ul> <li>☐ Removal/Suspension of Deportation</li> <li>☐ Registry Applicants</li> </ul>
,,,,,	erred Actio			☐ Special Immigrant Juvenile Status Applicant
☐ Asylee ☐ Defe		rced Depar		☐ Temporary Protection Status (TPS)
		nder LIFE . nder IRCA		☐ Victim of Trafficking☐ Withholding of Deportation
□ Other □ Orde	er of Supe	rvision		☐ Applicant for Asylum, LPR, TPS, or
☐ I do not want to provide ☐ Parc	oled into U	nited State	S	Withholding Deportation
What immigration document does PERSON 3 have? ☐ Permanent Resident card ☐ I-94 ☐ Visa ☐ Foreign Passport ☐ None ☐ Other:			Documen	i Number: n the U.S. since August 22, 1996? □ Yes □ N
Is PERSON 3 an Arizona resident? ☐ Yes ☐ No		SON 3 mo		a in the last 4 months?
Race (optional), select one or more:		.,		Ethnicity (optional):
☐ Asian ☐ Hawaiian or other Pa☐ Black or African American ☐ American Indian/Ala				☐ Hispanic/Latino☐ Non-Hispanic/Non-Latino
If PERSON 3 is American Indian or Alaska Native:				Carrier and Carrie
Is he/she enrolled in a federally recognized tribe?		□Ye	s 🛚 No	If 'Yes,' name of tribe:
Has he/she ever gotten services from Indian Health Serv health program, or urban Indian health program, or throu from one of these programs?			s 🗖 No	If 'No,' is he/she eligible? ☐ Yes ☐ No
\$ Is he/she living on a reservation?		□ Ye	s 🛚 No	If 'Yes,' name of reservation:
Tribal Census Number:				
Go to the ne Transmittal Number: AZ 13-0005-MM FA-001 (10/13) Arizona	kt page to effective Da	tell us mor te: October	about PE 1, 2013	RSON 3. Approval Date: September 30, 2013 Page

PERSON 3:

This section asks sapplying for benefi	specific questions for each type of benefit. ts, complete each applicable section.	If PERSON 3 is not a	pplying for	any bene	efits, go to p	age 11. If F	PERSON 3 is
<b>+ 3</b> \$ &	Questions for All Applicants: A	nswer the following qu	estions if P	ERSON	3 is applyin	g for benefits	S.
Is PERSON 3 phys	sically or mentally disabled?		☐ Yes	□ No			
Is PERSON 3 in ja	ill or prison?		☐ Yes	□ No			
Was PERSON 3 re	eleased from jail or prison in the last 4 mor	iths?	☐ Yes	□ No	If 'Yes,' rele	ease date: _	
<b>-</b> \$	AHCCCS Medical Assistance, Complete this section if PERSON 3 is a and/or Cash Assistance.	Help with Medica poplying for AHCCCS M	ledical Ass	istance a	nd/or help v	with Medicar	e costs,
Is PERSON 3 preg						ber of babie ected due d	
If 'No,' complete	nder age 19, are both of his/her parents liv e the information below:			□ No			
Parent's Name (Fi	irst, Last):	Social Security	/ Number: _			_Date of Bir	th:
		City:		State	<u> </u>	Zip Code	<b>?</b> :
		Reason parent		r - ryselyskyr -		☐ Out of ho	
	irst, Last):	Social Security		لتقت في المراقع في المراقع الم			<del></del>
·		City:				Zip Code	
<u> </u>		Reason parent			eceased	Out of ho	me
assistance, ser Does PERSON 3	ths? Ineed help with activities of daily living (bavices, nursing home, or other medical facily live with at least one child under age 19 aever received Supplemental Security Incor	ity? nd is the main care tal			0 Y 0 Y	es □ No	
\$	Nutrition Assistance and Cash applying for Nutrition Assistance and/or felony drug conviction. See page G for	Cash Assistance. PEI more information.	RSON 3 ma	ay still be	able to get	benefits if h	e/she has a
	ad a felony conviction for possession, use ance on or after August 23, 1996?	or distribution of a	□ Yes	□ No	City/state	ate of conviction conviction:	
Cash Assistanc	een found to have committed a Nutrition A e Intentional Program Violation in Arizona eing from law enforcement agencies on an	or any other state?	☐ Yes	□ No	If 'Yes,' r	name of state	ə:
	iolation of probation or parole according to						. :
<u> </u>	Nutrition Assistance Question			RSON 3 i			
expenses, ever	isabled or over age 60, does he/she have n if he/she has medical insurance (exampler, doctor visits, prescriptions, lab work, etc	e: travel expenses to a	dical ind from			∕es □ No	
Is PERSON 3 livin	ng in an assisted living facility or group hor	ne?			<u> </u>	∕es □ No	
\$	Cash Assistance Questions: A Assistance.	nswer this question if l	PERSON 3	is under	age 19 and	l applying fo	r Cash
If PERSON 3 is u	nder age 19 and is living with his/her pare	nts, are his/her shots o	urrent?		ים	∕es 🖸 No	)
	•	age to tell us more abo					
Tra	ansmittal Number: AZ 13-0005-MM Effe	ctive Date: October 1, 20	13	Appro	oval Date: Se	ptember 30, 2	2013

# PERSON 3:

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

•	\$ 6

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

Does PERSON 3 work?	☐ Yes	□ No	If yes	, give emp	oloyment information below:
	s Earnings		How o	ften paid'	How many hours worked
Phone Number: (before	deductions	):		a	per week?
	······································		······································		
Is PERSON 3 self-employed?	□ Ye	es 🗓 N	o li	'Yes.' tvp	e of work:
, , , , , , , , , , , , , , , , , , ,					nual net (after deductions) amount:
If 'Yes,' has PERSON 3 been in this business for 12 mor					business started:
Does PERSON 3's income change because of contract or	□ Ye	es 🗆 No			much income does PERSON 3 expect to the next 12 months?
seasonal employment?  Does PERSON 3 work in exchange for food or rent?	□ Ye	es 🗆 N		f 'Yes,' wh	
Tell us about other income: Tell us about other in	come PERS	ON 3 rece	sives Y	'ou may n	eed to provide proof of income
Type of Income:	Amount:		7, 1, 11	eived?	Who pays the income?
Social Security benefits		110W U			
Supplemental Security Income (SSI Cash)	a <u>n situs situadididi . 32536</u>	erszertészáhítálási		ansi fi di Malali di	
Retirement/pension					
Unemployment					
Disability/worker's compensation					
Child support			. 545/11 (14/3) 4		
Alimony  Veterans benefits					
Gifts or loans			1.505175061		
Tribal money				100011111111	
Per capita payments from natural resources, usage rights,	Promote Commence				
leases or royalties					
Payments from natural resources, farming, ranching,					
fishing, leases or royalties from Indian trust land  Money from selling things that have cultural significance					
Other:				ulia electeri filia i	
Check here if this person does not have income					
		***************************************		· · · · · · · · · · · · · · · · · · ·	
Potential Benefits: Tell us about PE	ERSON 3 to	help deter	mine if	he/she ma	ay be eligible for additional benefits.
Has PERSON 3 or his/her spouse (living or deceased) eve		☐ Yes	☐ No		employer name:
for a government agency or an employer with a pension pla	∍n?			If 'Yes,	dates of employment:
Has PERSON 3 or his/her spouse (living or deceased) server the server as	ed in the	☐ Yes	☐ No		branch of service:
military?  If PERSON 3 is under age 19, has his/her parent (living or	deceased)	☐ Yes	□ No		dates of service: branch of service:
served in the military?	ucocucco,			If 'Yes,	dates of service:
Federal Income Tax Filing: Tell u		_	file inco	me taxes	NEXT YEAR.
Will PERSON 3 file taxes NEXT YEAR?	☐ Yes	□ No		16041-	
If 'Yes,' will PERSON 3 file jointly with a spouse?	☐ Yes ☐ Yes	□ No □ No	ANTENNA.		name of spouse: name of dependent(s):
Will PERSON 3 claim dependents on his/her tax return?	■ IES	□ NO		11 165, 1	lame of dependent(s).
Will PERSON 3 be claimed as a dependent on someone else's tax return?	☐ Yes	□ No			name of tax filer:
Does PERSON 3 pay any expenses that may be	☐ Alimor	ייי			ship to tax filer: paid: How often?
deducted on the federal income tax return?		nt loan int	erest	Amount	oaid: How often?
Do not include self-employment expenses.	☐ Other	deduction	S	Amount	
Check all that apply.	7. 1 to 20 at 1 at 140 40 40 40 40	ribe dedu		us about D	EDSON 4 If NO go to page 18

# PERSON 4:

Tell us about the other people in y	our household	See page A for	r a definition of who v	vou must include.

Personal Information:							
Name (First, Middle, Last):					Gender:	☐ Male	☐ Female
	Security Number (opti-						
Relationship to Person 1: Spouse	☐ Child/Step	Child	☐ Pare		Other:		
☐ Grandchild	☐ Niece/Nep			Guardian			
Marital Status: ☐ Never Married ☐ Div  Does PERSON 2 live at the same address as			rried-name o	or spouse: _			
If 'No,' what is PERSON 2's home address?	reisonit: at	C5 W 140	,				
Is PERSON 4 attending school?	□ No If 'Y	es,' is PER		ding school : ade Level: _	: 🔾 Full Time	Part	Time
						· · · · · · · · · · · · · · · · · · ·	
Is PERSON 4 applying for help with health insurance costs?	1	□ No	If 'Yes,' AH	CCCS healtl ONAL. See p	h plan choice: age H for enroll	ment plan	choices.
Is PERSON 4 applying for help with Medic		☐ No			number:		
Does PERSON 4 need help paying for me from the last 3 months?	edical bills	☐ No	If 'Yes,' wha	at months?			
<ul> <li>Is PERSON 4 applying for Nutrition Assista</li> </ul>	ance? 🔲 Yes	□ No					
\$ Is PERSON 4 applying for Cash Assistance		□ No					,
s Is PERSON 4 applying for Tuberculosis Co		□ No					
	s applying for any bene						
If PERSON 4 is <b>NOT</b> a	applying for any benefits	s: go to page	14 to tell us at	oout PERSON	l 4's income.	***************************************	
Citizenship/Residenc citizenship/residency.  Is PERSON 4 a U.S. citizen or U.S. national?					ı may need to ☐ Choose		
If PERSON 4 is NOT a U.S. citizen, what is his							
□ Lawful Permanent Resident (LPR) □ Lawful Temporary Resident □ Non-Immigrant Status □ Asylee □ Refugee □ Conditional Entrant granted before 1980 □ Other □ I do not want to provide	□ Battered Spou □ Cuban-Haitiar □ Deferred Actio □ Deferred Enfo □ Legalization u □ Legalization u □ Order of Supe □ Paroled into U	use, Child or n Entrant on Status orced Depart nder LIFE A nder IRCA A ervision	ture act Applicant	□ Registry A □ Special Ir □ Tempora □ Victim of □ Withholdi □ Applicant	nmigrant Juve ry Protection S	enile Statu Status (TF tion .PR, TPS,	s Applicant PS)
What immigration document does PERSON 4  Permanent Resident card			Document N N 4 lived in		ce August 22,	1996? [	]Yes □ No
Is PERSON 4 an Arizona resident?    Yes	1100	SON 4 mov	e to Arizona ed:	in the last 4	months?	☐ Yes	□ No
Race (optional), select one or more:		**		E	thnicity (optior	nal):	
	or other Pacific Islan Indian/Alaska Native				Hispanic/Lat Non-Hispani		ino
If PERSON 4 is American Indian or Alaska Na	ntive:		e de tour		20.380.120.121		
Is he/she enrolled in a federally recognized tri	oe?	□ Yes	s □ No I	lf 'Yes,' nam	e of tribe:		· · · · · · · · · · · · · · · · · · ·
Has he/she ever gotten services from Indian I- health program, or urban Indian health progra from one of these programs?					e/she eligible?		s 🗆 No
Is he/she living on a reservation?		☐ Yes	s □ No	If 'Yes,' nar	me of reserval	lion:	
Tribal Census Number:	a to the payt page to			CONA			

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

5-MM Effective Date: October 1, 2013

PERSON 4:

Do you need help with this application? Visit  $\underline{www.healthearizonaplus.gov}$  or call 1-855-HEA-PLUS (432-7587)

	ks specific questions for each type of benefit. If PERSOnefits, complete each applicable section.	ON 4 is not appl	ying for	any ber	nefits, go to	page 14. If F	PERSON 4 is
<b>₽</b> • \$ &	Questions for All Applicants: Answer the	following quest	ions if F	PERSON	l 4 is apply	ng for benefit	s.
	physically or mentally disabled?		Yes	□ No			
IS PERSON 4 in			Yes	□ No	16 (3 ( )		
Was PERSON 4	4 released from jail or prison in the last 4 months?	L	l Yes	□ No	it Yes, re	elease date: _	
<b>+</b> \$	AHCCCS Medical Assistance, Help with Complete this section if PERSON 4 is applying for Cash Assistance.	th Medicare r AHCCCS Med	Costs	s, and	Cash As and/or help	sistance Q with Medical	uestions: re costs, and/or
Is PERSON 4 p	oregnant?		Yes	□ No		mber of babie pected due d	
	s under age 19, are both of his/her parents living in the lete the information below:	home? 📮	Yes	□ No		, F (7	
Parent's Name	(First, Last): So	ocial Security N	umber:			Date of Bir	th:
Mailing Address	s:Ci	ty:		Sta	te:	Zip Code	9:
The Company of the Co	그 가는 그는 살림에게 되는 점점에 가득하는 그 전에서 작은 살살을 위하는 것이 없는 그리고 모든 것이다. 그리고 없는 것이 없는 것이다.	eason parent is				☐ Out of ho	
	8	ocial Security N	<u> 1868 - Santaki d</u>				
		ity:				 Zip Code	
=		eason parent is				☐ Out of ho	
assistance, s Does PERSON	N 4 need help with activities of daily living (bathing, dresservices, nursing home, or other medical facility? N 4 live with at least one child under age 19 and is the r 4 ever received Supplemental Security Income (SSI C	main care taker ash)? ance Questio	of the c	child? Answer t	□ hese quest		DN 4 is
Υ Υ	applying for Nutrition Assistance and/or Cash Assi felony drug conviction. See page G for more infor	mation.					
	4 had a felony conviction for possession, use, or distrib bstance on or after August 23, 1996?	oution of a	⊒ Yes	□ No	City/sta Type of	te of convictio conviction:	
Cash Assistar	4 been found to have committed a Nutrition Assistance ance Intentional Program Violation in Arizona or any oth	ner state?	⊒ Yes	□ No		name of state	ə:
	fleeing from law enforcement agencies on any charges, n violation of probation or parole according to a court?	oris (	⊐ Yes	□ No			
expenses, ev medical provi	Nutrition Assistance Questions: Answer s disabled or over age 60, does he/she have any paid of ven if he/she has medical insurance (example: travel exider, doctor visits, prescriptions, lab work, etc.)?	or unpaid medic	al	RSON 4		for Nutrition / Yes	
IS PERSON 4 II	living in an assisted living facility or group home?					100 - 140	
\$	Cash Assistance Questions: Answer this Assistance.	question if PEF	RSON 4	is unde	r age 19 ar	nd applying fo	r Cash
If PERSON 4 is	s under age 19 and is living with his/her parents, are his		<del>~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~</del>		O	Yes 🖸 No	
FA-001 (10/13)		us more about I October 1, 2013	PERSO		roval Date: S	eptember 30, 2	2013 Page 13

# PERSON 4:

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

Ö	\$	b
 	- 1	

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

Does PERSON 4 work?	☐ Yes ☐ No If ye			No If y	f yes, give employment information below:			
Employer's Name and Phone Number:		Earnings deduction		How	often paid	? How many hours worked per week?		
Is PERSON 4 self-employed?			Yes	☐ No	If 'Yes,' typ	pe of work: nual net (after deductions) amount:		
If 'Yes,' has PERSON 4 been in this business for	or 12 mon	ths?	Yes	☐ No	If 'No,' dat	e business started:		
Does PERSON 4's income change because of co seasonal employment?	ntract or		Yes	□ No		much income does PERSON 4 expect to the next 12 months?		
Does PERSON 4 work in exchange for food or re-	nt?		Yes	□ No	If 'Yes,' w	nere?		
Other Income: Tell us about Type of Income:	ut other inc	come PER Amount			You may r	need to provide proof of income. Who pays the income?		
Social Security benefits								
Supplemental Security Income (SSI Cash)								
Retirement/pension								
Unemployment				and an equilibrium of the second				
Disability/worker's compensation								
Child support	THE STATE OF THE S		10.00	and the second second				
Alimony								
Veterans benefits								
Gifts or loans		rightin-fia.			Produk.			
Tribal money Gaming Other:	30.0000 6/960	राष्ट्रा संग्रहासूत नगावास			3.44444 (3.8184	From the research of the state		
Per capita payments from natural resources, usagleases or royalties								
Payments from natural resources, farming, ranchi fishing, leases or royalties from Indian trust land								
Money from selling things that have cultural signif	icance							
Other:/								
Potential Benefits: Tell us		RSON 4 t				ay be eligible for additional benefits.		
Has PERSON 4 or his/her spouse (living or deceator a government agency or an employer with a p	ension pla	n?			If 'Yes	,' employer name: ,' dates of employment: ,' branch of service:		
Has PERSON 4 or his/her spouse (living or decearmilitary?	aseu) serv	ea in the	<b></b>	Yes □ I		, branch of service:		
If PERSON 4 is under age 19, has his/her parent served in the military?	(living or d	deceased)	Π,	Yes 🗓 l	No If 'Yes	,' branch of service:,' dates of service:		
Federal Income Tax Filir	ng: Tell us	s how PEF	RSON	4 will file in	ncome taxes	S NEXT YEAR.		
Will PERSON 4 file taxes NEXT YEAR?		☐ Yes	a	No				
If 'Yes,' will PERSON 4 file jointly with a spouse	e?	☐ Yes	3 7 7 7 7 7 7 7 3	No	If 'Yes,'	name of spouse:		
Will PERSON 4 claim dependents on his/her tax	return?	☐ Yes	0	No	If 'Yes,'	name of dependent(s):		
Will PERSON 4 be claimed as a dependent on so else's tax return?	meone	☐ Yes		No		name of tax filer:ship to tax filer:ship to tax filer:ship to tax filer:ship to tax filer:		
Does PERSON 4 pay any expenses that may be deducted on the federal income tax return? Do not include self-employment expenses. Check all that apply.		☐ Othe	lent lo er ded	an interest uctions deduction	Amount Amount Amount s:	paid: How often? paid: How often? paid: How often?		

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

# **PERSON 5:**

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

household. See page A for a definition of who you must	include. Attac	h copied pages to	o this application.
Personal Information:			
Name (First, Middle, Last):			Gender: ☐ Male ☐ Female
Date of Birth: Social Security Nu	mber (optiona	l if not applying):	
Relationship to Person 1: Spouse Grandchild		ld/Step Child ce/Nephew	☐ Parent ☐ Other: ☐ Legal Guardian
Marital Status: ☐ Never Married ☐ Divorced ☐	☐ Widowed	☐ Married-nam	e of spouse:
Does PERSON 2 live at the same address as Person 1? If 'No,' what is PERSON 2's home address?	☐ Yes	□ No	
Is PERSON 5 attending school? ☐ Yes ☐ No Name of School:	If 'Yes,'		ending school :
Is PERSON 5 applying for help with health insurance costs?	☐ Yes □	No If 'Yes,' A	AHCCCS health plan choice: PTIONAL. See page H for enrollment plan choices.
Is PERSON 5 applying for help with Medicare costs?			Medicare claim number:
Does PERSON 5 need help paying for medical bills from the last 3 months?	☐ Yes □	☐ No If 'Yes,'	what months?
Is PERSON 5 applying for Nutrition Assistance?	☐ Yes □	⊒ No	
\$ Is PERSON 5 applying for Cash Assistance?		⊒ No	
5 Is PERSON 5 applying for Tuberculosis Control?	☐ Yes ☐	⊒ No	
If PERSON 5 is applying for	or any benefits:	continue answering	the questions below.
If PERSON 5 is <b>NOT</b> applying for a	any benefits: go	to page 17 to tell u	s about PERSON 3 \$ IIIcome.
Citizenship/Residency: Tell us citizenship/residency.	about PERSO	N 5's citizenship/	residency. You may need to provide proof of
Is PERSON 5 a U.S. citizen or U.S. national? See page	D for more inf	ormation. 🚨	Yes ☐ No ☐ Choose not to answer
If PERSON 5 is NOT a U.S. citizen, what is his/her immig	gration status?	)	
☐ Lawful Permanent Resident (LPR) ☐ Batt	tered Spouse,	Child or Parent	☐ Removal/Suspension of Deportation
— — ··································	oan-Haitian En erred Action S		<ul><li>☐ Registry Applicants</li><li>☐ Special Immigrant Juvenile Status Applicant</li></ul>
	erred Enforced		☐ Temporary Protection Status (TPS)
☐ Refugee ☐ Leg	alization unde	r LIFE Act	☐ Victim of Trafficking
	alization unde er of Supervis	r IRCA Applicant	<ul><li>□ Withholding of Deportation</li><li>□ Applicant for Asylum, LPR, TPS, or</li></ul>
	oled into Unite		Withholding Deportation
What immigration document does PERSON 5 have?  ☐ Permanent Resident card ☐ I-94 ☐ Visa ☐ Foreign Passport ☐ None ☐ Other:	lmm Has	nigration Documer PERSON 5 lived	nt Number: in the U.S. since August 22, 1996? ☐ Yes ☐ No
Is PERSON 5 an Arizona resident?		N 5 move to Arizo	na in the last 4 months?
Race (optional), select one or more:			Ethnicity (optional):
☐ Asian ☐ Hawaiian or other P☐ Black or African American ☐ American Indian/Ala		☐ White ☐ Other:	☐ Hispanic/Latino☐ Non-Hispanic/Non-Latino
If PERSON 5 is American Indian or Alaska Native:			
Is he/she enrolled in a federally recognized tribe?		☐ Yes ☐ No	If 'Yes,' name of tribe:
Has he/she ever gotten services from Indian Health Services health program, or urban Indian health program, or throughout one of these programs?		□ Yes □ No	If 'No,' is he/she eligible? ☐ Yes ☐ No
\$ Is he/she living on a reservation?		□ Yes □ No	If 'Yes,' name of reservation:
\$ Tribal Census Number:			
		DI	TOCON C

Go to the next page to tell us more about PERSON 5.

Transmittal Number: AZ 13-0005-MM FA-001 (10/13) Arizona

Effective Date: October 1, 2013

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This section asks specific questions for each type of benefit. If PERSON 5 is not applying for any benefits, go to page 17. If PERSON 5 is applying for benefits, complete each applicable section.

S PERSON 5 physically or mentally disabled?  S PERSON 5 released from jail or prison in the last 4 months?  □ Yes □ No  AHCCCS Medical Assistance, Help with Medicare Costs, and Cash Assistance Questions  Complete this section if PERSON 5 is applying for AHCCCS Medical Assistance and/or help with Medicare costs, and/or Cash Assistance.  ■ PERSON 5 pregnant?  □ Yes □ No  □ If Yes, number of bables due:  □ (f Yes, expected due date.  □ PERSON 5 under age 19, are both of his/her parents living in the home? □ I'No, complete the information below.  □ PERSON 5 is under age 19, are both of his/her parents living in the home? □ I'No, complete the information below.  □ PERSON 5 is under age 19, are both of his/her parents living in the home? □ I'No, complete the information below.  □ PERSON 5 is under age 19, are both of his/her parents living in the home? □ I'No, complete the information below.  □ PERSON 5 is under age 19, are both of his/her parents living in the home? □ I'No, complete the information below.  □ PERSON 5 is under age 19, are both of his/her parents living in the home? □ Date of Birth: □ Islailing Address: □ City: □ State: □ Zip Code: □ Tolene Number: □ Date of Birth: □ Islailing Address: □ City: □ State: □ Zip Code: □ Tolene Number: □ Date of Birth: □ Islailing Address: □ City: □ State: □ Zip Code: □ Tolene Number: □ Date of Birth: □ Islailing Address: □ City: □ State: □ Zip Code: □ Tolene Number: □ Date of Birth: □ Islailing Address: □ City: □ State: □ Zip Code: □ Tolene Number: □ Date of Birth: □ Islailing Address: □ City: □ State: □ Zip Code: □ Tolene Number: □ Date of Birth: □ Islailing Address: □ City: □ State: □ Zip Code: □ Tolene Number: □ Date of Birth: □ Islailing Address: □ City: □ State: □ Zip Code: □ Tolene Number: □ Date of Birth: □ Islailing Address: □ City: □ State: □ Zip Code: □ Tolene Number: □ Date of Birth: □ Islailing Address: □ Date		s physically or montally dischard?	DVac DNa
AHCCCS Medical Assistance, Help with Medicare Costs, and Cash Assistance Questions Complete this section if PERSON 5 is applying for AHCCCS Medical Assistance and/or help with Medicare costs, and Cash Assistance Questions if PERSON 5 is applying for AHCCCS Medical Assistance and/or help with Medicare costs, and Cash Cash Assistance and/or help with Medicare costs, and cash Cash Cash Cash Cash Cash Cash Cash C	IS PERSON		
AHCCCS Medical Assistance, Help with Medicare Costs, and Cash Assistance Questions Complete this section if PERSON 5 is applying for AHCCCS Medical Assistance and/or help with Medicare costs, and/or Cash Assistance PERSON 5 pregnant?  PERSON 5 pregnant?  PERSON 5 is under age 19, are both of his/her parents living in the home?  PERSON 5 is under age 19, are both of his/her parents living in the home?  PERSON 5 is under age 19, are both of his/her parents living in the home?  Parent's Name (First, Last):  Social-Security Number:  Date of Birth:  Alling Address:  City:  Social Security Number:  Date of Birth:  Alailing Address:  City:  State:  Zip Code:  Phone Number:  Date of Birth:  Alailing Address:  City:  State:  Zip Code:  Phone Number:  Date of Birth:  Alailing Address:  City:  State:  Zip Code:  Phone Number:  Date of Birth:  Alailing Address:  City:  State:  Zip Code:  Phone Number:  Date of Birth:  Alailing Address:  City:  State:  Zip Code:  Phone Number:  Date of Birth:  Alailing Address:  City:  State:  Zip Code:  Phone Number:  Date of Birth:  Alailing Address:  City:  State:  Zip Code:  Phone Number:  Date of Birth:  Alailing Address:  City:  State:  Zip Code:  Phone Number:  Date of Birth:  Alailing Address:  City:  State:  Zip Code:  Phone Number:  Date of Birth:  Alailing Address:  City:  State:  Zip Code:  Phone Number:  Date of Birth:  Alailing Address:  City:  State:  Zip Code:  Phone Number:  Date of Birth:  Alailing Address:  City:  State:  Zip Code:  Phone Number:  Date of Birth:  Alailing Address:  City:  State:  Zip Code:  Phone Number:  Date of Birth:  Alailing Address:  City:  State:  Zip Code:  Phone Number:  Date of Birth:  Alailing Address:  City:  State:  Zip Code:  Alailing Address:  City:  State:  Zip Code:  Alailing Address:  City:  State:  Zip Code:  Phone Number:  Date of Birth:  Alailing Address:  City:  State:  Zip Code:  Alailing Address:  City:  State:  Zip Code:  Alailing Address:  City:  State:  Zip Code:  Alailing Address:  Alailing Address:  Alailing Address:  Alailing			
Complete this section if PERSON 5 is applying for AHCCCS Medical Assistance and/or help with Medicare costs, and/or Cash Assistance.  PERSON 5 is under age 19, are both of his/her parents living in the home?		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
If Yes, expected due date:	<b>-</b> \$	Complete this section if PERSON 5 is	
If No, 'complete the information below.'    Poarent's Name (First, Last):	s PERSON 8	pregnant?	
Mailing Address:    City:			iving in the home?
Phone Number: Reason parent is absent: Deceased Out of home Parent's Name (First, Last): Social Security Number: Date of Birth: Mailing Address: City: State: Zip Code: Phone Number: Reason parent is absent: Deceased Out of home  AHCCCS Medical Assistance and Help with Medicare Costs Questions: Answer these question if PERSON 5 is applying for AHCCCS Medical Assistance and/or help with Medicare costs.  If PERSON 5 is under the age of 55, does he/she have a mential or physical disability that has kept or West Now Milk keep him/her from working for at least 12 months?  If PERSON 5 works and is under the age of 65, does he/she have a disability that is expected to last Security Now assistance, services, nursing home, or other medical facility?  Does PERSON 5 need help with activities of daily living (bathing, dressing, etc.) through personal Security Now Assistance, services, nursing home, or other medical facility?  Does PERSON 5 live with at least one child under age 19 and is the main care taker of the child? Security Now Assistance Augustions: Answer these questions if PERSON 5 is applying for Nutrition Assistance and/or Cash Assistance Questions: Answer these questions if PERSON 5 is applying for Nutrition Assistance and/or Cash Assistance PERSON 5 may still be able to get benefits if he/she has a felony drug conviction. See page 6 for more information.  Las PERSON 5 had a felony conviction for possession, use, or distribution of a Security Now Office on Viction: Type of conviction: Cash Assistance Intentional Program Violation in Arizona or any other state?  Seperson 5 fleeing from law enforcement agencies on any other state?  PERSON 5 fleeing from law enforcement agencies on any other state?  Seperson 5 fleeing from law enforcement agencies on any other state?  PERSON 5 is disabled or over age 80, does he/she have any paid or unpaid medical: Separation of probation or parole according to a court?  Nutrition Assistance Questions: Answer these questions if PERSON 5 is applying for Nutrition Assistance. PERSON	Parent's Nam	ne (First, Last):	Social Security Number: Date of Birth:
Parent's Name (First, Last):  Social Security Number:  City:  State:  Zip Code:  Phone Number:  Reason parent is absent:  Deceased  Out of home  AHCCCS Medical Assistance and Help with Medicare Costs Questions: Answer these question if PERSON 5 is applying for AHCCCS Medical Assistance and/or help with Medicare costs.  If PERSON 5 is under the age of 65, does he/she have a mental or physical disability that has kept or will keep him/her from working for at least 12 months?  If PERSON 5 works and is under the age of 65, does he/she have a disability that is expected to last least 12 months?  If PERSON 5 need help with activities of daily filving (bathing, dressing, etc.) through personal sasistance, services, nursing home, or other medical facility?  Does PERSON 5 live with at least one child under age 19 and is the main care taker of the child?  Sharp that a least one child under age 19 and is the main care taker of the child?  Wes Notation Assistance and Cash Assistance Questions:  Nutrition Assistance and Cash Assistance Deceased  Nutrition Assistance and Cash Assistance PERSON 5 may still be able to get benefits if he/she has a felony drug conviction. See page 6 for more information.  Las PERSON 5 had a felony conviction for possession, use, or distribution of a lyes No If Yes, date of conviction: controlled substance on or after August 23, 1996?  Nutrition Assistance August 23, 1996?  Nutrition Assistance Questions: Answer these questions if PERSON 5 is applying for Nutrition Assistance.  PERSON 5 fleeling from law enforcement agencies on any other state?  PERSON 5 is disabled or over age 60, does he/she have any paid or unpaid medical  Person 5 is violation of probation or parole according to a court?  Nutrition Assistance Questions: Answer these questions if PERSON 5 is applying for Nutrition Assistance.  PERSON 5 is disabled or over age 60, does he/she have any paid or unpaid medical  Person 5 is violation of probation or parole according to a court?	Mailing Addre	98S	City: State: Zip Code:
Alling Address: City: State: Zip Code: Phone Number: Reason parent is absent: Deceased Out of home  AHCCCS Medical Assistance and Help with Medicare Costs Questions: Answer these question if PERSON 5 is applying for AHCCCS Medical Assistance and/or help with Medicare costs.  If PERSON 5 is under the age of 65, does he/she have a mental or physical disability that has kept or Will keep him/her from working for at least 12 months? If PERSON 5 works and is under the age of 65, does he/she have a disability that is expected to last Yes No at least 12 months?  Does PERSON 5 need help with activities of daily living (bathing, dressing, etc.) through personal Yes No assistance, services, nursing home, or other medical facility?  Does PERSON 5 live with at least one child under age 19 and is the main care taker of the child? Yes No Has PERSON 5 ever received Supplemental Security Income (SSI Cash)? Yes No  Nutrition Assistance and Cash Assistance Questions: Answer these questions if PERSON 5 is applying for Nutrition Assistance and/or Cash Assistance. PERSON 5 may still be able to get benefits if he/she has a felony drug conviction. See page G for more information.  Has PERSON 5 had a felony conviction for possession, use, or distribution of Yes No If Yes, date of conviction: Cash Assistance and/or Yes No If Yes, had to fornicion: Type of conviction: Type of conviction: Type of conviction: Type of conviction: PERSON 5 fiseling from law enforcement agencies on any charges, or is Yes No  Nutrition Assistance Questions: Answer these questions if PERSON 5 is applying for Nutrition Assistance. PERSON 5 is disabled or over age 60, does he/she have any paid or unpaid medical Yes No  Nutrition Assistance Questions: Answer these questions if PERSON 5 is applying for Nutrition Assistance. PERSON 5 is disabled or over age 60, does he/she have any paid or unpaid medical Yes No  Nutrition Assistance Questions: Answer these questions if PERSON 5 is under age 19 and applying for Cash Assistance Questions: Answer this question if PERS	Phone Numb	er:	Reason parent is absent:   Deceased  Out of home
AHCCCS Medical Assistance and Help with Medicare Costs Questions: Answer these question if PERSON 5 is applying for AHCCCS Medical Assistance and/or help with Medicare costs.  If PERSON 5 is under the age of 65, does he/she have a mental or physical disability that has kept or wilk keep him/her from working for at least 12 months?  If PERSON 5 works and is under the age of 65, does he/she have a disability that has kept or wilk keep him/her from working for at least 12 months?  If PERSON 5 works and is under the age of 65, does he/she have a disability that is expected to last at least 12 months?  Does PERSON 5 heed help with activities of daily living (bathing, dressing, etc.) through personal yes No assistance, services, nursing home, or other medical facility?  Does PERSON 5 live with at least one child under age 19 and is the main care taker of the child? Yes No  Has PERSON 5 ever received Supplemental Security Income (SSI Cash)? Yes No  Nutrition Assistance and Cash Assistance Questions: Answer these questions if PERSON 5 is applying for Nutrition Assistance and/or Cash Assistance. PERSON 5 may still be able to get benefits if he/she has a felony drug conviction. See page G for more information.  Has PERSON 5 had a felony conviction for possession, use, or distribution of a Yes No If Yes,' date of conviction: Cash Assistance Intentional Program Violation in Arizona or any other state?  In SPERSON 5 feeling from law enforcement agencies on any other state?  PERSON 5 in violation of probation or parole according to a court?  Nutrition Assistance Questions: Answer these questions if PERSON 5 is applying for Nutrition Assistance. PERSON 5 is disabled or over age 60, does he/she have any paid or unpaid medical Yes No PERSON 5 is invibation of probation or parole according to a court?  PERSON 5 is disabled or over age 60, does he/she have any paid or unpaid medical Yes No	arent's Nam	ne (First, Last):	Social Security Number: Date of Birth:
AHCCCS Medical Assistance and Help with Medicare Costs Questions: Answer these question if PERSON 5 is applying for AHCCCS Medical Assistance and/or help with Medicare costs.  If PERSON 5 is under the age of 65, does he/she have a mental or physical disability that has kept or	/lailing Addre	ess:	City: State: Zip Code:
AHCCCS Medical Assistance and Help with Medicare Costs Questions: Answer these question if PERSON 5 is applying for AHCCCS Medical Assistance and/or help with Medicare costs.  If PERSON 5 is under the age of 65, does he/she have a mental or physical disability that has kept or	hone Numb	er:	Reason parent is absent:  Deceased  Out of home
applying for Nutrition Assistance and/or Cash Assistance. PERSON 5 may still be able to get benefits if he/she has a felony drug conviction. See page G for more information.  Has PERSON 5 had a felony conviction for possession, use, or distribution of a	Does PERS	ON 5 live with at least one child under age 19	and is the main care taker of the child? ☐ Yes ☐ No
controlled substance on or after August 23, 1996?  City/state of conviction:  Type of conviction:  Type of conviction:  Type of conviction:  Type of conviction:  Cash Assistance Intentional Program Violation in Arizona or any other state?  s PERSON 5 fleeing from law enforcement agencies on any charges, or is  PERSON 5 in violation of probation or parole according to a court?  Nutrition Assistance Questions: Answer these questions if PERSON 5 is applying for Nutrition Assistance.  f PERSON 5 is disabled or over age 60, does he/she have any paid or unpaid medical expenses, even if he/she has medical insurance (example: travel expenses to and from medical provider, doctor visits, prescriptions, lab work, etc.)?  s PERSON 5 living in an assisted living facility or group home?  Cash Assistance Questions: Answer this question if PERSON 5 is under age 19 and applying for Cash		Nutrition Assistance and Cool	
Has PERSON 5 been found to have committed a Nutrition Assistance and/or	\$	applying for Nutrition Assistance and/o	r Cash Assistance. PERSON 5 may still be able to get benefits if he/she ha
Nutrition Assistance Questions: Answer these questions if PERSON 5 is applying for Nutrition Assistance.  PERSON 5 is disabled or over age 60, does he/she have any paid or unpaid medical expenses, even if he/she has medical insurance (example: travel expenses to and from medical provider, doctor visits, prescriptions, lab work, etc.)?  PERSON 5 living in an assisted living facility or group home?  Cash Assistance Questions: Answer this question if PERSON 5 is under age 19 and applying for Cash	las PERSOI	applying for Nutrition Assistance and/o felony drug conviction. See page G for N 5 had a felony conviction for possession, us	r Cash Assistance. PERSON 5 may still be able to get benefits if he/she har more information.  se, or distribution of a
f PERSON 5 is disabled or over age 60, does he/she have any paid or unpaid medical expenses, even if he/she has medical insurance (example: travel expenses to and from medical provider, doctor visits, prescriptions, lab work, etc.)? s PERSON 5 living in an assisted living facility or group home?  Cash Assistance Questions: Answer this question if PERSON 5 is under age 19 and applying for Cash	las PERSON controlled s	applying for Nutrition Assistance and/o felony drug conviction. See page G for N 5 had a felony conviction for possession, usubstance on or after August 23, 1996?  N 5 been found to have committed a Nutrition	r Cash Assistance. PERSON 5 may still be able to get benefits if he/she had remore information.  se, or distribution of a
expenses, even if he/she has medical insurance (example: travel expenses to and from medical provider, doctor visits, prescriptions, lab work, etc.)?  s PERSON 5 living in an assisted living facility or group home?  Cash Assistance Questions: Answer this question if PERSON 5 is under age 19 and applying for Cash	las PERSON controlled s las PERSON Cash Assis s PERSON 6	applying for Nutrition Assistance and/o felony drug conviction. See page G for N 5 had a felony conviction for possession, usubstance on or after August 23, 1996?  N 5 been found to have committed a Nutrition tance Intentional Program Violation in Arizona feleing from law enforcement agencies on a	r Cash Assistance. PERSON 5 may still be able to get benefits if he/she had remore information.  see, or distribution of a
Cash Assistance Questions: Answer this question if PERSON 5 is under age 19 and applying for Cash	las PERSOI controlled s las PERSOI Cash Assis S PERSON 5	applying for Nutrition Assistance and/o felony drug conviction. See page G for N 5 had a felony conviction for possession, usubstance on or after August 23, 1996?  N 5 been found to have committed a Nutrition tance Intentional Program Violation in Arizona fleeing from law enforcement agencies on a in violation of probation or parole according to Nutrition Assistance Question	r Cash Assistance. PERSON 5 may still be able to get benefits if he/she had remore information.  se, or distribution of a
	las PERSOI controlled s las PERSOI Cash Assis S PERSON 5 PERSON 5	applying for Nutrition Assistance and/o felony drug conviction. See page G for N 5 had a felony conviction for possession, us substance on or after August 23, 1996?  N 5 been found to have committed a Nutrition tance Intentional Program Violation in Arizona fleeing from law enforcement agencies on a in violation of probation or parole according to the Nutrition Assistance Question is disabled or over age 60, does he/she have even if he/she has medical insurance (example).	r Cash Assistance. PERSON 5 may still be able to get benefits if he/she had remore information.  se, or distribution of a
	Has PERSON controlled s Has PERSON Cash Assis S PERSON 5 PERSON 5 expenses, medical pro	applying for Nutrition Assistance and/o felony drug conviction. See page G for N 5 had a felony conviction for possession, usubstance on or after August 23, 1996?  N 5 been found to have committed a Nutrition tance Intentional Program Violation in Arizona fleeing from law enforcement agencies on a in violation of probation or parole according to the Nutrition Assistance Question is disabled or over age 60, does he/she have even if he/she has medical insurance (examply violer, doctor visits, prescriptions, lab work, elements of the same disable of the same disable of the same disable or over age 60, does he/she have even if he/she has medical insurance (examply violer, doctor visits, prescriptions, lab work, elements of the same disable or over age 60.	r Cash Assistance. PERSON 5 may still be able to get benefits if he/she had a more information.  se, or distribution of a

# PERSON 5:

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

Employment: Tell us about PERSON 5's employment, including self-employment and rental income. You may need to provide proof of income. If self-employed, please attach the most current federal tax forms: 1040, SE, and applicable schedules such as C, C-EZ, E, F and K1. If you do not have tax forms, attach proof of business income and expenses for the last and current calendar month.

Does PERSON 5 work?		Yes	□ No	If ye	s, give em	ployment information below:
	oss Ear re dedu		):	How	often paid	? How many hours worked per week?
Is PERSON 5 self-employed?		☐ Ye	es 🗆	No	If 'Yes,' ty	pe of work:
If 'Yes,' has PERSON 5 been in this business for 12 n	nonths?	□ Ye	es 🗆			nual net (after deductions) amount: e business started:
Does PERSON 5's income change because of contract of seasonal employment?		☐ Ye		No I	If yes, how	much income does PERSON 5 expect to the next 12 months?
Does PERSON 5 work in exchange for food or rent?		☐ Ye	es 🗆		If 'Yes,' w	
Other Income: Tell us about other Type of Income: Social Security benefits		PERSO		2 . 2 . 2	You may received?	need to provide proof of income. Who pays the income?
Supplemental Security Income (SSI Cash)						
Retirement/pension						
Unemployment				1 12 Your 93		
Disability/worker's compensation  Child support					Section of the second	
Alimony				ya 4 Si	24. julija (4.5.24)	
Veterans benefits	i. Militari				<u>1771   T. J., 1813   1813   1815</u>	
Gifts or loans		3.1753				
Tribal money Gaming Other:	_					
Per capita payments from natural resources, usage right leases or royalties	is,					
Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land						
Money from selling things that have cultural significance						
Other:						Name and the state of the state
Check here if this person does not have income	J					
Potential Benefits: Tell us about Has PERSON 5 or his/her spouse (living or deceased) e for a government agency or an employer with a pension Has PERSON 5 or his/her spouse (living or deceased) s military? If PERSON 5 is under age 19, has his/her parent (living served in the military?	ever worl plan? served in	ked the	help de Yes Yes	IN IN	o If 'Yes If 'Yes o If 'Yes If 'Yes o If 'Yes	nay be eligible for additional benefits.  ,' employer name: ,' dates of employment: ,' branch of service: ,' dates of service: ,' branch of service: ,' dates of service:
Federal Income Tax Filing: Te Will PERSON 5 file taxes NEXT YEAR?				vill file inc	come taxes	NEXT YEAR.
If 'Yes,' will PERSON 5 file jointly with a spouse?		l Yes l Yes	□ No □ No		If 'Yes '	name of spouse:
Will PERSON 5 claim dependents on his/her tax return?		Yes	□ No			name of dependent(s):
Will PERSON 5 be claimed as a dependent on someone else's tax return?	ə 🗆	l Yes	□ No			name of tax filer:ship to tax fil
Does PERSON 5 pay any expenses that may be deducted on the federal income tax return?  Do not include self-employment expenses.  Check all that apply.		l Other	nt Ioan deducti	interest ons ductions:	Amount Amount Amount	paid: How often? How often? How often? How often?

Is there anyone else in PERSON 1's household? If YES, attach extra pages to tell us about the other people. If NO, go to page 18. Effective Date: October 1, 2013

# Nutrition Assistance, Cash Assistance and Tuberculosis Control Questions:

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

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

Name (	(First and Last):	Date Left:	Expected Return Dat			Temporary Address:	Why are they out of the home?
<b>*</b> \$	Resources and Assistance and/or C				tions if ar	nyone in your household is apply	
bank account IRAs, Keoghs	yone in your househo is (checking or saving s, or 401Ks?	s), credit union a	accounts,	□ Yes	□ No	If 'Yes,' total value: \$ Who owns? Name of financial institution:_	
stocks, bonds	yone in your househo s, money market acco runds, or life insurance	unts, Certificate		☐ Yes	□ No	If 'Yes,' total value: \$ Who owns? Name of financial institution: _	
Do you or anyone in your household own, rent, lease or maintain a home?			se or maintain	□ Yes	□ No	If 'Yes,' total value: Who owns? Where?	
Do you or anyone in your household own real property (land or buildings)?		☐ Yes	□ No	If 'Yes,' total value: \$ Who owns? Where?			
Do you or anyone in your household own vehicles (cars, trucks, boats, RVs, motorcycles, etc.)?				☐ Yes	□ No	If 'Yes,' total value: \$ How many vehicles?	
Do you or an	yone in your househo	ld own other res	ources?	□ Yes	□ No	If 'Yes,' total value: \$ Describe resources: Who owns?	
Did you or anyone in your household ever apply for or get benefits from any other state?				☐ Yes	□ No	If 'Yes,' who? What type of benefits? When did benefits stop? Name of state/county:	
Do you or anyone in your household pay for the care of a child or disabled adult in order to work, look for work, attend training, or attend school?		☐ Yes	□ No	If 'Yes,' who pays? Amount paid for care: \$ How often is care paid for? _			
costs to trave	yone in your househo I to/from the person c are or adult daycare?	r agency that pr		☐ Yes	□ No	If 'Yes,' amount: \$	
	yone in your househo		lered child	☐ Yes	□ No	If 'Yes,' who pays? Amount paid \$ How often paid?	
bank account	ousehold have enough t balances to cover you ld care payments?			☐ Yes	□ No	If 'No,' how are you paying yo	ur bills?

and prepares food.
your household huy and propare his/her own food sanarate fro

Does anyone in your household buy and prepare his/her own food separate from others in the household?

Ч	Yes	ш	Ν
---	-----	---	---

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

Name (First & Last):	Age:	Relationship to PERSON 1:	Does thi	s person penses?	What expenses?
			☐ Yes	□No	
			☐ Yes	☐ No	
			☐ Yes	□ No	
			☐ Yes	□ No	

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

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

# Health Insurance:

Do any applicants have health in If 'Yes,' give the following infor	surance other than AHCCCS or Medicare? mation:	☐ Yes	□ No	
Name of Insured:	Name of Insurance Provider:	Policy I	Number:	Coverage Effective Date:
Answer the follow	ving questions for everyone applying for AHCC	CCS Medical Assistar	nce and/or help with M	ledicare costs.
	rry or illness due to an accident or medical ma	<u> </u>		
Are any applicants currently ac	dmitted to a hospital?	☐ Yes	☐ No If 'Yes,' v	vho?
Health Insurance T	ax Credits:			
emiums. If you are not eligible arketplace to see about health		end your information	to the federal Health	
23	m Jobs: Tell us about health insurance that			
become eligible for coverage	surance coverage offered by an employer, or vige in the next 60 days?  YES: answer the questions below. If NO or I I	-	Yes No	☐ I do not know
Tell us about the job that offer	s health insurance coverage. If there are plan al pages. If you need help with the information	s offered by more tha	in one employer and y	ou need more
Employee Name:			curity Number:	
		Employer Identificati	on Number (EIN):	
Employer Address:			tate:Zip	Code:
	ployment health insurance coverage at this joutionary period for insurance offered by an emp		enroll in coverage?	
Who is eligible for coverage from				
	olth plan that meets the minimum value standa YES: answer the questions below. If <b>NO</b> or I I		☐ Yes ☐ No to the next page.	☐ I do not know
If the employer has wellness p	neets the minimum value standard* offered or programs, provide the premium that the employ grams, and did not receive any other discount:	ee would pay if he/s	he received the maxin	
	yee have to pay in premiums for that plan? \$_			🚨 I do not know
☐ Weekly ☐ Twice	e a month	☐ Quarterly ☐ Ye	early 🔲 I do not kno	w Dother:
☐ Employer will not offer heal	er make for the new plan year (if known)? th coverage health coverage to employees or change the p	oremium for the lowes	st-cost plan available o	only to the
employee that meets the m  How much will the emplo	byee have to pay in premiums for that plan? \$	•		🛘 I do not know
	ployee have to pay the premium? e a month ☐ Every 2 Weeks ☐ Monthly	☐ Quarterly ☐ Ye	early 🚨 I do not know	v 🚨 Other:
	ax Credit Coverage in Future Years			
To make it easier for the Federagree to allow the Marketplaceme make changes, and I can Yes, renew my eligibility	eral Facilitated Marketplace to determine my e e to use income data, including information fro opt out at any time.	ligibility for help payir om tax returns. The № I 3 years  □ 2 year	Marketplace will send	

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

# Sign the Application:



The application is not valid until it is signed. All unrelated adults without a child in common must sign the application. Otherwise, the application must be signed by one of the following:

- The applicant or the applicant's designee (we must have documentation showing this person is authorized to act on the applicant's behalf); or
- The applicant's spouse, if married and living within the same household; or
- The parent/legal guardian of a minor child.

## **Penalty Warning**

The information provided on this form may be verified by federal, state, and local officials. If any information is inaccurate, you may be denied benefits.

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

#### Release of Information

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

# Assignment of Rights to Other Benefits for Medical Care

I understand that if I am or members of my household are approved for DES and/or AHCCCS benefits, DES and/or AHCCCS can collect payment from any other parties who may be responsible for paying for my/our health costs. This includes:

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

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

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

### Assignment of Rights to Other Benefits for Cash Assistance

State and federal law (A.R.S. 46-407) provide that the legal rights to child support and spousal maintenance must be assigned to the State of Arizona for all persons receiving Cash Assistance. I understand:

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

#### Statement of Truth

By signing this application:

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

I swear under penalty of perjury that the statements and documents provided about myself and persons in my home, that relates to my eligibility for benefits, is true and correct to the best of my knowledge, and that I have not withheld any information. I swear under penalty of perjury that any photocopied information I have provided are the same as the original documents.

•	
Signature of Applicant:	Date:
Signature of Spouse:	Date:
Signature of Other Adult in Household:	Date:
Signature of Authorized Representative:	Date:
Signature of Witness (if signed with mark):	Date:

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### Attachment 2 AHCCCS DES Combined Application

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587)

# Voter Registration:

**\*\* \* \* 5 5** 

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

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

Would any person on this application over the age of 18 like to register to vote?	Yes	□ No	☐ Already registered to vote
If YES is not checked, all persons over the age of 18 on this application will be consi	dered to have	decided no	t to register to vote at this time.

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

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

# **Submit the Application:**



\$6

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

If any additional information is needed, you will be contacted.

You will be notified of our decision.

Thank you for applying!

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## How to Choose an AHCCCS Health Care Plan:



## You need to choose a health plan that services your county.

• All AHCCCS health plans provide the same covered medical services.

• Review the health plans for your county listed below. American Indians may choose American Indian Health Program or an AHCCCS health plan.

Before you choose a plan, check with your doctor, pharmacy, or hospital to see if they work with the plan that you
want. If you want more information about the doctors, specialists, or hospitals that work with a health plan that
serves your county, call the number listed below for the health plan.

If you do not choose a health plan, one will be assigned to you. If you have been enrolled in an AHCCCS health plan within the past 90 days, you may be enrolled with your previous health plan.

Enter the health plan choice on this application.

APACHE COUNTY UnitedHealthcare Community PlanHealth Choice ArizonaAmerican Indian Health Program	1-800-322-8670 928-729-8000
If your zip code is 85943, you must choose to plans listed under Navajo County.	from the health
COCHISE COUNTY University Family CareUnitedHealthcare Community PlanAmerican Indian Health Program	1-800-348-4058
COCONINO COUNTY UnitedHealthcare Community PlanHealth Choice ArizonaAmerican Indian Health Program	1-800-322-8670
If your zip code is 86336 or 86340, you mus the health plans listed under Yavapai Count	t choose from y.
GILA COUNTY Health Choice Arizona University Family Care American Indian Health Program	1-800-582-8686
GRAHAM COUNTY University Family CareUnitedHealthcare Community PlanAmerican Indian Health Program	1-800-348-4058
If your zip code is 85643, you must choose listed under Cochise County.	from the health plans
GREENLEE COUNTY University Family Care UnitedHealthcare Community Plan American Indian Health Program	1-800-348-4058
LA PAZ COUNTY UnitedHealthcare Community Plan University Family Care American Indian Health Program	1-800-582-8686
MARICOPA COUNTY Health Net of Arizona Care 1 <sup>st</sup> Arizona Health Choice Arizona UnitedHealthcare Community Plan Mercy Care Plan Maricopa Health Plan American Indian Health Program	1-866-560-4042 1-800-322-8670 1-800-348-4058 1-800-624-3879 1-800-582-8686

MOHAVE COUNTY UnitedHealthcare Community Plan
If your zip code is 86434, you must choose from the health plans listed under Yavapai County.
NAVAJO COUNTY UnitedHealthcare Community Plan
PIMA COUNTY           UnitedHealthcare Community Plan         1-800-348-4058           Health Choice Arizona         1-800-322-8670           Care 1 <sup>st</sup> Arizona         1-866-560-4042           University Family Care         1-800-582-8686           Mercy Care Plan         1-800-624-3879           American Indian Health Program         520-295-2479
If your zip code is 85645, you must choose from the health plans listed under Santa Cruz County.
PINAL COUNTY           Health Choice Arizona         1-800-322-8670           University Family Care         1-800-582-8686           American Indian Health Program         520-562-3321
If your zip code is 85242 or 85220, you must choose from the health plans listed under Maricopa County.
If your zip code is 85292 you must choose from the health plans listed under Gila County.
SANTA CRUZ COUNTY University Family Care
YAVAPAI COUNTY UnitedHealthcare Community Plan
If your zip code is 85342, 85358 or 85390, you must choose from the health plans listed under Maricopa County.
If your zip code is 86351 you must choose from the health plans listed under Coconino County.
VIIII A COLLETTY

YUMA COUNTY

UnitedHealthcare Community Plan ...... 1-800-348-4058

Con	ta	ct	Inf	orm	atio	n:

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

Name (First, Middle, Last):
Home Address: State: Zip Code:
Mailing Address (if different): Apt. #: City: State: Zip Code:
Do you live in a shelter? 🔲 Yes 🚨 No 💮 If 'Yes,' what kind of shelter?
Phone Number:This number is: ☐ Home ☐ Cell ☐ Work ☐ Message ☐ Other:
Other Phone Number:This number is:
What is the preferred SPOKEN household language? ☐ English ☐ Spanish ☐ Other:
What is the preferred WRITTEN household language? ☐ English ☐ Spanish ☐ Other:
I would like to get information about this application by:
Email: Q Yes Q No Email address:
Text: ☐ Yes ☐ No Number to text (standard text rates apply):
If 'Yes' is not marked for Email or Text, all information for this application will be sent via U.S. Mail to the mailing address provided.
I need the following help with this application (check all that apply):
☐ Reading/understanding this application ☐ Filling out this application ☐ Other:
☐ American Sign Language ☐ Braille ☐ Language Interpreter Language:
I need the following accommodations for this application (check all that apply):
☐ Hearing ☐ Speaking ☐ Seeing ☐ Writing ☐ Walking ☐ Other:
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### **Authorized Representative:**

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

Representative's Name:	Is representative your legal guardian? ☐ Yes ☐ No
Representative's Mailing Address:	City: State: Zip Code:
Representative's Phone Number:	This number is: ☐ Home ☐ Cell ☐ Work ☐ Message ☐ Other:
Representative's Other Phone Number:	This number is: ☐ Home ☐ Cell ☐ Work ☐ Message ☐ Other:
What is the representative's preferred SPOKEN language?	□English □ Spanish □ Other:
What is the representative's preferred WRITTEN language?	☐ English ☐ Spanish ☐ Other:
My representative would like to get information about this appl	lication by:
Email: 🔲 Yes 🚨 No Email address:	·
Text: ☐ Yes ☐ No Number to text (standard text rat	
If 'Yes' is not marked for Email or Text, all information for	or this application will be sent via U.S. Mail to the mailing address provided.
By signing below I, the customer, give permission for the person listed abo	
as my representative to act on my behalf in the process of qualifying me fo	
AHCCCS Medical Assistance, help with Medicare costs, Nutrition Assistan	nce, Provide only truthful and complete information under penalty of perjury.

Cash Assistance, and/or Tuberculosis Control. I, therefore:

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

- Fill in and sign needed forms.
- Obtain and give to DES and/or AHCCCS all information needed to determine if the customer can qualify for help with healthcare costs, help with Medicare costs, Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control, such as the customer's Social Security number, income, assets, citizenship, residency, medical insurance, and information about the customer's spouse, minor children, and parents (if the customer is a minor child).
- Tell DES and/or AHCCCS right away if the customer:
  - Has an increase or decrease in income;
  - Has an increase or decrease in assets;
  - Changes ownership of assets, including opening or closing financial 0 accounts;
  - Has a change in address; or
  - Has a change in health insurance or the amount of premiums paid

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

	,	administrative hea	ring or court proceeding.	
Signature of Applicant: Date:			Signature of Representative:	

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### Release of Information to Hospitals/Hospital Agents/Organizations/Agencies:

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

23.00.000000000000000000000000000000000						
•	al/Hospital's Agent/Organization/Agend	•				
			Phone Num	ber:		
Mailing Address	<u> </u>	City:	State:	Zip	Code:	
<ul><li>That I h</li><li>The info</li><li>If appro</li></ul>	for DES and/or AHCCCS staff to tell the hos ave applied for AHCCCS Medical Assistant ormation or proof needed to see if I can get ved for AHCCCS Medical Assistance, the e was approved. If denied for AHCCCS Med	he; AHCCCS Medical Assistance; an ffective date of my eligibility, the re	d determination due d		egory of ass	sistance for
Signature of Ap	plicant:		Date			
Access to	Electronic Benefit Tra	nsfer (EBT) Accou	nt:			
<b>*</b> \$&	This section is OPTIONAL. If you are may choose a person, called an Alter choose a person you trust. Remember	nate Cardholder, to get your be	enefits for you. If y			
EBT Representa	ative's Name:		_ EBT Representa	ative's Date of	Birth:	
EBT Represent	ative's Mailing Address:					
	ative's Phone Number:					
	ative's Other Phone Number:					3
	plicant:			_		
				***************************************	*********	
			•			
Someone	Who Knows You Well:					
<b>●</b> \$&	We often need to contact people or or When we contact these people or orga Economic Security (DES). We are proplete provide contact information be	anizations we tell them your na phibited by law from telling ther	me, our title and th	nat we work fo	r the Depa	artment of
Name of someor	e who knows you well:		Relationship t	o you:		
Mailing Address:		City:		_State:	Zip Code	
Daytime Phone i	lumber:					
	d:		Relationship	to you:	7: 0 !	
Mailing Address: Daytime Phone N		City:	<u></u>	_ State:	Zip Code	:
Daytime Frione i	urriber.				***************************************	
Emergen	cy Nutrition Assistance					
	Is anyone in your household applying	for Emergency Nutrition Assist	ance? If YES: fill o	out this section	n. <b>If NO</b> : g	go to page 3.
What is the total	amount of income, before deductions,	you expect to get this month?			\$	
<del></del>	amount of cash on hand and money in		······································		\$	
	al monthly housing costs (rent or morte		insurance, etc.)?		\$	www.mandananiswa.com.com.com.com
	al monthly utility costs (gas, electric, ph	none, water, etc.) ?			\$	— KI —
	ceive Tribal Food Distribution? rant or seasonal farm worker?		NYDEN, NEW WITE SEE S	<u> </u>	☐ Yes	□ No
	Nutrition Assistance benefits from any	other state?			☐ Yes☐ Yes	□ No □ No
If 'Yes,' who re		When?	State:			

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

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	-	*****				-	
8	-	*****	-			-	т.
				w	FF.		

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

Personal Information:	
Name (First, Middle, Last):	Gender:
Date of Birth: Social Security Number (optional if not applying):	
	ied-name of spouse:
Is PERSON 1 attending school?	: 🛘 Full Time 🚨 Part Time
Is PERSON 1 applying for help with health insurance costs □ Yes □ No If 'Yes,' AHCCCS health OPTIONAL. See page	h plan choice:age H for enrollment plan choices.
♣ Is PERSON 1 applying for help with Medicare costs?  ☐ Yes ☐ No If 'Yes,' Medicare claim	number:
Does PERSON 1 need help paying for medical bills ☐ Yes ☐ No If 'Yes,' what months? from the last 3 months?	
Is PERSON 1 applying for Nutrition Assistance? □ Yes □ No	
\$ Is PERSON 1 applying for Cash Assistance? ☐ Yes ☐ No	
b Is PERSON 1 applying for Tuberculosis Control? ☐ Yes ☐ No	
If PERSON 1 is applying for any benefits: continue answering the questions but If PERSON 1 is <b>NOT</b> applying for any benefits: go to page 5 to tell us about PERSON	
Citizenship/Residency: Tell us about PERSON 1's citizenship/residency. You citizenship/residency.	ı may need to provide proof of
Is PERSON 1 a U.S. citizen or U.S. national? See page D for more information.	☐ Choose not to answer
If PERSON 1 is NOT a U.S. citizen, what is his/her immigration status?	
□ Lawful Temporary Resident       □ Cuban-Haitian Entrant       □ Registry A         □ Non-Immigrant Status       □ Deferred Action Status       □ Special In Deferred Enforced Departure       □ Temporary Temporary Conditional Entrant granted before 1980       □ Legalization under LIFE Act       □ Victim of Under IRCA Applicant       □ Withholdit         □ Other       □ Order of Supervision       □ Applicant	mmigrant Juvenile Status Applicant ry Protection Status (TPS)
What immigration document does PERSON 1 have?  □ Permanent Resident card □ I-94 □ Visa □ Has PERSON 1 lived in the U.S. since the proof of the proof	ce August 22, 1996?
Is PERSON 1 an Arizona resident?	months?
Race (optional), select one or more:	thnicity (optional):
☐ Asian ☐ Hawaiian or other Pacific Islander ☐ White ☐	l Hispanic/Latino l Non-Hispanic/Non-Latino
If PERSON 1 is American Indian or Alaska Native;	
Is he/she enrolled in a federally recognized tribe?	me of tribe:
health program, or urban Indian health program, or through a referral from one of these programs?	e/she eligible? ☐ Yes ☐ No
\$\ \text{Is he/she living on a reservation?} \qquad \text{Yes}  \text{No}  \text{If 'Yes,' nar}	me of reservation:
Tribal Census Number:	

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

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Р	R	S	0	V	۱,	1 :

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

s PERSON 1 p	hysically or mentally disabled?		🗆 Yes 🗖 I	No			
S PERSON 1 in	n jail or prison?		☐ Yes ☐ I	<b>V</b> o			
Nas PERSON	1 released from jail or prison in the last 4 months?		☐ Yes ☐ I	No If "	Yes,' relea	se date: _	
<b>-</b> \$	AHCCCS Medical Assistance, Help v Complete this section if PERSON 1 is applying and/or Cash Assistance.						
s PERSON 1 p			⊒ Yes l			mber of ba	ibies due: e date:
	under age 19, are both of his/her parents living in ete the information below:	the home?	⊒ Yes 〔	⊒ No			
arent's Name	(First, Last):	Social Security	Number: _			Date of	Birth:
P. L. B. Maar 3.7592542	37 <u>- 1888 - 1888 - 1888 - 1888 - 1888 - 1888 - 1888 - 1888 - 1888 - 1888 - 1888 - 1888 - 1888 - 1888 - 1888 -</u>	City:		State	);	Zip C	ode:
		_Reason parent i	s absent:	αD	eceased	☐ Out of	home
فانسطنا للمحاقات فيخوف فيسام عادات فالتكريث	(First, Last):	Social Security	<u> </u>	artic edit access to the		Date of	Birth:
	3:	City:			9:		ode:
•		Reason parent i			, , , , , , , , , , , , , , , , , , , ,	☐ Out of	home
will keep him/	AHCCCS Medical Assistance and He questions if PERSON 1 is applying for AHCCCS under the age of 65, does he/she have a mental her from working for at least 12 months?  orks and is under the age of 65, does he/she have onths?	S Medical Assistan or physical disabili	ce and/or ty that has	help with kept or	n Medicare □.)	e costs. (es 🔲 N	Vo.
will keep him/ If PERSON 1 w at least 12 mo Does PERSON assistance, se	questions if PERSON 1 is applying for AHCCCs under the age of 65, does he/she have a mental wher from working for at least 12 months? works and is under the age of 65, does he/she have onths?  1 need help with activities of daily living (bathing, prvices, nursing home, or other medical facility?	S Medical Assistan or physical disabili e a disability that is dressing, etc.) thre	ce and/or ty that has expected ough perso	help with kept or to last onal	n Medicare	e costs. (es	10 10
will keep him/ f PERSON 1 w at least 12 mc Does PERSON assistance, se Does PERSON	questions if PERSON 1 is applying for AHCCCs under the age of 65, does he/she have a mental wher from working for at least 12 months? Forks and is under the age of 65, does he/she have onths?  I need help with activities of daily living (bathing, ervices, nursing home, or other medical facility?  I live with at least one child under age 19 and is	S Medical Assistan or physical disabili e a disability that is dressing, etc.) thro the main care take	ce and/or ty that has expected ough perso	help with kept or to last onal	n Medicare	e costs.  /es	No No
will keep him/ If PERSON 1 w at least 12 mo Does PERSON assistance, se Does PERSON	questions if PERSON 1 is applying for AHCCCs under the age of 65, does he/she have a mental wher from working for at least 12 months? works and is under the age of 65, does he/she have onths?  1 need help with activities of daily living (bathing, prvices, nursing home, or other medical facility?	S Medical Assistan or physical disabili e a disability that is dressing, etc.) thro the main care take	ce and/or ty that has expected ough perso	help with kept or to last onal	n Medicare	e costs.  /es	40 40
will keep him/ f PERSON 1 w at least 12 mc Does PERSON assistance, se Does PERSON las PERSON	questions if PERSON 1 is applying for AHCCCS under the age of 65, does he/she have a mental ther from working for at least 12 months? Torks and is under the age of 65, does he/she have onths?  1 need help with activities of daily living (bathing, ervices, nursing home, or other medical facility?  1 live with at least one child under age 19 and is 1 ever received Supplemental Security Income (SS Nutrition Assistance and Cash Assist for Nutrition Assistance and/or Cash Assistance conviction. See page G for more information.	S Medical Assistant or physical disabilities a disability that is dressing, etc.) through the main care take SI Cash)?	ce and/or ty that has expected bugh perso r of the chi  ons: Ans r still be ab	help with kept or to last onal ld? wer thes le to get	Medicare  y  y  y  se questior benefits if	e costs.  /es	No No No No ON 1 is apply as a felony dr
will keep him/ f PERSON 1 w at least 12 mc Does PERSON assistance, se Does PERSON das PERSON das PERSON	questions if PERSON 1 is applying for AHCCCS under the age of 65, does he/she have a mental ther from working for at least 12 months? Torks and is under the age of 65, does he/she have onths?  1 need help with activities of daily living (bathing, ervices, nursing home, or other medical facility?  1 live with at least one child under age 19 and is a lever received Supplemental Security Income (SS)  Nutrition Assistance and Cash Assistance and/or Cash Assistance	S Medical Assistant or physical disabilities a disability that is dressing, etc.) through the main care take SI Cash)?	ce and/or ty that has expected bugh perso r of the chi  ons: Ans r still be ab	help with kept or to last onal ld? wer thes le to get	Medicare  ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	e costs.  /es	No No No No ON 1 is apply as a felony dri
will keep him/ f PERSON 1 w at least 12 mc Does PERSON assistance, se Does PERSON das PERSON das PERSON controlled sub das PERSON Cash Assistan	questions if PERSON 1 is applying for AHCCCS under the age of 65, does he/she have a mental ther from working for at least 12 months?  Torks and is under the age of 65, does he/she have onths?  I need help with activities of daily living (bathing, ervices, nursing home, or other medical facility?  I live with at least one child under age 19 and is a leaver received Supplemental Security Income (SS Nutrition Assistance and/or Cash Assistance conviction. See page G for more information.  I had a felony conviction for possession, use, or destance on or after August 23, 1996?  I been found to have committed a Nutrition Assistance Intentional Program Violation in Arizona or an	S Medical Assistant or physical disabilities a disability that is dressing, etc.) through the main care take SI Cash)?  Stance Questice. PERSON 1 may istribution of a manage and/or y other state?	ce and/or ty that has expected bugh perso r of the chi ons: Ans r still be ab Tyes Tyes	help with kept or to last onal ld?  wer these le to get   No	Medicare  N  N  N  See question benefits if City/state Type of c	e costs.  fes	No No No ON 1 is apply as a felony dru viction:
will keep him/ If PERSON 1 w at least 12 mc Does PERSON assistance, se Does PERSON Has PERSON controlled sub Has PERSON Cash Assistal Is PERSON 1 file	questions if PERSON 1 is applying for AHCCCS under the age of 65, does he/she have a mental ther from working for at least 12 months?  Torks and is under the age of 65, does he/she have onths?  I need help with activities of daily living (bathing, ervices, nursing home, or other medical facility?  I live with at least one child under age 19 and is a leaver received Supplemental Security Income (SS Nutrition Assistance and/or Cash Assistance conviction. See page G for more information.  I had a felony conviction for possession, use, or destance on or after August 23, 1996?	S Medical Assistant or physical disabilities a disability that is dressing, etc.) through the main care take SI Cash)?  Stance Questice. PERSON 1 may istribution of a mance and/or y other state?	ce and/or ty that has expected bugh perso r of the chi ons: Ans r still be ab Tyes Tyes	help with kept or to last onal lid?	Medicare  N  N  N  See question benefits if City/state Type of c	e costs.  fes	No No No ON 1 is apply as a felony dri viction:
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will keep him/ f PERSON 1 w at least 12 mc Does PERSON assistance, se Does PERSON das PERSON das PERSON das PERSON controlled suk das PERSON 1 fi PERSON 1 in	questions if PERSON 1 is applying for AHCCCS under the age of 65, does he/she have a mental ther from working for at least 12 months? Torks and is under the age of 65, does he/she have onths?  I need help with activities of daily living (bathing, ervices, nursing home, or other medical facility?  I live with at least one child under age 19 and is a lever received Supplemental Security Income (SS)  Nutrition Assistance and/or Cash Assistance conviction. See page G for more information.  I had a felony conviction for possession, use, or dostance on or after August 23, 1996?  I been found to have committed a Nutrition Assistance Intentional Program Violation in Arizona or an leeing from law enforcement agencies on any chain violation of probation or parole according to a conviction Assistance Questions: Answerittion Assistance Questions:	S Medical Assistant or physical disabilities a disability that is dressing, etc.) through the main care take SI Cash)?  Stance Questice. PERSON 1 may istribution of a ance and/or y other state? rges, or is urt?	ce and/or ty that has sexpected bugh perso r of the chi ons: Ans r still be ab large Yes large Yes large Yes series of PERSo	help with kept or to last onal ld? wer these le to get look No	m Medicare  The	e costs.  Yes	No No No No No ON 1 is apply as a felony dri viction: ate:
will keep him/ f PERSON 1 w at least 12 mc Does PERSON assistance, se Does PERSON Has PERSON Controlled sub Has PERSON Cash Assistan S PERSON 1 in PERSON 1 in	questions if PERSON 1 is applying for AHCCCS under the age of 65, does he/she have a mental ther from working for at least 12 months?  orks and is under the age of 65, does he/she have onths?  1 need help with activities of daily living (bathing, ervices, nursing home, or other medical facility?  1 live with at least one child under age 19 and is a lever received Supplemental Security Income (SS)  Nutrition Assistance and Cash Assist for Nutrition Assistance and/or Cash Assistance conviction. See page G for more information.  1 had a felony conviction for possession, use, or dostance on or after August 23, 1996?  1 been found to have committed a Nutrition Assistance Intentional Program Violation in Arizona or an leeing from law enforcement agencies on any chain violation of probation or parole according to a contribution of probation or parole according to a contribution.	S Medical Assistant or physical disabilities a disability that is dressing, etc.) through the main care take SI Cash)?  Stance Questice. PERSON 1 may istribution of a mance and/or y other state? rges, or is urt?  wer these question aid or unpaid med	ce and/or ty that has sexpected bugh perso r of the chi ons: Ans r still be ab one Yes one Yes one Yes one Side PERSo ical	help with kept or to last onal ld? wer these le to get look No	se question benefits if 'Yes,' of City/state Type of City's applying for applying for the city of the city's t	e costs.  Yes	No No No No No ON 1 is apply as a felony dri viction: ate:

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

Effective Date: October 1, 2013

### PERSON 1:

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

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

Does PERSON 1 work?		Yes	□ No	If yes,	give employr		
Employer's Name and Phone Number:	Gross Ear (before dedu			How of	ten paid?	How m	any hours worked per week?
Is PERSON 1 self-employed?		☐ Yes			'Yes,' type of		11:
If 'Yes,' has PERSON 1 been in this business for	or 12 months?	☐ Yes	s 🗆 N		'Yes,' annual 'No,' date bu		ductions) amount:
Does PERSON 1's income change because of conseasonal employment?		☐ Yes		) If		h income do	es PERSON 1 expect to
Does PERSON 1 work in exchange for food or rer	nt?	☐ Yes	. □N		'Yes,' where'		
Other Income: Tell us about Type of Income: Social Security benefits		PERSO	2000 00	ives. Y ten rec			oof of income.
Supplemental Security Income (SSI Cash)							
Retirement/pension Unemployment							
Disability/worker's compensation			F4-10,8 LS 1.5				
Child support			YENNEN P				
Veterans benefits Gifts or loans			7.01 <b>- 23</b> 13.		. Pa. Ballia Rabe	casa dana	
Tribal money ☐ Gaming ☐ Other:						A STANDARD THE A	
Per capita payments from natural resources, usag leases or royalties	e rights,						
Payments from natural resources, farming, ranching fishing, leases or royalties from Indian trust land	ng,						destination of the section of the se
Money from selling things that have cultural significant of them.	cance						
Check here if this person does not have income							
Potential Benefits: Tell us  Has PERSON 1 or his/her spouse (living or decea for a government agency or an employer with a per Has PERSON 1 or his/her spouse (living or decea military?  If PERSON 1 is under age 19, has his/her parent served in the military?	ised) ever wor ension plan? ised) served in	ked [ ı the [	elp deter □ Yes □ Yes □ Yes	mine if I	If 'Yes,' em If 'Yes,' dat If 'Yes,' bra If 'Yes,' bra If 'Yes,' bra	iployer name tes of employ	ment:e:
Federal Income Tax Filin				file inco	me taxes NE	XT YEAR.	
Will PERSON 1 file taxes NEXT YEAR?  If 'Yes,' will PERSON 1 file jointly with a spouse	? 🗆	Yes	□ No □ No		If 'Yes,' name		
Will PERSON 1 claim dependents on his/her tax r	eturn?	l Yes	□ No		If 'Yes,' name	e of depende	nt(s):
Will PERSON 1 be claimed as a dependent on so else's tax return?			□ No		If 'Yes,' name Relationship	to tax filer: _	
Does PERSON 1 pay any expenses that may be deducted on the federal income tax return?  Do not include self-employment expenses.  Check all that apply	<b>.</b>	I Alimony I Student I Other d	loan inte	s	Amount paid Amount paid Amount paid	\$ <u></u>	How often? How often? How often?

Is there anyone else in PERSON 1's household? If YES, go to the next page to tell us about PERSON 2. If NO, go to page 18. Transmittal Number: AZ 13-0005-MM FA-001 (10/13) Arizona Effective Date: October 1, 2013 Approval Date: September 30, 2013

Personal Information:		·····	***************************************		·					************
Name (First, Middle, Last):						<u> </u>		_ Gender:	☐ Male	☐ Fema
Date of Birth:	Social Secur	ity Numbe								
Relationship to Person 1:	☐ Spouse ☐ Grandchild			ild/Step ( ece/Neph	ew		gal Gua		ner:	
Marital Status:   Never M			☐ Widowe			ame of s	oouse: _			
Does PERSON 2 live at the san If 'No,' what is PERSON 2's he		erson 1?	☐ Ye	s 🗆 N	<b>N</b> o					
s PERSON 2 attending school? Name of school:		No	If 'Ye	s,' is PEF	RSON 2 a	ttending : Grade L		☐ Full Tin	ne 🗆 Pa	rt Time
Is PERSON 2 applying for h	nelp with health		□ Yes	□ No	If 'Yes,	' AHCCC	S health	plan choic	e:	
insurance costs? Is PERSON 2 applying for h	nelo with Medicar	re	☐ Yes	□ No				e H for enrol number:		
costs?								· · · · · · · · · · · · · · · · · · ·		
Does PERSON 2 need help bills from the last 3 months?		ical	☐ Yes	□ No	If 'Yes,	' what mo	onths? _			
Is PERSON 2 applying for N	lutrition Assistan	ce?	Yes	□ No						
Is PERSON 2 applying for C	ash Assistance?	•	Yes	□ No						
Is PERSON 2 applying for T	uberculosis Con	trol?	☐ Yes	☐ No						
		iying ior ai	ly benefits: g	jo to page	o to ten us	about PE	RSON 2's	s income.		
Citizenship	p/Residency:			-				-	to provide	proof of
citizenship/re	p/Residency: sidency.	: Tell us a	bout PERS	SON 2's c	citizenship	o/residenc	cy. You	-		
citizenship/re s PERSON 2 a U.S. citizen or l	p/Residency: esidency. J.S. national? Se	: Tell us a ee page [	bout PERS	SON 2's c	citizenship	o/residenc	cy. You	may need t		
s PERSON 2 a U.S. citizen or Use PERSON 2 is NOT a U.S. citizen or Use I Lawful Permanent Resident (I Lawful Temporary Resident I Non-Immigrant Status I Asylee I Refugee I Conditional Entrant Granted I Other	p/Residency: esidency.  J.S. national? Sozen, what is his/h LPR)  before 1980	ee page [ ner immig     Batter     Cubar     Deferr     Deferr     Legali     Crder	bout PERS	informations? , Child are ntrant Status and Departer LIFE A per IRCA A sion	on. □  nd Parent  ture  act  Applicant	J Yes C Ren Reg Spe Ten Vict With	noval/Su jistry Ap icial Imm nporary im of Tra nholding	may need to choose replicants higrant Juve Protection S	not to answ of Deporta enile Statu Status (TF	wer tion s Applicant S)
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s PERSON 2 a U.S. citizen or U	b/Residency: esidency.  J.S. national? So zen, what is his/h LPR)  before 1980  es PERSON 2 ha li-94	ee page [ ner immig  Batter  Cubar  Deferr  Legali  Legali  Order  Parole ave? a er:  No	of for more ration statued Spouse Haitian End Action Statued Enforce zation under station under the dinto Unit Im Haitian End PERSO If 'Yes,' da	informations?  , Child are not and Depart and Depart are LIFE Are IRCA Are in	on.  on.  ond Parent cure Applicant on Docume ON 2 live e to Arizo	D/residence  ☐ Yes ☐ Ren ☐ Reg ☐ Ten ☐ Vict ☐ With ☐ App Withhole In the U	noval/Su jistry Appicial Immoprary Immof Transholding Deleng Loss Since	may need to consider the construction of Deportary Asylum, Leportation of August 22	not to answer of Deportation (TP), TPS, TPS, TPS, TPS	wer tion s Applicant S) or
S PERSON 2 a U.S. citizen or U	p/Residency: esidency.  J.S. national? So zen, what is his/h LPR)  before 1980  es PERSON 2 ha li-94	ee page [ ner immig     Batter     Cubar     Deferr     Legali     Crder     Parole ave? a er:     No     Tother Paci	of for more ration statued Spouse Haitlan Electron statued Action Statued Enforce zation under station under station under station under Supervised into Unit	informations?  , Child are not and Depart and Depart are LIFE Are IRCA Are in	citizenship on.  ond Parent cure act Applicant s on Docume ON 2 live e to Arizo d:	D/residence  ☐ Yes ☐ Ren ☐ Reg ☐ Ten ☐ Vict ☐ With ☐ App Withhole In the U	noval/Sujistry Applicial Immediate of Transholding Delection of the Property of the Immediate of the Immedia	may need to continuous personal continuous per	not to answer of Deportation (PR, TPS, 1996?   Presented to answer of the p	wer tion s Applican S) or Yes I
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s PERSON 2 a U.S. citizen or U	b/Residency: esidency.  J.S. national? So zen, what is his/h LPR)  before 1980  es PERSON 2 ha I-94	ee page [ ner immig     Batten     Cubar     Deferr     Legali     Crder     Parole ave? a er:     No  Cother Pacilian/Alask ? alth Service	o for more ration statued Spouse Haitian Eled Action Statued Enforce zation under zation under station under into Unit In Haitian Eled In Yes, da diffic Islander a Native	informations? , Child are not at the LIFE A der IRCA der	on. □  ond Parent  cure  act Applicant  and Docume ON 2 live  e to Arizo d:  ite ner: □  No	Presidence	noval/Sujistry Applicial Immorary im of Tranholding Delection of the control of t	may need to consider the construction of Deportary Asylum, Leportation on the construction of Deportation on the construction of Deportation on the construction of the construction on the construction of the construction on the construction of th	of Deportation Status (TF attion LPR, TPS, Deportation LPR, De	wer tion s Applican S) or Yes I

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

Transmittal Number: AZ 13-0005-MM FA-001 (10/13) Arizona

Effective Date: October 1, 2013

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	_	11.0	•			

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

ls PERSON 2 pl	hysically or mentally disabled?	□ Yes □ No
IS PERSON 2 ir		☐ Yes ☐ No
Was PERSON 2	2 released from jail or prison in the last	4 months?
<b>-</b> \$		nce, Help with Medicare Costs, and Cash Assistance Questions: 2 is applying for AHCCCS Medical Assistance and/or help with Medicare costs, and
s PERSON 2 pr	regnant?	☐ Yes ☐ No If 'Yes,' number of babies due: If 'Yes,' expected due date:
	under age 19, are both of his/her parer ete the information below:	
Parent's Name (	(First, Last):	Social Security Number: Date of Birth:
Vailing Address		City: State: Zip Code:
Phone Number:		Reason parent is absent: 🚨 Deceased 🚨 Out of home
oarent's Name (	(First, Last):	Social Security Number: Date of Birth:
Mailing Address	£	City: State: Zip Code:
Phone Number:		Reason parent is absent:
Does PERSON	ever received Supplemental Security I  Nutrition Assistance and Ca	19 and is the main care taker of the child?
	had a felony conviction for possession stance on or after August 23, 1996?	
Cash Assistan	been found to have committed a Nutrit nce Intentional Program Violation in Ariz	ion Assistance and/or
	eeing from law enforcement agencies o violation of probation or parole accordi	
)	Nutrition Assistance Questi	ons: Answer these questions if PERSON 2 is applying for Nutrition Assistance.
expenses, ev	disabled or over age 60, does he/she hen if he/she has medical insurance (exa der, doctor visits, prescriptions, lab work	ample: travel expenses to and from
	ving in an assisted living facility or grou	p home?
s PERSON 2 IN		
S PERSON 2 IN	Cash Assistance Questions Assistance.	3: Answer this question if PERSON 2 is under age 19 and applying for Cash

Effective Date: October 1, 2013 Approval Date: September 30, 2013

### PERSON 2:

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

<b>******</b>
---------------

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

the last and current calendar month.  Does PERSON 2 work?	☐ Yes	□ No If	ves. give emp	loyment information below:
Employer's Name and Gros	s Earnings	Но	w often paid	How many hours worked
Phone Number: (before	deductions			per week?
Is PERSON 2 self-employed?	□ Ye	s 🗆 No	If 'Yes,' typ	e of work:
				nual net (after deductions) amount:
If 'Yes,' has PERSON 2 been in this business for 12 mor				business started: much income does PERSON 2 expect to
Does PERSON 2's income change because of contract or seasonal employment?	□ Ye	es 🛭 No		the next 12 months?
Does PERSON 2 work in exchange for food or rent?	□ Ye	es 🚨 No	If 'Yes,' wh	
• Other Income: Tell us about other in	come PERS	ON 2 receives	s. You may no	eed to provide proof of income.
Type of Income:	Amount:	How often	received?	Who pays the income?
Social Security benefits				
Supplemental Security Income (SSI Cash)				T-00007-00-00-00-00-00-00-00-00-00-00-00-
Retirement/pension				
Unemployment	S ESCAS SERSE COMPUSS	ngogorks styrt (dae 1981) s. s.		
Disability/worker's compensation  Child support □ Court ordered □ Other:				
Alimony				
Veterans benefits			Harring Colombia Chemistra	0.6 (1888) 1890, 20 Bh. 1894 (1888) 1894 (1894) 1895 (1895)
Gifts or loans				
Tribal money Gaming Other:				
Per capita payments from natural resources, usage rights, leases or royalties				
Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land				
Money from selling things that have cultural significance				
Other:		5895948388 - 173163635		7.2.2.2.3.3.3.3.3.3.3.3.3.3.3.3.3.3.3.3.
Check here if this person does not have income				
Potential Benefits: Tell us about Pl	ERSON 2 to I	help determine	e if he/she ma	y be eligible for additional benefits.
Has PERSON 2 or his/her spouse (living or deceased) eve				employer name:
for a government agency or an employer with a pension pla				dates of employment:
Has PERSON 2 or his/her spouse (living or deceased) sen	ved in the	☐ Yes ☐		branch of service:dates of service:
military? If PERSON 2 is under age 19, has his/her parent (living or	deceased)	□ Yes □		branch of service:
served in the military?	acocaoca			dates of service:
Federal Income Tax Filing: Tell u	_	_	income taxes	NEXT YEAR.
Will PERSON 2 file taxes NEXT YEAR?	☐ Yes	□ No	16 () ( - 1 -	
If 'Yes,' will PERSON 2 file jointly with a spouse?	☐ Yes ☐ Yes	□ No		ame of spouse: ame of dependent(s):
Will PERSON 2 claim dependents on his/her tax return?	₩ IES	<b>-</b> N	и Iea, I	ane or dependent(s).
Will PERSON 2 be claimed as a dependent on someone else's tax return?	☐ Yes	□ No		ame of tax filer:
Does PERSON 2 pay any expenses that may be	☐ Alimor		Amount r	paid: How often?
deducted on the federal income tax return?	<ul> <li>In the control of the c</li></ul>	nt loan interes		paid: How often?
Do not include self-employment expenses.  Check all that apply.		deductions ribe deduction		paid: How often?
CHOK UR GIAL UPPLY.	Deac	., acadelloll	.~	

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

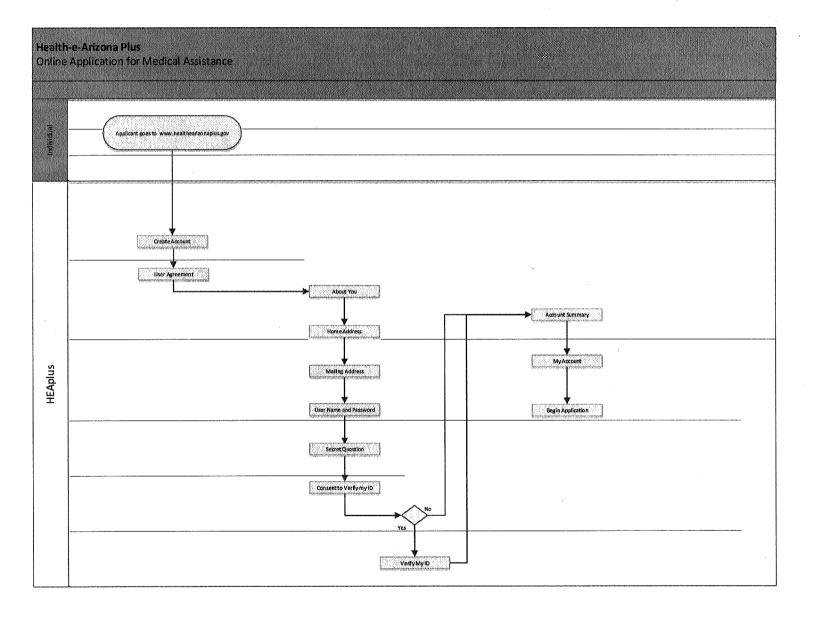
### PERSON 3:

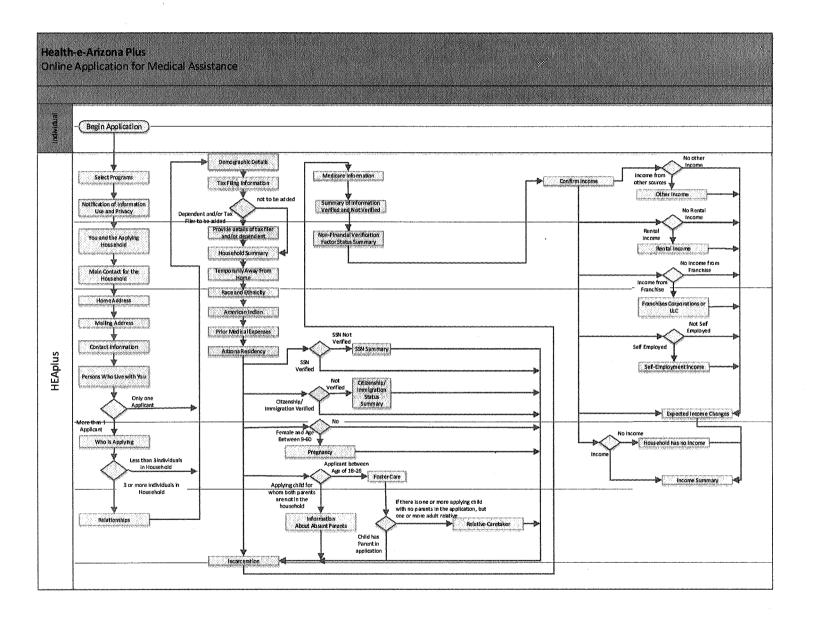
Tell us about the other people in your household. See page A for a definition of who you must include.

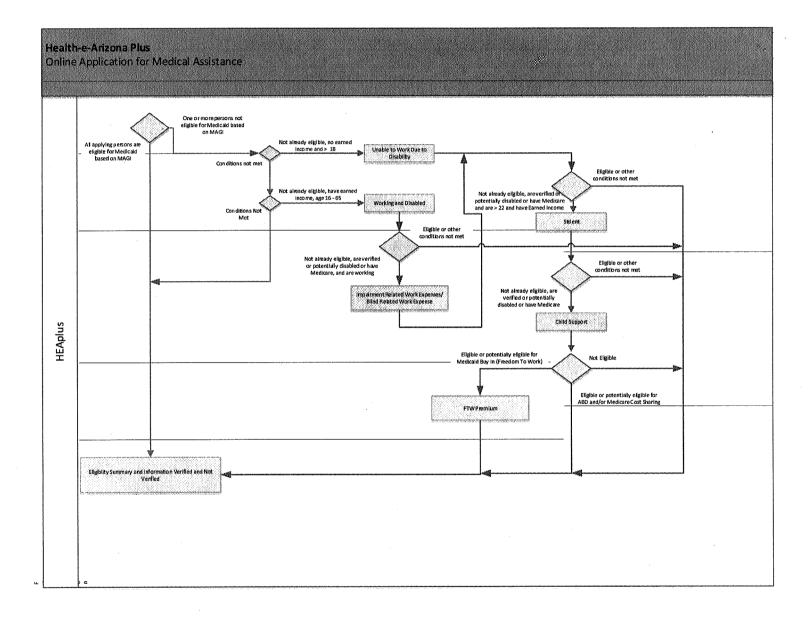
Personal Information:							
Name (First, Middle, Last):					Gender:	☐ Male	☐ Female
Date of Birth: Social Security Nu	mber (optior	nal if not a	pplying):				
Relationship to Person 1:	☐ Chil	ld/Step Ch ce/Nephev	ild (	⊒ Parent □ Legal Gu		er:	
Marital Status: ☐ Never Married ☐ Divorced ☐	☑ Widowed	☐ Mar	ried-name	of spouse: _			
Does PERSON 2 live at the same address as Person 1? If 'No,' what is PERSON 2's home address?	☐ Yes	s 🗆 No	)				
Is PERSON 3 attending school?   Yes  No Name of School:	If 'Yes	s,' is PER		nding school Grade Level:	: 🔲 Full Tir	ne 🖵 Par	t Time
Is PERSON 3 applying for help with health insurance costs?	☐ Yes	□ No	If 'Yes,' Al OPT	HCCCS heal	th plan choic page H for enr	e: ollment plan	choices.
Is PERSON 3 applying for help with Medicare costs?	□ Yes	□ No	If 'Yes,' M	edicare clair	n number:		
Does PERSON 3 need help paying for medical bills from the last 3 months?	☐ Yes	□ No					
Is PERSON 3 applying for Nutrition Assistance?	Yes	☐ No					
\$ Is PERSON 3 applying for Cash Assistance?	Yes	☐ No					
5 Is PERSON 3 applying for Tuberculosis Control?	☐ Yes	☐ No					
If PERSON 3 is applying f If PERSON 3 is <b>NOT</b> applying for	or any benefits	s: continue	answering th	ne questions babout PERSO	elow. N 3's income.		
<b>Citizenship/Residency:</b> Tell us citizenship/residency.	about PERS	ON 3's cit	izenship/re	sidency. Yo	u may need t	o provide p	proof of
Is PERSON 3 a U.S. citizen or U.S. national? See page	D for more i	informatio	n. 🗆 Y	′es □ No	□ Choo	se not to a	nswer
If PERSON 3 is NOT a U.S. citizen, what is his/her immig	gration statu	s?					
	tered Spous		Parent		I/Suspension	of Deporta	ation
	oan-Haitian E erred Action				Applicants Immigrant Ju	venile Stat	us Applicant
☐ Asylee ☐ Def	erred Enforc			☐ Tempora	ary Protection		
	alization und alization und				f Trafficking ling of Depor	tation	
☐ Other ☐ Ord	er of Superv	/ision	` .		it for Asylum,		, or
☐ I do not want to provide ☐ Par	oled into Uni	ited States	<b>3</b>	Withhol	ding Deporta	tion	
What immigration document does PERSON 3 have? ☐ Permanent Resident card ☐ I-94 ☐ Visa			Document N 3 lived in		nce August 2	2, 1996?	☐ Yes ☐ No
☐ Foreign Passport ☐ None ☐ Other:	Did DEDO	ON 2 may	o to Arizon	a in the last	1 months?	☐ Yes	□ No
Is PERSON 3 an Arizona resident?		date mov					<b>4</b> NO
Race (optional), select one or more:					Ethnicity (opti		
☐ Asian ☐ Hawaiian or other P☐ Black or African American ☐ American Indian/Ala		er 🔲 Wh			☐ Hispanic/La ☐ Non-Hispar		tino
If PERSON 3 is American Indian or Alaska Native:	rija sacasa kan			16672	o a fue sum a diff		
Is he/she enrolled in a federally recognized tribe?		☐ Yes	s □ No	If 'Yes,' nan	ne of tribe:		
Has he/she ever gotten services from Indian Health Services health program, or urban Indian health program, or throughout one of these programs?		☐ Yes	s □ No	If 'No,' is h	e/she eligible	? □ Ye	s 🛚 No
\$\ Is he/she living on a reservation?		☐ Yes	₃ □ No	If 'Yes,' na	me of reserv	ation:	
Tribal Census Number:							-
Go to the ne Transmittal Number: AZ 13-0005-MM FA-001 (10/13) Arizona	xt page to te Effective Date	ell us more : October 1	about PEF , 2013	RSON 3. Appro	val Date: Sept	ember 30, 2	013 Page 9

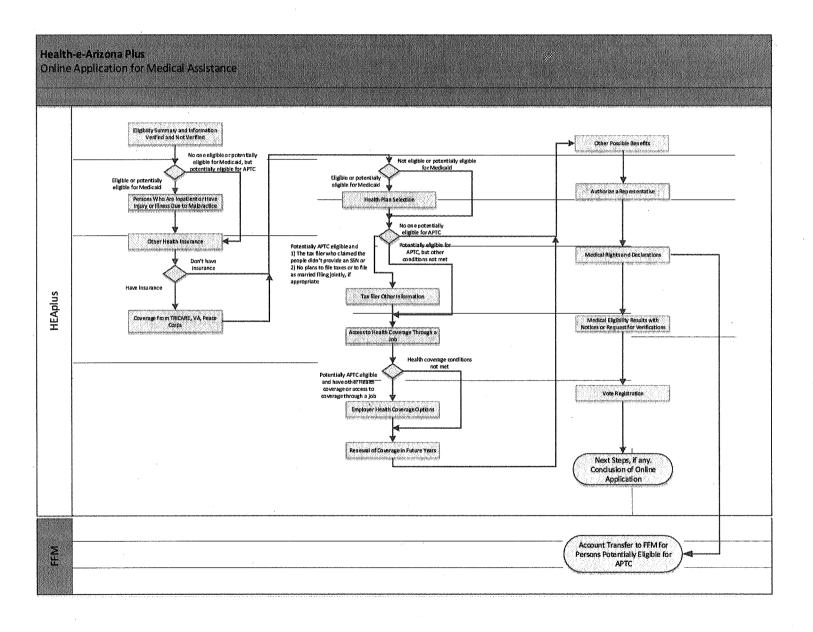
Do you need help with this application? Visit <a href="www.healthearizonaplus.gov">www.healthearizonaplus.gov</a> or call 1-855-HEA-PLUS (432-7587)

<b>* •</b> \$ 6		ng quocuome m		it o io appiyi	ing for benefits.
ls PERSON 3 p	hysically or mentally disabled?	☐ Yes	□ No		
s PERSON 3 ir	n jail or prison?	☐ Yes	□ No		
Was PERSON	3 released from jail or prison in the last 4 months?	☐ Yes	□ No	If 'Yes,' re	elease date:
<b>-</b> \$	AHCCCS Medical Assistance, Help with Medical Complete this section if PERSON 3 is applying for AHCC and/or Cash Assistance.				
ls PERSON 3 p	regnant?	☐ Yes	□No		mber of babies due: _ pected due date:
	under age 19, are both of his/her parents living in the home? lete the information below:	☐ Yes	□ No		
Parent's Name	(First, Last): Social Se	curity Number			Date of Birth:
Mailing Address	s:City:		Sta	ate:	Zip Code:
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Persons Applying/Not Applying	Online Application Page	Page Condition	Additional Comment
	Account Creation - User Agreement	•	
	Account Creation - About You		Identifying Information, email, phone numbers and communication preferences
	Home Address		is the state of th
	Mailing Address		
	User Name and Password		
	Secret Questions		
	Consent to Verify Identity		
	Identity Verification		
	Account Summary	<del> </del>	
	Select Programs		
	Notification of Information Use and Privacy		
	You and the Applying Household		Questions to establish whether the customer is applying for him/herself or his/her family or houesehold or is a representative for another household
	Main Contact Information		Identifying information about the primary applicant or representative
	Contact Home Address		
	Contact Mailing Address		
	Other Contact Information		Email and phone numbers
	Persons Who Live With You		Establishes who the applicant intends to include
All Persons	Who is Applying?	This screen will display if there is more than one person listed on the application	Establishes which persons want benefits
All Persons	Relationships	This screen will display only when there are three or more individuals in the household to define relationships between other applicants.	
All Persons	Demographic Details		Captures DOB, SSN (optional if not applying
Applying Persons	Demographic Details		Captures DOB, SSN, Citizenship, Immigration Status and relatinformation.
Primary Applicant	Tax Household Information		Collects the primary applicant's tax filing plans, status, and a dependents, including dependents living out of the househol or whether he/she is a tax dependent (if appropriate)
All Other Persons	Tax Household Information	This screen will display for persons 18 or older to capture other tax filers in the home	Collects all other persons' tax filing plans, status, and any dependents, including dependents living out of the househo or whether each is a tax dependent (if appropriate)
All Other Persons	Additional Tax Household Information	This screen will display for any tax dependent of a filer that he/she does not live with	Provides the option to supply information about the tax filer which is necessary for eligibility for APTC
All Persons	Household Summary		
Applying Persons	Temporarily Away From Home		
All Persons	Race and Ethnicity		
All Persons	American Indian		
Applying Persons	Prior Medical Expenses (Prior Quarter Coverage)		To be implemented for January 2014
Applying Persons	Arizona Residency		
Maria Z.	SSN Verification Results	This screen will display when one or more persons in the household has a SSN that could not be verified	Allows correction of entries and retry of verification or collection of clarifying information
	Citizenship/Immigration Summary	This screen will display when one or more persons in the household has Citizenship/Immigration Status that could not be verified	

Effective Date: October 1, 2013

Transmittal Number: AZ 13-0005-MM

Arizona

Applying Females (Medical) in the pregnancy range	Pregnancy	This screen will display if there is one or more female applicants between ages 9-60	
	Tell Us About Parents (Absent Parent(s))	This screen will display for if there is one or more applying children for whom one or both parents are not in the household	
	Caretaker Relative	This screen will display if there is one or more children with no parents in the application, but one or more adult relative	
Applying Persons	Incarceration		
Applying Persons	Medicare Coverage		
All Persons	Summary of Information Verified and Not Verified		Display of summary as feedback and transition
All Persons	Confirm Income Found From Electronic Sources		
All Persons	Additional Income Information	·	Collects incidence of income for jobs not found be electronic sources, self employment and other income and determines what additional pages are needed to collect income
All Persons	Rental Income	This screen will display for persons indicated to have Rental Income on the Additional Income Information screen	
All Persons	Self-Employment Income	This screen will display for persons indicated to have self- employment income on the Additional Income Information screen	
All Persons	Income from Franchises, Corporations or LLC	This screen will display for persons indicated to have Income from Franchise, Corporation or LLC on the Additional Income Information screen	
All Persons	Other Income	This screen should only display for persons who selected that they have Other Income on the Income Information screen	
All Persons	Expected Income Changes		Collects reasonably predictable changes
All Persons	Household Has No income	This screen will display if the the household that attests to having no income	
All Persons	Income Summary		
All Persons apart of the Tax Household	Allowed Deductions From Income	This screen will display if any applying person is not eligible for Medical Assistance at this point. If everyone in the houehold is eligible for Medical Assistance at this point, the system will skip this screen.	
	At this point, the system will know if the applicant(s) are eligible for Medicaid based on MAGI. The system may know whether persons are eligible for ABD, Medicaid Buy in or Medicare Cost Sharing (LMB, SLMB, OL-1) for persons that are not yet found eligible, the system will present pages and questions, as appropriate to determine the potential for eligibility in ABD, Medicaid Buy in or Medicare Cost Sharing, Note: Arizona's CHIP program is currently frozen)		
Applying Persons Not Already Found Eligible for Medicaid based on MAGI	Unable to Work Due to Disability	This screen will only display for persons who were not already eligible, DO NOT have EARNED income, and are greater than 18 years of age and are not already known to be disabled based on data from electronic sources	Eligibility checked if potential linkage to ABD exists
Applying Persons Not Already Found Eligible for Medicald based on MAGI	Working and Disabled	This screen will only display for persons who were not already eligible, have EARNED income, are between the ages of 16-65 and are not already known to be disabled based on data from electronic sources	Eligibility checked if potential linkage to Medicaid Buy in (called Freedom to Work) exists

Effective Date: October 1, 2013

Applying Persons Not Already Found Eligible for Medicaid based on MAGI	Impairment Related Work Expenses/Blind Related Work Expenses	This screen will only display for persons who were not already eligible, are verified or potentially disabled or have Medicare, and are working	Eligibility checked with deductions applied
Applying Persons Not Already Found Eligible for Medicaid based on MAGI	Student	This screen will only display for persons who were not already eligible, are verified or potentially disabled or have Medicare and are > 22 and have Earned Income	Eligibility checked with appropriate deductions applied
Applying Persons Not Already Found Eligible for Medicaid based on MAGI	Child Support	This screen will only display for persons who were not already eligible, are verified or potentially disabled or have Medicare	Eligibility for ABO checked with deductions applied
Person(s) eligible or potentially eligible for Medicaid Buy in (Program Called Freedom to Work)	Freedom to Work Premium	This sreen will display for persons who are eligible or potentially eligible for Freedom To Work.	
All Persons	Eligibiity Summary and Information Verified and Not Verified		Display of summary as feedback and transition
	Past Eligibility Questions Required to Complete Application		
Persons Eligible or Potentially Eligible for Medicaid	Persons Who Are Inpatient or Have Injury or Illness Due to Malpractice	This sreen will display if there are persons eligible or potentially eligible for Medicald pending verification.	Question regarding inpatient is required by State Rule to indicate need for expedited processing. It is not necessary if eligibility is successfully completed real-time. Question regarding potential source of TPL applies to any person eligible or potentially eligible for Medicaid
Persons Eligible or Potentially Eligible for Medicald	Other Health Insurance		
All Persons Eligible or Potentially Eligible for Medicaid or APTC	Insurance Coverage through TRICARE, VA, Peace Corps	This screen should only display for persons who selected that they have insurance on the insurance information screen (previous screen)	
Persons Eligible or Potentially Eligible for Medicaid	Health Plan Selection	This screen will display if applicants are potentially eligible for a Medicaid program	This is an optional question, but is important to the completion of their enrollment and avoid additional contact to obtain their choice.
Applying Persons Potentially Eligible for APTC	Tax Filer Other Information	This screen will display for persons who are potentially APTC eligible and 1) The tax filer who claimed the people didn't provide an SSN 2) People who are potentially eligible for APTC but did not plan to file a tax return or were not indicated as dependents 3) People who are potentially eligible for APTC and ARE married but indicated that they do not plan to file as married filing a joint return.	
Applying Persons Potentially Eligible for APTC	Insurance Coverage through a Job	This screen will display if there is one or more persons potentially APTC eligible	
Applying Persons Potentially Eligible for APTC who entered Other Health Coverage Information on the previous screen	Employer Health Coverage Options	This screen will display for persons who are potentially APTC eligible and who entered Other Health Coverage Information (on the previous screen)	·
Applying Persons Potentially Eligible for APTC	Renewal of Coverage in Future Years	This screen will display if there is one or more persons potentially eligible for APTC	
Persons Eligible or Potentially Eligible for Medicaid	Other Possible Benefits		Potential for access to pension or veterans administration benefits
	Name an Authorized Representative		
	Rights and Declarations - Signature		
	Eligibility Results with Notices and/or Request for Verification		
	Vote Registration		
	Next Steps		Next Steps as applicable to complete the eligibility and enrollment process or access benefits

Arizona Department of Economic Security/Family Assistance Administration (DES/FAA)

Arizona Health Care Cost Containment System (AHCCCS)

# Application for Help with Health Coverage Costs AHCCCS Medical Assistance, Help with Medicare Costs, and Tax Credits to help pay premiums

Tear off and keep pages A through D for your records. Use this application to see if you and your family qualify for: What is this application for? Free or low-cost insurance from AHCCCS Help with your Medicare costs A new tax credit that can help pay your health insurance premiums An application may be completed by you or anyone you choose who knows or can Who can use this application? get the information needed to complete the application for you and your family members. You can use this application to apply for anyone in your family, even if they already have insurance. Your family includes: Your spouse, if married Your children under age 22 who live with you Your partner who lives with you (but only if you have a child together who needs health insurance) People you claim on your income tax return even if they do not live with Relatives in your care who are under the age of 19 and live with you If you want to select a representative to complete your application, complete the Authorized Representative form on page 1 of the application. You can apply faster online at: www.healthearizonaplus.gov Where else can I apply? You can fill out this application and turn it in by mail, fax or in person to any local or any Department of Economic Security (DES)/Family Assistance Administration (FAA) office. You can find a list of local FAA offices at www.azdes.gov/faa, or you can call our 24 hour Interactive Voice Response system at 1-855-HEA-PLUS (432-7587). You may need: What information do I need to Birth dates complete this application? Social Security numbers Employer and income information for everyone in your family Information for any current health insurance Information about any job-related health insurance available to your family We ask about income and other information to make sure you and your family get Why do we ask for so much the correct benefits. information? We will keep all information you provide private, as required by law. Send your completed, signed application to the address on page 14 or take it to What happens next? your local DES office. If you do not have all of the information available, you can still submit your application and we will help you get the rest of the information. If you need help filling out this application, please tell us. If you need a language What if I need help? interpreter or accommodations for a disability, please check the kind of help you need on page 1 of the application. Online: www.healthearizonaplus.gov Phone: 1-855-HEA-PLUS (432-7587) In person: Visit www.azdes.gov/faa or call 1-855-HEA-PLUS (432-7587) to find

the office closest to you

### What is AHCCCS Medical Assistance?

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

AHCCCS Medical Assistance covers the following medical services:

- Prescription Medication\*
- Doctor's Office Visits\*\*
- · Laboratory and X-ray Services
- Hospital Services
- Dialysis

- Medical Supplies
- Medically Necessary Transportation
- Medically Necessary Specialist Care
- Behavioral Health Care
- Immunizations (shots)
- \* AHCCCS prescription coverage is limited for people who have Medicare.
- \*\* Wellness visits for people age 21 and over are not covered.

### What is Medicare Savings Program?

Medicare Savings Program may pay:

Medicare Part A premium
Medicare Part B premium

- Medicare deductibles and copayments
- · Automatic Extra Help for Medicare Part D prescription expenses

Chemotherapy

Emergency Medical Care

90 days of nursing care services

Page B

Rehabilitation Services

### What if I am not eligible for AHCCCS Medical Assistance?

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

### Do I need a Social Security number?

Federal law requires you give a Social Security number (SSN) for anyone who wants to get AHCCCS Medical Assistance or help with Medicare costs (42 U.S.C. § 1320b-7; 42 U.S.C. § 405(c)(2)(C), 7 U.S.C. §§ 2011-2036, and Social Security Act (SSA) of 1935 (Section 1137) as amended by P.L. 98-369).

- If you or anyone you are applying for does not have a Social Security number (SSN), we will refer you to the Social Security office to apply for one.
   Immigrants who are not legally able to get a Social Security number are not required to give one or apply for one. Any person you are applying for who is legally able to get a Social Security number but does not have one or does not apply for one will not be eligible for benefits.
- If you are not applying for benefits for yourself, you do not have to give us your Social Security number.
- We will not use your SSN as your DES or AHCCCS identification number.
- · We will not give any Social Security numbers to the United States Citizenship and Immigration Services (USCIS).

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

- · Verify identity
- Verity citizenship and immigration status
- Verify income
- · Prevent duplicate benefits
- Collect money we overpaid you in the form of benefits
- Computer match with state, local and federal agencies and our other programs to verify information
- · Share with other government agencies and their contractors to assess program management and compliance
- We may give your information to law enforcement officials for the purpose of arresting persons fleeing to avoid the law

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

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

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

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

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

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

### How does AHCCCS Medical Assistance work?

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

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

### How does a health plan work?

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

Transmittal Number: AZ 13-0005-MM Effective Date: October 1, 2013 Approval Date: September 30, 2013 AH-001 (10/13) Arizona

### Attachment 1 Application

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587)

### What is a primary doctor?

After you enroll in a health plan, your health plan will give you a list of primary doctors in your area to choose from. If you do not choose a primary doctor one will be assigned to you. You have the right to change your primary doctor at any time by calling your health plan's Member Services. Your primary doctor will:

- · Take care of your health care
- Be the first person you go to for non-emergency medical services
- · Send you to a specialist when needed

### How do I get behavioral health services?

To get behavioral health services you can go through your primary doctor, or call the behavioral health telephone number on your AHCCGS ID card.

### What if I have Medicare or other health insurance?

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

### What is an AHCCCS ID card and what do I do with it?

Your AHCCCS ID card has your unique AHCCCS ID number.

- · Show the card when you get medical care. You may also need to show picture ID.
- · Doctors, hospitals and pharmacists use your AHCCCS ID card to obtain faster verification of eligibility.
- · Keep your AHCCCS ID card with you at all times.
- · Do not let anyone else use your AHCCCS ID card or you may be prosecuted.

### What does AHCCCS Medical Assistance cost?

### Premiums:

- Most people do not have to pay a monthly premium for AHCCCS Medical Assistance.
- Some people with income too high to qualify for AHCCCS Medical Assistance with no monthly premium may be able to get it by paying a monthly premium. If you have to pay a premium, the premium amounts are \$10 to \$35 per person for employed people with disabilities.

#### Co-payments:

A co-payment is the amount you pay a health care provider when you receive a medical service. Your co-payment amount will vary depending on which AHCCCS program you are enrolled in and the services you need. For some AHCCCS programs, the provider can deny services if the co-payments are not made. Co-payments for services are:

- \$2.30 to \$10.00 for prescriptions
- \$0.00 to \$30.00 for non-emergency use of an emergency room
- \$3,40 to \$5,00 for outpatient visits for evaluation and management services including doctors office visits
- \$2.30 to \$3.00 for physical, occupational or speech therapy

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

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

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

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

Hospitalizations

- Emergency services
- Services paid for on a fee-for-service basis
- Family planning services and supplies
- Pregnancy related health care including tobacco cessation for pregnant women

### What are my rights and responsibilities?

### You have the RIGHT to:

- Be treated fairly and equally regardless of race, color, religion, national origin, sex, age, disability, or political beliefs.
- · Apply for AHCCCS Medical Assistance and/or help with Medicare costs and be given a letter that tells you if you are eligible or not.
- Review DES and/or AHCCCS manuals that show the rules and regulations of the DES and/or AHCCCS program if you want to know the reason for our decision.
- · Talk about your case with a worker or supervisor.
- · Have all information you give regarding your eligibility kept private according to state and federal law.
- Ask for a fair hearing if you disagree with your application being denied, your benefits ended, or your DES and/or AHCCCS services being reduced, or if a
  decision is not made on your application within 45 days and the delay is due to DES or AHCCCS.
- · Look at your file before a fair hearing.
- Bring an attorney or any other person to a fair hearing.

### You have the RESPONSIBILITY to:

- Provide DES and/or AHCCCS with the needed information to correctly determine your eligibility and authorize AHCCCS to investigate and contact any sources necessary to confirm the accuracy of the information which pertains to eligibility.
- Give us any information you have about an absent parent. If you have reason for not providing this information (such as adoption pending, abuse, incest, neglect, etc.) you may claim good cause. You must cooperate with the Division of Child Support Services (DCSS) to establish paternity, unless you can prove good cause.
- Take necessary steps to obtain any annuities, pensions, retirement and disability benefits to which you may be entitled, including, but not limited to Social Security benefits. Railroad retirement, Veterans benefits and unemployment compensation.

Effective Date: October 1, 2013

If you are approved for benefits, you will get a letter telling you what changes you must report. You MUST report changes timely.

### How to Choose an AHCCCS Health Care Plan:

You need to choose a health plan that services your county.

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

If you do not choose a health plan, one will be assigned to you. If you have been enrolled in an AHCCCS health plan within the past 90 days, you may be enrolled with your previous health plan.

Enter the health plan choice on this application. This health plan choice does not affect your plan selection through the federal Health Insurance Marketplace.

177	
	APACHE COUNTY UnitedHealthcare Community Plan1-800-348-4058 Health Choice Arizona
	If your zip code is 85943, you must choose from the health plans listed under Navajo County.
	COCHISE COUNTY University Family Care
	COCONINO COUNTYUnitedHealthcare Community Plan1-800-348-4058Health Choice Arizona1-800-322-8670American Indian Health Program928-283-2501
	If your zip code is 86336 or 86340, you must choose from the health plans listed under Yavapai County.
	GILA COUNTY         Health Choice Arizona       1-800-322-8670         University Family Care       1-800-582-8686         American Indian Health Program       928-475-2371
	GRAHAM COUNTY University Family Care
	If your zip code is 85643, you must choose from the health plans listed under Cochise County.
	GREENLEE COUNTY University Family Care
	LA PAZ COUNTYUnitedHealthcare Community Plan1-800-348-4058University Family Care1-800-582-8686American Indian Health Program928-669-2137
	MARICOPA COUNTY         Health Net of Arizona       1-888-788-4408         Care 1 st Arizona       1-866-560-4042         Health Choice Arizona       1-800-322-8670         UnitedHealthcare Community Plan       1-800-348-4058         Mercy Care Plan       1-800-624-3879         Maricopa Health Plan       1-800-582-8686         American Indian Health Program       602-263-1200

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

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

#### **NAVAJO COUNTY**

UnitedHealthcare Community Plan	1-800-348-4058
Health Choice Arizona	1-800-322-8670
American Indian Health Program	928-338-4911

#### **PIMA COUNTY**

UnitedHealthcare Community Plan	1-800-348-4058
Health Choice Arizona	1-800-322-8670
Care 1st Arizona	1-866-560-4042
University Family Care	1-800-582-8686
Mercy Care Plan	1-800-624-3879
American Indian Health Program	520-295-2479

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

### PINAL COUNTY

Health Choice Arizona	1-800-322-8670
University Family Care	
American Indian Health Program.	

If your zip code is 85242 or 85220, you must choose from the health plans listed under Maricopa County.

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

### **SANTA CRUZ COUNTY**

University Family Care	1-800-582-8686
UnitedHealthcare Community Plan	1-800-348-4058
American Indian Health Service	520-295-2479

#### YAVAPAI COUNTY

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

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

If your zip code is 86351 you must choose from the health plans listed under Coconino County.

#### YUMA COUNTY

UnitedHealthcare Community Plan	1-800-348-4058
University Family Care	1-800-582-8686
American Indian Health Program	760-572-4100

Transmittal Number: AZ 13-0005-MM Effective Date: October 1, 2013 Approval Date: September 30, 2013

Arizona Department of Economic Security/Family Assistance Administration (DES/FAA) Arizona Health Care Cost Containment System (AHCCCS)

## **Application for Help with Health Coverage Costs**

Contact Information:	
Tell us how we can contact an adult member of your family.	
Name (First, Middle, Last):	
	# City: State: Zip Code:
	# State: Zip Code:
Phone Number: This number	s: 🗆 Home 🗀 Cell 🚨 Work 🗅 Message 🗀 Other:
Other Phone Number: This number	
What is the preferred SPOKEN household language?    English	n 🛘 Spanish 🗔 Other:
What is the preferred WRITTEN household language? ☐ English	h 🛘 Spanish 🚨 Other:
I would like to get information about this application by: Email: ☐ Yes ☐ No Email address: Text: ☐ Yes ☐ No Number to text (standard text rates ap	ply):
If "Yes" is not marked for Email or Text, all information for thi	s application will be sent via U.S. Mail to the mailing address provided.
☐ American Sign Language ☐ Braille	this application
I need the following accommodations for this application (check all ☐ Hearing ☐ Speaking ☐ Seeing ☐ Writing	that apply):  Walking Other:
Theating Depeating Decing Divining	a waiking a other.
Authorized Representative:  This section is OPTIONAL. You may authorize someone else to re eligibility without your written consent.	present you. AHCCCS cannot release any information about your
Representative's Name:	Organization (if applicable):
Representative's Mailing Address	City: State: Zin Code:
Representative's Phone Number: This r	number is:   Home Cell Work Message Other:
Representative's Other Phone Number: This	number is: ☐ Home ☐ Cell ☐ Work ☐ Message ☐ Other:
What is the representative's preferred WRITTEN language?	
My representative would like to get information about this application	
Email: 🛘 Yes 🗘 No Email address:	
Text: Yes No Number to text (standard text rates app	oly):is application will be sent via U.S. Mail to the mailing address provided.
By signing below I, the customer, give permission for the person listed above	By signing below I, the representative, agree to act on the customer's behalf. I also
as my representative to act on my behalf in the process of qualifying me for AHCCCS Medical Assistance and/or Medicare Savings Program. I, therefore:  Give permission for my representative to complete and sign my application.  Give permission for my representative to provide any documents	agree to:     Provide only truthful and complete information under penalty of perjury.     Fill in and sign needed forms.     Obtain and give to DES and/or AHCCCS all information needed to determine if the customer can qualify for AHCCCS Medical Assistance and/or Medicare
requested, including personal information.  Give permission to my representative to sign on my behalf to permit other people, businesses, or agencies to give personal information about me to DES and/or AHCCCS, including protected health	Savings Program, such as the customer's Social Security number, income, citizenship, residency, medical insurance, and information about the customer's spouse, minor children, and parents (if the customer is a minor child).  Tell DES and/or AHCCCS right away if the customer:
information needed to determine if I am disabled.	o Has an increase or decrease in income;
<ul> <li>Agree to give information about my personal circumstances to my representative.</li> </ul>	<ul> <li>Has a change in address; or</li> <li>Has a change in health insurance.</li> </ul>
<ul> <li>Agree to allow my representative to assign all my rights to medical reimbursement claims to AHCCCS on my behalf.</li> </ul>	
assistance is withdrawn or denied, or when my eligibility ends. However, the	presentative tells you to stop it. This authorization will expire when my application for a suthorization will continue during any time while I am contesting my eligibility in an earing or court proceeding.
Signature of Applicant:	Signature of Representative:
Date:	Date:

Transmittal Number: AZ 13-0005-MM AH-001 (10/13) Arizona Effective Date: October 1, 2013 Approval Date: September 30, 2013

Page 1

### Attachment 1 Application

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587)

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

Personal Information:
Name (First, Middle, Last): Gender:
Date of Birth: Social Security Number (optional if not applying):
Marital Status:
Is PERSON 1 attending school full time? ☐ Yes ☐ No If yes, name of school:
Is PERSON 1 applying for help with health insurance costs?
Does PERSON 1 need help paying for medical bills
Check here if PERSON 1 only wants help with Medicare costs?   Medicare claim number:
If PERSON 1 is applying, continue answering the questions below.  If NOT applying, skip this page and go to the next page to tell us about PERSON 1's income.
Citizenship/Residency: Tell us about PERSON 1's citizenship/residency. You may need to provide proof of citizenship/residency.
Is PERSON 1 a U.S. citizen or U.S. national? See page B for more information. ☐ Yes ☐ No ☐ Choose not to answer
If PERSON 1 is NOT a U.S. citizen, what is his/her immigration status?
□ Lawful Permanent Resident (LPR) □ Lawful Temporary Resident □ Non-Immigrant Status □ Asylee □ Lawful Permanent Resident (LPR) □ Removal/Suspension of Deportation □ Registry Applicants □ Special Immigrant Juvenile Status Applicant □ Temporary Protection Status (TPS)
☐ Refugee ☐ Legalization under LIFE Act ☐ Victim of Trafficking ☐ Conditional Entrant granted before 1980 ☐ Legalization under IRCA Applicant ☐ Withholding of Deportation
☐ Other ☐ Order of Supervision ☐ Applicant for Asylum, LPR, TPS, or
□ I do not want to provide □ Paroled into United States Withholding Deportation  What immigration document does PERSON 1 have? □ Permanent Resident card □ I-94 □ Visa
☐ Foreign Passport ☐ None ☐ Other:
Is REPSON 1 an Arizona resident?
Race (optional), select one or more:    If yes, date moved:
☐ Asian ☐ Hawaiian or other Pacific Islander ☐ White ☐ Hispanic/Latino
□ Black or African American □ American Indian/Alaska Native □ Other: □ Non-Hispanic/Non-Latino
If PERSON 1 is American Indian or Alaska Native: Is he/she enrolled in a federally recognized tribe?  U Yes U No If yes, name of tribe:
Has he/she ever gotten services from Indian Health Service,
Program Screening: These questions will help determine what programs PERSON 1 may be eligible for.
If PERSON 1 is under the age of 65, does he/she have a mental or physical disability that has kept or will Ves Ves
keep him/her from working for at least 12 months?  If PERSON 1 works and is under the age of 65, does he/she have a disability that is expected to last at
least 12 months?  Does PERSON 1 need help with activities of daily living (bathing, dressing, etc.) through personal ☐ Yes ☐ No
assistance, services, nursing home, or other medical facility?
Is PERSON 1 pregnant?  If yes: Number of babies due: Expected due date:
Does PERSON 1 live with at least one child under age 19 and is the main care taker of the child?
Has PERSON 1 ever received Supplemental Security Income (SSI Cash)? ☐ Yes ☐ No
Additional Questions:
Is PERSON 1 in jail or prison?  Was PERSON 1 released from jail or prison within the last 4 months?  U Yes  No If yes, release date:
WIGO WENT BY A POLOGOOD FROM TOU OF DISCONDITION FOR A MODITICA LEVOR 11 NO. 17 VOC. FOLOGOOD COTO.

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

### PERSON 1:

Tell us about PERSON 1's expected taxes, income and potential be	efits. Complete this page even if PERSON 1 is not applying.
--	---

	II file incor	are a second and the second	AFVI IF	./\n.	
Will PERSON 1 file taxes NEXT YEAR?	☐ Yes	□ No			
If yes, will PERSON 1 file jointly with a spouse?	☐ Yes	□ No		If yes, name c	
Will PERSON 1 claim dependents on his/her tax return?	☐ Yes	□ No		If yes, name c	f dependent(s):
Will PERSON 1 be claimed as a dependent on someone else's tax return?	□ Yes	□ No		If yes, name o Relationship t	f tax filer:
Does PERSON 1 pay any expenses that may be deducted on the federal income tax return?  Do not include self-employment expenses.  Check all that apply.	☐ Other	ny nt loan in deduction cribe dedu	erest is	Amount paid: Amount paid: Amount paid:	How often? How often?
Employment: Tell us about PERSON 1's employment. Yourrent federal tax forms: 1040, SE, and apattach proof of business income and expenses.	plicable so	chedules	such as C	, C-EZ, E, F a	nd K1. If you do not have tax forms,
Does PERSON 1 work?	□ Yes	□ No	If yes	, give employr	nent information below:
Employer's Name and Gross E Phone Number: (before de	Earnings Eductions	):	How of	ten paid?	How many hours worked per week?
Is PERSON 1 self-employed?	☐ Yes	☐ No		, type of work: , annual net a	
Does PERSON 1's income change because of contract or seasonal employment?	☐ Yes	□ No		, how much in r the next 12 r	come does PERSON 1 expect to make nonths?
Other Income: Tell us about other income PERSON 1 red	ceives. Yo	ou may ne	ed to pro	vide proof of i	ncome.
Type of Income:	Amou	nt:	low ofter	n received?	Who pays the income?
Social Security benefits				47.148.00	AMERICAN CONTROL OF THE STATE O
Retirement/pension					
Unemployment					
Disability/worker's compensation					
Alimony					
Tribal money Gaming Other:					
<b></b>					55.8530000000000000000000000000000000000
Per capita payments from natural resources, usage rights, leases or royalties					
leases or royalties Payments from natural resources, farming, ranching,					等。 
leases or royalties Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land					
leases or royalties Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land Money from selling things that have cultural significance					
leases or royalties Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land Money from selling things that have cultural significance Other: Other:					
leases or royalties Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land Money from selling things that have cultural significance Other: Other:					
leases or royalties Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land Money from selling things that have cultural significance Other: Other: Check here if this person does not have income		to help de	etermine	······································	
leases or royalties  Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land  Money from selling things that have cultural significance  Other:  Other:  Check here if this person does not have income  Potential Benefits: Tell us about PERSON 1 and his/he Has PERSON 1 or his/her spouse (living or deceased) ever	er spouse worked	to help de	etermine		may be eligible for additional benefits.
leases or royalties Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land Money from selling things that have cultural significance Other: Other: Check here if this person does not have income  Potential Benefits: Tell us about PERSON 1 and his/he has PERSON 1 or his/her spouse (living or deceased) ever for a government agency or an employer with a pension plar	er spouse worked n?	☐ Yes	□ No	If yes, empl If yes, dates	may be eligible for additional benefits.  byer name:  of employment:
leases or royalties  Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land  Money from selling things that have cultural significance  Other:  Other:  Check here if this person does not have income  Potential Benefits: Tell us about PERSON 1 and his/he Has PERSON 1 or his/her spouse (living or deceased) ever for a government agency or an employer with a pension plar	er spouse worked n?			If yes, empl If yes, dates If yes, brand	may be eligible for additional benefits.  byer name:  of employment:
leases or royalties Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land Money from selling things that have cultural significance Other: Other: Check here if this person does not have income  Potential Benefits: Tell us about PERSON 1 and his/he Has PERSON 1 or his/her spouse (living or deceased) ever for a government agency or an employer with a pension plar Is PERSON 1 or his/her spouse (living or deceased) a veteral	er spouse worked n? an?	□ Yes	□ No	If yes, empl If yes, dates If yes, brand If yes, dates	may be eligible for additional benefits.  byer name:  of employment:  ch of service:  of service:
leases or royalties Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land Money from selling things that have cultural significance Other: Other: Check here if this person does not have income  Potential Benefits: Tell us about PERSON 1 and his/her spouse (living or deceased) ever for a government agency or an employer with a pension plar Is PERSON 1 or his/her spouse (living or deceased) a veteral Questions for People Under 19 Years Old: This	er spouse worked n? an?	□ Yes	□ No	If yes, empl If yes, dates If yes, brand If yes, dates ERSON 1 is ur If yes, brand	may be eligible for additional benefits.  byer name:  of employment:  ch of service:  of service:  der age 19.  ch of service:
leases or royalties Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land Money from selling things that have cultural significance Other: Other: Check here if this person does not have income  Potential Benefits: Tell us about PERSON 1 and his/he	er spouse worked n? an?	☐ Yes ☐ Yes ☐ requ	□ No □ No ired if PE	If yes, empl If yes, dates If yes, brand If yes, dates ERSON 1 is ur If yes, brand	may be eligible for additional benefits.  byer name:  of employment:  ch of service:  of service:

Effective Date: October 1, 2013

### **PERSON 2:**

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

Personal Information:	
	ender: 🗆 Male 🗀 Female
Date of Birth: Social Security Number (optional if not applying):	
Marital Status: ☐ Never Married ☐ Divorced ☐ Widowed ☐ Married-name of spouse:	
☐ Grandchild ☐ Niece/Nephew ☐ Legal Guardian	Other:
Does PERSON 2 live at the same address as Person 1? ☐ Yes ☐ No If no, what is PERSON 2's home address?	
Is PERSON 2 attending school full time?	
	D for enrollment plan choices.
Does PERSON 2 need help paying for medical bills	
Check here if PERSON 2 only wants help with Medicare costs?   Medicare claim number:	· · · · · · · · · · · · · · · · · · ·
If PERSON 2 is applying, continue answering the questions below.  If NOT applying, skip this page and go to the next page to tell us about PERSON 1's incor	ne.
Citizenship/Residency: Tell us about PERSON 2's citizenship/residency. You may need to provide proof	of citizenship/residency.
1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	ose not to answer
□ Lawful Temporary Resident □ Cuban-Haitian Entrant □ Registry Applicution Status □ Deferred Action Status □ Deferred Enforced Departure □ Temporary Proubles □ Legalization under LIFE Act □ Victim of Trafficult Conditional Entrant granted before 1980 □ Legalization under IRCA Applicant □ Withholding of	rant Juvenile Status Applicant otection Status (TPS) cking Deportation asylum, LPR, TPS, or
What immigration document does PERSON 2 have?	•
	her:
Immigration Document Number: Has PERSON 2 lived in the U.S. since Augu	
Is PERSON 2 an Arizona resident?	hs? 🛘 Yes 🖵 No
Race (optional), select one or more:  Asian Hawaiian or other Pacific Islander White Black or African American American Indian/Alaska Native Other:	Ethnicity (optional):  Hispanic/Latino Non-Hispanic/Non-Latino
If PERSON 2 is American Indian or Alaska Native:  Is he/she enrolled in a federally recognized tribe?  □ Yes □ No If yes, name of tribe:	
Has he/she ever gotten services from Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	□ Yes □ No
Program Screening: These questions will help determine what programs PERSON 2 may be eligible for.	
If PERSON 2 is under the age of 65, does he/she have a mental or physical disability that has kept or will keep him/her from working for at least 12 months?	☐ Yes ☐ No
If PERSON 2 works and is under the age of 65, does he/she have a disability that is expected to last at	☐ Yes ☐ No
least 12 months?	100 · 110
least 12 months?  Does PERSON 2 need help with activities of daily living (bathing, dressing, etc.) through personal	☐ Yes ☐ No
least 12 months?  Does PERSON 2 need help with activities of daily living (bathing, dressing, etc.) through personal assistance, services, nursing home, or other medical facility?  Is PERSON 2 pregnant?	
least 12 months?  Does PERSON 2 need help with activities of daily living (bathing, dressing, etc.) through personal assistance, services, nursing home, or other medical facility?  Is PERSON 2 pregnant?  If yes: Number of babies due: Expected due date: Does PERSON 2 live with at least one child under age 19 and is the main care taker of the child?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
least 12 months?  Does PERSON 2 need help with activities of daily living (bathing, dressing, etc.) through personal assistance, services, nursing home, or other medical facility?  Is PERSON 2 pregnant?  If yes: Number of babies due: Expected due date:	□ Yes □ No
least 12 months?  Does PERSON 2 need help with activities of daily living (bathing, dressing, etc.) through personal assistance, services, nursing home, or other medical facility?  Is PERSON 2 pregnant?  If yes: Number of babies due: Expected due date:  Does PERSON 2 live with at least one child under age 19 and is the main care taker of the child?  Has PERSON 2 ever received Supplemental Security Income (SSI Cash)??  Additional Questions:	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
least 12 months?  Does PERSON 2 need help with activities of daily living (bathing, dressing, etc.) through personal assistance, services, nursing home, or other medical facility?  Is PERSON 2 pregnant?  If yes: Number of babies due: Expected due date:  Does PERSON 2 live with at least one child under age 19 and is the main care taker of the child?  Has PERSON 2 ever received Supplemental Security Income (SSI Cash)??	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

### **PERSON 2:**

Fell us about PERSON 2's expected taxes.	income and potential benefits.	Complete this page even if PERSON 2 is not app	olying.

Federal Income Tax Filing: Tell us how PE	RSON 2 w	vill file incom	ne taxes N	NEXT YEA	AR.		
Will PERSON 2 file taxes NEXT YEAR?		☐ Yes	□ No				
If yes, will PERSON 2 file jointly with a spouse?	digita enderentenni from	□ Yes	□ No		f yes, name o	f spouse:	
Will PERSON 2 claim dependents on his/her tax re	eturn?	□ Yes	□ No	1	f yes, name o	f dependent(s):	
Will PERSON 2 be claimed as a dependent on son else's tax return?	neone	☐ Yes	□ No		f yes, name o Relationship to		
Does PERSON 2 pay any expenses that may be		□ Alimor	าง		Amount paid:		en?
deducted on the federal income tax return?			nt loan int	erest /	Amount paid:	How ofte	
Do not include self-employment expenses. Check all that apply.			deduction cribe dec		Amount paid:	How ofte	nî?
Employment: Tell us about PERSON 2's employment most current federal tax forms: 1 forms, attach proof of business i	1040, SE, a	and applical	ole sched	ules such	as C, C-EZ, I	E, F and K1. If you	
Does PERSON 2 work?		Yes	□ No	If yes	, give employı	ment information be	
Employer's Name and Phone Number:		Earnings leductions)	:	How of	ten paid?		nours worked week?
	*****************	***************		HANNIN AND AND AND AND AND AND AND AND AND AN			
Is PERSON 2 self-employed?		☐ Yes	□ No		type of work: _ annual net am	ount:	
Does PERSON 2's income change because of conseasonal employment?	ntract or	☐ Yes	□ No		how much inc the next 12 m	ome does PERSON onths?	N 2 expect to make
Other Income: Tell us about other income PEF	RSON 2 re	ceives. You	u may nee	ed to prov	ride proof of in	icome.	
Type of Income:		Amoun	t: H	ow often	received?	Who pays	the income?
Social Security benefits							
Retirement/pension					7 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -		
Unemployment							
Disability/worker's compensation							
Alimony							
Tribal money Gaming Other:							
Per capita payments from natural resources, usage leases or royalties	e rights,		Section of Contract				
Payments from natural resources, farming, ranchin fishing, leases or royalties from Indian trust land	ng,						
Money from selling things that have cultural signific	cance						
Other:							
Other:				dia dala			
Check here if this person does not have income							
Potential Benefits: Tell us about PERSON 2	and his/he	er spouse to	help dete	ermine if I	PERSON 2 ma	ay be eligible for ad	ditional benefits.
Has PERSON 2 or his/her spouse (living or decease			☐ Yes	□ No		oyer name:	
for a government agency or an employer with a p						of employment:	
Is PERSON 2 or his/her spouse (living or decease	d) a vetera	an?	☐ Yes	☐ No		h of service: of service:	4
Questions for People Under 19 Years (	Old: This	section is a	nly requir	ed if DED			
Is PERSON 2's parent (living or deceased) a veter		องเมนา เจ บ	☐ Yes	□ No	If yes, branc	h of service:	
Does PERSON 2 have a parent living outside the h	nome?		☐ Yes	□ No	If yes, dates	of service:	
Is there anyone else in PERSON 1's		YES, go to the			about PERSON	13. If NO, go to page	12.

Effective Date: October 1, 2013 Approval Date: September 30, 2013

### PERSON 3:

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

Personal Information:		***		<u> </u>	***************************************	***********************	************
Name (First, Middle, Last):					-		emale
Date of Birth:		-		al if not applying):			
Marital Status:		□ Widowe		rried-name of spouse:			
Relationship to Person 1:	☐ Spouse ☐ Grandchild	□ Niece/		☐ Parent ☐ Legal Guardia			
Does PERSON 3 live at the same addr If no, what is PERSON 3's home ad	dress?	☐ Yes					
Is PERSON 3 attending school full time	e? 🗆 Yes 🗅 No	o If yes	s, name of sc				
Is PERSON 3 applying for help with he	alth insurance costs?	Yes	□ No I	f yes, AHCCCS health p OPTIONAL. See	lan choice: page D for enre	ollment plan cho	oices.
Does PERSON 3 need help paying for from the last 3 months?		☐ Yes	□ No I	f yes, what months?			· .
Check here if PERSON 3 only wants he	elp with Medicare cos	sts? 🗖	Medicar	e claim number:		**********	
If NOT apply	If PERSON 3 is appl ring, skip this page and	ying, continu d go to the r	e answering the	ne questions below. ell us about PERSON 1's	income.		
Citizenship/Residency: Tell us a							у.
Is PERSON 3 a U.S. citizen or U.S. na				☐ Yes ☐ No	☐ Choose no	t to answer	
If PERSON 3 is NOT a U.S. citizen, who Lawful Permanent Resident (LPR)  Lawful Temporary Resident  Non-Immigrant Status  Asylee  Refugee  Conditional Entrant granted before  Other  I do not want to provide  What immigration document does PER  Immigration Document Number:  Is PERSON 3 an Arizona resident?	□ Batte □ Cuba □ Defei □ Defei □ Lega 1980 □ Lega □ Orde □ Parol	red Spouse in-Haitian E rred Action rred Enforci lization und lization und r of Superv led into Uni Permanent Foreign Pas Ha Did PERS	e, Child or Pa intrant Status ed Departure er LIFE Act er IRCA App ision ted States Resident car ssport s PERSON 3	Registry Applicant Withholding None	oplicants migrant Juver Protection St rafficking g of Deportation A Sylum, LP g Deportation Visa Other: August 22, 19	nile Status Apprinted (TPS) on PR, TPS, or	
	Hawaiian or other Pa American Indian/Ala	acific Island		e	☐ Hispa	(optional): nic/Latino Hispanic/Non-l	atino
If PERSON 3 is American Indian or Ala Is he/she enrolled in a federally recog	ıska Native:			If yes, name of tribe:		nspanio/Non-	
Has he/she ever gotten services from a tribal health program, or urban Inc	Indian Health Servic dian health program,	e, 💷 \		If no, is he/she eligible		Yes □ No	,,,
through a referral from one of these	programs						
Program Screening: These que		mine what p	orograms PE	RSON 3 may be eligible	for.		
Program Screening: These que  If PERSON 3 is under the age of 65, do keep him/her from working for at leas	estions will help deternoes he/she have a most 12 months?	ental or phy	sical disabili	ty that has kept or will	□ Yes	□No	
Program Screening: These que If PERSON 3 is under the age of 65, do keep him/her from working for at leas If PERSON 3 works and is under the a least 12 months?	estions will help deten bes he/she have a most 12 months? ge of 65, does he/she	ental or phy e have a dis	sical disabilits	y that has kept or will	□ Yes	□ No	
Program Screening: These que If PERSON 3 is under the age of 65, do keep him/her from working for at leas If PERSON 3 works and is under the a least 12 months? Does PERSON 3 need help with activit	estions will help deten bes he/she have a most at 12 months? ge of 65, does he/she ties of daily living (bat	ental or phy e have a dis thing, dress	sical disabilits	y that has kept or will	□ Yes		
Program Screening: These que  If PERSON 3 is under the age of 65, do keep him/her from working for at leas  If PERSON 3 works and is under the a least 12 months?	estions will help deten bes he/she have a most at 12 months? ge of 65, does he/she ties of daily living (bat	ental or phy e have a dis thing, dress ity?	sical disabilits	y that has kept or will	□ Yes	□ No	
Program Screening: These que  If PERSON 3 is under the age of 65, de keep him/her from working for at least If PERSON 3 works and is under the a least 12 months?  Does PERSON 3 need help with activit assistance, services, nursing home, of Is PERSON 3 pregnant? If yes: Number of babies due:  Does PERSON 3 live with at least one	estions will help determines he/she have a most 12 months? ge of 65, does he/she ties of daily living (bat or other medical facili  Expected due da child under age 19 a	ental or phy e have a dis thing, dress tty? ate: nd is the m	rsical disability that is sing, etc.) through the care take	y that has kept or will expected to last at ough personal	□ Yes □ Yes □ Yes □ Yes □ Yes	□ No □ No □ No □ No	
Program Screening: These que If PERSON 3 is under the age of 65, deep him/her from working for at leas If PERSON 3 works and is under the a least 12 months? Does PERSON 3 need help with activit assistance, services, nursing home, of Is PERSON 3 pregnant? If yes: Number of babies due: Does PERSON 3 live with at least one Has PERSON 3 ever received Suppler	estions will help determines he/she have a most 12 months? ge of 65, does he/she ties of daily living (bat or other medical facili  Expected due da child under age 19 a	ental or phy e have a dis thing, dress tty? ate: nd is the m	rsical disability that is sing, etc.) through the care take	y that has kept or will expected to last at ough personal	□ Yes □ Yes □ Yes □ Yes	□ No □ No □ No	
Program Screening: These que If PERSON 3 is under the age of 65, de keep him/her from working for at leas If PERSON 3 works and is under the ac least 12 months? Does PERSON 3 need help with activit assistance, services, nursing home, of Is PERSON 3 pregnant? If yes: Number of babies due: Does PERSON 3 live with at least one	estions will help determines he/she have a most 12 months? ge of 65, does he/she ties of daily living (bat or other medical facili  Expected due da child under age 19 a	ental or phy e have a dis thing, dress tty? ate: nd is the m	sical disability sability that is sing, etc.) through the care take sh)?	y that has kept or will expected to last at ough personal	□ Yes □ Yes □ Yes □ Yes □ Yes	□ No □ No □ No □ No	

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

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				w		

Tell us about PERSON 3's expected taxes, income and potential benefits. Complete this page even if PERSON 3 is not applying.

Federal Income Tax Filing: Tell us how PERSON 3	will file incor	ne taxes N	· NEXT YE	AR.	
Will PERSON 3 file taxes NEXT YEAR?	☐ Yes	□ No			
If yes, will PERSON 3 file jointly with a spouse?	☐ Yes	□ No		lf yes, name o	f spouse:
Will PERSON 3 claim dependents on his/her tax return?	□ Yes	□ No	J. P. S. F.V	lf yes, name o	f dependent(s):
Will PERSON 3 be claimed as a dependent on someone else's tax return?	☐ Yes	□ No		If yes, name o	
Does PERSON 3 pay any expenses that may be deducted on the federal income tax return?  Do not include self-employment expenses.  Check all that apply.	Other	ny nt loan int deduction scribe ded	erest . Is	Amount paid: Amount paid: Amount paid:	How often? How often?
Employment: Tell us about PERSON 3's employment. most current federal tax forms: 1040, SE forms, attach proof of business income a	, and applica	ble sched	ules such	as C, C-EZ,	E, F and K1. If you do not have tax
Does PERSON 3 work?	Yes	□ No	If yes	, give employ	ment information below:
	s Earnings deductions	):	How of	ten paid?	How many hours worked per week?
s PERSON 3 self-employed?	☐ Yes	□ No		type of work: _ annual net am	lount:
Does PERSON 3's income change because of contract or seasonal employment?	☐ Yes	□ No		how much inc the next 12 m	ome does PERSON 3 expect to make onths?
Type of Income: Social Security benefits Retirement/pension	Amour	71 (1 (1 (1 (1 (1 (1 (1 (1 (1 (1 (1 (1 (1	JW OILEII	received?	Who pays the income?
Unemployment				14	
Disability/worker's compensation					
Alimony					
Tribal money Gaming Other:	i osoba kirotog ekontonin	STORESTORAD CRASS V.	200 BASS (800 NGC 9 C	eacunicativity tracer in ca	
Per capita payments from natural resources, usage rights, leases or royalties					
Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land					
Money from selling things that have cultural significance					
Other:			destalentendind		
Other:					
Check here if this person does not have income	<u> </u>		·····		
Potential Benefits: Tell us about PERSON 3 and his/h	ner spouse to	help dete	ermine if I	PERSON 3 ma	ay be eligible for additional benefits.
Has PERSON 3 or his/her spouse (living or deceased) ever		☐ Yes	□ No	If yes, emplo	
for a government agency or an employer with a pension p Is PERSON 3 or his/her spouse (living or deceased) a vete		☐ Yes	□ No	If yes, branc	of employment:
Questions for People Under 19 Years Old: This	s section is o	nly require	ed if PER	SON 3 is und	er age 19.
Is PERSON 3's parent (living or deceased) a veteran?	2 300,011 10 0	☐ Yes	□ No	If yes, branc	h of service:
Does PERSON 3 have a parent living outside the home?		☐ Yes	□ No	ii yes, dates	of service:
Is there anyone else in PERSON 1's family? If	VFS go to the			about PERSON	4 If NO on to page 12

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### PERSON 4:

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

Personal Information:	
	ender: 🛘 Male 🗘 Female
Date of Birth: Social Security Number (optional if not applying):	
Marital Status: ☐ Never Married ☐ Divorced ☐ Widowed ☐ Married-name of spouse:	
☐ Grandchild ☐ Niece/Nephew ☐ Legal Guardian	Other:
Does PERSON 4 live at the same address as Person 1?	
Is PERSON 4 attending school full time? ☐ Yes ☐ No ☐ If yes, name of school:	
	D for enrollment plan choices.
Does PERSON 4 need help paying for medical bills	
Check here if PERSON 4 only wants help with Medicare costs?   Medicare claim number:	
If PERSON 4 is applying, continue answering the questions below.  If NOT applying, skip this page and go to the next page to tell us about PERSON 1's incon	ne.
Citizenship/Residency: Tell us about PERSON 4's citizenship/residency. You may need to provide proof	
	Choose not to answer
If PERSON 4 is NOT a U.S. citizen, what is his/her immigration status?	
☐ Lawful Permanent Resident (LPR) ☐ Battered Spouse, Child or Parent ☐ Removal/Susp	ension of Deportation
☐ Lawful Temporary Resident ☐ Cuban-Haitian Entrant ☐ Registry Applic	
	ant Juvenile Status Applicant tection Status (TPS)
☐ Refugee ☐ Legalization under LIFE Act ☐ Victim of Traffic	cking
☐ Conditional Entrant granted before 1980 ☐ Legalization under IRCA Applicant ☐ Withholding of	
☐ Other ☐ Order of Supervision ☐ Applicant for A☐ I do not want to provide ☐ Paroled into United States ☐ Withholding De	sylum, LPR, TPS, or
	•
What immigration document does PERSON 4 have? ☐ Permanent Resident card ☐ I-94 ☐ Vis ☐ Foreign Passport ☐ None ☐ Ott	
Immigration Document Number: Has PERSON 4 lived in the U.S. since Augus	
Is PERSON 4 an Arizona resident?	hs? ☐ Yes ☐ No
Race (optional), select one or more:	Ethnicity (optional):
□ Asian □ Hawaiian or other Pacific Islander □ White	☐ Hispanic/Latino
□ Black or African American □ American Indian/Alaska Native □ Other:	☐ Non-Hispanic/Non-Latino
If PERSON 4 is American Indian or Alaska Native:  Is he/she enrolled in a federally recognized tribe?  U Yes U No If yes, name of tribe:	
Has he/she ever gotten services from Indian Health Service, a tribal health program, or urban Indian health program, or	□ Yes □ No
through a referral from one of these programs?	•
Program Screening: These questions will help determine what programs PERSON 4 may be eligible for.	
If PERSON 4 is under the age of 65, does he/she have a mental or physical disability that has kept or will keep him/her from working for at least 12 months?	□ Yes □ No
If PERSON 4 works and is under the age of 65, does he/she have a disability that is expected to last at least 12 months?	☐ Yes ☐ No
Does PERSON 4 need help with activities of daily living (bathing, dressing, etc.) through personal assistance, services, nursing home, or other medical facility?	□ Yes □ No
Is PERSON 4 pregnant?  If yes: Number of babies due: Expected due date:	☐ Yes ☐ No
Does PERSON 4 live with at least one child under age 19 and is the main care taker of the child?	
	☐ Yes ☐ No
Has PERSON 4 ever received Supplemental Security Income (SSI Cash)?	☐ Yes ☐ No ☐ Yes ☐ No
Additional Questions:	

PERSON 4:				
Tell us about PERSON 4's expected taxes, income and pot	ential benefits	. Complete this	page even if PE	ERSON 4 is not applying.
Federal Income Tax Filing: Tell us how PERSON 4	will file incom	e taxes NEXT YI	EAR.	
Will PERSON 4 file taxes NEXT YEAR?	□ Yes	□ No		
If yes, will PERSON 4 file jointly with a spouse?	☐ Yes	□ No	If yes, name o	
Will PERSON 4 claim dependents on his/her tax return?	☐ Yes	□ No	ir yes, name o	f dependent(s):
Will PERSON 4 be claimed as a dependent on someone	☐ Yes	□ No	If yes, name o	f tax filer:
else's tax return?	. 25. 1000- <u>120</u> 0. ( <b>DS.</b> 10086-1970)	K-1965-2000 (1910) (1910) (1910) (1910-1910) (1910-1910)	Relationship to	
Does PERSON 4 pay any expenses that may be deducted on the federal income tax return?	☐ Alimon	y it loan interest	Amount paid: Amount paid:	How often? How often?
Do not include self-employment expenses.		deductions	Amount paid:	
Check all that apply.		cribe deductions		
Employment: Tell us about PERSON 4's employment. most current federal tax forms: 1040, SE forms, attach proof of business income a Does PERSON 4 work?	, and applicab	le schedules suc for the last and c	ch as C, C-EZ, I urrent calendar	E, F and K1. If you do not have tax
	s Earnings		فيتنسسينس	How many hours worked
	deductions):	: How o	often paid?	per week?
Is PERSON 4 self-employed?	Yes		, type of work: _	ount:
Does PERSON 4's income change because of contract or seasonal employment?	☐ Yes	☐ No If yes	, annual net am , how much inc er the next 12 m	ome does PERSON 4 expect to make
Other Income: Tall up about other income DEDCON 4	······································	. may peed to my	avida proof of in	
Other Income: Tell us about other income PERSON 4			n received?	Who pays the income?
Type of Income: Social Security benefits	Amount			Table   Ta
	Heromorphic (WC)		ii ieceiveu?	
			receiveu?	S. C. S. P. S.
Retirement/pension				
Retirement/pension Unemployment				
Retirement/pension Unemployment Disability/worker's compensation			Treetered?	Secretary of the secret
Retirement/pension Unemployment			Treceived 2	
Retirement/pension Unemployment Disability/worker's compensation Alimony				
Retirement/pension Unemployment Disability/worker's compensation Alimony Tribal money  Gaming  Other: Per capita payments from natural resources, usage rights,				
Retirement/pension Unemployment Disability/worker's compensation Alimony Tribal money  Gaming  Other: Per capita payments from natural resources, usage rights, leases or royalties Payments from natural resources, farming, ranching,				
Retirement/pension Unemployment Disability/worker's compensation Alimony Tribal money  Gaming  Other: Per capita payments from natural resources, usage rights, leases or royalties Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land Money from selling things that have cultural significance Other:				を受け、対象のでは、     ********************************
Retirement/pension Unemployment Disability/worker's compensation Alimony Tribal money  Gaming  Other: Per capita payments from natural resources, usage rights, leases or royalties Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land Money from selling things that have cultural significance Other:				を受け、対象のでは、     ********************************
Retirement/pension Unemployment Disability/worker's compensation Alimony Tribal money  Gaming  Other: Per capita payments from natural resources, usage rights, leases or royalties Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land Money from selling things that have cultural significance Other:				を受け、対象のでは、     ********************************
Retirement/pension Unemployment Disability/worker's compensation Alimony Tribal money Gaming Gother: Per capita payments from natural resources, usage rights, leases or royalties Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land Money from selling things that have cultural significance Other: Other: Check here if this person does not have income  Potential Benefits: Tell us about PERSON 4 and his/	ner spouse to	help determine it	f PERSON 4 ma	ay be eligible for additional benefits.
Retirement/pension Unemployment Disability/worker's compensation Alimony Tribal money Gaming Gother: Per capita payments from natural resources, usage rights, leases or royalties Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land Money from selling things that have cultural significance Other: Other: Check here if this person does not have income  Potential Benefits: Tell us about PERSON 4 and his/lease person does not deceased) eve	ner spouse to		f PERSON 4 ma	ay be eligible for additional benefits.
Retirement/pension Unemployment Disability/worker's compensation Alimony Tribal money Gaming Gother: Per capita payments from natural resources, usage rights, leases or royalties Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land Money from selling things that have cultural significance Other: Other: Check here if this person does not have income  Potential Benefits: Tell us about PERSON 4 and his/	ner spouse to r worked blan?	help determine it	f PERSON 4 ma If yes, emplo If yes, dates	ay be eligible for additional benefits.

Is there anyone else in PERSON 1's family? If YES, go to the next page to tell us about PERSON 5. If NO, go to page 12.

☐ Yes

□ Yes

☐ No

If yes, branch of service: If yes, dates of service:

Questions for People Under 19 Years Old: This section is only required if PERSON 4 is under age 19.

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Is PERSON 4's parent (living or deceased) a veteran?

Does PERSON 4 have a parent living outside the home?

### **PERSON 5:**

If there are more than 5 people in your household, make a copy of pages 10 and 11, then tell us about the other people in your household. See page A for a definition of who you must include.

for a definition of who you must include.		
Personal Information:		
Name (First, Middle, Last):	Gender: ☐ Male ☐ Fen	nale
Date of Birth: Social S	Security Number (optional if not applying):	
Marital Status: ☐ Never Married ☐ Divorced ☐	Widowed ☐ Married-name of spouse:	
Relationship to Person 1: Spouse Grandchild	☐ Child/Step Child ☐ Parent ☐ Other: Diece/Nephew ☐ Legal Guardian	
Does PERSON 5 live at the same address as Person 1? If no, what is PERSON 5's home address?	☐ Yes ☐ No	
Is PERSON 5 attending school full time? ☐ Yes ☐ No	If yes, name of school:	
Is PERSON 5 applying for help with health insurance costs?	☐ Yes ☐ No If yes, AHCCCS health plan choice:OPTIONAL. See page D for enrollment plan choices	S
Does PERSON 5 need help paying for medical bills from the last 3 months?	☐ Yes ☐ No If yes, what months?	
Check here if PERSON 5 only wants help with Medicare cost	s?  Medicare claim number:	
If PERSON 5 is applyi	ng, continue answering the questions below.	
If NOT applying, skip this page and	go to the next page to tell us about PERSON 1's income.	
Citizenship/Residency: Tell us about PERSON 5's citi	zenship/residency. You may need to provide proof of citizenship/residency.	
Is PERSON 5 a U.S. citizen or U.S. national? See page B	for more information.	
If PERSON 5 is NOT a U.S. citizen, what is his/her immigration		
	red Spouse, Child or Parent	
	n-Haitian Entrant	
<b>3</b>	red Action Status  □ Special Immigrant Juvenile Status Applic red Enforced Departure □ Temporary Protection Status (TPS)	anı
	ization under LIFE Act	
	ization under IRCA Applicant	
	r of Supervision	
	ed into United States Withholding Deportation	
	3 - F	
What immigration document does PERSON 5 have?	Permanent Resident card	
	Permanent Resident card	
	Foreign Passport	⊒ No
	Foreign Passport	⊒ No
Immigration Document Number:	Foreign Passport	⊒ No
Immigration Document Number:  Is PERSON 5 an Arizona resident?	Foreign Passport	
Immigration Document Number:  Is PERSON 5 an Arizona resident?    Yes    No  Race (optional), select one or more:  Asian	Foreign Passport	
Immigration Document Number:  Is PERSON 5 an Arizona resident?	Foreign Passport	
Immigration Document Number:  Is PERSON 5 an Arizona resident?  Yes  No  Race (optional), select one or more:   Asian  Hawaiian or other Pa  American Indian/Ala:   If PERSON 5 is American Indian or Alaska Native:   Is he/she enrolled in a federally recognized tribe?  Has he/she ever gotten services from Indian Health Service	Foreign Passport	
Immigration Document Number:  Is PERSON 5 an Arizona resident?  Yes  No  Race (optional), select one or more:   Asian  Hawaiian or other Pa  American Indian/Ala:  If PERSON 5 is American Indian or Alaska Native:   Is he/she enrolled in a federally recognized tribe?  Has he/she ever gotten services from Indian Health Service a tribal health program, or urban Indian health program, or	Foreign Passport	
Immigration Document Number:  Is PERSON 5 an Arizona resident?  Yes  No  Race (optional), select one or more:   Asian  Hawaiian or other Pa  American Indian/Ala:   If PERSON 5 is American Indian or Alaska Native:   Is he/she enrolled in a federally recognized tribe?  Has he/she ever gotten services from Indian Health Service	Foreign Passport	
Immigration Document Number:  Is PERSON 5 an Arizona resident?  Yes  No  Race (optional), select one or more: Asian  Hawaiian or other Pa American Indian Ala: If PERSON 5 is American Indian or Alaska Native: Is he/she enrolled in a federally recognized tribe?  Has he/she ever gotten services from Indian Health Service a tribal health program, or urban Indian health program, or through a referral from one of these programs?  Program Screening: These questions will help determing If PERSON 5 is under the age of 65, does he/she have a me	Foreign Passport	
Immigration Document Number:  Is PERSON 5 an Arizona resident?  Yes  No  Race (optional), select one or more: Asian  Hawaiian or other Paragram Black or African American  American Indian/Ala: If PERSON 5 is American Indian or Alaska Native: Is he/she enrolled in a federally recognized tribe?  Has he/she ever gotten services from Indian Health Service a tribal health program, or urban Indian health program, or through a referral from one of these programs?  Program Screening: These questions will help determine If PERSON 5 is under the age of 65, does he/she have a me keep him/her from working for at least 12 months? If PERSON 5 works and is under the age of 65, does he/she	Foreign Passport	
Immigration Document Number:  Is PERSON 5 an Arizona resident?  Yes  No  Race (optional), select one or more: Asian  Hawaiian or other Paragram Black or African American Indian or Alaska Native: Is he/she enrolled in a federally recognized tribe?  Has he/she ever gotten services from Indian Health Service a tribal health program, or urban Indian health program, or through a referral from one of these programs?  Program Screening: These questions will help determine the person of the program in the person of the program in the person of the programs of the person of the program of the person of the perso	Foreign Passport	
Immigration Document Number:  Is PERSON 5 an Arizona resident?  Yes  No  Race (optional), select one or more: Asian  Hawaiian or other Paragram Black or African American  American Indian/Ala: If PERSON 5 is American Indian or Alaska Native: Is he/she enrolled in a federally recognized tribe?  Has he/she ever gotten services from Indian Health Service a tribal health program, or urban Indian health program, or through a referral from one of these programs?  Program Screening: These questions will help determine If PERSON 5 is under the age of 65, does he/she have a me keep him/her from working for at least 12 months? If PERSON 5 works and is under the age of 65, does he/she	Foreign Passport	
Immigration Document Number:  Is PERSON 5 an Arizona resident?  Yes  No  Race (optional), select one or more:   Asian	Foreign Passport	
Immigration Document Number:  Is PERSON 5 an Arizona resident?  Yes  No  Race (optional), select one or more:  Asian  Hawaiian or other Palaka Native:  Black or African American Indian or Alaska Native:  Is he/she enrolled in a federally recognized tribe?  Has he/she ever gotten services from Indian Health Service a tribal health program, or urban Indian health program, or through a referral from one of these programs?  Program Screening: These questions will help determine the Age of 65, does he/she have a mekeep him/her from working for at least 12 months?  If PERSON 5 works and is under the age of 65, does he/she least 12 months?  Does PERSON 5 need help with activities of daily living (bath assistance, services, nursing home, or other medical facility is PERSON 5 pregnant?  If yes: Number of babies due: Expected due data Does PERSON 5 live with at least one child under age 19 and	Foreign Passport	
Immigration Document Number:  Is PERSON 5 an Arizona resident?  Yes  No  Race (optional), select one or more:   Asian	Foreign Passport	
Immigration Document Number:  Is PERSON 5 an Arizona resident?  Yes  No  Race (optional), select one or more:  Asian  Hawaiian or other Pala American American Indian/Ala:  If PERSON 5 is American Indian or Alaska Native: Is he/she enrolled in a federally recognized tribe?  Has he/she ever gotten services from Indian Health Service a tribal health program, or urban Indian health program, or through a referral from one of these programs?  Program Screening: These questions will help determine the American Indian Health Service a tribal health program, or urban Indian health program, or through a referral from one of these programs?  Program Screening: These questions will help determine the American Indian Health Service a tribal health program, or urban Indian health program, or through a referral from one of these programs?  Program Screening: These questions will help determine the American Indian Health Service a tribal health program, or urban Indian Health Service a tribal health program, or urban Indian Health Service a tribal health program, or urban Indian Health Service a tribal health program, or urban Indian Health Service a tribal health program, or urban Indian Health Service a tribal health program, or urban Indian Health Service a tribal health program, or urban Indian Health Service a tribal health program, or urban Indian Health Service a tribal health program, or urban Indian Health Service a tribal health program, or urban Indian Health Service a tribal health program, or urban Indian Health Service a tribal health program, or urban Indian Health Service a tribal health program, or urban Indian Health Service a tribal health program, or urban Indian Health Service a tribal health program, or urban Indian Health Service a tribal health program, or urban Indian Health Service a tribal health program, or urban Indian Health Service a tribal health program, or urban Indian Health Program I	Foreign Passport	
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### PERSON 5:

Tell us about PERSON 5's expected taxes, income and potential benefits. Complete this page even if PERSON 5 is not applying.

Federal Income Tax Filing: Tell us how PERSON 5	will file incom	ne taxes l	NEXT YE	AR.
Will PERSON 5 file taxes NEXT YEAR?	□ Yes	□ No		
If yes, will PERSON 5 file jointly with a spouse?	Yes	□ No		If yes, name of spouse:
Will PERSON 5 claim dependents on his/her tax return?	□ Yes	□ No		If yes, name of dependent(s):
Will PERSON 5 be claimed as a dependent on someone else's tax return?	□ Yes	□ No		If yes, name of tax filer:
Does PERSON 5 pay any expenses that may be	☐ Alimor	ny .		Amount paid: How often?
deducted on the federal income tax return? Do not include self-employment expenses. Check all that apply.	☐ Studer ☐ Other	nt loan in	terest is	Amount paid: How often? How often?
Employment: Tell us about PERSON 5's employment.	, and applical	ole sched	lules such	n as C, C-EZ, E, F and K1. If you do not have tax
Does PERSON 5 work?	Yes	□ No	If yes	s, give employment information below:
	s Earnings deductions)		How o	ften paid?  How many hours worked per week?
is PERSON 5 self-employed?	☐ Yes	□ No		type of work:annual net amount:
Does PERSON 5's income change because of contract or seasonal employment?	☐ Yes	□ No		how much income does PERSON 5 expect to make the next 12 months?
Other Income: Tell us about other income PERSON 5 r	receives. You	u mav ne	ed to pro	vide proof of income.
Type of Income:	Amoun	_		received? Who pays the income?
Social Security benefits				
Retirement/pension				
Unemployment		SILLEN 2811.334 BIRCUSS		
Disability/worker's compensation				
Alimony				
Tribal money    Gaming   Other:				
Per capita payments from natural resources, usage rights, leases or royalties				
Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land	-			
Money from selling things that have cultural significance				
Other:				
Other:				
Check here if this person does not have income	0			
Potential Benefits: Tell us about PERSON 5 and his/h	ner spouse to		ermine if	
Has PERSON 5 or his/her spouse (living or deceased) ever		☐ Yes	□ No	If yes, employer name:
for a government agency or an employer with a pension p		<b></b>	- N	If yes, dates of employment:
Is PERSON 5 or his/her spouse (living or deceased) a vete	ran? 	☐ Yes	□ No	If yes, branch of service: If yes, dates of service:
Questions for People Under 19 Years Old: This	s section is o	nly requir	ed if PEF	RSON 5 is under age 19.
Is PERSON 5's parent (living or deceased) a veteran?		☐ Yes	□ No	If yes, branch of service: If yes, dates of service:
Does PERSON 5 have a parent living outside the home?		☐ Yes	☐ No	
Go to the next	page to tell us	s about h	ealth insu	urance.

Effective Date: October 1, 2013

Health Insurance:							
Inalth Ingresonan Carragan	everyone appl	ying.					
lealth Insurance Coverage		,					
Do any applicants have health insur		an AHCCCS or Medi	care?	☐ Yes	□ No		
If yes, give the following informat							
If yes, give the following	Nome of Ir	nsurance Provider:	Dalia	Niumbari		Cavaraga I	Effective Date:
nformation:	Name of it	isurance Provider:	POIIC	y Number:		Coverage i	Effective Date:
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<u>an an 18. Than ta Affrica Street de la Stational de Stational de Stational de la Stational de</u>				on			
Do any applicants have an injury or			cal malpractice?	☐ Yes	☐ No	If yes, who	
Are any applicants currently admitte	ed to a hospita	ા?	· · · · · · · · · · · · · · · · · · ·	☐ Yes	□ No	If yes, who	o?
Health Insurance Tax	Credits:						
f you are not eligible for AHCCCS N			gible for federal to	y gradita to ba	ln with vo	ur boolth in	curanca
r you are not eligible for Ancocs representations. If you are not eligible for							
Marketplace to see about health ins			we win seria your	mormation to	uie ieuei	ai i icailii iris	Surance
nametrials to see about notion inc	aranoo tax or	,					
nsurance from Jobs: Tell us	about health	insurance that may b	e offered through	a job.			
s anyone eligible for health insuran	ce coverage o	offered by an employe	er, or will you beco	me	☐ Yes	s 🖵 No	☐ I do not know
eligible for coverage in the next 60 c	days?	one of an employ	o., o , oa ooo				
If VES	anguar tha ai						
11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	answer the qu	iestions below. If <b>NC</b>	), or <b>I DO NOT K</b> N	IOW go to the	next page	э.	
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Yes, renew my eligibility for the next: ☐ 5 years ☐ 4 years No, do not use information from tax returns to renew my coverage \*An employer-sponsored health plan meets "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs. Go to the next page to sign the application.

☐ 3 years ☐ 2 years

agree to allow the Marketplace to use income data, including information from tax returns. The Marketplace will send me a notice, let

Transmittal Number: AZ 13-0005-MM

me make changes, and I can opt out at any time.

Effective Date: October 1, 2013

Approval Date: September 30, 2013

□ 1 year

### Sign the Application:

The application is not valid until it is signed. All unrelated adults without a child in common must sign the application. Otherwise, the application must be signed by one of the following:

- The applicant or the applicant's designee (we must have documentation showing this person is authorized to act on the applicant's behalf);
- · The applicant's spouse, if married and living within the same household; or
- · The parent/legal guardian of a minor child.

#### **Penalty Warning**

The information provided on this form may be verified by federal, state, and local officials. If any information is inaccurate, you may be denied benefits.

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

### Release of Information

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

#### Assignment of Rights to Other Benefits for Medical Care

I understand that if I am or members of my family are approved for AHCCCS benefits, AHCCCS can collect payment from any other parties who may be responsible for paying for my/our health costs. This includes:

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

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

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

### By signing this application:

#### Statement of Truth

- I agree I have read and understand my rights and responsibilities, and provided Social Security numbers for each applicant that has a Social Security number.
- I agree I have read and understand the assignment or rights to other benefits for Medical Care above.
- I agree to cooperate with Arizona or Federal personnel in the completion of a quality control review on my eligibility for benefits.
- I understand that my records will be kept confidential and will only be released for purposes authorized by federal and state law.

I swear under penalty of perjury that the statements and documents provided about myself and persons in my home, that relates to my eligibility for benefits, is true and correct to the best of my knowledge, and that I have not withheld any information. I swear under penalty of perjury that any photocopied information I have provided are the same as the original documents.

have provided are the same as the original documents.	
Signature of Applicant:	
Signature of Spouse:	Date:
Signature of Other Adult in Household:	Date:
Signature of Authorized Representative:	Date:
Signature of Witness (if signed with mark):	Date:

### Release of Information to Hospitals/Hospital Agents/Organizations/Agencies:

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

Name of Hospital/Hospital's Agent/Organi Contact Person:	zation/Agency:	Phone Number:	
Mailing Address:	City:	State:	Zip Code:
<ul> <li>If approved for AHCCCS Medical As</li> </ul>		nce; and iy, the redetermination due date, a	and the category of assistance for
Signature of Applicant:		Date:	

Transmittal Number: AZ 13-0005-MM Effective Date: October 1, 2013 Approval Date: September 30, 2013

#### Attachment 1 Application

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587)

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Tell us if any person over the age of 18 listed on this application would like to register to vote. If yes, we will mail a voter registration form. You may also access a voter registration form at www.azsos.gov/election/voterinformation.htm. If you would like help filling out the voter registration application form, we will help you. You may fill out the application form in private. Your answer to this question will not impact the programs you are eligible for.

Would any person on this application over the age of 18 like to register to vote?	☐ Yes	□ No	☐ Already registered to vote								
If YES is not checked, all persons over the age of 18 on this application will be considered to have decided not to register to vote at this time.											
If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:											
State Election Director Secretary of State's Office											

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

### **Application Checklist:**

Before submitting your application, remember to:

- ☐ Give us your contact information
- Include information about each person in your family
- ☐ Sign the application

### **Submit the Application:**

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

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

Thank you for applying!

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Effective Date: October 1, 2013

#### Attachment 5 Key Differences HEA plus

# Key Differences Between Arizona's Health-e-Arizona Plus Online Application and the CMS Document for the Health Insurance Marketplace Online Application

Health-e-Arizona Plus (<u>www.healthearizonaplus.gov</u>) will be Arizona's integrated online application for Medicaid, CHIP, SNAP, and TANF Cash Assistance.

The Health-e-Arizona Plus online application was compared to the CMS document *List of Items in the Online Application to Support Eligibility Determinations for Enrollment through the Health Insurance Marketplace and for Medicaid and the Children's Health Insurance Program*, 4/29/2013.

The following questions or data elements are collected on the CMS Health Insurance Marketplace online application, but are not on the Health-e-Arizona Plus online application:

### **Eligible Immigration Status**

Because there is a requirement that a Medicaid applicant attest to their qualified immigration status, we cannot use the method outlined on the CMS single streamlined application. Not all legal statuses are Medicaid qualified immigration statuses. Therefore, we have listed the statuses for selection. We also provide the individual with the option to indicate they do not want to provide their immigration status. In this situation the person can only be eligible for emergency services.

### Potential Disability

Per the CMS document, disability related questions are asked of all applicants to 'screen applicants for the potential for Medicaid eligibility on a basis other than Modified Adjusted Gross Income (MAGI)'. Arizona asks potential disability questions only for those persons not otherwise confirmed to be disabled by electronic data sources and who are not already found eligible on the basis of MAGI.

#### Expedited Income

Per the CMS document, Section IX, describes a process 'for tax filers whose income tax data indicates that the household income is above a certain amount so the household doesn't need to answer questions about current/monthly income.' Arizona will not use FTI and does not ask these questions.

### American Indian/Alaska Native income guestions

While income, including tribal income is collected, it is collected along with all other types of income, rather than broken out to a separate series of questions.

#### Discrepancies

The CMS document includes 10 questions asked for an person where the electronic income data is not reasonably compatible with the household income attestation. Arizona asks similar conditional questions when, upon reviewing the income data from electronic sources, indicates that the income data is not, or no longer, accurate. These questions and the rules associated with the answers to these questions are integral to Arizona's verification plan and specifically Arizona's rules for reasonable compatibility.

### **Special Enrollment Periods**

We have not included special enrollment period questions for potential APTC eligible persons. The CMS paper Single Streamlined Application does not include these questions. Guidance also indicates that these are not required for alternative paper or online applications.

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Arizona

The following questions or data elements are collected on the Health-e-Arizona Plus online application, but are not on the CMS Health Insurance Marketplace online application:

### **Questions Related to All Medical Assistance Programs**

#### Relationships

We ask for relationships of all persons in relation to other persons, not just in relationship to the primary applicant.

### **Immigration Status**

Because there is a requirement that a Medicaid applicant attest to their qualified immigration status, we cannot use Because there is a requirement that a Medicaid applicant attest to their qualified immigration status, we cannot use the method outlined on the CMS single streamlined application. Not all legal statuses are Medicaid qualified immigration statuses. Therefore, we have listed the statuses for selection. We also provide the individual with the option to indicate they do not want to provide their immigration status. In this situation the person can only be eligible for emergency services.

### Pregnancy

We ask for the expected due date in order to follow-up when no newborn has been reported by the expected due date.

### Arizona resident

We ask this question to ensure that the individual considers him/herself a resident of Arizona. We also ask whether any applying person has moved to Arizona in the last month (or in the last four months if prior quarter coverage is needed).

### **Potential Benefits**

We ask two questions to identify potential benefits for which the individual may be eligible. This includes through access to pension or veterans administration benefits

### No Income

For households attesting to having 'No Income', we ask questions related how they are meeting their needs. Based on the answers to the questions, they may have income that is considered countable income (e.g., working odd jobs) that they had not previously entered. As indicated in our verification plan, we will perform post eligibility checks of data sources at 6 months to determine if the household is receiving income.

### **Questions Related to Medicaid and CHIP only**

### <u>Inpatient</u>

State rule requires that we determine eligibility expedited timeframe for persons who are inpatient in a hospital inpatient. This question is asked following eligibility determination, but before signature.

Injury or illness due to an accident or medical malpractice

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Attachment 5 Key Differences HEA plus

We ask this question to identify potential sources of third party liability. This question is asked following eligibility determination, but before signature and is a federal requirement to pursue sources of third party liability

**Health Plan Choice** 

We ask the individuals who are eligible for Medicaid or CHIP, or are eligible pending verification, to indicate their health plan choice. This is an optional question, but is important to the completion of their enrollment and avoid additional contact to obtain their choice. This question is asked following eligibility determination, but before signature.

### Questions Related to CHIP Only (Note: Arizona's CHIP program enrollment is frozen)

### **Chronic or Serious Illness**

If the CHIP program should reopen, we would ask if any CHIP eligible child, that has lost insurance in the last 90 days, has a chronic or serious illness. Arizona waives the 90 day bare period for an eligible child with a chronic or serious illness

### Questions Related to ABD and Medicaid Buy In (i.e., Freedom to Work (FTW)) Programs

We ask the following questions only as needed for persons identified by data sources to be blind or disabled or otherwise not eligible for Medicaid or CHIP on the basis of MAGI.

### Past receipt of Supplemental Security Income (SSI Cash)

We ask this question to identify potential eligibility for certain ABD categories.

### **Potential Disability**

We ask if the person has a mental or physical disability that has or will keep him/her from working for at least 12 months to identify potential eligibility for the Aged, Blind, Disabled (ABD) program.

We ask if the person works and has a significant impairment to identify potential eligibility for the Freedom to Work program.

#### Impairment/Blind Related Work Expenses

We collect eligible expenses only as applicable and needed to complete the eligibility determination

### Student Earned Income Exclusion

We collect student status for persons under age 22, disabled or potentially disabled, and having earned income, and otherwise over income for these programs in order to apply the student earned income exclusion.

### **Court-Ordered Child Support**

We collect court-order child support for parents of a disabled or potentially disabled person who is otherwise over income for these programs, in order to apply the child support deduction

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