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State/Territory Name: Utah

State Plan Amendment (SPA) #: UT-16-0004-MM

This file contains the following documents in the order listed:

1) Approval Letter
2) Additional Companion Letter
3) CMS 179 Form/Summary Form (with 179-like data)
4) Approved SPA Pages
5) Additional Attachments that are part of the state plan

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Denver Regional Office
1961 Stout Street, Room 08-148
Denver, CO 80294

REGION VIII - DENVER

December 12, 2016

Joseph K. Miner, M.D., MSPH, Executive Director
Utah Department of Health
P.O. Box 141000
Salt Lake City, UT 84114- 1000

RE: Utah #16-0004-MM

Dear Dr. Miner:

Enclosed is an approved copy of Utah's state plan amendment (SPA) 16-0004-MM, which was submitted to CMS on December 23, 2015. SPA 16-0004-MM revises the alternative single streamline paper application to include both hospital and pregnant women presumptive eligibility as well as includes revisions to the paper application for multiple human services programs effective January 1, 2016.

The approval of SPA 16-0004-MM includes full approval of your state's revised alternative single streamlined paper application and paper application for multiple human service programs only. During the course of review of the SPA, CMS has determined that Utah does not have a fully-approvable single, streamlined online application, and is out of compliance with section 1902(a)(19) of the Social Security Act under which the state plan must assure that eligibility for care and services under the plan will be determined and provided in a manner consistent with the simplicity of administration and the best interests of the recipients. CMS requires Utah submit a corrective action plan for completing the required online application changes as outlined in the separate companion letter issued with this SPA approval.

Please be informed this State Plan Amendment was approved December 9, 2016 with an effective date of January 1, 2016. We are enclosing the following:

- Summary Form (similar to the CMS-179)
- Revised S94 template
- Attachment 1 – Alternative single streamlined paper application
- Attachment 2 – Multi-benefit paper application

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 Mandy Strom at mandy.strom@cms.hhs.gov or (303) 844-7068.

Sincerely,

[redacted]

Richard C. Allen
Associate Regional Administrator
Division for Medicaid and Children's Health Operations

cc: Nathan Checketts, Medicaid Director, UT
Jeff Nelson, UT
Craig Devashrayee, UT

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December 12, 2016

Joseph K. Miner, M.D., MSPH, Executive Director
Utah Department of Health
P.O. Box 141000
Salt Lake City, UT 84114- 1000

RE: Utah #16-0004-MM Companion Letter

Dear Dr. Miner:

This letter is being sent as a companion to Centers for Medicare & Medicaid Services (CMS) approval of state plan amendment (SPA) UT 16-0004-MM, which was submitted to CMS on December 23, 2015. Our review of this submission included a review of the state's alternative single streamlined paper and online applications and paper application used to apply for multiple human service programs.

Approval of SPA 16-0004-MM included full approval of the state's revised alternative single streamlined paper application and paper application for multiple human service programs only. During the course of review of the SPA, CMS has determined that Utah does not have a fully-approvable single, streamlined online application, and is out of compliance with section 1902(a)(19) of the Social Security Act under which the state plan must assure that eligibility for care and services under the plan will be determined and provided in a manner consistent with the simplicity of administration and the best interests of the recipients.

As stated in 42 CFR 435.905, the application must be 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, or an alternative single, streamlined application developed by state in accordance with the regulations above, which may be no more burdensome than the streamlined application developed by the Secretary. The state is currently using an alternative single streamlined online application that is not fully dynamic and compliant with 42 CFR Part 435. Requiring applicants to provide information, which is not necessary for determining their eligibility for coverage, is inconsistent with the simplicity of administration of the state plan and is not in the best interests of Medicaid recipients or applicants.

CMS requires Utah to submit a corrective action plan within 90 days of this letter providing a plan and timeline for completing required online application changes. Please submit the corrective action plan to CMS for review no later than March 12, 2017. If the details outlined in

the corrective action plan are satisfactory, CMS may postpone taking any further action. Our goal is to have the state agency come into compliance, and CMS continues to be available to provide technical assistance to Utah in achieving this outcome. If you have any questions about this letter, please contact Mandy Strom at Mandy.Strom@cms.hhs.gov or (303)844-7068.

Sincerely,

[redacted]

Richard C. Allen
Associate Regional Administrator
Division for Medicaid and Children's Health Operations

cc: Nathan Checketts, Medicaid Director, UT
Jeff Nelson, UT
Craig Devashrayee, UT

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: **Utah**

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.

UT-16-0004

Proposed Effective Date

01/01/2016 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

Pub. L. No. 111-148

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2016	$0.00
Second Year	2017	$0.00

Subject of Amendment

Eligibility Process

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:

Signature of State Agency Official

Submitted By:	**Craig Devashrayee**
Last Revision Date:	**Dec 2, 2016**
Submit Date:	**Dec 23, 2015**

Medicaid Eligibility

State Name: Utah

OMB Control Number: 0938-1148

Transmittal Number: UT - 16 - 0004

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	
+	Facsimile	Individuals may complete a paper application form and transmit the form via facsimile machine.	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

Once every 3 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.

Medicaid Eligibility

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.

V.20140415

DWS-ESD 61APP
Rev. ~~5/2015~~

State of Utah
Department of Workforce Services

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

Esta solicitud también se encuentra disponible en Español

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

Check The Services You Are Applying For:

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

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

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

1. Your Information:

Name: _____
First Middle Last

Home Address: _____ City: _____ Zip: _____

Mailing Address (If different from Home Address): _____

City: _____ Zip: _____

Phone #: _____ Other Phone #: _____

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

Primary language spoken in your home? _____

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

Case # (optional): _____ Signature: _____

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

3. Do ALL individuals who are applying for medical benefits have a Utah Medicaid medical card? (This card is used for both Medicaid and PCN) .....☐ Yes ☐ No
If no, who needs a card? _____

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

Your Rights:

- **IF YOU NEED HELP FILLING OUT THIS APPLICATION, WE ARE HAPPY TO HELP.**
- **YOU HAVE THE RIGHT TO AN INTERPRETER AT NO CHARGE.**
- Translation services are available if you require additional assistance during the application process.
- Food Stamps and Medical:
  You can turn in an incomplete application with only your name, address and signature; however, before we can determine your eligibility for benefits, all questions will need to be answered. You can send in your application by: fax: 877-313-4717, mail: PO Box 143245, SLC, UT 84114-3245 or drop off at your local office
  - We will issue your assistance based on the date we receive your application. If your application is received outside business hours (Monday through Friday 8:00 a.m. to 5:00 p.m.) it will be effective the following business day.
- Financial and Child Care:
  - In order to file a Financial assistance application you **must** complete questions **1, 4 – 6, 8 – 30, the Financial Section AND sign page 16.**
  - In order to file a Child Care assistance application you **must** complete questions **1, 4 – 6, 8 –10, 12- 23, 30, the Child Care Section AND sign page 16**.
  - If you **do not** complete all of the required questions for Financial or Child Care, the application for Financial and/or Child Care will be considered incomplete and no action will be taken.

- If eligible for Financial and/or Child Care, benefits are effective the date that we receive the completed application with the exception of the General Assistance financial program where benefits will be effective the first day of the month following the month an application is completed.

Food Stamp, Financial and Medicaid Information for Immigrants:

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

Medical Only Information

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

Expedited Food Stamp Information

The following households are entitled to expedited services:

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

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

HOUSEHOLD AND GENERAL INFORMATION

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

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

[1] Social Security number and Citizenship information are only needed for the people applying for benefits. If someone wants help getting a Social Security number, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778. Social Security number is not required for Child Care.

[2] Utah Resident is optional for all programs

[3] Race (optional): AI = American Indian or Alaska Native (**For medical applicants only, complete Attachment A**)

	GC = Guamanian or Chamorro	ASI = Asian Indian	CH = Chinese	JA = Japanese	KO = Korean
	OPI = Other Pacific Islander	FI = Filipino	VI = Vietnamese	AS = Asian	OA = Other Asian
	BL = Black or African American	SA = Samoan	NH = Native Hawaiian	OT = Other	WH = White
[4] Ethnicity (optional):	N = Not Hispanic , Latino or Spanish Origin	M = Mexican	MA = Mexican American		CH = Chicano/a
	PR = Puerto Rican CU = Cuban	AH = Another Hispanic, Latino or Spanish Origin			OT = Other

[5] Marital Status is not required for Food Stamps

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

If yes, list below:

Name	Relationship to you	Do you purchase and prepare food with this person? (applicable to Food Stamps only)
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

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

Name: _____ Date entered the home: _____

Name: _____ Date entered the home: _____

7. Answering this question is only required for medical assistance:

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

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

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

Relationship:_____		Name: _____ Living with tax filer: ☐ Yes ☐ No
		Name: _____ Living with tax filer: ☐ Yes ☐ No

8. This question is not required for Food Stamps:
Is anyone who is applying for benefitscurrently pregnant or has anyone been pregnant in the last 3 months? ..... ☐ Yes ☐ No

If yes, who?_____

Due date (if still pregnant): _____

How many babies are expected during this pregnancy? _____

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

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

Who? _____ Name of institution: _____
Date entered the institution: _____ Anticipated release date (if known)_____

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

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

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

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

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

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

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

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

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

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

If applying for Medical Assistance and you are an American Indian or Alaska Native, please complete Attachment A as this can help you receive better benefits.

This question is not required for Food Stamps or Child Care:
Is anyone listed in question #12 a Veteran, an active-duty member of the U.S. Military or has a

spouse or parent who is a Veteran or an active-duty member of the U.S. Military?..... ☐ Yes ☐ No
If yes, who? _____

13. Is anyone in your household attending school? ..... ☐ Yes ☐ No
If yes, complete all columns:

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

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

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

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

INCOME

17. Does anyone in your household have earned income? ..... ☐ Yes ☐ No
If yes, complete all columns:

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

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

18. Is anyone in your household self-employed? ..... ☐ Yes ☐ No
If yes, complete all columns:

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

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

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

19. Does anyone in your household expect any changes in earnings or in the number of hours worked? ☐ Yes ☐ No
If yes, who? _____ Explain change(s):_____

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

If yes, complete the following information:

If left a job:

Name: _____ Name of employer: _____

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

Reason the job ended: _____ Do you need child care to job search?* ☐ Yes ☐ No

**This question is only for Child Care assistance*

If reduced work hours:

Name: _____ Name of employer: _____

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

Reason hours reduced: _____

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

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

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

If yes, complete all columns:

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

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

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

Type	Amount	Who Pays This	How Often Paid?	Date Expense Started

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

If yes, complete all columns:

	Type	Recipient's Name	Gross (Before Deductions) Amount Received	How Often Paid? (ex: weekly, monthly)	Date Income Started
☐	Social Security				
☐	SSI				
☐	Child Support received directly from parent or another state				
☐	Child Support received through ORS				
☐	Unemployment State:				
☐	Money received from family, friends or church From who?				
☐	Retirement				
☐	Pension				

☐	Alimony				
☐	Veteran's Benefits				
☐	Workers Compensation				
☐	Tribal Income				
☐	Lump Sum Payments				
☐	Other income (ex: Adoption, Mineral Rights, Rental, Royalty, Child and Adult Care Food Program payments etc.): _____				

Other than taxes, are any deductions being withheld from anyone's income listed? ..... ☐ Yes ☐ No
If yes, complete the following information:

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

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

ASSETS*

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

24. Does anyone in your household have cash on hand? ..... ☐ Yes ☐ No
If yes, who? _____ Amount: $_____

25. Does anyone in your household have financial accounts? ..... ☐ Yes ☐ No
If yes, list all accounts owned by you or anyone applying with you. Some examples of financial accounts are Checking, Savings, 401K*, IRA*, Annuities, Money Market, Stocks/Bonds/Mutual Funds, etc.
** Not Required for Food Stamps*

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

26. Does anyone in your household have any vehicles? ..... ☐ Yes ☐ No
If yes, complete all columns. Some examples of vehicles are cars, trucks, boats or water craft, motorcycles, snowmobiles, motor homes, ATV's, etc.

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

27. Does anyone in your household have any of the following property assets? ..... ☐ Yes ☐ No
If yes, complete all columns:

	Type	Who Owns This?	Fair Market Value	Amount Owed	Date Acquired
☐	Home you live in				
☐	Land				

☐	Rental Home				
☐	Vacation Home/Time Share				
☐	Equipment/Tools				
☐	Machinery				
☐	Trailers				
☐	Livestock				
☐	Mineral/Other Rights				
☐	Other:				

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

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

If yes, who? _____

29. This question is not required for medical assistance:

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

If yes, explain: _____

EXPENSES*

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

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

If yes, complete all columns:

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

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

If yes, complete all columns:

	Type	**Amount Paid**	**Your Portion** (not required for medical assistance)	**Who Pays This Expense?**	**Does This Person Live in Your Home?**	**How Often Paid?**	**Date This Started**
☐	Rent, Subsidized Rent, Rental Insurance				☐ Yes ☐ No		
☐	Mortgage, Second Mortgage, Home Equity Loan, Property Taxes				☐ Yes ☐ No		
☐	Home Owners Insurance, HOA,				☐ Yes ☐ No		

	Condo Fees						
☐	Trailer/Lot Space				☐ Yes ☐ No		

This question is not required for medical assistance:
Is someone else helping you pay this expense (family member, organization, state agency, etc.)?.... ☐ Yes ☐ No
If yes, who? _____ Monthly Amount: $ _____

32. Is anyone in your household responsible to pay any of the following utility expenses separately from rent and/or mortgage? ..... ☐ Yes ☐ No
If yes, mark all that apply:

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

33. Does anyone in your household who is at least 60 years old, or disabled have any medical expenses?..... ☐ Yes ☐ No
(Expenses must be reported and some expenses must be verified by your household to receive a deduction.)
If yes, complete all columns:

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

FINANCIAL ASSISTANCE SECTION

34. Has anyone in your household been disqualified in any state from the TANF (Financial) program for a program violation? ..... ☐ Yes ☐ No
If yes, who? _____ State: _____

35. Has anyone in your household received out-of-state TANF months? ..... ☐ Yes ☐ No
If yes, who? _____ State(s):_____ Number of months: _____

36. Are any children in your household home-schooled? ..... ☐ Yes ☐ No
If yes, who? _____ Is this school district approved? ..... ☐ Yes ☐ No

37. Do you have rent that is subsidized by any federal, state, or local government agency, including a private social service agency? ..... ☐ Yes ☐ No
If yes, select one: ☐ Public Housing Agency ☐ Other Agency:

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

If yes, who? _____

39. Does any child who is applying for coverage have a parent living outside the home? ..... ☐ Yes ☐ No
If yes, are you willing to cooperate with the Office of Recovery Services (ORS) regarding establishment or collection of Child Support from an absent parent? ..... ☐ Yes ☐ No
List the name of the absent parent(s) and the name of the child(ren) of the absent parent.
Absent Parent Name: _____ Child(ren) of Absent Parent: _____
Reason for Absence:
☐ Single Parent Adoption ☐ Divorced ☐ Separated ☐ Legally Separated
☐ Incarceration ☐ Death ☐ Other: _____
Absent Parent Name: _____ Child(ren) of Absent Parent: _____
Reason for Absence:
☐ Single Parent Adoption ☐ Divorced ☐ Separated ☐ Legally Separated
☐ Incarceration ☐ Death ☐ Other: _____

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

41. Do you or anyone in your household currently live in a treatment or substance abuse facility? (i.e mental or drug) ..... ☐ Yes ☐ No
If yes, who? _____ Name of Facility:_____

CHILD CARE SECTION

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

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

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

45. Do you consider yourself homeless? ..... ☐ Yes ☐ No
(Some examples of homelessness are: living in a motel, hotel, camping grounds, or not having a fixed, regular, and adequate nighttime residence.)

46. Have you selected a provider? ..... ☐ Yes ☐ No
**If you have not selected a child care provider, you can go to careaboutchildcare.utah.gov to search online for licensed providers in your area.*

- Has your selected provider agreed to care for your child(ren)? ..... ☐ Yes ☐ No
  - If yes, complete the information below on the child care provider
  - If no, contact your provider to obtain the information.

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

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

Do you expect the monthly charge for child care to change? ..... ☐ Yes ☐ No
If yes, include the expected date the provider charge will change and explain why. If the change is temporary, include the expected end date: _____

Compare your work and training schedule with the hours your provider is open. This will help you know how many weekly hours you need for child care coverage. Only provide us with the number of hours you work and your child care provider is available to care for your child.

47. Is child care needed when a parent works? ..... ☐ Yes ☐ No
If yes, how many weekly hours of child care do you need while you work?

Parent Name: _____ Weekly Hours: _____
Parent Name: _____ Weekly Hours: _____

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

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

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

Parent Name: _____ Hours: _____

Parent Name: _____ Hours: _____

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

Parent Name: _____ School Name: _____ Type of Training/degree: _____

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

Parent Name: _____ School Name: _____ Type of Training/degree: _____

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

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

If yes, who? _____

FOOD STAMP SECTION

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

If yes, who? _____ State: _____

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

If yes, who? _____

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

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

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

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

If yes, explain: _____

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

If yes, who? _____

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

If yes, who? _____

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

If yes, explain: _____

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

If yes, who? _____

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

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

Who? _____ What activities are required? _____

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

If yes, who? _____ Which program? _____

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

If yes, who? _____ Which program? _____

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

If yes, who? _____

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

If yes, who? _____

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

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

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

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

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

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

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

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

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

MEDICAL SECTION

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

72. Is anyone who is applying for coverage enrolled in or eligible for COBRA coverage or continued health insurance through an employer? ..... ☐ Yes ☐ No
If yes completed question 73 below (Do not list Medicaid, Medicare, CHIP, or PCN)

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

74. Does anyone in your household currently have health insurance (Veterans, Tricare, or Peace Corps), have insurance available but not enrolled, or has had insurance in the past 6 months?..... ☐ Yes ☐ No

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

Insurance 1: ☐ Enrolled
☐ Not Enrolled, but available If you checked that your insurance status is "Not enrolled, but available" and this insurance is offered through your job or someone else's job such as a parent or spouse, complete Attachment C)
☐ Date Ended: _____

Name(s) of individual(s) covered: _____
Name of insurance company: _____ Phone #: _____
Address of insurance company: _____ Group #: _____
Policyholder name: _____ Policy #: _____
Policyholder birth date: _____ Policyholder SS#: _____
If insurance is through an employer, list employer's name and phone #:

_____

_____ Coverage: ☐ Limited ☐ Comprehensive

Is this insurance through the Federally Facilitated Marketplace (FFM)? ☐ Yes ☐ No

Insurance 2: ☐ Enrolled
☐ Not Enrolled, but available (Complete Attachment C)
☐ Date Ended: _____

Name(s) of individual(s) covered: _____
Name of insurance company: _____ Phone #: _____
Address of insurance company: _____ Group #: _____
Policyholder name: _____ Policy #: _____
Policyholder birth date: _____ Policyholder SS#: _____
If insurance is through an employer, list employer's name and phone #:
Is this insurance through the Federally Facilitated Marketplace (FFM)? ☐ Yes ☐ No

_____ Coverage: ☐ Limited ☐ Comprehensive

74. Does who is applying for coverage currently have Medicaid, CHIP or Medicare? If yes, check the type of coverage and write the person(s) name(s) next to the coverage they have.

☐ Medicaid: _____
☐ CHIP: _____
☐ Medicare: _____

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

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

77. Does who is applying for coverage have a major medical need? ..... ☐ Yes ☐ No
(This includes cancer/kidney disease/heart disease etc. Answering this question may get you extra help.)
If yes, who? _____ What is the medical need? _____

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

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

80. Was anyone who is applying for coverage in forster care on or after his/her 18th birthday?..... ☐ Yes ☐ No
If yes, who? _____
Did they receive Medicaid at that time?..... ☐ Yes ☐ No

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

☐ Alimony: _____ _____ _____
☐ Student Loan Interest: $ _____ Who? _____ How often? _____
☐ Other Deductions Type:_____ $ _____ Who? _____ How often? _____

82. Deductions: Do you have pre-tax dedctions taken out of your paycheck such as health insurance premiums and 401K contributions?..... ☐ Yes ☐ No
If yes complete the section below:
☐ Health Insurance Premium: _____ _____ _____
☐ 401K Contribution: $ _____ Who? _____ How often? _____
☐ Other Pre-tax Deductions Type:_____ $ _____ Who? _____ How often? _____

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

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

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

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

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

85. What is your email address? _____

SIGNATURE SECTION

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

represented by the signature on this document. Providing a Social Security number and information pertaining to immigration or alien status is voluntary; however any person who wants assistance but does not provide such information may not be eligible for benefits. Failure to provide this information will not subject the applicant to criminal charges.

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

SIGNATURE (check one) ☐ Applicant ☐ Authorized Representative _____ Date

_____
Birth Date of Authorized Representative (Food Stamps only)

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

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

Name(s) of authorized representative: _____

Phone number: _____ Address: _____

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

Does someone have legal power of attorney for anyone in your household? ..... ☐ Yes ☐ No
If yes, who? _____

Medical Representatives
Would you like to grant an authorized representative access to your case? ..... ☐ Yes ☐ No
If yes, complete Attachment D

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

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

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

Organization name: _____

ID number (if applicable): _____

Voter Registration Information

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

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

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

- If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with Lt. Governor, State of Utah, 203 State Capitol Building, Salt Lake City, UT, 84114.

Medical Only

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

Yes, renew my eligibility automatically for the next:

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

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

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

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ATTACHMENT A
AMERICAN INDIAN/ALASKA NATIVE HOUSEHOLD MEMBER INFORMATION

(Required only for Medical Assistance)

Case Name: _____ Case #: _____

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

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

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special month enrollment periods.

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

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

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DWS-ESD 741
10/2013

ATTACHMENT B
TAX DEPENDENTS NOT LIVING WITH YOU

(Required only for Medical Assistance)

Case Name: _____ Case #: _____

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

1. Name: _____
First Middle Last

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13. Yearly Income: Complete only if your dependent's income changes from month to month.
Total income THIS year: $ _____ Total income NEXT year: $ _____

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DOH Form 116M
05/2014

ATTACHMENT C
EMPLOYER'S HEALTH INSURANCE INFORMATION

Case Name: _____ Case #: _____

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

A. General Information

Employee Information

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

Employer Information

Employer Name: _____

EIN: _____ Phone #: _____

Address: _____
Street Apt.# City State Zip

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

Contact Name: _____

Phone #: _____ Email address: _____

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. When will/did coverage begin? (mm/dd/yy) _____

3. When does the company's next open enrollment begin? (mm/dd/yy)
_____

4. Complete the chart below. **Do not** include the cost of dental, vision or other coverage if it is separate.

	Monthly Premium

	Employee's Portion	Company's Portion
Employee	$	$
Employee + spouse	$	
Employee + child	$	
Family	$	

Yearly Health Plan Deductible	
Individual amount	$
Family amount	$

C. Employee's Health Plan Choice

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

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

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

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

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

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

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

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

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

Yearly Health Plan Deductible	
Individual amount	$
Family amount	$

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

D. Signature

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

Signature: _____ Date: _____

Name (please print): _____

Title: _____ Phone: _____

Please return completed form to:

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

Equal Opportunity Employer Program

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

DWS-ESD 114AR
Rev. ~~07/2013~~

ATTACHMENT D
AUTHORIZATION TO DISCLOSE MEDICAL ELIGIBILITY INFORMATION

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

I _____ hereby give
(Customer or Authorized Representative)

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

(check only one box)

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

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

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

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

_____
Address and Phone Number of Authorized Representative

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

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

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

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

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

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

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

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

_____

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

General Information

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

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

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

You can send in your verifications by:

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

You may contact us by phone, 801-526-0950 or 1-866-435-7414 (toll free).

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

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

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

If You Are Approved
You will receive your Financial and/or Food Stamp benefits on a Utah Horizon Card.
Your medical card(s) will be mailed at initial program approval, upon request and every 36 months.
Child Care benefits will be paid directly to the provider(s) you have selected.

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

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

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

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

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

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

Food Stamp Program

When Food Stamps are Available

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

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

Using your EBT Card for Food Stamps

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

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

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

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

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

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

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

Do not trade or sell your food stamps or EBT card.

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

Reporting Changes

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

Financial Programs

Financial Information

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

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

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

Financial Participation

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

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

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

- Social Security benefits
- Unemployment Compensation
- Veteran's benefits
- Workman's Compensation
- Insurance settlements
- Financial assistance programs from American Indian Tribes
    - Temporary Assistance for Needy Families (TANF) program is available in Utah through the Navajo Nation Tribal TANF Program. If you are an enrolled member of one of these tribes or live within the boundaries of the tribal program, you may be eligible for financial benefits through the tribal TANF program.
    - The Bureau of Indian Affairs administers a General Assistance financial program that may be offered through a local Indian tribe.

How To Use Your Financial Benefits

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

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

Purchasing Items

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

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

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

Financial – Families with Children

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

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

Family Programs & Child Support

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

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

Financial – Without Children

General Assistance Program

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

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

Refugee Cash Assistance

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

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

Child Care Programs

Child Care Information

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

- You will have to pay a co-payment based on your household size and income. DWS determines the amount of subsidy you are eligible for and the amount of your co-payment.
- Since providers may charge more than the subsidy rate, you may have additional out-of-pocket expenses you owe to your provider above the co-payment. You are responsible to pay your provider the difference between what they charge you and what DWS pays.
    - For example:
        - Your provider charges $530 per month for services.
        - DWS determines that you are eligible for $510 minus a $77 co-payment. The subsidy amount DWS pays to your provider is
        - $433. ($510-$77=$433)
        - You pay your co-payment of $77 plus an additional $20 charged by the provider. ($530-$433=$97)

- The total cost you owe to your provider is $97.

Households earning at or less than 100% of the federal poverty limit are not subject to the co-payment requirements. However, these families may still have out-of-pocket expenses that they are responsible to pay to their provider.

- If you are using more than one provider, there is no guarantee more than one provider will receive a payment.
  - Once approved for Child Care, the payment will be paid directly to the provider you have selected.

Eligibility for Child Care Assistance

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

- Working parents must be earning minimum wage for the number of hours they work.
- A single parent must be working an average of 15 hours per week.
- In a two-parent family: one parent must work an average of 15 hours per week, and the other parent must work an average of 30 hours per week.
- Child Care may also be approved for training if the parent(s) meet the minimum work requirements and can complete the training within 24 months. Post graduate work, or obtaining a second degree is not supported.
- Self-employed parents must have been self-employed for at least three months. Expenses can be deducted from the gross income. The net income must equal minimum wage for the number of hours working each month.

Selecting a Child Care Provider

You have the right to select the type of child care provider which best meets your family needs.

- Go to careaboutchildcare.utah.gov to search online for providers in your area and learn more about child care and what to look for in a child care setting.
- You may also contact your local Care About Childcare agency for help finding a provider.
  - Call the Child Care Professional Development Institute toll free at 855-531-2468 to find your local Care About Childcare agency.
- Report your selection of a child care provider if you have already met with the provider, have negotiated a start date and provider charge. There may be a delay in processing your application if you have not selected a child care provider at the time you apply.
- If you have not selected a child care provider, changes may be reported on jobs.utah.gov/mycase or by contacting the Eligibility Service Center, 801-526-0950 or 1-866-435-7414 (toll free).

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

- They must apply with Child Care Licensing (CCL) to become a DWS-FFN approved provider prior to any Child Care assistance being approved.
- Your provider may submit an application online at childcarelicensing.utah.gov or call 800-883-9375 to apply.
- If your FFN provider has not completed the application process, an information notice will be sent to you to give to your provider. Your Child Care application will start the day your FFN provider becomes approved.
- Your provider and their household members age 12 and older must pass a criminal background check and complete all Health and Safety requirements administered by Child Care Licensing.
- If you select a provider who lives with you an exemption will be considered only if a child in the home has special needs.
- If you have selected a provider who is currently DWS FFN Approved, make sure your provider contacts CCL to report they will be providing care for your children. They will need your DWS case number. They are limited to the number of children they may provide care for. If they are over the limit, you may need to choose another provider.

Provider Payments

Payments will be made directly to your chosen provider each month. Your provider will receive the child care payment by either direct deposit to a financial institution of their choice or by check.

- Your provider will need to contact the Office of Child Care at occ@utah.gov to set up an account in the DWS Provider Portal for direct deposit.

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

Job Search Child Care Assistance

Up to two additional months of Child Care assistance will be available for eligible parents to look for a new job while their children can remain in a stable child care setting. Job Search resources are also available from the Office of Child Care for those who request it.

Eligibility Requirements:

- Must have received Employment Support or Transitional Child Care in the month of job loss.
- Must have been working at least 32 hours per week and have a complete loss of employment.
- Be a single parent head of household.

- Report the job loss within 10 days of the job ending to DWS and request Job Search Child Care. Changes may be reported on jobs.utah.gov/mycase or by contacting the Eligibility Service Center, 801-526-0950 or 1-866-435-7414 (toll free).
- Meet all other Child Care program eligibility requirements.

Job Search Child Care is limited to one time in a 12-month period. Job termination must be verified to receive a second month of Job Search Child Care. The number of hours approved for job search will match the hours approved for the last month of employment.

Other Information

UTA Discount Bus Passes

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

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

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

Helpful Websites for Other Services

General

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

Food Assistance

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

Financial

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

Child Care

- For more information: jobs.utah.gov/occ/index.html
- Search for quality child care: http://careaboutchildcare.utah.gov

RIGHTS AND RESPONSIBILITIES

YOUR RIGHTS

- You have the right to an interpreter. Free language assistance services are available to you. Please call 1-801-526-0950 or see below:
  - **Spanish**
    ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-801-526-0950.
  - **Chinese**
    注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-801-526-0950。
  - **Vietnamese**
    CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-801-526-0950.
  - **Korean**
    주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-801-526-0950 번으로 전화해 주십시오
  - **Navajo**
    Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-801-526-0950.
  - **Nepali**
    ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-801-526-0950 ।
  - **Tongan**
    FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea teke lava 'o ma'u ia. Telefoni mai 1-801-526-0950.

- **Serbo-Croation**
  OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-801-526-0950.
- **Tagalog**
  PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-801-526-0950.
- **German**
  ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-801-526-0950.
- **Russian**
  ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-801-526-0950.
- **Cambodian**
  ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-801-526-0950។
- **French**
  ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-801-526-0950.
- **Japanese**
  注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-801-526-0950。
- **Arabic**
  لحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-801-526-0950 .

- You have the right to be treated fairly and with courtesy, dignity, and respect.
- Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA, DWS or DOH through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).
- For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call 1-866-526-3663 or 1-800-371-7897; found online at http://www.fns.usda.gov/snap/contact_info/hotlines.htm.
- USDA is an equal opportunity provider and employer.
- In accordance with Federal law and U.S. Department of Health and Human Services (DHHS) regulations, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. To file a complaint of discrimination, visit www.hhs.gov/ocr/office/file or contact the DHHS Office for Civil Rights at 999 18th Street, South Terrace, Suite 417, Denver, Colorado, 80202 or 303-844-2024, 303-844-3439 (TDD).
- Title VI of the Civil Rights Acts of 1964 allows us to ask for racial/ethnic information. You do not have to give us racial/ethnic information. If you do not want to give us this information, it will have no effect on your case. If you do not give us the information, the worker will enter an answer. This information is collected to ensure program benefits are issued without regard to race, color, or national origin.
- You have the right to apply or reapply any time for any of the assistance programs offered by the Department of Workforce Services (DWS). Applications for CHIP, the Primary Care Network program (PCN), and UPP are only accepted during open enrollment periods.
- You have the right to know if your application was approved or denied and the reasons for the decision.
  - For Food Stamps - benefits must be available to eligible household members no later than 30 days from the date of application.
  - For Medicaid, Financial and Child Care assistance, a decision will be provided within 30 days. If a disability decision is required for Medicaid approval may take up to 90 days.
  - For PCN/UPP/CHIP, a decision will be provided within 30 days.
  - Your application will be considered for all programs selected. You may receive separate approval and/or denial notices based on the individual program rules on your application.
- You have the right to know if your assistance is reduced or ended. For Food Stamp benefits, there is one important exception to this rule. You will not receive advance notice of a Food Stamp benefit decrease if approved for Financial assistance.

- If you received payments under a long-term care partnership insurance plan, some assets may not count to decide yor eligibility. In this case, the State will not recover medical costs from those assets after your death.
- If you are in an institution and apply for Food Stamps and SSI at the same time, the filing date for Food Stamps will be the date of release from the institution.
- You have several options if you do not agree with the decisions made regarding your case, you may:
  - Talk to your worker to make sure you are not misunderstanding each other.

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

- You have the right to privacy in your home. DWS may not enter your home without your permission or use coercion or force to enter your home. DWS may not visit you after working hours without an appointment.
- The Department of Workforce Services may contact you, or have someone contact you, about the effectiveness of services you received.
- You have the right to access your case record information.
- You have the right to receive information regarding registering to vote and may request help to complete the voter registration form.
- The information you provide on your application may be disclosed to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law.
- When your income has increased enough that you no longer get Financial assistance, you may continue to get medical assistance, Food Stamps, and Child Care if you meet certain requirements. Ask your employment counselor for more information.
- In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.
- Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.
- To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:
  - Mail: U.S. Department of Agriculture
    Office of the Assistant Secretary for Civil Rights
    1400 Independence Avenue, SW
    Washington, D.C. 20250-9410
  - Fax: (202) 690-7442; or
  - Email: program.intake@usda.gov.
- This institution is an equal opportunity provider.

YOUR RESPONSIBILITIES

- Medical assistance (Medicaid, CHIP, UPP, PCN) recipients are automatically enrolled in the Utah Clinical Health Information Exchange (cHIE). For more information or to opt out of cHIE participation, visit www.mychie.org or contact your health care provider.
- You must report changes that affect your eligibility for assistance programs. Your worker will provide you specific information on changes you must report when your application is approved.
- You must provide the Social Security number for each household member requesting assistance, with the exception of Child Care, CHIP and Emergency Medicaid. If you do not have a number, you must provide proof of applying for a number. You can receive assistance while you are waiting to receive a number.
- You must cooperate with any review of your case by Quality Control and/or DWS.

- You must provide the information necessary to prove you are eligible for assistance. If you do not understand what is required, or if you cannot give the necessary information, please let your worker know.
- You must report to us if you are fleeing the law to avoid prosecution, being taken in to custody, or going to jail for a felony crime, or violating conditions of probation or parole.
- Participation in Food Stamp Employment & Training Activities: Once you are approved, you may be required to participate in employment and training activities to keep getting Food Stamp benefits. You may be required to:
  - Register for work
  - Complete required workshops
  - Complete job search activities
- If you are required to participate in additional activities, you will receive a notice.
- If you fail to participate in Employment & Training activities, you will be disqualified from getting Food Stamp benefits for a minimum of one month for the first occurrence, three months for the second occurrence and six months for subsequent occurrences. You must serve your sanction period (one, three or six months) unless you meet an exemption or have good cause. Once your sanction period is over, you may be eligible for Food Stamp benefits if you agree to participate in Employment & Training activities or you are exempt from participation.
- You are exempt from Employment & Training activities if you meet any of the following:
  - Age 60 or older
  - Younger than age 16
  - Age 16 or 17 attending school at least half time
  - Age 16 or 17 enrolled in school
  - Age 16 or 17 and not named as head of household
  - Physically or mentally unfit for employment
  - Receiving Financial for families with children
  - Receiving a Financial diversion payment
  - Responsible for the care of a dependent child under age 6
  - Responsible for the care of an incapacitated person
  - Receiving Unemployment Insurance or applying/awaiting a decision
  - Participating regularly in a drug and alcohol treatment program
  - Working at least 30 hours per week OR earning at least Federal Minimum wage times 30 hours per week.
  - Student enrolled at least half time and meet student eligibility requirements
  - Participating in refugee employment services
- You may be sanctioned from receiving Food Stamp benefits if you do any of the following within 30 days of your application or while receiving Food Stamp benefits:
  - Voluntarily quit a job working 30 hours or more per week while earning minimum wage
  - Voluntarily reducing your work hours
- The sanction period is one month for the first occurrence, three months for the second occurrence and six months for subsequent occurrences. You must serve your sanction period (one, three or six months) unless you meet an exemption or have good cause.
- Able-Bodied Adults Without Dependents: Able-bodied adults are healthy, have not had a doctor diagnose a disability and do not have dependent children living in their home. The Food Stamp program allows able-bodied adults without dependent children to receive Food Stamp benefits for 3 months in a 36 month period without participating in an able-bodied employment or training activity. After the initial three months, an able-bodied adult must meet one of the following in order to remain Food Stamp eligible:
  - Work 20 hours a week
  - Attend training at least part-time
- If you receive medical assistance, you must tell DWS, if you have health insurance. You may be required to enroll in a medical health plan.
- If you are approved for Financial assistance, you will need to sign over to the Office of Recovery Services any child support, medical support, or alimony you would have received on behalf of your household during the time you are getting assistance. Child support and alimony will be used to offset the costs of providing Financial assistance for your household.
- To receive Financial assistance through the "Family Employment Program", you must cooperate with Office of Recovery Services in obtaining child and/or medical support, unless you have "good cause" not to cooperate.
- You may be eligible to claim "good cause" NOT to cooperate with Office of Recovery Services. Good cause for not cooperating includes:
  - The child for whom support is sought was conceived as a result of incest or rape.
  - Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction, or a public or licensed private social agency is helping the individual resolve the issue of whether to keep or relinquish the child for adoption and the discussions have not gone on for more than three months.
  - Cooperation in establishing paternity or securing support is reasonably expected to result in physical or emotional harm to you or your child(ren).The source of physical or emotional harm may be from individuals other than the absent parent.

- If you do not have evidence to support your good cause claim, you may request a fair hearing and your sworn testing may be accepted as evidence to support good cause.

- If you do not cooperate with Office of Recovery Services or have good cause to not cooperate, your family will not be eligible for ongoing Financial assistance.
- Parents have the responsibility to support their minor children until they are emancipated by turning age 18, married, or otherwise directed by court order. Parents who receive Financial or medical are required to cooperate with child and medical support orders and collections, unless you can provide good cause for not cooperating.
- If the Utah Department of Health (UDOH) pays for your medical care, you assign to it your rights to payments from any third party and to benefits for medical services. You will give to the UDOH any money you collect from an insurance policy, legal settlement or from someone required to pay for your medical expenses. You authorize payment directly to the UDOH or the Office of Recovery Services and will hold harmless any party making payment to them. You agree to cooperate with the State of Utah to pursue any third party responsible for medical expenses.
- You authorize any person or organization to release medical records or information about your health or the health of your dependents to the UDOH, Division of Health Care Financing or designee. The UDOH and the Department of Workforce Services may give health care providers information about your eligibility for medical assistance.
- In the event of my death and my spouse's death, the state has the right to recover from my estate all money spent to pay my medical bills if I receive PCN and/or Medicaid at any time while I am 55 years of age or older. The state does not have the right to recover from my estate those costs paid as a benefit of eligibility for a Medicare cost-sharing program (QMB, SLMB, or QI).
- You agree that the assistance you receive under any medical program is limited to that described in the Provider Manuals that the Utah Department of Health has written. You understand that the benefits you are eligible to receive may be changed without your knowledge or consent. You further agree to be responsible for any co-pays to providers at the time of medical service unless you are exempt from those co-pays.
- Children enrolled in Medicaid are automatically enrolled in the Utah Statewide Immunization Information System (USIIS). If you do not want your children enrolled in this system, you must call the USIIS HelpLine at (801) 538-6872 or the Immunization Hotline at (800) 275-0659.
- If you receive benefits for which you are not eligible, you must pay them back.
- If you choose a license-exempt child care provider, the State of Utah does not regulate or monitor the child care. We can give you more information about how to choose a quality child care provider.

VERIFICATION OF INFORMATION

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

OBEY PROGRAM RULES

- All the members of your household must obey the program rules and provide complete and accurate information. Do not provide false information in order to receive benefits. Do not give Food Stamp benefits to anyone who has no right to use them or purchase ineligible items. Do not use other individuals' Food Stamp benefits unless you are the authorized representative.
- Do not trade or sell an EBT card. Do not use Food Stamp benefits to buy nonfood items, such as alcohol, cigarettes, or to pay on credit accounts. Using Food Stamp benefits to purchase food on credit could result in a disqualification.
- **If you break any of these rules, you may be disqualified from receiving Food Stamp benefits, Child Care or Financial assistance.**
  - **The first time you violate a rule, you may not be eligible for these benefits for 12 months.**
  - **The second rule violation may result in a 24 month disqualification.**
  - **The third time, you may be ineligible permanently for Food Stamp, Child Care or Financial program benefits. You may also be prosecuted under other laws.**
  - **There may also be a fine up to $250,000 or a jail sentence up to 20 years.**
  - **The court may also order an additional 18 months of Food Stamp ineligibility if convicted of a felony or misdemeanor related to inappropriate use of Food Stamp benefits.**

- **If a court of law finds you guilty of using or receiving benefits in a transaction involving the sale of a controlled substance, you will not be eligible for benefits for two years for the first offense, and permanently for the second offense.**
- **If a court of law finds you guilty of having used or received benefits in a transaction involving the sale of firearms, ammunition or explosives, you will be permanently ineligible to participate in the Program upon the first occasion of such violation.**
- **If a court of law finds you guilty of having trafficked benefits for an aggregate amount of $500 or more, you will be permanently ineligible to participate in the Program upon the first occasion of such violation.**
- **If you are found to have made a fraudulent statement or representation with respect to the identity or place of residence in order to receive multiple Food Stamp benefits simultaneously, you will be ineligible to participate in the Program for a period of 10 years.**

- Knowingly providing false information or fraudulent participation in any program may result in criminal or civil action and/or administrative claims.
- If you sell food you purchased with your Food Stamp benefits, you will be disqualified from the Food Stamp program for 12 months for the first offense, 24 months for the second offense, and permanently for any additional offenses.
- You will be disqualified for Food Stamps, Financial and Child Care programs for 10 years each for the first and second offenses if you make a fraudulent statement regarding your identity and residence to get multiple benefits. The third offense will result in permanent disqualification.
- An EBT card cannot be used to access cash benefits at a Point-of-Sale or ATM machine in an establishment that primarily sells liquor, allows gambling or gaming, or provides adult-oriented entertainment where performers disrobe or perform unclothed.
- A customer who accesses FEP cash benefits at one of the above establishments may be disqualified from Family Employment Programs for 12 months for an intentional program violation.

Equal Opportunity Employer/Program

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

Please tear this page off and keep it for your information.

UTAH DEPARTMENT OF HEALTH MEDICAID

APPLICATION INFORMATION

CHIP | PCN | UPP | MEDICAID | HPE | BYB | PRIVATE HEALTH INSURANCE | APTC

WHAT AM I APPLYING FOR?

Health coverage is important for you and your family to get the medical care you need. When you submit this application, you will be considered for all medical programs that are now open for enrollment, including:

- **CHIP (Children's Health Insurance Program)**
  Provides medical and dental insurance for uninsured children in families who qualify based on family size and income. For more information, visit: www.health.utah.gov/chip
- **PCN (Primary Care Network)**
  Provides primary preventive health coverage for uninsured adults who qualify based on family size and income. For more information, visit: www.health.utah.gov/pcn
- **UPP (Utah's Premium Partnership for Health Insurance)**
  Provides a monthly premium reimbursement when a previously uninsured individual or family enrolls in their employer's health plan or COBRA. For more information, visit: www.health.utah.gov/upp
- **Medicaid**
  Provides medical benefits for low-income families, children, pregnant women, and disabled, blind and elderly individuals. For more information, visit: medicaid.utah.gov
- **HPE (Hospital Presumptive Eligibility)**
  Provides temporary Medicaid coverage for parents/caretaker relatives, children, pregnant women, and former foster care individuals who qualify based on preliminary information.
- **BYB (Baby Your Baby)**
  Provides temporary Medicaid coverage for pregnant women who qualify based on preliminary information. For more information, visit: www.babyyourbaby.org
- **Private Health Insurance**
  Provides comprehensive coverage to help you stay well. This is offered through the Federally Facilitated Marketplace (FFM). For more information, visit: www.healthcare.gov
- **APTC (Advanced Premium Tax Credit)**
  This is a tax credit that can immediately help pay your premiums for health coverage in the Federally Facilitated Marketplace (FFM). For more information, visit: www.healthcare.gov

WHAT DO I NEED TO DO NEXT?

On your application, tell us about all of your family members who live with you. You can apply for and get benefits for eligible family members, even if your family includes other members who are not eligible because of their immigration status. For example, U.S. citizens or legal immigrant children may qualify for benefits even though their parents may not qualify. If you file taxes, we need you to tell us about everyone on your tax return. *(Note: You don't need to file taxes to get health coverage.)* The program you qualify for depends on the number of people in your family and their income. This information helps us make sure everyone gets the best health coverage.

See back of this cover sheet for more instructions.

WHAT DO I NEED TO DO NEXT? (CONT.)

Follow the instructions below based on the program(s) that you are applying for:

CHIP, PCN, UPP, Medicaid, Private Health Insurance, and/or APTC

- You may apply online at jobs.utah.gov/mycase OR fill out this application and return it to:

  Department of Workforce Services
  PO Box 143245
  SLC, UT 84114-3245
  Fax: 1-801-526-9505
  Toll-free Fax: 1-888-522-9505

- Skip page 8 of the application if you are NOT applying for Hospital Presumptive Eligibility or Baby Your Baby.

- You may be asked to have your employer fill out the "Employer's Health Insurance Form" (Attachment C). Please keep this form in case you are asked to do so.

- If more information is needed to determine your eligibility for benefits, an eligibility worker from DWS will contact you. If you have not heard from DWS within 10 days, please call toll-free 1-866-435-7414.

HPE or BYB

- We can best determine your eligibility if all questions are answered. However, for HPE and BYB, at a minimum you must fill out the questions on the four pages listed below.

  Page 1 Section A: Name, Address, Phone#
  Section B: Question 1 Only
  Page 2 Section C: Questions 1, 6, and 9
  (For BYB, question 6 is not required.)
  Page 8 Section K: All Questions
  (For BYB, question 6 is not required.)
  Page 10 Section L: Signature

- The hospital or clinic will determine HPE or BYB eligibility and will forward your application to the Department of Workforce Services (DWS) to determine continued medical benefits. DWS will notify you of your eligibility decision. If more information is needed to determine your eligibility for benefits, an eligibility worker from DWS will contact you. If you have not heard from DWS within 10 days, please call toll-free 1-866-435-7414.

- Applying for continued medical benefits is not a requirement for HPE or BYB. If you choose not to apply, refer to number 8 on page 8.

WHERE CAN I GET MORE INFORMATION OR HELP?

- Translation services are available if you need help during the application process.
- Auxiliary aids and services are available upon request to individuals with disabilities by calling 801-526-9240. Individuals with speech and/or hearing impairments may call Relay Utah by dialing 711 or Spanish Relay Utah by dialing 1-888-346-3162.
- For answers to your questions about how to complete the application, your application status, or to find out if you qualify, please access your information online at www.jobs.utah.gov/mycase
- If you have questions about how to complete the application and/or you are unable to access the website, please call DWS at 1-866-435-7414.
- For general questions about the health care services covered by Medicaid or PCN, call the Medicaid Hotline at 1-800-662-9651.
- For general questions about CHIP, PCN or UPP, call the Health Information Hotline at 1-888-222-2542.

APPLICATION

A APPLICANT INFORMATION

Name: _____
first (start with yourself) middle initial maiden last

Home Address: _____
(leave blank if you don't have one) street apt.# city state zip

Mailing Address: _____
(if different from home address) street apt.# city state zip

Home Phone: (_____)_____ Cell/Other Phone: (_____)_____

E-mail (optional): _____

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

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

B HOUSEHOLD INFORMATION

1. List everyone who is living in your household. Check the box for those applying for health coverage.

Name (first, m.i., last) ☑ Check box if applying for coverage.	Relation to You	[1]Social Security#	Birth Date (mm/dd/yy)	Sex (f/m)	[2]Race	[3]Ethnicity	[4]Marital Status	Full Time Student (y/n)	Utah Resident [1]U.S. Citizen/ National Eligible Non-Citizen
☐	Self								☐Utah Resident ☐U.S. Citizen/National ☐Eligible Non-Citizen
☐									☐Utah Resident ☐U.S. Citizen/National ☐Eligible Non-Citizen
☐									☐Utah Resident ☐U.S. Citizen/National ☐Eligible Non-Citizen
☐									☐Utah Resident ☐U.S. Citizen/National ☐Eligible Non-Citizen
☐									☐Utah Resident ☐U.S. Citizen/National ☐Eligible Non-Citizen
☐									☐Utah Resident ☐U.S. Citizen/National ☐Eligible Non-Citizen

[1]Social Security Number & Citizenship: Social Security Number (SSN) and citizenship information are only needed for people applying for benefits. SSN is not required for people applying for presumptive eligibility. If someone needs help getting a SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

[2]Race Codes (Optional): **WH:** White, **BL:** Black/African American, **AI:** American Indian/Alaska Native, **ASI:** Asian Indian, **CH:** Chinese, **FI:** Filipino, **JA:** Japanese, **KO:** Korean, **VI:** Vietnamese, **OA:** Other Asian, **NH:** Native Hawaiian, **SA:** Samoan, **GC:** Guamanian/Chamorro, **OPI:** Other Pacific Islander, **OT:** Other

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

[4]Marital Status: Single, Married, Divorced, Widowed

B HOUSEHOLD INFORMATION (CONT.)

2. If you are an American Indian or Alaska Native, please complete Attachment A as this can help you receive better benefits.
3. If anyone in your household has an eligible immigration status and is applying for benefits, complete the chart below.

Name	Immigration Document Type	Alien or I-94#	Document ID# *(if different from Alien#)*	Lived in the U.S. Since 1996? (y/n)	Is a veteran or an an active-duty member of the U.S. military, or has spouse or parent who is (y/n)

C GENERAL INFORMATION

Please answer the following questions for anyone in your household that is applying for benefits. This will help us select the right medical program.

☐Yes ☐No 1. Do ALL individuals who are applying for medical benefits have a Utah Medicaid card *(This card is used for both Medicaid and PCN)*?
If no, who needs a card? _____

☐Yes ☐No 2. Do you want help paying any medical bills from the last 3 months?
If yes, for who:_____ For which month(s):_____

☐Yes ☐No 3. Do you want help paying for COBRA or your employer's health insurance plan?

☐Yes ☐No 4. Does anyone who is applying for coverage have a major medical need? This includes cancer, kidney disease, heart disease, etc. *(Answering this question may get you extra help.)*
If yes, who:_____
What is the medical need?_____

☐Yes ☐No 5. Are you the primary person taking care of a child living in your home under age 19?

☐Yes ☐No 6. Was anyone who is applying for coverage in foster care on or after his/her 18th birthday?
If yes, who:_____
Did he/she receive Medicaid at that time? ☐Yes ☐No

☐Yes ☐No 7. Does anyone who is applying for coverage have a disability (a physical, mental, or emotional health condition that causes limitations in activities like bathing, dressing, daily chores, etc.)?
If yes, who:_____

☐Yes ☐No 8. Is anyone who is applying for coverage living in an institution (such as a hospital, nursing home, jail, or prison)?
If yes, who: _____ When:_____ How long: _____

☐Yes ☐No 9. Is anyone who is applying for coverage currently pregnant or has been pregnant in the last 3 months?
If yes, who:_____ Due date:_____
How many babies are expected during the pregnancy? _____
Has she smoked or used tobacco in the past 6 months? ☐Yes ☐No
(Information about tobacco use among pregnant women is needed only to determine potential eligibility for tobacco cessation programs. Response to this question is optional.)

☐Yes ☐No 10. Does any child who is applying for coverage have a parent living outside the home?
If yes, are you willing to cooperate with the Office of Recovery Services to establish medical support from an absent parent(s)? ☐Yes ☐No

D INCOME

☐Yes ☐No 1. Does anyone in your household have earned income?
If yes, list any earned income received by all people who live in your home.

Employed Person (name)	Employer Name, Address & Phone Number	Hourly Rate or Monthly Salary ($900/mo., $9/hr.)	Hours Worked Weekly	How Often Paid (weekly, monthly)	Additional Income (tips, bonus, commission, etc.)
		/			
		/			

☐Yes ☐No 2. Does anyone in your household have self-employment income?
If yes, list any self-employment income received by all people who live in your home.

Self-Employed Person (name)	Company Name	Type of Business (LLC, S-Corp, etc.)	Business Start Date	Percent of Company Owned	Net Income This Month (profit once business expenses are paid)

☐Yes ☐No 3. Do you expect any changes in earnings or in the number of hours worked?
If yes, who: _____Explain change(s):_____

☐Yes ☐No 4. In the past year, did anyone in your household change jobs, stop working or start working fewer hours?
If yes, who:_____Explain change(s): _____

☐Yes ☐No 5. Does anyone in your household receive income from any of the following?

Check All That Apply Below:	Gross Amount Before Any Deductions	How Often	Approximate Start Date (month/year)	Name of Person Receiving the Income
☐Unemployment				
☐Pensions				
☐Social Security				
☐Retirement Accounts				
☐Alimony Received				
☐Net Farming/Fishing				
☐Net Rental/Royalty				
☐Other Income Type: _____				

E DEDUCTIONS

1. List the amount paid and how often you pay it. If you pay for certain things that cannot be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. *(Note: You shouldn't include a cost already considered in your answer to net self-employment income.)*

Check All That Apply Below:	Amount Paid	How Often	Name of Person Paying the Expense
☐Alimony Paid			
☐Student Loan Interest Paid			
☐Other Deductions Type: _____			

☐Yes ☐No 2. Do you have pre-tax deductions taken out of your paycheck such as health insurance premiums and 401K contributions. If yes, complete the chart below.

Check All That Apply Below:	Amount	How Often	Name of Person with pre-tax deduction
☐Health Insurance Premium			
☐401K Contribution			
☐Other Pre-tax Deductions Type: _____			

F YEARLY INCOME

Complete only if your income changes from month to month. If you don't expect changes from month to month, skip to the next section.

Total income THIS year: _____

Total income NEXT year: _____
(if you think it will be different)

G TAX FILER INFORMATION

Please answer the following questions to help us select the program for your household. In addition to the questions below, please complete Attachment B of this application for all dependents that are not living with you, but are claimed on your tax return.

☐Yes ☐No 1. Do you plan to file a federal income tax return next year or will you be claimed as a dependent on someone's tax return next year?
If yes, complete the chart below. *(If you are claiming more than 5 dependents on your tax return, make a copy of this page to complete the information for the additional dependents.)*

Check one: ☐Tax Filer OR ☐Tax Dependent	Applicable to Tax Filer Only: Filing Jointly with Spouse	Applicable to Tax Filer Only: Dependents
Name: _____ ☐Yes ☐No Will you be claimed as a dependent on someone's tax return? If yes, list name of tax filer and your relationship to the tax filer: Name: _____ Relationship: _____	☐Yes ☐No Are you filing jointly with your spouse? If yes, name of spouse: _____	Dependent #1 Name: _____ ☐Yes ☐No Living with Tax Filer? Dependent #2 Name: _____ ☐Yes ☐No Living with Tax Filer? Dependent #3 Name: _____ ☐Yes ☐No Living with Tax Filer? Dependent #4 Name: _____ ☐Yes ☐No Living with Tax Filer? Dependent #5 Name: _____ ☐Yes ☐No Living with Tax Filer?
Check one: ☐Tax Filer OR ☐Tax Dependent	Applicable to Tax Filer Only: Filing Jointly with Spouse	Applicable to Tax Filer Only: Dependents
Name: _____ ☐Yes ☐No Will you be claimed as a dependent on someone's tax return? If yes, list name of tax filer and your relationship to the tax filer: Name: _____ Relationship: _____	☐Yes ☐No Are you filing jointly with your spouse? If yes, name of spouse: _____	Dependent #1 Name: _____ ☐Yes ☐No Living with Tax Filer? Dependent #2 Name: _____ ☐Yes ☐No Living with Tax Filer? Dependent #3 Name: _____ ☐Yes ☐No Living with Tax Filer? Dependent #4 Name: _____ ☐Yes ☐No Living with Tax Filer? Dependent #5 Name: _____ ☐Yes ☐No Living with Tax Filer?

H HEALTH INSURANCE INFORMATION

☐Yes ☐No 1. Does anyone in your household who is applying for coverage currently have Medicaid, CHIP, or Medicare?
If yes, check the type of coverage and write their names next to the coverage they have.
☐Medicaid: _____
☐CHIP: _____
☐Medicare: _____

☐Yes ☐No 2. Has anyone who is applying for coverage been injured in an accident or been a victim of assault in the last 12 months?

☐Yes ☐No 3. Is someone outside your home required to pay for your household's medical services?

☐Yes ☐No 4. Is anyone who is applying for coverage enrolled or eligible for COBRA coverage or continued health insurance through an employer? If yes, complete the chart below.

☐Yes ☐No 5. Does anyone in your household currently have health insurance (including Veterans, Tricare, or Peace Corps.), have insurance available but not enrolled, or has had insurance in the past 6 months? If yes, complete the chart below.

INSURANCE 1

(Do not list Medicaid, Medicare, CHIP, or PCN)

☐Enrolled, start date: _____ ☐Not enrolled, but available ☐Ended, date ended: _____

(If you checked that your insurance status is "Not enrolled, but available" and this insurance is offered through your job or someone else's job such as a parent or spouse, please also complete Attachment C - Employer's Health Insurance Information Form attached to this application.)

Name(s) of individuals covered: _____

Name of insurance company: _____ Phone: _____

Address of insurance company: _____ Group#: _____

Policyholder name: _____ Policy#: _____

Policyholder birth date: _____ Policyholder SS#: _____

☐Yes ☐No Is this insurance through the Federally Facilitated Marketplace (FFM)?

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

Type of coverage: ☐Comprehensive ☐Limited

INSURANCE 2

(Do not list Medicaid, Medicare, CHIP, or PCN)

☐Enrolled, start date: _____ ☐Not enrolled, but available ☐Ended, date ended: _____

(If you checked that your insurance status is "Not enrolled, but available" and this insurance is offered through your job or someone else's job such as a parent or spouse, please also complete Attachment C - Employer's Health Insurance Information Form attached to this application.)

Name(s) of individuals covered: _____

Name of insurance company: _____ Phone: _____

Address of insurance company: _____ Group#: _____

Policyholder name: _____ Policy#: _____

Policyholder birth date: _____ Policyholder SS#: _____

☐Yes ☐No Is this insurance through the Federally Facilitated Marketplace (FFM)?

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

Type of coverage: ☐Comprehensive ☐Limited

OTHER TYPES OF MEDICAL PROGRAMS

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

I OTHER BENEFITS, INCOME, AND EXPENSES

☐Yes ☐No 1. Has anyone in your household applied for, received, or been denied Social Security Income, VA, Unemployment, or Worker's Compensation?
If yes, explain: _____

☐Yes ☐No 2. Has anyone in your household been determined disabled by Social Security?
If yes, who: _____

☐Yes ☐No 3. Does anyone in your household that has been determined disabled by Social Security pay child support or alimony?
If yes, list name, amount paid, and how often: _____

☐Yes ☐No 4. If employed, do you expect any changes in earnings or in the number of hours worked?
If yes, explain: _____

☐Yes ☐No 5. Does anyone help you pay your mortgage/rent, food, or utility bills?
If yes, explain: _____

☐Yes ☐No 6. Does anyone in the household work in exchange for mortgage/rent, food, or utility bills?
If yes, explain: _____

☐Yes ☐No 7. Does anyone in the household pay for dependent care so he/she can go to work?
If yes, list name, amount paid, and how often: _____

J ASSETS

☐Yes ☐No 1. Do you or anyone in your household have any of the following financial assets? Check all that apply.

☐Annuity	☐401K/Retirement	☐Checking Account $_____
☐IRA	☐Money Market Fund	☐Savings Account $_____
☐Stock	☐Trust Fund	☐Other: _____
☐Bond	☐Time Certificate	

☐Yes ☐No 2. Do you or anyone in your household have any of the following assets? Check all that apply.

☐Land	☐Cemetery Plot	☐Rental/Investment Property
☐Home	☐Life Estate	☐Burial Plan/Fund
☐Tools	☐Timeshare	☐Other: _____
☐Camper/Trailer	☐Livestock	
☐Life Insurance	☐Mineral/Timber Right	

☐Yes ☐No 3. Do you own any vehicles?
If yes, using the chart below, list any vehicles that are owned by you and anyone who lives with you. Type of vehicle includes all cars, trucks, vans, snow mobiles, motorcycles, motor homes, boats/motors, ATVs, or other vehicles.

Make	Model	Year	Licensed (y/n)	License Plate#	State	Owner/Joint Owners	Amount Owed

HOSPITAL PRESUMPTIVE ELIGIBILITY (HPE)
&
BABY YOUR BABY (BYB)

If there is anyone in your household who is applying for HPE or BYB, you are required to answer questions on this page in addition to the specified questions on page 1 and 2. Please refer to the Application Information coversheet to identify which specific questions on page 1 and 2 you must answer. Make sure you sign the application on page 10.

K HPE AND BYB QUESTIONS

☐Yes ☐No 1. Does anyone in your household have earned or unearned income?
Enter total monthly household earned income before taxes. $_____ (must complete.)
Enter total unearned income your household receives each month. $_____

☐Yes ☐No 2. Is anyone in your household who is applying for benefits, but is not a U.S. Citizen or National, an eligible non-citizen? If yes, complete the chart below.

Applicant's Name	Eligible Non-Citizen Status	Date Granted Status (month/year)

☐Yes ☐No 3. Is anyone in the household currently on Utah Medicaid, CHIP, PCN, UPP, BYB, HPE, or has been approved for Utah Medicaid with a spenddown?
If yes, who: _____

☐Yes ☐No 4. Has anyone in your household been denied Utah Medicaid, CHIP, PCN, or UPP in the last 30 days?
If yes, who: _____
If yes, what household circumstances changed since the denial? _____
_____

☐Yes ☐No 5. Has anyone in your household been approved for HPE in the last calendar year or if there is anyone pregnant, has she been approved for HPE or BYB for this pregnancy?
If yes, who: _____

☐Yes ☐No 6. Is there any child in the household who has a parent who is absent from the home, unable to work due to an injury or illness, deceased, receives Unemployment Benefits, or works less than 100 hours per month.
If yes, list the child(ren)'s name(s): _____

☐Yes ☐No 7. Does anyone in your household currently have health insurance? *(This information is optional.)*
If yes, complete the chart below.

Insurance Information	
Name(s) of individual(s) covered: _____	
Name of insurance company: _____	Phone: _____
Address of insurance company: _____	Group#: _____
Policyholder name: _____	Policy#: _____

8. Applying for continued medical benefits is not a requirement for HPE and BYB.
☐ By checking this box, I opt out of applying for continued medical benefits.

L I UNDERSTAND THAT:

The State of Utah (the State) referenced below includes the Utah Department of Health, the Department of Workforce Services and/or the Office of Recovery Services.

- The State cannot discriminate against me due to my race, color, national origin, sex, age, sexual orientation, gender identity or disability as provided by federal law. I can file a complaint by visiting www.hhs.gov/ocr/office/file or contacting the DHHS Office for Civil Rights at 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201 or 1-800-368-1019, 1-800-537-7697 (TDD).
- If I give any false information or fail to report changes, I may be prosecuted for fraud. Benefits may be reduced, denied or stopped because of the reported information. If I receive benefits I am not eligible to receive, I must repay the State.
- The State has the right to recover from my estate all money spent to pay my medical bills if I receive PCN and/or Medicaid at any time while I am 55 years of age or older. The State will only collect after my spouse and I die.
- The State will not recover from my estate costs paid by the Medicare cost-sharing programs (QMB, SLMB, QI).
- I authorize the State to tell my healthcare providers if I am eligible for benefits. While I am eligible, the State may exchange information with my health insurance provider or employer.
- I must cooperate with the State in pursuing any third party responsible for medical expenses. I must cooperate with the State to establish medical support or paternity for my family. If I have good cause not to cooperate, I will not be required to cooperate.
- I must report any changes within 10 days. This includes changes in my income, address, phone number, household size, and access to health insurance coverage.
- I will receive a medical card for myself or others in my family if determined eligible. I will only allow the person named on the medical card to use it to receive services.
- I assure that all household members applying for medical assistance are U.S. citizens or aliens in lawful immigration status. Someone who only needs help for a medical emergency does not have to be a citizen or lawful alien. I do not have to report the citizenship information of someone who is not applying. The State verifies lawful alien status with the U.S. Citizenship and Immigration Service. The State will not report undocumented people in my home.
- The Utah Statewide Immunization Information System (USIIS) is an electronic registry. It keeps complete, up-to-date records of my child's immunization history. For more information, or to withdraw my child from USIIS, I can call 1-800-275-0659.
- The Utah Clinical Health Information Exchange (cHIE) is an electronic system that gathers my medical history from participating cHIE healthcare providers. The cHIE provides a safe place for my healthcare providers to share my medical information. For more information or to opt out of the cHIE participation, I can visit www.mychie.org or contact my healthcare provider.
- If I receive payments under a long-term care partnership insurance plan, some assets may not count to decide my eligibility. In this case, the State will not recover medical costs from those assets after I die.
- I have been given a copy of the Rights and Responsibilities and Change Reporting Requirements.
- The benefits I am eligible to receive may be changed without my knowledge or consent. I must pay any co-pays to providers when I receive services unless I am exempt from those co-pays.
- The medical benefits I may receive are described in the State's Provider Manuals. I am not eligible for services that are not listed in these manuals. I understand the State may change these manuals without my consent or knowledge.
- I must follow the medical assistance program rules. My spouse and/or children, if eligible, must also follow these rules.
- I authorize the State to verify any information provided. I understand this occurs when I apply for and after I receive benefits.
- If the State pays for my medical care, I assign to it my rights to payments for medical services from any third party. I will give the State any money I receive from an insurance policy or from someone who must pay my medical costs. I authorize payments be made directly to the State. I will hold harmless any party making payment to the State.
- I may ask for a fair hearing if I disagree with the decision made on this application.

I understand the State will use Social Security Numbers for those who are applying for benefits to make sure households are eligible for benefits. The State uses the State Income and Eligibility Verification System to do computer matches. The State uses the information it finds for benefit reviews and audits. The agencies that may receive, provide or use this information include: Workforce Services, Health, Human Services, Homeland Security, Social Security, and Internal Revenue Service. The State may also use information from consumer reporting agencies. The State may ask for information from banks or credit unions, and other organizations or people who may have eligibility information about my household. I must give the State proof that shows my household is eligible.

I, (print name) _____, have read the statements above or someone has read them to me. I understand and agree to those statements. Under penalty of perjury, I swear that the answers I give on this application are complete and correct. I am the person represented by the signature on this document. I know I may be subject to federal or state penalties if I give false or untrue information. Providing a Social Security Number and information pertaining to immigration or alien status is voluntary; however, any person who wants assistance but does not provide such information may not be eligible for benefits. Failure to provide this information will not subject the applicant to criminal charges.

_____ _____

Signature (check one): ☐ Applicant ☐ Authorized Representative Date

☐Yes ☐No Would you like someone to act as an authorized representative and have access to the information regarding your case? If yes, please complete Attachment D - Authorization to Disclose Medical Eligibility Information form, attached to this application.

M RENEWAL OF COVERAGE IN FUTURE YEARS

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

Yes, renew my eligibility automatically for the next
☐5 years (the maximum number of years allowed), or for a shorter number of years:
☐4 years ☐3 years ☐2 years ☐1 year ☐Don't use information from tax returns to renew my coverage.

N VOTER REGISTRATION INFORMATION

☐Yes ☐No If you are not registered to vote where you live now, would you like to apply to register to vote today? If you do not check either of these boxes, we will assume you have decided not to register to vote at this time. You may fill out the application form in private. If you would like help in filling out the voter registration application form, we will help you. The decision to seek or accept help is yours. Choosing to register or declining to register to vote will not affect the amount of benefit that you will be provided by this agency. If you believe that someone has interfered with your right to register, your right to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Lt. Governor, State of Utah, PO Box 142220, SLC, UT 84114.

O RETURN COMPLETED FORM TO:

You have now completed the application. Please return this completed application form and any needed attachments to:

Department of Workforce Services, PO Box 143245, SLC, UT 84114-3245
Fax: 1-801-526-9505
Toll-free Fax: 1-888-522-9505

Please tear this page off and keep it for your information.

YOUR RIGHTS & RESPONSIBILITIES

YOU HAVE THE RIGHT TO:

- **Receive free language assistance services.**
  You have the right to an interpreter. Free language assistance services are available to you. Please call 801-526-0950 or see below:

  Spanish
  ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 801-526-0950.

  Chinese
  注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 801-526-0950.

  Vietnamese
  CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 801-526-0950.

  Korean
  주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 801-526-0950 번으로 전화해 주십시오.

  Navajo
  Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 801-526-0950.

  Nepali
  ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 801-526-0950 ।

  Tongan
  FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea teke lava 'o ma'u ia. Telefoni mai 801-526-0950.

  Serbo-Croatian
  OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 801-526-0950.

  Tagalog
  PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 801-526-0950.

  German
  ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 801-526-0950.

  Russian
  ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 801-526-0950.

  Cambodian
  ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 801-526-0950។

  French
  ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 801-526-0950.

  Japanese
  注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。801-526-0950。

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

Please tear this page off and keep it for your information.

YOUR RIGHTS & RESPONSIBILITIES (Cont.)

YOU HAVE THE RIGHT TO:

- **Apply or re-apply any time for medical benefits.**
  Some medical benefits are only available during open enrollment periods. If you need help to apply, ask for help from our staff.

- **Receive a notice when we approve or deny your application.**
  The notice will tell you the reason for the decision. For medical benefits, we have 30 days to process your application. We have 90 days if you claim to be disabled. You can ask for more time. If you need more time, let us know before the end of the 30 or 90 days.

- **Receive a notice when we reduce, stop or hold your medical benefits.**
  We will notify you 10 days in advance before we take any negative actions.

- **Look at information in your case.**
  Information about you and your case is confidential. We may give information to other agencies to decide if you are eligible for other benefits.

- **If you do not agree with decisions we make:**
  - Talk to your worker. Make sure you understand the decision.
  - Talk to your worker's supervisor.
  - Talk to Constituent Services: 1-801-526-4390 or call toll-free 1-800-331-4341
  - Ask for a fair hearing. You have 90 days to ask for a hearing. If you ask within 10 days of the notice date, your benefits may continue during the hearing process.
  - You cannot have a hearing if you are denied for presumptive eligibility.
  - You may have a lawyer help with your fair hearing. You may qualify for free legal help from Utah Legal Services. In Ogden, call 1-801-394-9431 or in Salt Lake, call 1-801-328-8891. The toll-free number is 1-800-662-2538. You may also ask for a referral for legal help from the Salt Lake Lawyer Referral at 1-801-531-9075.

YOU ARE RESPONSIBLE FOR:

- **Verifying information for us to decide if you are eligible for benefits.**
  - You must give us the Social Security Number (SSN) of each household member who wants medical benefits (Social Security Act (U.S.C. 1320 b - 7 (a) (1)). The State uses your SSN to make sure you are eligible. The State does computer matches through the State Income and Eligibility Verification System. The State uses computer match data for benefit reviews and audits. If you do not have a SSN, you must prove you have applied. You may be eligible for benefit while you wait for your number.
  - If you apply for Medicaid only to cover emergency services, you do not have to give us a SSN.

- **Cooperating and providing information about other sources of medical payments and on obtaining medical support.**
  If you feel you could be harmed by giving this information, you can ask for a "good cause" claim. Your worker can explain the process.

- **Utah Statewide Immunization Information System (USIIS)**
  The State enrolls children who receive Medicaid in USIIS. If you do not want your children enrolled in this system, call the USIIS HelpLine at 1-801-538-6872 or the Immunization Hotline at 1-800-275-0659.

- **Utah Clinical Health Information Exchange (cHIE)**
  If you receive medical benefits (Medicaid, CHIP, UPP, PCN), the State enrolls you in the cHIE. The cHIE provides a safe place for participating healthcare providers to share and view patient medical information. You may opt out of the cHIE at any time. For more information or to opt out of the cHIE, visit www.mychie.org or call your healthcare provider.

- **Cooperating on reviews of your case by Quality Control, Recovery Services, and the Bureau of Eligibility Policy.**

- **Following medical benefit rules.**
  This applies to you and your medical household members.

Please tear this page off and keep it for your information.

CHANGES YOU MUST REPORT

Remember you are required to report changes in your situation WITHIN 10 DAYS of the day you learn of the change. Do not delay reporting changes. Changes can affect your eligibility. If you receive benefits which you are not eligible to receive, you will have to repay that amount. To report changes, contact DWS online at www.jobs.utah.gov/mycase or call 1-866-435-7414.

IF YOU RECEIVE MEDICAL COVERAGE BENEFITS, YOU MUST REPORT:

- **Changes in Marital Status, Pregnancy Status, or Living Arrangement**
  Getting married, separated, or divorced; moving in with a roommate; changing an address or phone number; absent parent moving in; pregnancy; birth of a baby or end of a pregnancy; household member moving in or out; death of a household member; hospital stays for more than 30 days; anyone in your household going to jail or prison; receiving help with your household expenses, etc.

- **Changes in Source of Income**
  Getting a job, terminating a job, or working for temporary agencies; receiving educational income, SSI, SSA, or unemployment compensation, etc.; receiving a lump sum, such as SSA benefits or accident/injury awards.
  (Note: For CHIP and UPP, this is only required at review.)

- **Changes in Amount of Earned or Unearned Gross Monthly Income**
  Working more OR less hours, overtime, getting a raise, etc.; change in the amount of SSI, SSA, Unemployment Compensation, etc.
  (Note: For CHIP and UPP, this is only required at review.)

- **Changes in Any Asset(s)**
  Changes in ownership or value of stocks, bonds, property, vehicles, life insurance, trust funds, burial plans, and cash, etc. for all household members; opening and closing of bank accounts. (Includes joint ownership of any asset with spouse, parents, children, etc.)
  (Note: This is not required for CHIP, PCN, UPP, Child or Family Medicaid unless you pay a spenddown.)

- **Changes in Insurance Coverage**
  Gaining or losing health insurance coverage or changing the health insurance premium or plan. You must also report accidents or injuries which may be payable by a third party.

- **Changes in Expenses Paid**
  Changes in child care expense, shelter or utility costs, or support payments.
  (Note: This is not required for CHIP, PCN and UPP.)

FOR CHILD OR FAMILY MEDICAID, CHIP, UPP, OR PCN, YOU MUST ALSO REPORT:

- **Changes in Tax Filing Status or Number of Dependents Claimed on Your Taxes**
  (Note: For CHIP and UPP, this is only required at review.)

- **Changes in Earnings of a Child**
  (Note: For CHIP and UPP, this is only required at review.)

- **Changes in Student Status of a Child**
  (Note: For CHIP and UPP, this is only required at review.)

- **Changes in Access to Health Insurance Coverage**
  Gaining access to coverage under an employer sponsored health insurance plan, COBRA, Veteran's Administration, or Medicare. For PCN, this also includes health plans offered by a college/university.
  (Note: This is only required for CHIP, PCN and UPP.)

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ATTACHMENT A

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

Complete this attachment if you or a family member are American Indian or Alaska Native. Submit this with your application. If you have more people to include, make a copy of this page and attach it to your application.

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.

	AI/AN Person 1	AI/AN Person 2
1. 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 received a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐Yes ☐No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, 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.	Amount: $_____ How often: _____	Amount: $_____ How often: _____

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ATTACHMENT B

Information About Your Dependents That Are Not Living With You

Complete this attachment for all dependents that ARE NOT living with you, but are claimed on your tax return. If you have more dependents that are not living with you, but are claimed on your tax return, please make a copy of this page and attach it to your application.

A. GENERAL INFORMATION

Complete the following chart for your dependent:

Name of Dependent (first, m.i., last)	Relationship to You	Date of Birth (mm/dd/yy)	Sex (f/m)	SSN# (optional)

☐Yes ☐No 1. Is your dependent currently pregnant or has been pregnant in the last 3 months?
If yes, due date: _____ How many babies are expected during the pregnancy? _____

B. INCOME

☐Yes ☐No 1. Does your dependent have earned income? If yes, complete the chart below:

Employer Name, Address and Phone#	Hourly Rate or Monthly Salary ($900/mo., $9/hr.)	Hours Worked Weekly	How Often Paid (weekly, monthly)	Additional Income (tips, bonus, commission, etc.)
	/			

☐Yes ☐No 2. Does your dependent have self-employment income? If yes, list any self-employment income received.

Company Name	Type of Business (LLC, S-Corp, etc.)	Business Start Date	% Company Owned	Net Income This Month (profit once business expenses are paid)

☐Yes ☐No 3. In the past year, did your dependent change jobs, stop working or start working fewer hours?

☐Yes ☐No 4. Does your dependent have/receive any of the following? Check all that apply.

☐Unemployment $_____ How Often: _____
☐Pensions $_____ How Often: _____
☐Social Security $_____ How Often: _____
☐Alimony Received $_____ How Often: _____
☐Retirement Accts. $_____ How Often: _____
☐Net Farming/Fishing $_____ How Often: _____
☐Net Rental/Royalty $_____ How Often: _____
☐Other Income $_____ How Often: _____
Type: _____

C. DEDUCTIONS

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

☐Alimony Paid $_____ How Often: _____
☐Student Loan Interest $_____ How Often: _____
☐Other Deductions $_____ How Often: _____
Type: _____

D. YEARLY INCOME

Complete only if your dependent's income changes from month to month.

Total income THIS year: _____ Total income NEXT year: _____
(If you think it will be different)

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ATTACHMENT C

Employer's Health Insurance Information

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

A. GENERAL INFORMATION

Employee Information

Employee Name: _____ Employee SSN#: _____
(first, m.i., last)

Employer Information

Employer Name: _____

EIN#: _____ Phone#: _____

Address: _____
street apt.# city state zip

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

Contact Name: _____

Phone#: _____ E-mail address: _____

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

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

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

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

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

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

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

8. For the lowest-cost plan that meets the *minimum value standard offered only to employee (don't include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on the wellness programs:
a. How much would the employee have to pay in premiums for that plan? $_____
b. How often? ☐weekly ☐every 2 weeks ☐twice a month ☐quarterly ☐yearly

☐Yes ☐No 9. Do you know what change the employer will make for the new plan year? If yes, complete the following:
☐Employer won't offer health insurance
☐Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the *minimum value standard. (Premium should not reflect the discount for wellness programs. See question 8.)
a. How much will the employee have to pay in premiums for that plan? $_____
b. How often? ☐weekly ☐every 2 weeks ☐twice a month ☐quarterly ☐yearly

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

B. EMPLOYER'S LEAST EXPENSIVE PLAN OR AVENUE H DEFAULT PLAN

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

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

2. When will/did coverage begin? (mm/dd/yy)_____

3. When does the company's next open enrollment begin? (mm/dd/yy) _____

4. Complete the chart below. **Do not** include the cost of dental, vision or other coverage if it is separate.

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

Yearly Health Plan Deductible	
Individual Amount	$
Family Amount	$

C. EMPLOYEE'S HEALTH PLAN CHOICE

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

1. Insurance company and plan name: _____

2. Policy number, if known: _____

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

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

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

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

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

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

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

Yearly Health Plan Deductible	
Individual Amount	$
Family Amount	$

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

D. SIGNATURE

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

Signature: _____ Date: _____

Name (please print): _____

Title: _____ Phone#: _____

Please return completed form to:

Department of Workforce Services, PO Box 143245, SLC, UT 84114-3245

Fax: 1-801-526-9500 Toll-Free Fax: 1-877-313-4717

ATTACHMENT D
Authorization to Disclose Medical Information

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."

_____ _____ ____/____/____
Customer Name | Case # | Date of Birth

I, _____, hereby give _____the authority to:
Name of Customer or Authorized Representative | Name of Individual or Organization

(check only one box)

☐ Receive Medicaid, CHIP, UPP, PCN or Buyout eligibility information regarding my current application, ongoing case or a recent case denial or closure. This authorization is effective from the date this form is signed to whichever of the following occurs first:
- The following date: _____; or
- The medical application is denied*; or
- 30 days from the month the medical program is closed*.

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

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

Address of Authorized Representative: _____

Phone Number of Authorized Representative: _____

- I understand that I may revoke this authorization at any time by sending a written notification to the Department of Workforce Services (DWS). I understand that a revocation is not effective to the extent that the Utah Department of Health, through its Division of Medicaid and Health Financing (DMHF) or the DWS has relied on the disclosed health information.
- I understand my rights and responsibilities described in the Notice of Privacy Practices. For a duplicate Notice of Privacy Practices, access the following URL - http://health.utah.gov/hipaa/privacy.htm
- I understand that I may refuse to sign this authorization. I also understand that the DWS cannot deny eligibility for benefits if I refuse to sign this authorization.
- I understand that giving an individual authorized representative power allows them to act on my behalf, which includes making changes to my medical case and any changes that they make, I may be liable for if an overpayment is incurred.
- I understand that once information is disclosed pursuant to this authorization, it is possible that it will no longer be protected by medical privacy laws and could be disclosed by the person or agency that receives it.
  Note: DMHF and DWS will not disclose controlled documents without the consent of their Legal Departments.
- By signing this form, I acknowledge I have been provided a copy of this signed authorization.

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

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

_____