Washington State Department of Social & Health Services
Transforming lives

# Eligibility Review

**If you need help reading or completing this form, please ask us for help.**
**Keep this page for your records.**

**How do I apply for cash or food assistance?**

- You can **start** the process now by submitting this review at a community services office. It must have your name, address, and signature or the signature of your authorized representative. You can file your review now even if it only contains these three items.
- You may get more benefits or get them sooner if you complete and give us your review and any other information we ask for as soon as you can.
- You can take your review to a local office or fax to 1-888-338-7410. See www.dshs.wa.gov for locations.
- Mail your review to one of the following:

DSHS
CSD-Customer Service Center
PO Box 11699
Tacoma, WA 98411-6699

DSHS
Home and Community Services – Long Term Care Services
PO Box 45826
Olympia, WA 98504-5826

- You can fill out this review online at www.washingtonconnection.org
- **This Eligibility Review form can only be used to renew coverage for the Washington Apple Health programs listed on this form. For other health care coverage you must apply either online at www.wahealthplanfinder.org, by calling 1-855-923-4633, or by using the HCA Application for Health Care Coverage (HCA 18-001).**

**How soon can I receive help with food and cash?**

- If you need food assistance right away, fill in Questions 1 through 14 and take this form to your local office. We decide if you are eligible for food assistance *within 7 days* if you show proof of your identity *and* meet eligibility rules.
- We issue benefits by the day after we decide you are eligible.
- Food assistance usually starts the day we receive your application.
- Cash assistance usually starts the day we have all the information to decide you are eligible.
- We must decide if you are eligible for Food Assistance within 30 days of the date you submit your application.
- If you are submitting your application from an institution, the start date is the date of your release or discharge.

**If you're applying for Food Assistance and other programs:**

We must follow the SNAP rules for processing your application. This includes processing the application within time limits, issuing proper notices, and advising you of your administrative rights. We cannot deny your Food Assistance just because your application for other assistance programs was denied.

**Civil Rights**

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating based on race, color, national origin, religion, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. 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 responsible 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.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation:

1. Mail: Food and Nutrition Services, USDA
   1320 Braddock Place, Room 334
   Alexandria VA 22314;
2. Fax: (833) 256-1665 or (202) 690-7442; or
3. Email: FNSCIVILRIGHTSCOMPLAINTS@usda.gov

USDA is an equal opportunity provider.

**Immigration Status and Social Security Numbers**

You may get assistance for some people you live with even if others you live with can't because of their immigration status. You must tell us the immigration status of anyone who applies. Immigration status of household members may be verified by USCIS (formerly known as INS). Information received from USCIS may affect eligibility and benefit amounts. We have health care coverage that may cover some aliens.

Under Federal Law (42 CFR § 435.910, 45 CFR §205.52, 7 CFR §273.6), you must give us the Social Security Number (SSN) for anyone you live with who applies for Washington Apple Health. TANF, or food assistance. We may also need SSNs of parents and spouses who live with you but don't apply. We have health care coverage for some people who don't have SSNs.

**Citizenship and Identity for Washington Apple Health**

U.S. citizens must prove citizenship and identity to receive Washington Apple Health. We can help you obtain the proof. If we need a document that will cost you money, we send for it and pay the cost. We don't need proof for anyone in your household who receives Medicare, Social Security Disability Insurance (SSDI) based on their own disability or Supplemental Security Income (SSI).

**Repaying the State for Medical and Long Term Care**

Under Washington State Estate Recovery law (RCW 41.05A.090, RCW 43.20B.080), your estate may need to pay back the costs the State paid for certain types of medical and long-term services and supports you received after you turned age 55. There is no age limit if you received state-only funded services. Estate Recovery begins after your death; payment is due after the death of your surviving spouse, or when your child(ren) turns age 21, unless the child was blind/disabled at your time of death. The State can file a pre-death lien on your real property, at any age, if you live in a nursing home and are unlikely to return home. The State can collect on this lien if you sell or transfer the property, or after your death. If you return home the State removes the lien. For more information, including a list of services subject to Estate Recovery, see Chapter 182-527 WAC.

**Privacy and Your Cash and Food Assistance**

The Food and Nutrition Act of 2008, lets us collect the information we ask for on the application. Providing the requested information is voluntary, however, failure to provide information without a good reason can result in the denial of Basic Food benefits. We verify some information with computer matching programs, including the federal Income and Eligibility Verification System (IEVS).

| **We use this information to:** | **We may give this information to:** |
|---|---|
| • Decide who is eligible for our programs.<br>• Collect overpayments of food assistance.<br>• Manage our programs.<br>• Make sure we follow the law. | • Federal and state agencies for official use.<br>• Law Enforcement agencies pursuing people who are fleeing to avoid the law.<br>• Private collection agencies to collect food assistance overpayments. |

**Information reported to the Department of Social and Health Services may affect eligibility for health care coverage administered by the Health Care Authority and the Health Benefit Exchange.**

**Food Assistance Penalty Warning**

**We check with other agencies that your information is correct.** If any information is incorrect, the persons who apply may not get Food Assistance.

**Any member who breaks any of the rules on purpose can be:**

- Subject to prosecution under other applicable Federal and State laws.
- Barred from the SNAP for one year to permanently.
- Fined up to $250,000.
- Imprisoned up to 20 years.
- Barred from SNAP for an additional 18 months if court ordered.

**If a court finds you guilty of:**

| **Receiving benefits in a transaction involving:** | **You may be:** |
|---|---|
| • The sale of a controlled substance | Disqualified from two years to permanently. |
| • The sale of firearms, ammunition, or explosives | Permanently disqualified. |
| • Trafficking benefits of more than $500 combined | Permanently disqualified. |
| • Residency or identity fraud | Disqualified for 10 years. |

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# Eligibility Review

**Ask us if you need help filling out this form.**

| 1. FIRST NAME MIDDLE INITIAL LAST NAME | SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTATIVE (REQUIRED) | 2. CLIENT ID NUMBER (IF KNOWN) |
|---|---|---|
| 3. STREET ADDRESS WHERE YOU LIVE CITY STATE ZIP CODE | | 4. PRIMARY PHONE NUMBER<br>☐ CELL ☐ HOME ☐ MESSAGE |
| 5. MAILING ADDRESS (IF DIFFERENT) CITY STATE ZIP CODE | | 6. SECONDARY PHONE NUMBER(S)<br>☐ CELL ☐ HOME ☐ MESSAGE |
| | | 7. EMAIL ADDRESS |

8. I am applying for (check all that apply):

☐ Cash
☐ Food
☐ Medicare Savings Program
☐ Hospice
☐ Assisted Living / Adult Family Home
☐ In-Home Long Term Care Services
☐ Nursing Home
☐ Healthcare / Workers with Disabilities (HWD)
☐ Health Care coverage for the aged, blind, or disabled
☐ Tailored Supports for Older Adults Services

9. I or someone in my household (check all that apply): ☐ Are in a domestic violence situation
☐ Have a disability ☐ Can't work because of health problems
☐ Are pregnant; name: _____ due date: _____

10. How much money do you expect your household to get this month? $_____

11. How much money does your household have in cash and bank accounts? $_____

12. How much does your household pay for rent or mortgage? $_____

13. What utilities does your household pay for? ☐ Heating/cooling ☐ Telephone ☐ Other: _____

14. Is anyone in your household a seasonal or migrant farm worker? ☐ Yes ☐ No

15. If applying for food assistance, how many people in your household do you buy and prepare food for? _____

**FOR OFFICE USE ONLY – Household eligible for expedited service: ☐ Yes ☐ No Screener's Initials: _____ Date: _____**

16. ☐ I need an interpreter. I speak: _____ or ☐ sign; translate my letters into: _____

17. List everyone in your household even if you are not applying for them (attach additional sheets, if necessary).

| NAME (FIRST, MIDDLE, LAST) | GENDER | HOW IS THIS PERSON RELATED TO YOU? | DATE OF BIRTH | CHECK IF YOU WANT BENEFITS FOR THIS PERSON | OPTIONAL FOR NON-APPLICANTS | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | SOCIAL SECURITY NUMBER | CHECK IF U.S. CITIZEN | RACE (SEE SAMPLES BELOW) | TRIBE NAME (For American Indians, Alaska Natives) |
| | | Myself | | ☐ | | ☐ | | |
| | | | | ☐ | | ☐ | | |
| | | | | ☐ | | ☐ | | |
| | | | | ☐ | | ☐ | | |
| | | | | ☐ | | ☐ | | |
| | | | | ☐ | | ☐ | | |
| | | | | ☐ | | ☐ | | |



Barcode label

14078

| APPLICANT'S NAME | SOCIAL SECURITY NUMBER | CLIENT IDENTIFICATION NUMBER |
|---|---|---|
| | | |

18. My ethnic background is Hispanic or Latino: ☐ Yes ☐ No

Race and Ethnic background information is voluntary and will not affect eligibility or benefit amounts. This information is used to assure program benefits are distributed without regard to race, color, or national origin. . For Food Assistance the USDA requires us to answer for you if no information is provided. **Race examples:** White, Black or African American, Asian, Native Hawaiian, Pacific Islander, American Indian, Alaska Native, or any combination of races.

## I. General Information

1. In the past 30 days, I received cash or food from another state, tribe, or other source. ☐ Yes ☐ No
2. Someone I'm applying for lives outside Washington State: ☐ Yes ☐ No Who: _____
3. I or someone in my household is a sponsored alien: ☐ Yes ☐ No Who: _____
4. I or someone in my household age 16 or older is in (check all that apply): ☐ High School ☐ a High School Equivalency Program ☐ College ☐ Trade School Who: _____
5. Someone is temporarily out of my home: ☐ Yes ☐ No Who: _____
6. I or someone in my home has served in the U.S. Armed Forces, National Guard, or Reserves or been a dependent or spouse of someone who has served: ☐ Yes ☐ No If yes, who: _____
7. I am or someone I'm applying for is fleeing from the law to avoid going to court or jail for a felony crime: ☐ Yes ☐ No
8. I am living in: ☐ My own house or apartment ☐ Group Home ☐ Other: _____
   ☐ Facility (list type): _____ Date entered: _____
9. I am: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ In a Registered Domestic Partnership
10. I or someone in my home was convicted of trading Food Assistance for drugs after September 22, 1996: ☐ Yes ☐ No
11. I or someone in my home was convicted of buying or selling Food Assistance over $500 after September 22, 1996: ☐ Yes ☐ No
12. I or someone in my home was convicted of trading Food Assistance for guns, ammunitions, or explosives after September 22, 1996: ☐ Yes ☐ No
13. I or someone in my home was convicted of getting Food Assistance in more than one State after September 22, 1996: ☐ Yes ☐ No
14. I or someone in my home is: a. On strike: ☐ Yes ☐ No b. A boarder: ☐ Yes ☐ No
15. I or someone in my household has won $4,250 or more in lottery or gambling winnings: ☐ Yes ☐ No
    If yes, who: _____ Date received: _____
    Amount (dollar amount before taxes): _____

## II. Health Insurance Information (Not needed for Basic Food)

**I, my spouse, or someone in my household:**

1. Plan to enter, are in, or recently left a medical facility (such as a hospital or nursing home) ... ☐ Yes ☐ No
2. Need help with unpaid medical bills for any of the past three months ..... ☐ Yes ☐ No
3. Have health insurance: ☐ Yes ☐ No (check all that apply): ☐ Medicare (not Washington Apple Health) ☐ Tricare ☐ Long-Term Care Insurance ☐ Indian Health Services ☐ Other Health Insurance:

## III. Resources (Attach Proof; not needed for HWD, or Basic Food)

A resource is anything you own or are buying that can be sold, traded, or converted into cash or money held by others. A resource does not include personal property such as furniture, or clothing. Examples of resources are:

- Cash
- Checking accounts
- Savings accounts
- College Funds
- Trusts
- IRA / 401k
- Homes, Land or Buildings
- CDs
- Money Market accounts
- Bonds
- Retirement fund
- Burial funds, prepaid plans
- Business equipment
- Livestock
- Life Insurance

| APPLICANT'S NAME | SOCIAL SECURITY NUMBER | CLIENT IDENTIFICATION NUMBER |
|---|---|---|
| | | |

## III. Resources (Attach Proof; not needed for HWD, or Basic Food) (Continued)

Please list the resources you, your spouse, or anyone you are applying for owns or is buying:

| RESOURCE | WHO OWNS | LOCATION | VALUE |
|---|---|---|---|
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |

2. I, my spouse, or someone I'm applying for have cars, trucks, vans, boats, RVs, trailers, or other motor vehicles:

| YEAR (E.G., 1980) | MAKE (E.G., FORD) | MODEL (E.G., ESCORT) | CHECK IF LEASED | CHECK IF VEHICLE IS USED FOR MEDICAL PURPOSES | AMOUNT OWED |
|---|---|---|---|---|---|
| | | | ☐ | ☐ | $ |
| | | | ☐ | ☐ | $ |

3. I, my spouse, or someone I'm applying for has sold, traded, given away, or transferred a resource in the last five years (including trusts, vehicles, cash or life estates): ☐ Yes ☐ No
   If yes, what: _____ when: _____

## IV. Annuities (Investments made by any household member to receive regular payments now or in the future.)

| WHO OWNS THE ANNUITY? | COMPANY OR INSTITUTION? | AMOUNT OR VALUE | MONTHLY INCOME | DATE PURCHASED |
|---|---|---|---|---|
| | | $ | $ | |
| | | $ | $ | |
| | | $ | $ | |

If you, or your spouse, have an interest in an annuity and you accept Washington Apple Health Long Term Care, SSI Related or CN coverage, you must name the State of Washington as a remainder beneficiary of the annuity.

## V. Earned Income (Attach Proof)

1. I, my spouse, or someone I'm applying for had a job that ended in the past 30 days: ☐ Yes ☐ No
2. I, my spouse, or someone I'm applying for has income from work: ☐ Yes ☐ No If yes, please complete this section:

| WHO EARNS THIS INCOME | GROSS AMOUNT RECEIVED (DOLLAR AMOUNT BEFORE DEDUCTIONS) |
|---|---|
| _____<br>EMPLOYER'S NAME AND PHONE NUMBER<br>_____<br>START DATE<br>_____<br>Is this job self-employment? ☐ Yes ☐ No<br>Monthly self-employment expense amount: $_____ | $_____every: ☐ Hour ☐ Week<br>☐ Two weeks ☐ Twice a month ☐ Month<br>Hours per week: _____<br>Pay dates (e.g., 1st and 15th, or every Friday): |
| WHO EARNS THIS INCOME | GROSS AMOUNT RECEIVED (DOLLAR AMOUNT BEFORE DEDUCTIONS) |
| _____<br>EMPLOYER'S NAME AND PHONE NUMBER<br>_____<br>START DATE<br>_____<br>Is this job self-employment? ☐ Yes ☐ No<br>Monthly self-employment expense amount: $_____ | $_____every: ☐ Hour ☐ Week<br>☐ Two weeks ☐ Twice a month ☐ Month<br>Hours per week: _____<br>Pay dates (e.g., 1st and 15th, or every Friday): |

| APPLICANT'S NAME | SOCIAL SECURITY NUMBER | CLIENT IDENTIFICATION NUMBER |
|---|---|---|
| | | |

## VI. Other Income (Attach Proof, Report for All Household Members)

- Unemployment benefits
- Social Security income
- Tribal income
- Gaming income
- Educational benefits (student loans, grants, work - study)
- Supplemental Security income (SSI)
- Child Support or spousal maintenance
- Railroad benefits
- Rental income
- Retirement or pension
- Veteran Administration (VA) or military benefits
- Labor and Industries (L&I)
- Trusts
- Interests / Dividends

| UNEARNED INCOME TYPE | WHO GETS THE INCOME? | GROSS MONTHLY AMOUNT |
|---|---|---|
| | | $ |
| | | $ |
| | | $ |
| | | $ |

## VII. Monthly Expenses

| RENT | MORTGAGE | SPACE RENT | HOMEOWNER'S INSURANCE | PROPERTY TAXES | OTHER FEES |
|---|---|---|---|---|---|
| $ | $ | $ | $ | $ | $ |

What utilities does your household pay for <u>separately</u> from rent or mortgage?
☐ Heat (Electric/Gas) ☐ Electric (Not Heat) ☐ Water ☐ Home/Cell Phone ☐ Sewer ☐ Garbage

Another person or agency, such as subsidized housing, helps me pay either all or part of these expenses: ☐ Yes ☐ No If yes, who: _____ What expense: _____ Amount they pay: $ _____

☐ I received a Low Income Home Energy Assistance Act (LIHEAA) payment in the past 12 months.

I, my spouse, or someone in my household pay or are supposed to pay (check all that apply):

| | | |
|---|---|---|
| ☐ Child or Adult Dependent Care (including transportation costs) | Monthly amount: $ | Who pays: |
| ☐ Medical bills for persons with disabilities or age 60 + (including transportation costs and health insurance premiums) | Monthly amount: $ | Who pays: |
| ☐ Child support (attach proof) | Monthly amount: $ | Who pays: |

If you do not report any of the above listed expenses, we will consider this as a statement by your household that you do not want to receive a deduction for this expense.

## VIII. Authorized Representative

An Authorized Representative is someone you allow DSHS to talk with about your benefits. You can name someone, but you do not have to.

Do you have an Authorized Representative? ☐ Yes ☐ No
Is this person your legal guardian? ☐ Yes ☐ No
Does this person have Power of Attorney? ☐ Yes ☐ No

You may need to complete the Authorized Representative form (DSHS 14-532) if you are renewing your health care coverage.

| NAME | RELATIONSHIP | TELEPHONE NUMBER | |
|---|---|---|---|
| | | | |
| MAILING ADDRESS | CITY | STATE | ZIP CODE |
| | | | |

## Authorization for Asset Verification

**For Washington Apple Health Aged, Blind or Disabled Medicaid programs only.**
I understand the information I provide to apply for or renew assistance will be subject to verification by federal and state officials to determine if it is correct. I authorize the Washington State Health Care Authority (HCA) and Department of Social and Health Services (DSHS) to conduct asset verification to determine my eligibility and to verify the accuracy of my financial information. I understand the HCA and DSHS may investigate and contact any financial institution, state or federal agency, or private database, as part of the asset verification process. I understand this authorization ends when a final adverse decision is made on my application, my eligibility for benefits ends, or if I revoke this authorization at any time by providing HCA or DSHS with written notice. **Should I revoke or refuse to provide authorization, I understand that I will not be eligible for any Washington Apple Health Aged, Blind or Disabled Medicaid program.**

| APPLICANT'S NAME | SOCIAL SECURITY NUMBER | CLIENT IDENTIFICATION NUMBER |
|---|---|---|
| | | |

## Voter Registration

The Department offers voter registration services, including automatic voter registration. **Applying to register or declining to register to vote will not affect the services or amount of benefits that you may receive from this agency.** If you would like help in filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration form in private. 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: Washington State Elections Office PO Box 40229, Olympia, WA 98504-0229 (1-800-448-4881).

**Do you want to register to vote or update your voter registration?** ☐ Yes ☐ No

**If you do not check either box, we will consider you to have decided not to register to vote at this time,** unless you are eligible for, and do not decline, automatic voter registration**.**

Unless you checked "No" above, you may be eligible for automatic voter registration. You are eligible for automatic voter registration if you will be at least 18 years old by the next election, you are a citizen of the United States of America, and DSHS has your name, residential and mailing address, date of birth, verification of citizenship information, and your signature attesting to the truth of the information provided on this application.

**Do you want to be automatically registered to vote?** ☐ Yes ☐ No

**If you checked the box marked "Yes," or do not check either box and you meet automatic voter registration eligibility requirements, DSHS will send your information to the Office of the Secretary of State and you will be automatically registered to vote.**

## Declaration and Signatures

**For cash, all adults (or authorized representatives) in the household must sign.**

**For food assistance or health care coverage the applicant (or authorized representative) must sign.**

I understand I must:

- Give correct information and follow reporting requirements.
- Provide proof I am eligible.
- Assign certain rights to child support to the State of Washington when I receive Temporary Assistance for Needy Families (TANF). However, I can ask DSHS not to pursue child support if it would endanger me or my children.
- Cooperate with food assistance work requirements.

If I don't do these things, I may be denied benefits or have to pay them back.

I understand I can be criminally prosecuted if I willfully make a false statement or fail to report something I should report.

I authorize DSHS to contact other persons or agencies when necessary to help me get proof that I am eligible.

For cash and food, I have read or had explained to me my rights and responsibilities and received a copy of the Client Rights and Responsibilities, DSHS 14-113. For health care coverage, I have read or had explained to me my rights and responsibilities and received a copy of the Client Rights and Responsibilities, HCA 18-003, **I certify or declare under penalty of perjury under the laws of the State of Washington that the information I gave in this application, including the information concerning citizenship and alien status of the members applying for benefits, is true and correct.**

| APPLICANT'S SIGNATURE | DATE | PRINTED NAME OF APPLICANT | CITY AND STATE WHERE SIGNED |
|---|---|---|---|
| | | | |
| OTHER ADULT APPLICANT'S SIGNATURE | DATE | PRINTED NAME OF OTHER ADULT | CITY AND STATE WHERE SIGNED |
| | | | |
| HELPER OR REPRESENTATIVE'S SIGNATURE | DATE | PRINTED NAME OF REPRESENTATIVE | CITY AND STATE WHERE SIGNED |
| | | | |
| WITNESS' SIGNATURE IF SIGNED WITH AN "X" | DATE | PRINTED NAME OF WITNESS | |
| | | | |