ACCESS FLORIDA APPLICATION

I would like to apply for: ☒ **Food Assistance** ☐ **Cash** ☐ **Relative Caregiver** ☐ **Medical** ☐ **Hospice** ☐ **OSS/Optional State Supplementation** ☐ **Medicaid Waiver/Home & Community Based Services** ☐ **Nursing Home Care** – Living address prior to entering Nursing Home:

APPLICANT INFORMATION

Name: (Head of Household – see "Before You Begin" section)

First	Middle	Last
Candice	Michelle	Bernstein

Home Address: (Leave blank if you do not have one.)

Street	Apt. No.	City	State	Zip Code	County
2753 NW 34TH St.		Boca Raton	FL	33434	Palm Beach

Address where you get your mail: (if different from where you live)

Street/P. O. Box	City	State	Zip Code

Home or Message Phone Number: (561) 245-8588

Work Phone Number:

Cell Phone Number:

E-Mail Address: tourcandy@gmail.com

Do you want to get information about this application by email? ☐ YES ☒ NO

Do you have a reason that makes it difficult for you to come to the office for an interview?

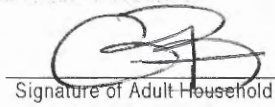
☐ Illness ☐ Transportation ☐ Work or Training ☐ Live in a Rural Area ☐ Care for a sick or Disabled Household Member ☐ Other (explain):

What is your preferred spoken or written language (if not English)? English

STATEMENT OF UNDERSTANDING

I understand that information that I provide with this application, interview, or when requesting other benefits, including computer information matches with other agencies, is subject to verification by DCF and other Federal and State agencies including Division of Public Assistance Fraud (DPAF). I understand and agree to the following: DCF, DPAF, and authorized Federal Agencies may verify the information I give on this form, interview, or when requesting other benefits. Information may be obtained from my past or present employers. My signature authorizes release of such information to DCF and/or DPAF. As a condition of participation in Medicaid, I consent to review and release of all medical records deemed necessary by Medicaid under its auditing and investigatory powers. If any information is incorrect, benefits may be reduced or denied and I may be subject to criminal prosecution or disqualified from the program for knowingly providing incorrect or false information or hiding information. I have read my Rights and Responsibilities. I certify under penalty of perjury that the information on this form is true to the best of my knowledge, including the citizen or noncitizen status of those who are applying for benefits. I hereby acknowledge receipt of the Florida DCF CFOP 60-17, Chapter 1, Attachment 2, Management and Protection of Personal Health Information Policy.

SIGNATURES



2/25/15

Signature of Adult Household Member / Date Signed

Signature of Witness if signed with an "X"

Authorized/Designated Representative – Please print

Name	
Address	Phone Number

Signature of Authorized/Designated Representative

FOR OFFICE USE ONLY	Community Access Site Participant Name/Phone Number:	Date Stamp:

EXPEDITED FOOD ASSISTANCE: Eligible households may receive benefits within 7 days.

Is your household's gross income less than $150? ☒ YES ☐ NO	Do you pay to heat or cool your home? ☒ YES ☐ NO
Are your total liquid assets (such as cash, bank accounts, etc) less than $100? ☒ YES ☐ NO	What is the monthly amount of your rent or mortgage? $ 0
Is your household's monthly gross income plus your total liquid assets less than your monthly rent or mortgage plus utilities? ☒ YES ☐ NO	Has all of your household's income recently stopped? ☐ YES ☒ NO **If yes, WHEN?**
Check the bills you pay: ☒ Electricity ☐ Gas ☒ Water ☐ Sewage ☒ Phone	Is anyone in your household a migrant or seasonal farmworker? ☐ YES ☒ NO **If yes, WHO?**

HOUSEHOLD INFORMATION: If you need extra space in the following sections, please use extra pages. Please provide as much information as you can to help us determine your eligibility quickly.

In Sections A and B, list yourself and all people living in your home even if you are not applying for them. If you are not applying for a member, you do not have to give their SSN or citizenship status. Include your spouse, your children under 21 who live with you, anyone you include on your tax return, even if they do not live with you, and anyone else under 21 who you take care of and lives with you. If living in a nursing home or other institutional arrangement, list only self, spouse and dependents.

ETHNICITY (Voluntary/Optional Information): **A** = Hispanic or Latino or, **B** = Not Hispanic or Latino

RACE (Voluntary/Optional Information): You may choose one or more numbers: **1** – American Indian or Alaskan Native; **2** – Asian or Pacific Islander; **3** – Black or African American, Not of Hispanic Origin; **4** – White, Not of Hispanic Origin; **5** – Southeast Asian; **6** – Other; or, **7** – Unknown. This will not affect eligibility or the level of benefits. The reason we ask for this information is to assure program benefits are distributed without regard to race, color, or national origin.

SECTION A – List All Adults Living At Your Address

Adult's Legal Name First, Middle, Last	Want to Apply?	Sex	Social Security Number (see instructions above)	Date and Place of Birth*	U.S. Citizen	Ethnicity (see above)	Race (see above)	Marital Status	Attends School/ # Hours / Week/ Last Grade Completed*	Buys and Eats Food with You
1. Candice Michelle Bernstein Relationship to you: SELF	☒ Yes ☐ No	☒ F ☐ M	569-31-8897	10/9/72 CA	☒ Yes ☐ No USCIS #	☐ A ☒ B	☐ 1 ☐ 2 ☐ 3 ☒ 4 ☐ 5 ☐ 6 ☐ 7	M	☐ Yes ☒ No # hours per week: * Last Grade Completed:	☒ Yes ☐ No
2. Eliot Ivan Bernstein Relationship to you: Spouse	☒ Yes ☐ No	☐ F ☒ M	361-62-2566	9/30/63 IL	☒ Yes ☐ No USCIS #	☐ A ☒ B	☐ 1 ☐ 2 ☐ 3 ☒ 4 ☐ 5 ☐ 6 ☐ 7	M	☐ Yes ☒ No # hours per week: * Last Grade Completed:	☒ Yes ☐ No
3. Relationship to you:	☐ Yes ☐ No	☐ F ☐ M			☐ Yes ☐ No USCIS #	☐ A ☐ B	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7		☐ Yes ☐ N # hours per week: * Last Grade Completed:	☐ Yes ☐ No
4. Relationship to you:	☐ Yes ☐ No	☐ F ☐ M			☐ Yes ☐ No USCIS #	☐ A ☐ B	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7		☐ Yes ☐ No # hours per week: * Last Grade Completed:	☐ Yes ☐ No

SECTION B – List All Children Living At Your Address. If anyone is pregnant, list "unborn" as the name and the due date as the date of birth.

Child's Legal Name First, Middle, Last	Want to Apply?	Sex	Social Security Number (see instructions above)	Date and Place of Birth*	U.S. Citizen	Ethnicity (see above)	Race (see above)	*Child under Age 5 Immunized	Attends School/ School Name/	*Date To Graduate	Buys and Eats Food with You
1. Daniel E. A.D. Bernstein Relationship to you: son	☒ Yes ☐ No	☐ F ☒ M	626-35-8203	11/26/02 CA	☒ Yes ☐ No USCIS #	☐ A ☒ B	☐ 1 ☐ 2 ☐ 3 ☒ 4 ☐ 5 ☐ 6 ☐ 7	☒ Yes ☐ No	☒ Yes ☐ No School Name: OMNI MIDDLE	2021	☒ Yes ☐ No
2. Joshua Ennio Z Bernstein Relationship to you: son	☒ Yes ☐ No	☐ F ☒ M	625-98-3283	8/27/97 CA	☒ Yes ☐ No USCIS #	☐ A ☒ B	☐ 1 ☐ 2 ☐ 3 ☒ 4 ☐ 5 ☐ 6 ☐ 7	☒ Yes ☐ No	☒ Yes ☐ No School Name: Spanish River H.S.	2015 ~~2017~~	☒ Yes ☐ No
3. Jacob noahA Bernstein Relationship to you: son	☒ Yes ☐ No	☐ F ☒ M	593-81-1289	1/1/99 FL	☒ Yes ☐ No USCIS #	☐ A ☒ B	☐ 1 ☐ 2 ☐ 3 ☒ 4 ☐ 5 ☐ 6 ☐ 7	☒ Yes ☐ No	☒ Yes ☐ No School Name: spanish river HS	2017	☒ Yes ☐ No
4. Relationship to you:	☐ Yes ☐ No	☐ F ☐ M			☐ Yes ☐ No USCIS #	☐ A ☐ B	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7	☐ Yes ☐ No	☐ Yes ☐ No School Name:		☐ Yes ☐ No

SECTION C – ABSENT PARENT INFORMATION: Provide the following information for each child in Section B whose mother and/or father is not in the home.

		Name, Address, Phone number	Date of Birth	Social Security Number	Race (see page 2)	Reason for Absence	Child's Legal Parent?
Child 1	Mother						☐ YES ☐ NO
	Father						☐ YES ☐ NO
Child 2	Mother						☐ YES ☐ NO
	Father						☐ YES ☐ NO
Child 3	Mother						☐ YES ☐ NO
	Father						☐ YES ☐ NO
Child 4	Mother						☐ YES ☐ NO
	Father						☐ YES ☐ NO

SECTION D – GENERAL INFORMATION: Answer the following questions about the people listed in Sections A and B who are applying for assistance.

Is anyone in your home fleeing the law due to a felony or a probation or parole violation?
☐ YES ☒ NO **If yes, who?**

Has anyone in your home sold or given away any property or assets in the last 3 months (food assistance purposes) or 5 years (Medicaid)?
☐ YES ☒ NO **If yes, who?**

Has anyone in your home been convicted of a drug trafficking felony including agreeing, conspiring, combining, or confederating with another person to commit the act committed on or after 8/22/1996? ☐ YES ☒ NO **If yes, who?**

Did anyone in your home quit a job in the last 60 days or is anyone on strike?
☐ YES ☒ NO **If yes, who?**

Has anyone in your home been convicted on or after 8/22/96, of receiving food assistance, temporary cash assistance, or Medicaid in more than one state at the same time? ☐ YES ☒ NO **If yes, who?**

Has anyone in your home received food, cash, or medical assistance from another state or source in the last 30 days?
☐ YES ☒ NO **If yes, who?**

Is everyone a resident of the state of Florida? ☒ YES ☐ NO **If no, who is not?**

Is anyone in the household pregnant? ☐ YES ☒ NO **If yes, who?**
Due Date: **Number of Babies Due:**

*Has anyone attended a school conference for any of the children who are ages 6-18?
☐ YES ☒ NO **If yes, who?** **When?**

Is anyone in your household a sponsored noncitizen? ☐ YES ☒ NO **If yes, who?**

Is anyone living in a special setting such as a homeless shelter, drug treatment center, nursing home, assisted living facility, adult family care home, mental health residential treatment facility, or other institution? ☐ YES ☒ NO **If yes, who?**
Facility Name and Type:

Is anyone a foster child? ☐ YES ☒ NO **If yes, who?**

Was anyone in Florida foster care at age 18 or older? ☐ YES ☒ NO **If yes, who?**

*If you are applying for nursing home type services, do you have a child (of any age) living in your home who is blind or disabled?
☐ YES ☒ NO **If yes, who?** **What is their relationship to you?**

Has anyone been determined disabled by Social Security or the State of Florida? ☐ YES ☒ NO **If yes, who?**

*Has anyone been denied Supplemental Security Income (SSI) in the past 90 days?
☐ YES ☒ NO **If yes, who?** **When?**

*Does anyone in your household need help with Medicare premiums or medical bills from the past three (3) months?
☐ YES ☒ NO **If yes, who?**

*Does anyone who was denied for disability have a new medical condition not considered by the Social Security Administration?
☐ YES ☒ NO **If yes, who?**

Is anyone in your household a victim of human trafficking? (Victims of human trafficking are people taken, kept, or moved by force or fraud for sexual exploitation or forced labor.) ☐ YES ☒ NO **If yes, who?**

Have you or any member of your household been convicted of trading food assistance benefits for drugs, convicted of buying or selling food assistance benefits over $500, or convicted of trading food assistance benefits for guns, ammunitions, or explosives?
☐ YES ☒ NO **If yes, who?**

Does anyone in the household pay for a room (Roomer) or for room and meals (Boarder)?
☐ YES ☒ NO **If yes, who?**

*Does anyone have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical faciltiy or nursing home? ☐ YES ☒ NO **If yes, who?**

*Is any child limited or prevented in any way in his or her ability to do the same things most children of the same age do?
☐ YES ☒ NO **If yes, who?**

*Does anyone need or get special therapy, such as physical, occupational or speech therapy, or treatment or counseling for an emotional, developmental, or behavioral problem? ☐ YES ☒ NO **If yes, who?**

*Does any child need or use more medical care, mental health, or educational services than is usual for most children of the same age?
☐ YES ☒ NO **If yes, who?**

SECTION E – ASSETS: Answer the following questions about the people listed in Sections A and B who are applying for assistance. If you need extra space in the following sections, please use extra pages.

Does anyone you are applying for own all or part of any assets, such as: ***vehicles**, bank accounts, tax sheltered accounts, property, Certificates of Deposit (CDs), cash, mortgage notes, promissory notes, ***loans**, ***IRAs**, ***401Ks**, bonds, ***annuities**, stocks, real estate, life estate, trusts, ***Keogh plans**, ***continuing care retirement community or life care community contracts**, burial contracts/plots, prepaid funeral expenses, savings bonds or certificates, business assets, large sums of money received in last 3 months, ***health/long-term care/life/auto insurance, *HMOs, Medicare or Medicare supplements**, etc? ***Include the assets/insurance of parents of minor child applicants if living in the home and assets/insurance of spouses of applicants if living in the home.** ☒ YES ☐ NO **If yes, list below:**

***IMPORTANT INFORMATION FOR OWNERS OF AN ANNUITY:** In accordance with Public Law 109-171, individuals (and their spouses) who are applying for or receiving Medicaid Institutional Care Program (nursing home care), Hospice, Home and Community Based Services waiver programs, or the Program of All-Inclusive Care for the Elderly must list all annuities they own. Certain annuity purchases (or other transactions) made on or after 11/01/2007, will be considered a transfer of an asset for less than fair market value unless the annuity names the State of Florida, Agency for Health Care Administration, as the first remainder beneficiary (or second remainder beneficiary after the community spouse or minor or disabled child) for the total amount of Medicaid funds paid on the Medicaid recipient's behalf.

*DCF must determine the value of assets of Medicaid applicants and recipients of aged (65 or older), blind, or disabled individuals. Applicants and recipients must agree to allow DCF to ask for financial records from any bank, savings and loan, credit union, or other financial institution by completing the Financial Information Release, form CF-ES 2613.

Individual	Type of Asset or Insurance	Vehicles Year, Make, Model*	Amount Owed on Vehicle/Property	Location of Asset/Insurance Bank/Company Name and Address	Account # or Insurance ID #	Amount or Value
Candice Bernstein	auto	VOLVO 2008 XC90	∅			10,000.00
Candice Bernstein	auto	KIA 2013 SOUL	∅			10,000.00

Are any of the above assets set aside to cover burial expenses? ☐ YES ☒ NO **If yes, which?** **Amount?**

Has anyone closed bank accounts or other investments, added anyone to the title of an asset, given away assets or property, or liquidated assets greater than $3,000 to buy another asset or service in the last 3 months (food assistance) or 5 years (Medicaid)? ☐ YES ☒ NO

If yes, who?

What? **When?** **Value?**

Are any assets jointly owned with a person that does not live with you? ☐ YES ☒ NO

If yes, who?

What? **When?** **Value?**

YOU CAN APPLY TO REGISTER TO VOTE HERE

If you are not registered to vote where you live now, would you like to register to vote here today? Check YES if you would like to apply to register to vote or update your voter registration information. If you check the NO box or do not check a box, you will be considered to have decided not to apply to register to vote or update your voter registration information. Checking YES, NO, or leaving this question blank, will not affect your receipt of benefits.

☐ YES ☐ NO

NOTICE OF RIGHTS

Help: If you would like help in filling out your voter registration application, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration application in private.

Benefits: If you are applying for public assistance from this agency, applying to register, or declining to register to vote will not affect the amount of assistance you will be provided by this agency.

Privacy: Your decision not to register or update your record and the location where you applied to register or update your voter registration record is confidential and may only be used for voter registration purposes.

Formal Complaint: If you believe someone has interfered with either your right to apply to register or to decline to register to vote, your right to privacy in deciding whether to apply to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with: Florida Secretary of State, Division of Elections, NVRA Administrator, R.A. Gray Building, 500 S. Bronough Street, Tallahassee, Florida 32399-0250. Forms for filing a complaint are available at http://election.dos.state.fl.us/nvra/index.shtml or call 1-850-245-6200.
[Authority: National Voter Registration Act (42 U.S.C. 1973 gg), ss. 97.023, 97.058 and 97.0585, F.S.]

SECTION F – INCOME: Answer the following questions about the people listed in Sections A and B who are applying for assistance.
Does anyone that you are applying for receive any type of income, such as: wages, tips, self-employment, Social Security/Railroad Retirement or Disability, SSI, other disability, VA income, pension, Civil Service, unemployment, child support, alimony, dividends, interest, stipend, money from another person, annuity, rent, workers' compensation, estate/trust, public assistance, grants, scholarships, student loans, reparations payments, training allowances, etc? (Include the income of parents living at home with minor child applicants and income of spouses and dependents of applicants if living in the home.) ☐ YES ☒ NO **If yes, list below:**

Individual	Type of Income	Name of Employer or Source of Income	Phone Number of Employer	Monthly Amount Before Deductions	How Often Received (weekly/biweekly /monthly)	Pay Day on What Day of the Week	Weekly # of Work Hours

Has anyone's income in the household ended or had their work hours reduced in the last 60 days or the past year? ☐ YES ☒ NO
If yes, who? **When?** **Source?**

Will anyone in your household receive additional income from the source that ended? ☐ YES ☒ NO **Gross amount (before deductions received in this month only?** $
If yes, who? **When?**

Does anyone have a pending application for Social Security or Unemployment Compensation benefits? ☐ YES ☒ NO
If yes, who? **Which Benefit?**

Have deposits been made to Income or Miller Type Trusts in any of the past 3 months? ☐ YES ☒ NO **If yes, whose trust?** **Date(s) and amount of deposit(s)?**

If self-employed, what is the type of work? Monthly net income amount (profits after paying business expenses): $

*Do you plan to file a federal income tax return NEXT YEAR? ☐ YES ☒ NO **If yes, answer the questions below:**
*Will you file jointly with your spouse? ☐ YES ☐ NO **If yes, what is your spouse's name?**
*Will you claim any dependents on your tax return? ☐ YES ☐ NO **If yes, list the names of dependents:**
*Will someone else claim you as a dependent on their tax return? ☐ YES ☒ NO **If yes, what is the name of the tax filer?** **How are you related to this tax filer?**

*Is anyone listed on this application offered health coverage from a job? ☐ YES ☒ NO **If yes, who?**

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

*Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months? ☐ YES ☒ NO

*Does the employer offer a health plan that meets the minimum value standard? ☐ YES ☒ NO [An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986.]

*For the lowest-cost plan that meets the minimum value standard offered to the employee (don't include family plans): If the employer has wellness programs, provide the premium the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive another discounts based on wellness programs. How much would the employee have to pay in premiums for this plan? $
How often? ☐ **Weekly** ☐ **Biweekly** ☐ **Monthly** ☐ **Quarterly** ☐ **Yearly**

*What change will the employer make for the new plan year? ☐ **Employer won't offer health coverage** ☐ **Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard. How much will the employee have to pay in premiums for that plan?** $
How often? ☐ **Weekly** ☐ **Biweekly** ☐ **Monthly** ☐ **Quarterly** ☐ **Yearly** **Date of change?**

SECTION G – EXPENSES: Answer the following questions about the people listed in Sections A and B who are applying for assistance.
Is anyone that you are applying for required to pay expenses, such as: rent, mortgage, property tax, homeowner's insurance, condo/maintenance fees, gas, electric, fuel, LIHEAP, medical bills such as but not limited to: prescriptions, glasses, transportation, doctor visits, dental, health aides, hospitalization, nursing home bills, or insurance or Medicare premiums not covered by insurance or another third party, telephone, child or adult care, or court ordered child support for a child not in your household? Include the expenses of parents of minor child applicants if living in the home and expenses of spouse of applicants if the spouse is living at home. ☒ YES ☐ NO **If yes, list below:**

Failure to report and/or verify any of the listed expenses will be considered as a statement by the household that they do not want to receive a deduction for the unreported expense.

Type of Expense	Who is Obligated To Pay This Expense	If a Medical Expense, Who Received the Medical Service?	Monthly Amount	Paid to Whom	Date Paid	Still Owed?	For Court Ordered Child Support Only, Name of Child for Whom Support is Paid
electric	Candice		400.00	FPL	2/24/15	☒ YES ☐ NO	
water	Candice		80.00	CITY OF Boca Raton	3/1/15	☒ YES ☐ NO	
phone	Candice		200.00	comcast	3/3/15	☒ YES ☐ NO	
TRASH [redacted]	Candice		30.00	CITY OF BOCA RATON	3/1/15	☒ YES ☐ NO	
auto insurance	Candice		366.00	STATE FARM	3/18/15	☒ YES ☐ NO	

How do you heat or cool your home? electric

Does anyone help you pay expenses? ☒ YES ☐ NO **If yes, who?** Candice's Mother

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. You should not include a cost you already considered in your answer to net self-employment. Check all that apply, give the amount, and how often you pay it.

☐ **Alimony paid $** ..... **How often?**

☐ **Student loan interest $** ..... **How often?**

☐ **Other deductions, Type:** .....**How often?**

SECTION H – YOUR FAMILY'S HEALTH COVERAGE: Answer the questions for anyone who needs health coverage.

*Is anyone enrolled in health coverage now from any of the following? ☒ YES ☐ NO **If yes, write their name(s) next to the coverage they have.**

☒ Medicaid: Candice, Eliot, Joshua, Jacob, Daniel

☐ Medicare: _____

☐ VA health programs: _____

☐ Employer insurance: _____
Name of Insurance: _____
Name of person insured: _____
Policy number: _____
Is this COBRA coverage? ☐ YES ☐ NO
Is this a retiree health plan? ☐ YES ☐ NO

☐ Florida KidCare: _____

☐ TRICARE: _____
(for TRICARE, do not check if you have direct care or Line of Duty)

☐ Peace Corps: _____

☐ Other: _____
Name of Health Insurance: _____
Name of person insured: _____
Policy number: _____
Is this a limited-benefit plan (like school accident policy)?
☐ YES ☐ NO

*Has anyone voluntarily canceled health insurance for children in the last two months for any of these reasons?

☐ The cost of an applicant child's health insurance is more than 5% of your family's income.
☐ Domestic violence led to the loss of coverage for an applicant child.
☐ Parent lost a job that provided employer-sponsored coverage for an applicant child.
☐ The coverage does not cover the applicant child's health care needs.
☐ Parent who had the health coverage for an applicant child is deceased.
☐ The employer providing the applicant child's coverage canceled the coverage.
☐ The applicant child's coverage ended because the child reached the maximum lifetime coverage limit or an annual benefit limit.
☐ An applicant child has a medical condition that, without medical care, would cause serious disability, loss of function, or death.
☐ The applicant child's parent canceled COBRA coverage or the COBRA coverage reached its legal limit.
☐ A non-custodial parent dropped the applicant child's coverage.

YOU MAY BE ELIGIBLE FOR REDUCED TELEPHONE RATES

Check YES if you would like DCF to release your Name, SSN, Phone Number, and the fact that you receive food assistance, Temporary Cash Assistance, or Medicaid to the local telephone company so you may receive a reduced telephone rate through the Lifeline Program. ☐ YES ☒ NO

SECTION I – AMERICAN INDIAN OR ALASKA NATIVE FAMILY MEMBER: Complete this section if you or a family member are American Indian or Alaska Native.

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

Name First, Middle, Last	Member of a Federally recognized tribe	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 yes, tribe name:**	☐ YES ☐ NO	If no, is this person eligible to get services from one of these programs? ☐ YES ☐ NO
	☐ YES ☐ NO **If yes, tribe name:**	☐ YES ☐ NO	If no, is this person eligible to get services from one of these programs? ☐ YES ☐ NO
	☐ YES ☐ NO **If yes, tribe name:**	☐ YES ☐ NO	If no, is this person eligible to get services from one of these programs? ☐ YES ☐ NO
	☐ YES ☐ NO **If yes, tribe name:**	☐ YES ☐ NO	If no, is this person eligible to get services from one of these programs? ☐ YES ☐ NO

*Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income 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?** ☐ YES ☐ NO
If yes, who? **Amount:** $

☐ **Payments from natural resouces, farming, ranching, fishing, leases, or royalties from land by the Department of Interior (including reservations and former reservations?** ☐ YES ☐ NO
If yes, who? **Amount:** $

☐ **Money from selling things that have cultural significance?** ☐ YES ☐ NO
If yes, who? **Amount:** $

AUTHORIZED REPRESENTATIVE

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative". If you are a legally appointed representative for someone on this application, submit proof with the application. By entering the information on page 1, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

FOR CERTIFIED APPLICATION COUNSELORS, NAVIGATOR, AGENTS, AND BROKERS ONLY: Complete this section if you are a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

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

Name: First, Middle, Last: ____________________

Organization Name and ID number (if applicable): ____________________

SIGNING THIS APPLICATION: By signing this application you are confirming and attesting that:

- *No one applying for health insurance on this application is incarcerated.
- *The information provided on this application establishes the identity of children under age 16.
- You have read and understand your rights and responsibilities.
- *You are giving the Medicaid agency rights to pursue and get any money from other health insurance, legal settlements, or other third parties. You are also giving the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- *You know this information will be used to check your eligibility for help paying for health coverage if you choose to apply. We will check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, Department of Homeland Security, and/or a consumer reporting agency.