Table of Contents

State Name: Delaware

State Plan Amendment (SPA) #: 14-0004-MM2

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

CENTERS FOR MEDICARE & MEDICAID SERVICES

Region III/Division of Medicaid and Children's Health Operations

SWIFT# 061820144008

JUL 23 2014

Stephen Groff, Director
Division of Medicaid & Medical Assistance
Delaware Health and Social Services
1901 N. DuPont Highway
New Castle, DE 19720-0906

Dear Mr. Groff:

Enclosed is an approved copy of Delaware state plan amendment (SPA) 14-0004 MM2, which was submitted to CMS on March 18, 2014. This SPA revised the alternative single streamlined paper application. The effective date of this SPA is March 1, 2014.

CMS appreciates the significant amount of work your staff dedicated to preparing this state plan amendment. If you have any questions concerning this SPA, please contact Michael Cleary at 215-861-4282.

Sincerely,

[redacted]

Francis McCullough
Associate Regional Administrator

Enclosures

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name:
Delaware
Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

DE-14-0004

Proposed Effective Date

03/01/2014 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

Patient Protection and Affordable Care Act (Public Law 111-148); 42 CFR 431, 42 CFR 435; and, 45 CFR 155

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$ 0.00
Second Year	2015	$ 0.00

Subject of Amendment

State of Delaware Medicaid MAGI Eligibility Process State Plan Amendment. This SPA supersedes S94, pages 1-2 and Document 2 - Ã‚Â“ statement of use with respect to the alternative single streamlined paper application.

Governor's Office Review

- ○ **Governor's office reported no comment**
- ○ **Comments of Governor's office received**
  Describe:
- ○ **No reply received within 45 days of submittal**
- ◉ **Other, as specified**
  Describe:
  Governor's Comments Under Separate Correspondence

Signature of State Agency Official

Submitted By:
Sharon Summers
Last Revision Date:
Jul 22, 2014
Submit Date:
Mar 18, 2014

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

General Eligibility Requirements Eligibility Process	S94

42 CFR 435, Subpart J and Subpart M

Eligibility Process

☑ The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

☐ The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

☒ An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

☒ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

☒ The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

☐ An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

◉ Yes ○ No

Medicaid Eligibility

Indicate the other electronic means below:

	Name of Method	Description	
+	Fax Machine	application accepted by facsimile transmission	X
+	Email	application accepted by email attachment	X

☑ The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Redetermination Processing

☑ 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 435.916:

■ Once every 12 months

■ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency

■ 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.

■ Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

☒ Once every 12 months

☐ Once every 6 months

☐ Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

☑ The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

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 40 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.

DELAWARE HEALTH AND SOCIAL SERVICES (DHSS)
APPLICATION FOR HEALTH COVERAGE AND HELP PAYING COSTS (SHORT FORM)

Welcome to the State of Delaware Health and Social Services (DHSS)

Apply faster online

Apply faster online at www.assist.dhss.delaware.gov

Use this application to see what coverage you qualify for

- Free or low-cost insurance from Medicaid or CHIP
- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage

Who can use this application?

Single adults who:

- Don't have any dependents and can't be claimed as a dependent on someone else's tax return
- Aren't offered health coverage from their employer
- Only declare a tax deduction for student loan interest

NOTE: If any of the following apply, you need to fill out a different form to make sure you get the most benefits possible

- You're married or have dependent children.
- You were in the foster care system, and you're under age 26.
- You're American Indian or Alaska Native.

NOTE: You can choose an authorized representative to assist you with completing this application. Complete Step 5.

What you may need to apply

- Your Social Security Number (or document number if you're a legal immigrant)
- Employer and income information (for example, from paystubs, W-2 forms, or wage and tax statements)

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private, as required by law.**

What happens next?

Please use the stamped self-addressed envelope to mail your signed application. **If you don't have all the information we ask for, sign and submit your application anyway.** If needed, we will follow up with you. Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

- If you have questions, please call 1-800-372-2022.
- If you need help with translation call 1-866-843-7212.
- For TTY call 711 or 1-800-232-5460.
- En Español: Llame a nuestro centro de ayuda gratis al 1-866-843-7212.

DELAWARE HEALTH AND SOCIAL SERVICES (DHSS)
APPLICATION FOR HEALTH COVERAGE AND HELP PAYING COSTS (SHORT FORM)

Welcome to the State of Delaware Health and Social Services (DHSS)

STEP 1 Tell us about yourself.

1.First name, Middle name, Last name, & Suffix

2. Home Address (Leave blank if you don't have one.) | 3. Apartment or suite number

4. City | 5. State | 6. Zip Code

7. Mailing address (if different from home address) | 8. Apartment or suite number

9. City | 10. State | 11. Zip Code

12. Primary Phone Number ( ) – | 13.Secondary Phone Number ( ) –

14. Preferred Methods of Contact
I want to receive information about this application and future communication by: ☐ Email Address ☐ U.S. Mail
E-Mail Address:_____

15. Do you plan to stay in Delaware? ☐ Yes ☐ No

16. Date of birth (mm/dd/yyyy) | 17. Sex ☐ Male ☐ Female

18. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
We need this if you want health coverage and have an SSN. We use SSN's to check income and other information to see if you're eligible for help with health coverage costs. If you need help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

19. Ethnicity: (OPTIONAL) ☐ Hispanic ☐ Non-Hispanic

20. Race (OPTIONAL – check all that apply.)
☐ Alaskan ☐ American Indian ☐ Asian ☐ Black ☐ Hawaiian ☐ Pacific Islander ☐ White

21. Are you a U.S. Citizen or U.S. national? ☐ Yes ☐ No

22. If you are not a U.S. Citizen or U.S. national, do you have eligible immigration status?
☐ Yes - Fill in your document type and ID number below.
a) Immigration document type _____
b) Document ID number _____
c) Have you lived in the U.S. since 1996? ☐ Yes ☐ No
d) Are you a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

23. Preferred spoken or written language (if not English)

24. Are you pregnant? ☐ Yes ☐ No
If yes, how many babies are expected during this pregnancy? _____ What is your expected due date? _____

25. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, working, etc.) or live in a medical facility or nursing home? ☐ Yes ☐ No

26. Do you pay student loan interest (not the amount of the loan) that can be deducted on a federal income tax return?
☐ Yes ☐ No
If yes, how much do you pay? $_____ How often?_____

27. Were you in Delaware Foster Care at age 18 or older and receiving Delaware Medicaid Benefits? ☐ Yes ☐ No

STEP 2 Tell us about your health care.

1. Are you enrolled in health coverage now? ☐ Yes ☐ No

If yes, check which coverage you have:

- ☐ Medicaid
- ☐ CHIP
- ☐ Medicare
- ☐ TRICARE (don't check if you have Direct Care or Line of Duty)
- ☐ Peace Corps
- ☐ VA health care programs
- ☐ Other

Name of health insurance _____

Policy number _____

STEP 3 Tell us about your income.

- ☐ EMPLOYED START AT QUESTION #1
- ☐ SELF EMPLOYED START AT QUESTION # 9
- ☐ NOT EMPLOYED START AT QUESTION # 10

☐ CURRENT JOB 1

1. Employer name and address	2. Employer phone number	3. Average hours worked each week
	( ) –	

4. Wages/tips/commissions (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a Month ☐ Monthly ☐ Yearly

$_____

☐ CURRENT JOB 2 (If you have more jobs and need more space, attach another sheet of paper.)

5. Employer name and address	6. Employer phone number	7. Average hours worked each week
	( ) –	

8. Wages/tips/commissions (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a Month ☐ Monthly ☐ Yearly

$_____

☐ SELF EMPLOYED

9. Type of Work _____

How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$_____

☐ OTHER INCOME THIS MONTH

10. Check all that apply, and give the amount and how often you get it.

☐ None

	Amount	How Often		Amount	How Often
☐ Unemployment Compensation	$_____	_____	☐ Alimony received	$_____	_____
☐ Pensions	$_____	_____	☐ Net farming/fishing	$_____	_____
☐ Social Security	$_____	_____	☐ Net rental/royalty	$_____	_____
☐ Retirement Accounts	$_____	_____	☐ Other Income	$_____	_____

Type _____

☐ CHANGE IN EMPLOYMENT

11. In the past year, did you: ❑Change jobs ❑Stop working ❑Start working fewer hours ❑None of these

STEP 4 Read & sign this application.

RIGHTS AND RESPONSIBILITIES

I have read or have had read to me all statements on this form and the information I give is true and complete to the best of my knowledge. I understand that I could be penalized if I knowingly give false information. I understand that all information I give is confidential and federal and state laws limit disclosure of information about me.

I understand and agree to give proof of my statements. I understand and agree that Delaware Health and Social Services (DHSS) may contact other persons or organizations to obtain the necessary proof of my eligibility.

I must give the Social Security Number for each person applying and it will be used to check records with other government agencies. DHSS also asks me to give the Social Security Number of anyone whose income is used to determine my eligibility. Non-lawful aliens are not required to give a Social Security Number.

I understand that this application will be considered without regard to race, color, sex, age, disability, religion, national origin, or political belief.

I understand that I must apply for and accept other benefits that I may be eligible to get such as Unemployment Compensation or Social Security.

I will allow DHSS, or its representatives, to act as my agent in recovering money spent by the medical assistance programs when other money from insurance, etc., becomes available to pay my medical bills.

I may have to repay to DHSS any medical assistance received for which I am not entitiled. My obligation to repay such assistance applies both during my period of eligibility and after I am no longer receiving medical assistance.

As required by law, as conditions of eligibility, I assign all rights to medical support and to payment for medical care from any third party to DHSS, and I understand I must cooperate with the Division of Child Support Enforcement in establishing paternity and obtaining medical support for any child receiving medical assistance.

I understand that pregnant women are not required to cooperate in establishing paternity and obtaining medical support and that I may claim to have good cause for refusing to cooperate in establishing paternity or in identifying and providing information about liable third parties.

I understand that as a medical assistance recipient, I will automatically receive full child support services from the Division of Child Support Enforcement, unless I state that I want to receive only child support services related to medical support.

I understand that if I am a Medicaid or Delaware Healthy Children Program applicant/recipient I have the right to a fair hearing if I am not satisfied with any decision made about my eligibility. I understand that I may be represented by an attorney or any other person I choose.

I agree to allow DHSS, directly or through its agents or the Diamond State Health Plan or the Delaware Healthy Children Program, to have access to all medical and school-based health and related services records of every member of my household who is eligible for medical assistance in order to administer the medical assistance program, coordinate care, determine medical necessity, and evaluate or pay for pending or incurred medical services.

I certify, under penalty of perjury, that I am a U.S. Citizen or alien in lawful immigration status. I must give proof of lawful immigration status and it will be checked with U.S. Citizenship and Immigration Services (USCIS). Non-lawful alien status will not be checked. This will not affect any public charge determination or lead to deportation proceedings. Non-lawful aliens may be eligible for emergency services and labor and delivery only.

I agree to report within 10 days changes in my situation that could affect my eligbility, such as a change in how many people live with me, a new job or change in income, or if I move.

☐ I confirm I am not incarcerated, detained or jailed.

☐ I understand I cannot receive Medicaid/CHIP while incarcerated.

RENEWAL OF COVERAGE IN FUTURE YEARS

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

Yes, renew my eligibility automatically for the next

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

☐4 years ☐3 years ☐2 years ☐1 year ☐Don't use information from tax returns to renew my coverage.

This application must be signed by an adult household member (age 18 or over) or by an emancipated minor (under age 18).

I have received the "Rights and Responsibilities" and understand what it means.

_____ _____

Signature of Applicant or Representative Date

FOR PERSONS WHO CANNOT SPEAK ENGLISH

Translation services were offered or a family member or other person was present to translate.

_____ _____ _____

Signature of Translator Date Phone Number & Agency/Relationship

STEP 5 Assistance with Completing this Application - Optional

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact Delaware Health and Social Services (DHSS), If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)		
2. Address		3. Apartment or suite number
4. City	5. State	6. Zip Code
7. Phone number ( ) –		
8. Organization name		9. ID number (if applicable)
By signing, you allow this person to sign your application, get information about this application, and act for you on all future matters with this agency.		
10. Your Signature		11. Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)	
2. First name, Middle name, Last name, & Suffix	
3. Organization name	4. ID number (if applicable)

STEP 6 Mail completed application.

Please use the stamped self-addressed envelope to mail your signed application. **If you don't have all the information we ask for, sign and submit your application anyway.** If needed, we will follow up with you. Filling out this application doesn't mean you have to buy health coverage.

DELAWARE HEALTH AND SOCIAL SERVICES (DHSS)
APPLICATION FOR MEDICAL ASSISTANCE

Welcome to the State of Delaware Health and Social Services (DHSS)

Apply faster online

Apply faster online at www.assist.dhss.delaware.gov
This includes anyone wishing to apply for Medical Assistance only.

Who can use this application?

- Use this application to apply for anyone in your home including any tax dependents who are out of the home.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If applying for Medical Assistance only, you may be able to use a short form.

What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants)
- Employer and income information for everyone in your household (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family. You may need to complete Appendix A.

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.**

What happens next?

Please use the stamped self-addressed envelope to mail your signed application. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow-up with you. You'll get instructions on the next steps. If you don't hear from us, call 1-800-372-2022.

Get help with this application

- **Phone:** Call our Customer Relations Unit at **1-800-372-2022.**
- **In person:** There may be social workers/case managers in your area who can help.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-866-843-7212.**
- **In a language other than English:** Call **1-866-843-7212.**
- **TTY users:** Call **711** or **1-800-232-5460.**

DELAWARE HEALTH AND SOCIAL SERVICES (DHSS)
APPLICATION FOR MEDICAL ASSISTANCE

Welcome to the State of Delaware Health and Social Services (DHSS)

We help Delawareans in need by providing Medical Assistance Programs that include:

- free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP)
- doctors, hospitals, prescriptions, labs, and x-rays
- affordable, private health insurance plans through the Marketplace
- a new tax credit that can immediately help pay your premiums for health coverage

We can provide information about other helpful services in your community. A friend or relative, or anyone that you wish, may help you complete this application. If you wish to have someone else manage your case and act as your representative, please complete Appendix C.

Your application is not complete until you sign the last page. Return the application to us.

STEP 1 Tell us about yourself.

(We need one adult in the household to be the contact person for your application.)

First name, Middle name, Last name, & Suffix		
Home Address		Apartment or suite number
City	State	Zip Code
Mailing address (if different from home address)		Apartment or suite number
City	State	Zip Code
Primary Phone Number ( ) –	Secondary Phone Number ( ) –	
Preferred Methods of Contact I want to receive information about this application and future communication by: ☐ Email Address ☐ U.S. Mail E-Mail Address:_____		
Preferred spoken or written language (if not English)		

STEP 2 Tell us about yourself and the people in your household.

Are you? ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Civil Union ❑ Widowed ❑ Unmarried Partnership

Instructions

Fill in the blocks for all of the people who live with you. If you file taxes, we need to know about everyone on your tax return.

Race: B = Black/African American W=White **Ethnic Group:** H=Hispanic/Latino
PI = Native Hawaiian/Pacific Islander A=Asian N=Non-Hispanic/Latino
I = American Indian/Alaskan Native (If anyone in your household is American Indian/Alaskan Native, also complete Appendix B.)

Last Name	First Name, Middle Name	Relation to you	Are you applying for this person?	Sex M/F	Birth Date mm/dd/yyyy	Social Security Number*	Race/ Ethnic Group (optional)		U.S. Citizen? Answer for applicants only. **
		Self	❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No
			❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No
			❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No
			❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No
			❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No
			❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No
			❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No

*We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

**** Applies to applicants for health coverage only.**

Complete this section for legal alien applicants only.

1. Do applicants have eligible immigration status? ❑ Yes. Complete the section below.

Name	Immigration Document Type	Document ID number	Have you lived in the U.S. since 1996?	Are you or your spouse or parent a veteran or an active-duty member of the U.S. military?

2. Does any child under the age18 applying have an absent parent?	❑ Yes ❑ No
3. Are there any children under the age 19 living in the household?	❑ Yes ❑ No

If yes, fill in below.

Parent or Caregiver's Name	Child's Name

STEP 3 Tell us about your health care.

Is anyone in your household offered health coverage from a job (even if the coverage is from someone else's job, such as a parent or spouse)? **If yes, you'll need to complete Appendix A.** ❑ Yes ❑ No

Is this a state employee benefit plan? ❑ Yes ❑ No

Other than Medicaid does anyone in your household have health insurance or Medicare? ❑ Yes ❑ No

If yes, provide the following information:

Name of Policy Holder	Name of Insurance	Who is Covered	Circle what is Covered	Policy Number
			Doctor · Hospital · Lab Tests · X-rays	
			Doctor · Hospital · Lab Tests · X-rays	
			Doctor · Hospital · Lab Tests · X-rays	

4. Name anyone in your household who is pregnant _____due date_____

How many babies are expected during this pregnancy? _____

5. Name anyone who has a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, working, etc.) or live in a medical facility or nursing home_____

6. Name anyone who was injured in the last 2 years (car accident, work related injury, medical malpractice, etc.)

7. Does anyone plan to file a tax return for current year? ❑ Yes ❑ No
(You can still apply for medical assistance even if you don't file a tax return.)

If yes, please fill in below and answer questions A. If no, skip to question B.

Name of Tax Filer	Who will be claimed as a Tax Dependent

A. Will anyone file jointly with a spouse? ❑ Yes ❑ No
If yes, name of spouse:

B. Will you be claimed as a dependent on someone's tax return? ❑ Yes ❑ No
If yes, please list the name of the tax filer and how you are related to the tax filer: _____
_____

8. Name anyone in your household who was in Delaware Foster Care at age 18 or older and received Delaware Medicaid Benefits:

STEP 4 Tell us about the money people in your household get.

☐ EMPLOYED START AT QUESTION #9 (If anyone is currently employed, tell us about his or her income.)
☐ SELF EMPLOYED SKIP TO QUESTION #19
☐ NOT EMPLOYED SKIP TO QUESTION # 21

☐ CURRENT JOB 1

9. Please list the person's name:

10. Employer name and address

11. Employer phone number
( ) –

12. Wages/tips/commissions (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a Month ☐ Monthly ☐ Yearly

$_____

13. Average hours worked each WEEK

☐ CURRENT JOB 2

14. Please list the person's name:
(If you have more jobs and need more space, attach another sheet of paper.)

15. Employer name and address

16. Employer phone number
( ) –

17. Wages/tips/commissions (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a Month ☐ Monthly ☐ Yearly

$_____

18. Average hours worked each WEEK

☐ SELF EMPLOYMENT

19. Please list the person's name:

20. **If self-employed, answer the following questions:**
a. Type of Work _____
b. How much net income (profits once business expenses are paid) will you get from this self-employment this month? $_____

☐ OTHER INCOME THIS MONTH

21. Check all that apply, and the amount and how often you get it.

☐ None

Where does money come from	Who gets the money?	How much do they get?	How often are they paid?
☐ Unemployment Compensation		$	
☐ Pensions		$	
☐ Social Security		$	
☐ Retirement Accounts		$	
☐ Alimony received		$	
☐ Net farming/fishing		$	
☐ Net rental/royalty		$	
☐ Other income		$	

☐ CHANGE IN EMPLOYMENT

22. In the past year, did anyone: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

STEP 5 Tell us about your tax deductions.

Check all that apply, and give the amount and how often you pay it.
If you pay for certain things that can be deducted on a tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 20b).

- ❑ Alimony paid $_____ How often?_____
- ❑ Student loan interest $_____ How often?_____Type: _____
- ❑ Other tax deductions * $_____How often?_____

*For other potential deductions, refer to your current tax return form 1040 under the Adjusted Gross Income section.

Authorizations

Authorization for Receipt of Pregnancy Prevention Information

If you wish to receive information, you can call Planned Parenthood at 1–800–230–PLAN (7526).

To get teen pregnancy information, call the Alliance for Adolescent Pregnancy Prevention at 1–800–499–WAIT (9248). You can also call the Delaware Helpline at 211 or 1–800–464–4357 for the Public Health Family Planning clinic in your area.

STEP 6 Read & sign this application.

RIGHTS AND RESPONSIBILITIES

I have read or have had read to me all statements on this form and the information I give is true and complete to the best of my knowledge. I understand that I could be penalized if I knowingly give false information. I understand that all information I give is confidential and federal and state laws limit disclosure of information about me.

I understand and agree to give proof of my statements. I understand and agree that Delaware Health and Social Services (DHSS) may contact other persons or organizations to obtain the necessary proof of my eligibility.

I must give the Social Security Number for each person applying and it will be used to check records with other government agencies. DHSS also asks me to give the Social Security Number of anyone whose income is used to determine my eligibility. Non-lawful aliens are not required to give a Social Security Number.

I understand that this application will be considered without regard to race, color, sex, age, disability, religion, national origin, or political belief.

I understand that I must apply for and accept other benefits that I may be eligible to get such as Unemployment Compensation or Social Security.

I will allow DHSS, or its representatives, to act as my agent in recovering money spent by the medical assistance programs when other money from insurance, etc., becomes available to pay my medical bills.

I may have to repay to DHSS any medical assistance received for which I am not entitiled. My obligation to repay such assistance applies both during my period of eligibility and after I am no longer receiving medical assistance.

As required by law, as conditions of eligibility, I assign all rights to medical support and to payment for medical care from any third party to DHSS, and I understand I must cooperate with the Division of Child Support Enforcement in establishing paternity and obtaining medical support for any child receiving medical assistance.

I understand that pregnant women are not required to cooperate in establishing paternity and obtaining medical support and that I may claim to have good cause for refusing to cooperate in establishing paternity or in identifying and providing information about liable third parties.

I understand that as a medical assistance recipient, I will automatically receive full child support services from the Division of Child Support Enforcement, unless I state that I want to receive only child support services related to medical support.

I understand that if I am a Medicaid or Delaware Healthy Children Program applicant/recipient I have the right to a fair hearing if I am not satisfied with any decision made about my eligibility. I understand that I may be represented by an attorney or any other person I choose.

I agree to allow DHSS, directly or through its agents or the Diamond State Health Plan or the Delaware Healthy Children Program, to have access to all medical and school-based health and related services records of every member of my household who is eligible for medical assistance in order to administer the medical assistance program,

coordinate care, determine medical necessity, and evaluate or pay for pending or incurred medical services.

I certify, under penalty of perjury, that I am a U.S. Citizen or alien in lawful immigration status. I must give proof of lawful immigration status and it will be checked with U.S. Citizenship and Immigration Services (USCIS). Non-lawful alien status will not be checked. This will not affect any public charge determination or lead to deportation proceedings. Non-lawful aliens may be eligible for emergency services and labor and delivery only.

I agree to report within 10 days changes in my situation that could affect my eligbility, such as a change in how many people live with me, a new job or change in income, or if I move.

☐ I confirm that no one applying for medical assistance on this application is incarcerated, detained or jailed.

☐ If not, _____ is incarcerated. I understand that I cannot receive Medicaid Assistance or CHIP benefits while incarcerated.

RENEWAL OF COVERAGE IN FUTURE YEARS

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

Yes, renew my eligibility automatically for the next

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

☐4 years ☐3 years ☐2 years ☐1 year ☐Don't use information from tax returns to renew my coverage.

This application must be signed by an adult household member (age 18 or over) or by an emancipated minor (under age 18).

I have received the "Rights and Responsibilities" and understand what it means.

_____ _____

Signature of Applicant or Representative Date

FOR PERSONS WHO CANNOT SPEAK ENGLISH

Translation services were offered or a family member or other person was present to translate.

_____ _____ _____

Signature of Translator Date Phone Number & Agency/Relationship

STEP 7 Assistance with Completing this Application - Optional

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact Delaware Health and Social Services (DHSS). If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)		
2. Address		3. Apartment or suite number
4. City	5. State	6. Zip Code
7. Phone number ( ) –		
8. Organization name		9. ID number (if applicable)
By signing, you allow this person to sign your application, get information about this application, and act for you on all future matters with this agency.		
10. Your Signature		11. Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)	
2. First name, Middle name, Last name, & Suffix	
3. Organization name	4. ID number (if applicable)

STEP 8 Mail completed application.

Please use the stamped self-addressed envelope to mail your signed application. **If you don't have all the information we ask for, sign and submit your application anyway.** If needed, we will follow up with you. Filling out this application doesn't mean you have to buy health coverage.

DELAWARE HEALTH AND SOCIAL SERVICES **APPENDIX A**

Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

EMPLOYEE Information

1. Employee name (First, Middle, Last)	2. Employee Social Security number _____ - _____ - _____

EMPLOYER Information

3. Employer name		4. Employer Identification Number (EIN) _____ - _____
5. Employer address		6. Employer phone number ( ) –
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above) ( ) –	12. Email address	

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

☐ **Yes** (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

☐ **No** (Stop here and go to Step 5 in the application)

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15)
☐ No (Stop and return form to employee)

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

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

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

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

b. How often? ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Once a month ☐Quarterly ☐Yearly

Date of change (mm/dd/yyyy): _____

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

EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below matches the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

EMPLOYEE Information

1. Employee name (First, Middle, Last)	2. Employee Social Security number _____ - _____ - _____

EMPLOYER Information

3. Employer name		4. Employer Identification Number (EIN) _____ - _____
5. Employer address		6. Employer phone number ( ) –
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above) ( ) –	12. Email address	

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

☐ **Yes** (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____
(mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

☐ **No** (Stop here and go to Step 5 in the application)

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15)
☐ No (Stop and return form to employee)

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

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

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $_____
b. How often? ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Once a month ☐Quarterly ☐Yearly

Date of change (mm/dd/yyyy): _____

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

Delaware Health and Social Services (DHSS) **APPENDIX B**

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

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

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

DELAWARE HEALTH AND SOCIAL SERVICES (DHSS)
APPLICATION FOR FOOD BENEFITS, CASH, MEDICAL, AND CHILD CARE ASSISTANCE

Welcome to the State of Delaware Health and Social Services (DHSS)

Apply faster online

Apply faster online at www.assist.dhss.delaware.gov
This includes anyone wishing to apply for Medical Assistance only.

Who can use this application?

- Use this application to apply for anyone in your home including any tax dependents who are out of the home.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.
- If applying for Medical Assistance only, you may be able to use a short form.

What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants)
- Employer and income information for everyone in your household (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family. You may need to complete Appendix A.

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.**

What happens next?

Please use the stamped self-addressed envelope to mail your signed application. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow-up with you. You'll get instructions on the next steps. If you don't hear from us, call 1-800-372-2022.

Get help with this application

- **Phone:** Call our Customer Relations Unit at **1-800-372-2022.**
- **In person:** There may be social workers/case managers in your area who can help.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-866-843-7212.**
- **In a language other than English:** Call **1-866-843-7212.**
- **TTY users:** Call **711** or **1-800-232-5460.**

DELAWARE HEALTH AND SOCIAL SERVICES (DHSS)
APPLICATION FOR FOOD BENEFITS, CASH, MEDICAL, AND CHILD CARE ASSISTANCE

Welcome to the State of Delaware Health and Social Services (DHSS)

We help Delawareans in need by providing food benefits, medical, child care, and cash assistance. We can provide information about other helpful services in your community. You can answer only the questions related to the program(s) you are applying for. If you answer ALL the questions on the Assistance Application, we can see if you are eligible for all programs. A friend or relative, or anyone that you wish, may help you complete this application.

Your application is not complete until you sign the last page. Return the application to us.

At your interview, you will need to show us:

- Proof of who you are
- Proof of your address
- Proof of child care costs (only for cash assistance)
- Proof of money you have received in the last 30 days

STEP 1 Tell us about yourself.

(We need one adult in the household to be the contact person for your application.)

For which program(s) are you applying? ❑ Cash Assistance ❑ Food Benefits ❑ Medical Assistance ❑ Child Care

First Name, Middle Name, Last Name, & Suffix		
Home Address		
City	**State**	**Zip Code**
Mailing Address (if different from Home Address)		
City	**State**	**Zip Code**
Primary Telephone	**Secondary Telephone**	

Preferred Methods of Contact

I want to receive information about this application and future communication by: ☐ **Email Address** ☐ **U.S. Mail**

E-Mail Address:_____

Preferred spoken or written language (if not English)

If you wish to have someone else manage your case and act as your representative, please complete Appendix C.

For Food Benefits, the day we get this first page of the application with your name, address, and signature sets the date benefits may start if you sign and return the completed application to DHSS within 30 days.

_____ _____
Applicant's Signature (Required) **Date**

_____ _____
Authorized Representative's Signature **Date**

DELAWARE HEALTH AND SOCIAL SERVICES (DHSS)
APPLICATION FOR FOOD BENEFITS, CASH, MEDICAL, AND CHILD CARE ASSISTANCE

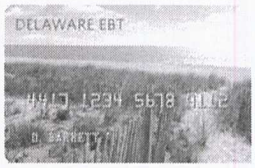
Delaware's Emergency Food Benefit

If your household has little or no income right now, you may be able to receive emergency food benefits within 7 days from the day we receive your completed application.

You may be able to get emergency food benefits in seven days if:

- Your household expects to receive less than $150 in income this month
- Your household does not have more than $100 in cash or bank accounts
- Your household is a migrant or seasonal farm worker household
- Your household's rent, mortgage, and utilities are more than your household's gross monthly income and liquid resources combined

Delaware's Food First Electronic Benefits Transfer (EBT) Card



We issue food benefits on an EBT card. To use your food benefits, you must have an EBT card and a Personal Identification Number (PIN). When we approve your benefits, our EBT vendor will mail your card to you if you never had one before. You can also go to a card issuance site to get your card.

In each of the headings in this application, you will see program symbols. These symbols will help you to identify the questions you must answer for the program(s) you are requesting.

Symbols	Programs
	**Medical Assistance Programs** (doctors, hospitals, prescriptions, labs, and x-rays) - free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP) - affordable, private health insurance plans through the Marketplace - a new tax credit that can immediately help pay your premiums for health coverage
	**Child Care Assistance** (help with the cost of child care)
	**Cash Assistance - Temporary Assistance for Needy Families (TANF) - General Assistance (GA) – Refugee Cash Assistance (RCA)**
	**Food Supplement Program** (help with monthly food expenses)
	**Signature Required**

Terms	Definition
Alien:	A person who is not a U.S. citizen
EBT card:	Electronic Benefit Transfer—a plastic card that you use at a store to buy food.
Eligible:	Meeting all of the guidelines to get benefits.
Household:	A person or a group of people who live together and buy food and fix meals together.
ABAWD:	Able Bodied Adult Without Dependents—An adult aged 18 through 50 years old, without dependents, and physically able to work.

STEP 2 Tell us about yourself and the people in your household.

Are you? ❑ Single ❑ Married ❑ Divorced ❑ Civil Union ❑ Separated ❑ Widowed ❑ Unmarried Partnership

Instructions

Fill in the blocks for all of the people who live with you. If you are applying for medical assistance and file taxes, we need to know about everyone on your tax return.

Race: B = Black/African American; W=White; PI = Native Hawaiian/Pacific Islander; A=Asian; I = American Indian/Alaskan Native (If anyone in your household is American Indian/Alaskan Native, also complete Appendix B.)

Ethnic Group: H=Hispanic/Latino; N=Non-Hispanic/Latino

Last Name	First Name, Middle Name	Relation to you	Are you applying for this person?	Sex M/F	Birth Date mm/dd/yyyy	Social Security Number*	Race/ Ethnic Group (optional)		U.S. Citizen? Answer for applicants only. **
		Self	❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No
			❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No
			❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No
			❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No
			❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No
			❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No
			❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No

***We need this if you want health coverage and have an SSN.** Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

****Applies to applicants for health coverage only.**

Complete this section for legal alien applicants only.

1. Do applicants have eligible immigration status? ❑ Yes. Complete the section below.

Name	Immigration Document Type	Document ID number	Have you lived in the U.S. since 1996?	Are you or your spouse or parent a veteran or an active-duty member of the U.S. military?

2. Has anyone ever received cash, food, or child care assistance in another state? ❑ Yes ❑ No

What benefits? _____ Name of state? _____ Month/Year _____

3. Has anyone ever been disqualified for cash or food assistance in another state? ❑ Yes ❑ No

What benefits? _____ Name of state? _____ Month/Year _____

4. Is anyone in your household in violation of probation or parole or fleeing prosecution? ❑ Yes ❑ No
(Applies to TANF, food benefits, and general assistance.)

5. Has anyone been convicted of a drug felony after August 22, 1996? ❑ Yes ❑ No
(Applies to TANF and general assistance.)

6. Have you or any member of your household been convicted of trading food benefits for drugs after September 22, 1996? (Applies to food benefits.) ❑ Yes ❑ No

7. Have you or any member of your household been convicted of buying or selling food benefits over $500 after September 22, 1996? (Applies to food benefits.) ❑ Yes ❑ No

8. Have you or any member of your household been convicted of fraudulently receiving duplicate food benefits in any state after September 22, 1996? (Applies to food benefits.) ❑ Yes ❑ No

9. Have you or any member of your household been convicted of trading food benefits for guns, ammunitions, or explosives after September 22, 1996? (Applies to food benefits.) ❑ Yes ❑ No

10. Answer the questions below if a parent(s) of any child under 18 does not live in your household.

Child's Name	Absent Parent's Name	Absent Parent's Date of Birth	Absent Parent's Social Security Number	Absent Parent's Address	Absent Parent's Employer

11. Are there any children under the age 19 living in the household? ❑ Yes ❑ No If yes, fill in below.

Parent or Caregiver's Name	Child's Name

STEP 3 Tell us about your health care.

Is anyone in your household offered health coverage from a job (even if the coverage is from someone else's job, such as a parent or spouse)? If yes, you'll need to complete Appendix A. ❑ Yes ❑ No

Is this a state employee benefit plan? ❑ Yes ❑ No

Other than Medicaid does anyone in your household have health insurance or Medicare? ❑ Yes ❑ No

If yes, provide the following information:

Name of Policy Holder	Name of Insurance	Who is Covered	Circle what is Covered	Policy Number
			Doctor · Hospital · Lab Tests · X-rays	
			Doctor · Hospital · Lab Tests · X-rays	
			Doctor · Hospital · Lab Tests · X-rays	

12. Name anyone in your household who is pregnant_____due date _____
How many babies are expected during this pregnancy? _____

13. Name anyone who has a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, working, etc.) or live in a medical facility or nursing home_____.

14. Name anyone who was injured in the last 2 years (car accident, work related injury, medical malpractice, etc.). _____

15. Does anyone plan to file a tax return for current year? ❑ Yes ❑ No

(You can still apply for medical assistance even if you don't file a tax return.)

If yes, please fill in below and answer question A. If no, skip to question B.

Name of Tax Filer	Who will be claimed as a Tax Dependent

A. Will anyone file jointly with a spouse? ❑ Yes ❑ No

If yes, name of spouse: _____

B. Will you be claimed as a dependent on someone's tax return? ❑ Yes ❑ No

If yes, please list the name of the tax filer and how you are related to the tax filer: _____

_____

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

17. Name anyone in your household who was in Delaware Foster Care at age 18 or older and received Delaware Medicaid Benefits: _____

STEP 4 Tell us about the money people in your household get.

❑ **Employed**
If anyone is currently employed, tell us about his or her income. Start with question 18.

❑ **Not employed**
Skip to question 30.

❑ **Self-employed**
Skip to question 28.

❑ CURRENT JOB 1

18. Please list the person's name:

19. Employer name and address

20. Employer phone number
( ) –

21. Wages/tips/commission (before taxes) ❑ Hourly ❑ Weekly ❑ Every 2 weeks ❑ Twice a month ❑ Monthly ❑ Yearly

$ _____

22. Average hours worked each WEEK

❑ CURRENT JOB 2

23. Please list the person's name:

(If your household has more jobs, attach another sheet of paper.)

24. Employer name and address

25. Employer phone number
( ) –

26. Wages/tips/commission (before taxes) ❑ Hourly ❑ Weekly ❑ Every 2 weeks ❑ Twice a month ❑ Monthly ❑ Yearly

$ _____

27. Average hours worked each WEEK

❑ SELF-EMPLOYMENT

28. Please list the person's name:

29. **If self-employed, answer the following questions:**

a. Type of Work

b. How much gross income will you get from this self-employment this month?

$

c. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$

30. ❑ OTHER INCOME

Where does the money come from?	Who gets the money?	How much do they get?	How often are they paid?
Social Security		$	
Supplemental Security Income (SSI)		$	
VA Benefits		$	
Pensions		$	
Retirement Accounts		$	
Unemployment Compensation		$	
Workers Compensation		$	
Child Support		$	
Alimony Received		$	
Work Study		$	
Money Earned from Interest or Dividends		$	
Net Farming/Fishing		$	
Net Rental/Royalty		$	
Other Income		$	

☐ CHANGE IN EMPLOYMENT

31. In the past year, did anyone: ❑Change jobs ❑Stop working ❑Start working fewer hours ❑None of these

Complete questions 32 - 34 for Food Benefits Only

32. Has anyone in your household quit a job in the last 30 days? ❑ Yes ❑ No

If yes, employer name _____

33. Is anyone in your household a migrant or seasonal worker? ❑ Yes ❑ No

If yes, who? _____

34. Is anyone in your household on strike? ❑ Yes ❑ No

If yes, who? _____

STEP 5 Which of the following do you have?

Complete this section for Cash Assistance Only

35. Does anyone in your household have any vehicles (don't include your car)?

❑ Yes ❑ No If yes, provide the following information:

Make	Model	Year	Amount Still Owed
			$
			$

36. Does anyone have or own any land, buildings, or houses other than the one you live in? ❑ Yes ❑ No

If yes, who owns it? _____

37. Does anyone receive income from these properties? ❑ Yes ❑ No

If yes, how much? $ _____

38. Does anyone in your household have any of the following?

Type of Account	Yes or No	Name on the account	Account Number	Balance
Bank or Credit Union	❑ Yes ❑ No			$
Stocks or Bonds	❑ Yes ❑ No			$
Savings Certificates	❑ Yes ❑ No			$
IRAs or Keogh	❑ Yes ❑ No			$
Trust Funds	❑ Yes ❑ No			$
Cash On Hand	❑ Yes ❑ No			$
Other	❑ Yes ❑ No			$

STEP 6 Tell us about your tax deductions.

Check all that apply, and give the amount and how often you pay it.
If you pay for certain things that can be deducted on a tax return, telling us about them could make the cost of health coverage a little lower.
NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 29c).

❑ Alimony paid $ _____ How often? _____

❑Student loan interest $ _____ How often? _____ Type: _____

❑ Other tax deductions* $ _____ How often?_____

*For other potential deductions, refer to your current tax return form 1040 under the Adjusted Gross Income section.

STEP 7 Tell us about your medical expenses.

If you or anyone in your household has medical expenses and are age 60 or older, or blind, and/or receiving Federal disability benefits (SSA, SSI, VA), please list the name of the person and the amount of the medical expenses paid monthly.

Name		Name	
Hospitalization	$	Hospitalization	$
Prescription drugs	$	Prescription drugs	$
Doctor	$	Doctor	$
Eye Care	$	Eye Care	$
Dental	$	Dental	$
Insurance Premiums	$	Insurance Premiums	$
Transportation for medical care	$	Transportation for medical care	$
Other	$	Other	$

STEP 8 Tell us about your household expenses.


Please tell us about your bills. (Copies of bills may be needed.)

Shelter:

What are your shelter expenses (enter what you are required to pay)?

39. Rent: $ _____ per month

Is this Section 8, HUD or other rental assistance? ❑ Yes ❑ No

Does your rent include meals (room and board)? ❑ Yes $_____ ❑ No

Or are you paying for meals only? ❑ Yes $_____ ❑ No

40. Mobile Home Lot Rent $ _____ per month

41. Mortgage/ Mobile Home $ _____ per month

42. Second Mortgage or Home Equity Loan $ _____ per month

43. Homeowner's Insurance $ _____ per month

44. Property Taxes $ _____ per month

45. Special Assessment $ _____ per month

46. Condominium/Association Fees $ _____ per month

Utilities:

Check the boxes that apply and fill in the amount.

❑ Electric $ _____

❑ Air Conditioning (central or window unit) $ _____

❑ Heat (gas, electric, oil, propane, wood, kerosene) $ _____

❑ Gas (cooking) $ _____

❑ Water/Sewer $ _____

❑ Trash $ _____

❑ Telephone $ _____

❑ HUD/WHA/DSHA (utility allowance check) $ _____

❑ Excess Utilities Only $ _____

Other:

47. Dependent Care Expenses? ❑ Yes $_____ ❑ No

48. Legally-obligated Child Support Payments? ❑ Yes $_____ ❑ No

Reporting and Verifying Expenses:

Please be sure to enter all of your expenses so that you can qualify for the full amount of food benefits that you need. If you do not put an expense down, we will not be able to count it as we decide the amount of aid to give you.

- Shelter (rent/mortgage/lot) expenses;
- Real estate taxes;
- Water and sewage expenses;
- Phone expenses;
- Dependent care expenses;
- Homeowner's Insurance;
- Utility expenses (gas/electric/oil);
- Garbage expenses;
- Medical expenses;
- Child support expenses paid to children who do not live in your household.

Do You Need Child Care?

Please tell us why you need child care?

❑ Working ❑ High School or GED completion

❑ Education/training (as part of DSS Employment & Training Program (E&T))

❑ Health (explain): _____

❑ Other (explain): _____

Child(ren)'s Name(s) Needing Child Care	How many hours needed?	Provider name, address and phone number	Provider ID number	DHSS Provider Or Self-arranged	Date Care Began

Is Anyone in Your Household in School?

Complete this section for Cash Assistance, Food Supplement, and Child Care Only

Complete the table for anyone in your household attending school, including trade school.

Person(s) In School	Name of School	Full/Part Time	Grade	Expected Graduation Date if 16 or Older

Authorizations

Authorization for Receipt of Pregnancy Prevention Information

If you wish to receive information, you can call Planned Parenthood at 1–800–230–PLAN (7526).

To get teen pregnancy information, call the Alliance for Adolescent Pregnancy Prevention at 1–800–499–WAIT (9248). You can also call the Delaware Helpline at 211 or 1–800–464–4357 for the Public Health Family Planning clinic in your area.

Penalties

For the Food Supplement, Cash and Medical Assistance Programs

Although providing Social Security Numbers is voluntary, you understand that if you fail to give Social Security Numbers you or a member of your household may be denied services. Your Social Security Number will be used to determine initial and ongoing eligibility. Non-lawful aliens are not required to give a Social Security Number.

We will use your Social Security Number to check information in our records with other Federal, State, and Local agency computer matching systems. If you give us false information on purpose, we will take legal action against you.

If you receive benefits that you should not get, you will be responsible to repay those benefits during your period of eligibility and after you are no longer receiving benefits.

An individual will not be able to get Food Benefits or Cash Assistance if:

- he/she is fleeing to avoid prosecution, custody or confinement after a conviction that is a felony, or
- violating a condition of probation or parole imposed under a Federal or State law

Penalties in the Cash Assistance Program

Do Not give false information or hide information to get or continue to get Cash Assistance.

If...	You will ...
▪ Any member of your household breaks a Temporary Assistance for Needy Families (TANF) rule on purpose	▪ lose cash assistance for 12 months for the first violation ▪ lose cash assistance for 24 months for the second violation ▪ lose cash assistance permanently for the third violation
▪ Any applicant or recipient gives false information in order to obtain benefits	▪ be subject to penalties that include a fine of up to $500 and imprisonment up to 6 months
▪ Any member of your household is found guilty of misrepresenting his or her place of residence in order to get multiple benefits in two or more states for the same month from programs funded under TANF	▪ lose cash assistance for 10 years
▪ Any member of your household is convicted of a felony for having, using, or selling controlled substances	▪ lose cash assistance permanently

TANF Job Quit Penalties
If an individual quits a job without good cause the entire TANF case will close for one month or until the individual meets work and training requirements for four weeks in a row, whichever is later.

TANF Work and Training Penalties
When an individual does not comply with work and training the entire TANF case will close for one month or until the individual meets work and training requirements for four weeks in a row, whichever is later.

Penalties in the Food Supplement Program

If you…	You will lose food benefits…
▪ Hide information or make false statements ▪ Use EBT cards that belong to someone else ▪ Use food benefits to buy alcohol or tobacco ▪ Trade or sell benefits or EBT cards	▪ 12 months for the first offense ▪ 24 months for the second offense and ▪ permanently for the third offense
▪ Trade food benefits for controlled substances, such as drugs	▪ for 24 months for the first offense and ▪ permanently for the second offense
▪ Trade food benefits for firearms, ammunition or explosives	▪ Permanently
▪ Trade, buy or sell food benefits of $500 or more	▪ Permanently
▪ Give false information about who you are and where you live so you can get extra food benefits	▪ 10 years for each offense

You can also be fined up to $250,000 or put in prison for up to 20 years or both, for doing these things. You may also be charged under Federal laws.

The information you give us will be checked to make sure your household is eligible for food benefits and Cash Assistance. Federal, State, and Local officials will check the information you give us. The information you give us may also be checked by other Federal Aid programs and Federally-Aided State programs, such as School Lunch and Medicaid. If any information given is found to be incorrect, you may be denied Food Benefits/Cash Assistance. If you give false information on purpose, legal action may be taken against you. You may also have to pay back the amount of benefits you should not have received.

For Food Benefits
Nondiscrimination Statement

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at http://www.fns.usda.gov/snap/contact_info/hotlines.htm.
USDA is an equal opportunity provider and employer.

For Cash Assistance, Medical Assistance, and Child Care

Nondiscrimination Statement

I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file**.

What You Need To Know About the Medical Assistance Program

For the Food Supplement, Cash and Medical Assistance Programs

I understand and agree:

- I will apply for and accept other benefits that I may be eligible to get such as Unemployment Compensation, Social Security, or Medicare.
- By law, as a condition of eligibility, I assign all rights to medical support and to payment for medical care from any third party to DHSS.
- To allow DHSS, directly or through its agents or the Diamond State Health Plan or the Delaware Healthy Children Program, to have access to all medical and school-based health and related services records of every member of my household who is eligible for Medical Assistance. This will allow DHSS to administer the medical assistance program, coordinate care, determine medical necessity, and evaluate or pay for pending or incurred medical services.
- I confirm that no one applying for medical assistance on this application is incarcerated (detained or jailed). If not, _____ is incarcerated. I understand that I cannot receive Medical Assistance or CHIP benefits while incarcerated.

  We need this information to check your eligibility for help paying for medical assistance if you choose to apply. Your answers will be checked using information from electronic databases. If the information does not match, you may be asked to send proof.

Renewal of coverage in future years

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

Yes, renew my eligibility automatically for the next ❑ 5 years (the maximum number of years allowed), or for a shorter number of years:

❑ 4 years ❑ 3 years ❑ 2 years ❑ 1 year ❑ Don't use information from tax returns to renew my coverage.

I understand and agree:

- I will automatically receive child support services from the Division of Child Support Enforcement (DCSE).
- I must cooperate with DCSE in establishing paternity and obtaining medical support for any child receiving medical assistance.
- DCSE is authorized to deduct directly from my support payments, any and all monies owed to the Division of Social Services.
- I will not be eligible for benefits if I fail to cooperate with DCSE unless a good cause is established. My child(ren) may still be eligible.
- Pregnant women are not required to cooperate in establishing paternity and obtaining medical support.

Some Medicaid programs require you to enroll in a managed care organization.

To enroll in a managed care organization (MCO), call the Health Benefits Manager at 1-800-996-9969.

Disclosure of Information

For All Programs
All information and documentation gathered for determining your Cash Assistance, Food Supplement, Child Care and Medical Assistance eligibility or other program related use is confidential. Each program provides safeguards, restricting the use and disclosure of information about you to purposes directly connected with the administration of the program.

Releasing information concerning your eligibility to anyone not authorized to receive the information is a violation of State and Federal law and may result in legal action.

We will keep your eligibility information confidential, unless you give us permission to release information to others.

Certifications and Signatures

Certification of Citizenship and Alien Status
I certify, under penalty of perjury, that I, and any other members of my household, are U.S. citizens or aliens in lawful immigration status. Non-lawful aliens may be eligible for emergency services and labor and delivery only.

Certification of Head of Household Selection
I have read and have had explained to me the provisions about selecting a head of household. I have selected the following person to be the head of household and I certify that all adult members in my household agree to this selection.

_____

(Head of Household Designee)

Certification of Understanding and Accuracy of Application Answers
I understand the questions on this application and the penalty for hiding or giving false information or breaking any of the rules listed in the penalty warning. I certify, under penalty of perjury, that all my answers are correct and complete including information about the citizenship or alien status of each household member applying for benefits. I understand and agree to provide documents to prove what I have said. I understand and agree that DHSS may contact other persons or organizations to obtain the necessary proof of my eligibility and level of benefits.

I have read, or have had read to me, all statements on this form and the information I give is true and complete to the best of my knowledge. I understand that I could be penalized if I knowingly give false information. I

understand that all information I give is confidential and federal and state laws limit disclosure of information about me.

I agree to allow Delaware Health and Social Services, or its representatives, to act as my agent in recovering money spent by its medical assistance programs when other money from insurance, estates, etc. is available to pay my medical bills.

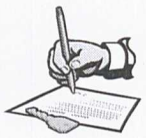
I have a right to request a Fair Hearing if I am not satisfied with any decision made about my eligibility or benefits. An attorney or any other person I choose may represent me.

I have read, or had read to me, and understand the current Rights and Responsibilities. I have received a copy of the Rights and Responsibilities from the DHSS worker.

The person who filled out step 1 should sign this application. If you are an authorized representative, you may sign here as long as you have provided the information required in Appendix C.

Applicant's Signature	Date	Witness
Authorized Representative's Signature	Date	Witness
Spouse/Partner's Signature (Not required for medical assistance)	Date	Witness

For Persons Who Cannot Speak English



Translation services were offered or a family member or other person was present to translate.

Translator's Signature	Date	Phone Number & Agency/Relationship

DELAWARE HEALTH AND SOCIAL SERVICES — APPENDIX A

Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

EMPLOYEE Information

1. Employee name (First, Middle, Last)	2. Employee Social Security number _____ - _____ - _____

EMPLOYER Information

3. Employer name		4. Employer Identification Number (EIN) _____ - _____
5. Employer address		6. Employer phone number ( ) –
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above) ( ) –	12. Email address	

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

☐ **Yes** (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

☐ **No** (Stop here and go to Step 5 in the application)

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15)
☐ No (Stop and return form to employee)

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

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

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

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

b. How often? ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Once a month ☐Quarterly ☐Yearly

Date of change (mm/dd/yyyy): _____

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

EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below matches the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

EMPLOYEE Information

1. Employee name (First, Middle, Last)	2. Employee Social Security number _____-_____-_____

EMPLOYER Information

3. Employer name		4. Employer Identification Number (EIN) _____-_____
5. Employer address		6. Employer phone number ( ) –
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above) ( ) –	12. Email address	

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

☐ **Yes** (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

☐ **No** (Stop here and go to Step 5 in the application)

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15)
☐ No (Stop and return form to employee)

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

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

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $_____
b. How often? ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Once a month ☐Quarterly ☐Yearly

Date of change (mm/dd/yyyy): _____

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

Delaware Health and Social Services (DHSS) **APPENDIX B**

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

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

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

Assistance with Completing this Application

You can choose an authorized representative for

- ❑ Medical Assistance
- ❑ Cash Assistance
- ❑ Child Care
- ❑ Food Benefits
- ❑ EBT Card

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact the Delaware Health and Social Services (DHSS). If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First Name, Middle Name, Last Name, & Suffix)

2. Address		3. Apartment or Suite Number
4. City	5. State	6. Zip Code

7. Phone Number ( ) –

Authorized Representative For My EBT Card

I, _____ want _____

Your Name **Your Representative's Name**

to be my representative to be issued an Electronic Benefit Transfer (EBT) card for my food benefit account and will be able to use it to purchase food. I understand that this gives the representative access to my food benefits and that any benefits spent by the representative will not be replaced.

8. Organization name

9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

10. Your signature

11. Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)

2. First Name, Middle Name, Last Name, & Suffix

3. Organization name

4. ID number (if applicable)