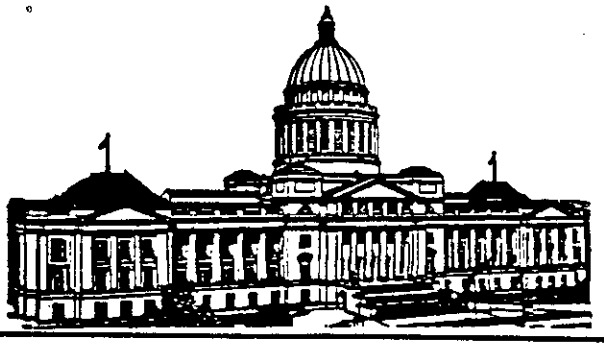
ARKANSAS REGISTER

Transmittal Sheet



Sharon Priest
Secretary of State
State Capitol Rm. 01
Little Rock, Arkansas 72201-1094

For Office Use Only: Effective Date 2/3/00 Code Number 016.20.00-001

Name of Agency Department of Human Services

Department Division of County Operations

Contact Person Roy D. Kindle, Jr. Phone 682-8251

Statutory Authority for Promulgating Rules P.L. 104-193, The Food Stamp Act of 1977

FSC 99-24

		Date
Intended Effective Date	Legal Notice Published	12-20-99
☐ Emergency	Final Date for Public Comment	1-18-00
☑ 10 Days After Filing	Filed With Legislative Council	12-20-99
☐ Other	Reviewed by Legislative Council	
	Adopted by State Agency	3-1-00

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted In Compliance with Act 434 of 1967 As Amended.

Signature

682-8325
Phone Number

Director
Title

12-14-99
Date

FILED
AR. REGISTER DIV.
00 JAN 24 PM 3:58
SHARON PRIEST
SECRETARY OF STATE
STATE OF ARKANSAS
BY

DEPARTMENT OF HUMAN SERVICES
DIVISION OF COUNTY OPERATIONS
AMENDING LEGISLATIVE REGULATION
ARKANSAS LEGISLATIVE COUNCIL

NUMBER AND TITLE: FSC 99-24

PROPOSED EFFECTIVE DATE: March 1, 2000

STATUTORY AUTHORITY: The Personal Responsibility and Work Opportunity Reconciliation Act of 1996

NECESSITY AND FUNCTION: Combined Application (DCO-180). Currently, we use separate applications for TEA, certain Food Stamps and Medicaid categories. The new application will be used for all three programs.

PAGES FILED: A total of 9 pages were filed.

Roy D. Kindle, Jr.
Assistant Director
Office of Program Planning and Development

PROMULGATION DATE: March 1, 2000

CONTACT PERSON:

Roy D. Kindle, Jr.
Assistant Director
Office of Program Planning and Development
P.O. Box 1437, Slot 1220
Little Rock, AR 72203-1437

(501) 682-8251

NOTICE OF RULE MAKING

Pursuant to the Food Stamp Act of 1977 and the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 a proposed revision to TEA Application (DCO-180). Currently, we use separate applications for TEA, certain Food Stamps and Medicaid categories. The new application will be used for all three programs.

Copies of the revised policy may be obtained by writing to the Division of County Operations, Attention: Food Stamp Policy Section, P. O. Box 1437, Slot 1241, Little Rock, AR 72203-1437. All comments must be submitted within 30 days of the date of publication of this notice. If you need any material in a different format, such as large print, contact our Americans with Disabilities Act Coordinator at 682-8920 (Voice) or 682-8933 (TDD). The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and operates, manages and delivers services without regard to political affiliation, religion, disability, age, veteran status, sex, race, color or national origin.

Ruth Whitney
Director
Division of County Operations

QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL AND JOINT INTERIM COMMITTEE

DEPARTMENT/AGENCY HUMAN SERVICES

DIVISION COUNTY OPERATIONS

DIVISION DIRECTOR Ruth Whitney

CONTACT PERSON Roy D. Kindle, Jr.

ADDRESS Donaghey Plaza South, P.O. Box 1437, Slot 1220, Little Rock, AR 72203-1437

PHONE NO. (501) 682-8251

INSTRUCTIONS

A. Please make copies of this form for future use.
B. Please answer each question completely using layman terms. You may use additional sheets if necessary.
C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.
D. Submit two (2) copies of this questionnaire attached to the front of two (2) copies of your proposed rule and mail or deliver to:

Donna K. Davis
Subcommittee on Administrative Rules and Regulations
Arkansas Legislative Council
Bureau of Legislative Research
Room 315, State Capitol
Little Rock, AR 72201

****

1. What is the short title of this rule?

   DCO-180, Application for Medicaid, TEA and Food Stamp Benefits.

2. What is the subject of the proposed rule?

   Three applications were in use – one for the TEA Program, one for the Medicaid Program, and one for the Food Stamp Program. These three applications have been combined. The combined application will be used in all three programs.

3. Is this rule required to comply with federal statute or regulations? _____ YES XX NO

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? _____ YES XX NO

   If yes, what is the effective date of the emergency rule? _____

   When does the rule expire? _____

   Will this emergency rule be promulgated under the regular provisions of the Administrative Procedure Act? _____ YES _____ NO

5. Is this a new rule? ____ YES __XX__ NO

   Does this repeal an existing rule? ____ YES __XX__ NO

   Is this an amendment to an existing rule? __XX__ YES ____ NO

   Is this an amendment to an existing rule? <u>If yes, please attach a markup showing the changes in the existing rule and a summary of the substantive changes</u>.

   Currently we use separate applications for TEA, certain Food Stamps and Medicaid categories. The new application will be used for all three programs.

6. What state law grants the authority for this proposed rule? If codified, please give Arkansas Code citation.

   Arkansas Code 20-76-401 (the Arkansas Personal Responsibility and Public Assistance Reform Act) as amended by Act of 1567 of 1999

7. What is the purpose of this proposed rule? Why is it necessary?

   This form will be used in conjunction with the new integrated, interactive automated system under development for the Division of County Operations.

8. Will a public hearing be held on this proposed rule? ____YES __XX__ NO

9. When does the public comment period end? 1-18-00

10. What is the proposed effective date of this proposed rule 3-1-00

11. Do you expect this rule to be controversial? ____YES __XX__ NO
    If yes, please explain.

12. Please give the names of persons, groups, or organizations which you expect to comment on these rules. Please provide their position (for or against) if known.

NAME	GROUP/ORGANIZATION	ADDRESS
David Manley *Attorney at Law*	*Legal Services of Arkansas*	*209 West Capitol* *Little Rock, AR 72203*

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

DEPARTMENT HUMAN SERVICES

DIVISION COUNTY OPERATIONS

PERSON COMPLETING THIS STATEMENT Betty Helmbeck

TELEPHONE NO. 682-8284 FAX NO. 682-1469

FINANCIAL IMPACT STATEMENT

To comply with Act 884 of 1995, please complete the following Financial Impact Statement and file with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE

DCO-180, Application for Medicaid, TEA and Food Stamp Benefits

1. Does this proposed, amended, or repealed rule or regulation have a financial impact? YES XX NO ____

2. If you believe that the development of a financial impact statement is so speculative as to be cost prohibited, please explain.

3. If the purpose of this rule or regulation is to implement a federal rule or regulation, please give the incremental cost for implementing the regulation.

1999-2000 Fiscal Year		2000-2001 Fiscal Year	
General Revenue	$ -0-	General Revenue	$ -0-
Federal Funds	$ -0-	Federal Funds	$ -0-
Cash Funds	$ -0-	Cash Funds	$ -0-
Special Revenue	$ -0-	Special Revenue	$ -0-
Other	$ -0-	Other	$ -0-
Total	$ -0-	Total	$ -0-

4. What is the total estimated cost by fiscal year to any party subject to the proposed, amended, or repealed rule or regulation?
1999-2000 Fiscal Year $ -0- 2000-2001 Fiscal Year $ -0-

5. What is the total estimated cost by fiscal year to the agency to implement this regulation?
1999-2000 Fiscal Year $ -0- 2000-2001 Fiscal Year $ -0-

FILED
AR. REGISTER DIV.
00 JAN 24 PM 3:58
SHARON WEST
SECRETARY OF STATE
STATE OF ARKANSAS
BY

MANUAL TRANSMITTAL

Arkansas Department of Human Services

Division of County Operations

☐	Policy	X	Form	☐	Policy Directive

Issuance Number 99-24

Food Stamp Certification **Manual**

Issuance Date 3/1/00

From: Ruth Whitney
Director

Expiration Date Until Superseded

Subj: Joint Application (DCO-180P)

A combined *Medicaid, Food Stamp and TEA Application* (DCO-180P) is being issued for use with the ANSWER system. This form will not be used in any county until the ANSWER system is operational in that county. Until then, the county office will continue to use the individual form for each Program.

Additional instructions for the use of the form will be provided at the time of ANSWER implementation.

Inquiries to: **Betty Helmbeck, (501) 682-8284**

IF YOU NEED THIS MATERIAL IN A DIFFERENT FORMAT SUCH AS LARGE PRINT, CONTACT YOUR LOCAL DHS OFFICE.

ARKANSAS DEPARTMENT OF HUMAN SERVICES
Application for Medicaid, Food Stamp, and TEA Benefits

Name	Social Security Number	Date of Birth

Mailing Address	City	State	Zip Code

Signature	Today's Date	Your Telephone Number

✓ MEDICAID – You may use this application to apply for Medicaid for yourself or your children. (If you are applying for payments to a nursing home or if you are applying for services under the ElderChoices Program or Alternatives for Adults with Physical Disabilities, please ask the DHS County Office for an *Application for Long Term Care*.) Under the Medicaid Program, the State helps low-income individuals and families pay for medical services.

Check here if you want to apply for Medicaid benefits. ❑

✓ FOOD STAMPS – You may use this application to apply for food stamp benefits. The Food Stamp Program is designed to increase the food purchasing power of low-income families.

Check here if you want to apply for food stamp benefits. ❑

✓ TEA – You may use this application to apply for Transitional Employment Assistance (TEA). The TEA Program provides assistance to parents of a minor child when one or both of the parents are unemployed or under employed. The TEA Program may also provide assistance to relatives who are caring for a minor child in the absence of both parents.

Check here if you want to apply for TEA benefits. ❑

INSTRUCTIONS

In order to receive Medicaid, food stamp and/or TEA benefits, applicants must meet income and resource guidelines. The information you are asked to provide on this application will help the county office determine if you meet these guidelines. Some sections must be completed for all programs. Other sections must be completed only for one or two programs. Read the instructions in each section to see if you need to complete that section. If you have problems, ask any DHS employee for help in completing the application.

☛ SPECIAL INSTRUCTIONS FOR FOOD STAMP PROGRAM APPLICANTS – To apply for food stamp benefits, enter at least your name, address and signature on this page, tear it off, and turn it in to the Department of Human Services (DHS) County Office. The date you turn your application in to the DHS County Office is your application date. If you are eligible, we must authorize your first food stamp benefits within 30 days from your application date. (NOTE: If you are applying under the SSI Prerelease Program, your application date is the date of your release from the institution.) Before we can find out if you are eligible for food stamp benefits, you must fill out pages 3-7 and turn them in. You may turn these pages in now or wait and turn them in later.

***IF YOU NEED FOOD STAMP BENEFITS RIGHT AWAY**: Food stamp benefits can be authorized within seven days of the date of application if a household is eligible to receive food stamp benefits and meets certain rules. Before we can find out if your household can get expedited service, we must have the entire application form. Complete the questions on page 2, and then fill out as much of pages 3 through 8 as you can. Turn in the completed application right away.*

DO YOU WANT THE COUNTY OFFICE TO DETERMINE IF YOU ARE ENTITLED TO EXPEDITED SERVICE? YES ❑ NO ❑

FOR COUNTY USE ONLY

Soc. Sec. # _____ Program(s) _____ Appl. Dt. _____

Food Stamp Program Expedited Service? ❑ YES ❑ NO Screener _____ Screen Date _____

Denial Date _____ Reason (Optional) _____

FOOD STAMP PROGRAM – EXPEDITED SERVICE SCREENING

EXPEDITED SERVICE - Food stamp benefits for certain eligible households will be authorized within seven days of the date they file an application. The answers to the questions below will help us decide if you qualify for expedited service. Answer for yourself and all other household members.

1. Will your household's total income for this month be less than $150? (Include money already received this month. Also, include money you expect to receive later this month.) YES ☐ NO ☐
2. Does your household have $100 or less in cash, checking accounts, savings accounts, etc.? YES ☐ NO ☐
3. Is anyone in your household a migrant or seasonal farm worker? YES ☐ NO ☐
   If yes, answer questions A and B below. If no, go to question 4.
   A. Did your household's only income recently stop? YES ☐ NO ☐
   B. Do you or anyone else expect any income from a new source this month? YES ☐ NO ☐
4. Are your household's total shelter costs more than your household's total monthly income and the money your household has in cash, bank accounts, etc.? YES ☐ NO ☐

The information you provide in sections II, VI, VII and VIII of the application will be used in the screening process. Be sure to complete these sections of the application. Please ask for help if you need it.

SOCIAL SECURITY NUMBERS

If you are applying for food stamp benefits, you must give us a Social Security Number (SSN) for each household member. This is required by the Food Stamp Act of 1977, as amended by PL 97-98. SSNs are subject to verification and reviews or audits to assure your household is eligible for food stamp benefits. SSNs are used to check the identity of household members, to prevent duplicate participation and to facilitate mass changes. During this process, we may contact your employer, bank or other parties.

FOOD STAMP PROGRAM - INTENTIONAL PROGRAM VIOLATIONS

Any member of your household who intentionally breaks any of the following rules will not be able to get food stamp benefits for one year. The second time a household member intentionally breaks one of these rules, he or she will not be able to get food stamp benefits for two years. The third time a household member intentionally breaks one of these rules, he or she will never again be allowed to get food stamp benefits.

- **DO NOT GIVE FALSE INFORMATION OR WITHHOLD INFORMATION IN ORDER TO GET OR TO CONTINUE TO GET FOOD STAMP BENEFITS.**
- **DO NOT ALTER ANY AUTHORIZATION DOCUMENT TO GET FOOD STAMP BENEFITS YOU ARE NOT ELIGIBLE TO RECEIVE.**
- **DO NOT USE FOOD STAMP BENEFITS TO BUY NON-FOOD ITEMS LIKE ALCOHOLIC DRINKS, TOBACCO, OR PERSONAL GROOMING ITEMS.**
- **DO NOT TRADE OR SELL FOOD STAMP BENEFITS OR ALLOW UNAUTHORIZED USE OF ELECTRONIC BENEFITS TRANSFER (EBT) CARDS.**
- **DO NOT USE SOMEONE ELSE'S EBT CARD FOR YOUR HOUSEHOLD'S BENEFIT.**

A court of law can ban anyone who intentionally breaks Food Stamp Program rules from getting food stamps for an additional 18 months. A court can also impose fines of up to $250,000 or send the violator to jail for up to 20 years or both.

TEA PROGRAM - INTENTIONAL PROGRAM VIOLATIONS

Intentional Program Violation – This is any false or misleading statement, misrepresentation, concealment, or withholding of facts by an individual for the purpose of establishing or maintaining the family's eligibility for TEA or for the purpose of increasing or preventing a decrease in the amount of the TEA grant. The family of any individual who pleads guilty or nolo contendere to, or is found guilty of, an intentional program violation in the TEA program will be ineligible for further participation in the program for one year for the first offense, for two years for the second offense and permanently for any subsequent offense. The family will continue to be ineligible for TEA until the resulting overpayment is repaid to the State.

Fraudulent Misrepresentation of Residence – This is a fraudulent statement or misrepresentation of residence in order to receive assistance simultaneously from two or more states. The family of an individual who is convicted in a federal or state court of a fraudulent misrepresentation of residence will be ineligible to receive TEA for a minimum of ten years beginning with the date of conviction. The family will continue to be ineligible for TEA until the resulting overpayment is repaid to the State.

OTHER DISQUALIFICATIONS

Individuals found to have made a fraudulent statement or representation about their identity or residence in order to get food stamp benefits in two locations during the same month will be barred from getting food stamp benefits for ten years.

The Following Individuals are Permanently Banned From Participating in the Food Stamp Program

- Violators found guilty in a court of law of buying or selling fire arms, ammunition, explosives, or controlled substances (illegal drugs or certain drugs for which a doctor's prescription is required) in exchange for food stamp benefits.
- Violators convicted in a court of law of trafficking food stamp benefits in excess of $500.

The Following Individuals are Ineligible to Participate in Either the Food Stamp or the Tea Program

- Fugitive felons and parole or probation violators.
- Individuals found guilty of or pled guilty or nolo contendere (no contest) to any state or federal offense classified as a felony by the law or jurisdiction involved, and which has as an element of the offense the distribution or manufacture of a controlled substance.

MEDICAID, FOOD STAMP, AND TEA APPLICATION - PART II

☛ SECTION I – NAME AND ADDRESS. *(All Medicaid, Food Stamp and TEA Applicants must complete this section.)*

NAME OF APPLICANT _____ **Social Security Number** _____

Street Address _____

City _____ **County** _____ **State** _____ **Zip** _____ **Telephone** _____

Mailing address if different _____

✓ Would you like to register to vote? YES ❑ NO ❑

✓ Have you or any other household member been found guilty of or pled guilty or no contest to a felony offense involving the manufacture or distribution of a controlled substance? YES ❑ NO ❑

☛ SECTION II – HOUSEHOLD MEMBERS – *(All Medicaid, Food Stamp and TEA Applicants must complete this section.)*
LIST ALL THE PEOPLE WHO LIVE IN YOUR HOME. INCLUDE YOURSELF. If necessary, use the front page of another application or a separate sheet of paper to list everyone in your household.

Social Security Number	NAME (First, middle initial & last)	BIRTHDATE (Month, day, year)	Relationship to you	CITIZENSHIP			Race	Sex	What Program or Programs is this person applying for?			
				U.S. Citizen	Legal Alien	Other			Medicaid Benefits	Food Stamp Benefits	TEA Benefits	None

☛ SECTION III – HEALTH INSURANCE & MEDICAL SERVICES *(Only Medicaid applicants must complete this section.)*

1. Does anyone in your home now have health insurance of any kind including Medicare? **YES ❑ NO ❑** *If yes, name household member(s) and insurance including Medicare. Enter policy number or Medicare number.*
2. Has anyone in your home had health insurance other than Medicaid in the last 12 months? **YES ❑ NO ❑** *If yes, name household member(s) and insurance company. State why insurance is no longer available.*
3. Does a child in your home have a chronic illness or disability (special health need)? **YES ❑ NO ❑** *If yes, list name(s).*
4. Is anyone in your household pregnant? **YES ❑ NO ❑** *If yes, list name(s)* _____
5. Do you have any unpaid medical expenses from the last three months? **YES ❑ NO ❑**

FAMILY PLANNING –
I may be eligible for Family Planning Services and:
- ❑ I do want Family planning Services.
- ❑ I want more information.
- ❑ I do not want Family Planning Services.
- ❑ I would like Family Planning Services when my pregnancy ends.

CHILD HEALTH SERVICES (Health Checkups)
The health checkup program has been explained to me and:
- ❑ I do want this service for all eligible persons
- ❑ I do want this service for only the following persons: _____
- ❑ I do not want this service.

☛ SECTION IV – FOOD STAMP HOUSEHOLD MEMBERS *(Only Food Stamp applicants must complete this section.)*

1. Are you or any other household member paying money for a room or meals to a person with whom you live? **YES ❑ NO ❑**
2. Are you or any other household member age 60 or older and unable to shop for food or cook meals because of a disability? **YES ❑ NO ❑**
3. Are you or any other household member participating in the Food Stamp Program in another place? **YES ❑ NO ❑**
4. Are you or any other household member now disqualified, or have you or any other household member ever been disqualified, from the Food Stamp Program for providing incorrect information or for failing to provide information that affected food stamp eligibility and benefits? **YES ❑ NO ❑**
5. Are you or any household member attending or have you applied for admission to an institution of higher education such as a college, vocational school, or any other training program beyond high school ? **YES ❐ NO ❐**

☛ SECTION V – AUTHORIZED REPRESENTATIVE *(Only Food Stamp applicants will complete this section.)*

You can authorize someone outside your household to make an application for food stamp benefits for your household. You can authorize the same person or someone else to use your EBT card to buy food for your household. If you would like to authorize someone, write the name below.

Name	Name
Address	Address
Telephone	Telephone

☛ SECTION VI – RESOURCES (*All Medicaid, TEA and Food Stamp applicants must complete this section.*)

Complete this section for yourself, your children, and all other members of your household. Report all resources your household owns, is buying or has access to.

DO YOU HAVE?	YES	NO	OWNER'S NAME	Total Value	OTHER
Cash on hand and/or savings at home				$	
Savings accounts/ Certificates of Deposit (CD) Credit Union Accounts				$	Bank Name -
				$	Bank Name -
Checking accounts				$	Bank Name -
Stocks, bonds, IRAs Keogh Plans, Mutual Funds				$	Stock Name -
Cars and Trucks (Running or Not) # 1 Licensed? YES ☐ NO ☐				$	Make Model Year
# 2 Licensed? YES ☐ NO ☐				$	Make Model Year
# 3 Licensed? YES ☐ NO ☐				$	Make Model Year
Boats & Motors, Campers Motorcycles, three or four, wheelers, etc.				$	Make Model Year
Real estate other than your home				$	Location Amount Owed $
Other (Prepaid burial plans, trust funds, etc.)				$	Description -

If you are applying for TEA or Medicaid benefits, please answer the following two questions:

1. Do you or anyone in your household own a life insurance policy? **YES ❐ NO ❐** Value $_____
2. If you have declared a vehicle, are you making payments on the vehicle? **YES ❐ NO ❐** Amount owed? $_____

If you are applying for food stamp benefits, please answer the following question.

HAVE YOU OR ANYONE IN YOUR HOUSEHOLD SOLD, TRADED OR GIVEN AWAY ANYTHING OF VALUE IN THE LAST THREE MONTHS? **YES ❐ NO ❐**
IF YES, PLEASE TELL WHAT HAPPENED.

☛ Section VII – INCOME - CASH, BENEFIT CHECKS, ETC. *(All Medicaid, food stamp and TEA applicants must complete this section.* ***Please answer each question on this page.)***

① Complete this section to tell us whether you or any member of your household receives any of the listed income.

SOURCE OF INCOME	Does anyone receive Yes	No	IF YES, NAME OF PERSON WHO RECEIVES CHECK / PAYMENT	AMOUNT OF EACH CHECK OR PAYMENT	MOST RECENT DATE OF PAYMENT	HOW OFTEN RECEIVED? (weekly, monthly, etc.)
Social Security			1.	$		
			2.	$		
Supplemental Security Income (SSI)			1.	$		
			2.	$		
Veteran's Benefits (VA)			1.	$		
			2.	$		
Unemployment Compensation			1.	$		
			2.	$		
Child Support/ Alimony			1.	$		
			2.	$		

② **Complete this section to report money or checks coming in from any of the income sources listed here –Railroad Retirement or other pensions, utility assistance payments, rental income, roomers, boarders, interest, dividends, royalties, mineral rights payments, contributions from friends and relatives, loans, prizes, gifts, payments from the sale of property you used to own, or any other unearned income. If you receive TEA cash assistance, we have a record of your payments.**

State Source of Income	Name of Household Member Who Receives This Income	Amount of Each Check or Payment	How Often Received (weekly, monthly, etc.)
		$	
		$	
		$	

③ **Did you or anyone in your household recently apply to receive money from any source? YES ❑ NO ❑**

IF YES, STATE TYPE OF BENEFIT _____ **WHO APPLIED?** _____

WORK INCOME

1. Did you or anyone in your household receive any wages, salaries, tips or commissions from work this month? **YES ❑ NO ❑**

If yes, complete the information below for each job held by a household member. Attach a sheet of paper if you need more room.

Name _____ Employer/Company _____

Name _____ Employer/Company _____

2. Did you or anyone in your household quit a job in the last 60 days? **YES ❑ NO ❑** If yes, who? _____

3. Are you or anyone in your household on strike? **YES ❑ NO ❑** If yes, who? _____

4. Are you or anyone in your household self-employed? **YES ❑ NO ❑** If yes, who? _____

5. Are you or anyone in your household participating in job training? **YES ❑ NO ❑** If yes, who? _____

6. Are you or anyone currently in your household serving in the active military, National Guard or a reserve unit? **YES ❑ NO ❑**

If yes, who? _____ Branch of service _____

7. Do you expect to go to work or to have any changes in any job declared on this application? **YES ❑ NO ❑**

If yes, explain what will change. _____

Notice to Food Stamp Applicants – To receive a deduction for any of the expenses listed on this page, you must report the expense and provide verification, if requested. Failure to report or (if requested) to provide verification of any of these expenses will be seen as a statement by your household that you do not want to receive a deduction.

☛ SECTION VIII – MEDICAL & SHELTER EXPENSES *(Only food stamp applicants must complete this section.)*

1. **The current medical costs of anyone who is age 60 or older or who gets disability benefits are deductible. Please complete this section if you or anyone in your household is aged or gets disability benefits.**

Does any aged or disabled household member pay medical costs? **YES** ❑ **NO** ❑
If yes, enter the names of the household members who pay medical costs.

_____

Proof of Current Medical Expenses. Your application can be completed without proof of medical expenses. However, if you wish to get a medical deduction, you must provide receipts, bills, or other documentation to prove your current medical expenses.

2.. **List your household's *current* shelter costs. Do not list past due amounts.**

EXPENSE	AMOUNT
Rent	$
Mortgage (House Payment)	$
Property Tax (If not included with house payment)	$
Home Owner's Insurance (If not included with house payment)	$

EXPENSE	AMOUNT
Electricity	$
Garbage/Trash Pickup	$
Natural OR Butane Gas	$
Water/Sewer	$

EXPENSE	AMOUNT
Telephone	$
Utility Installation Charges	$
Other_____	$
Other_____	$

Does any person or agency help pay your shelter costs? **YES** ❐ **NO** ❐ If yes, who? _____

☛ SECTION IV – CHILD SUPPORT AND DEPENDENT CARE EXPENSE *(Both Food Stamp and Medicaid applicants must complete this section.)*

1. Do you or anyone else in your home pay child support to someone living outside your home? **YES** ❑ **NO** ❑

If yes, who pays?	Amount Paid $ _____
To whom? Name - _____	How often? (Choose one) Weekly ❑ Bi-weekly ❑
Address - _____	Monthly ❑ Other ❑
Telephone Number - _____	Are these payments court ordered? YES ❑ NO ❑

You must provide verification of both your obligation to pay child support and the amount you actually pay.

2. Do you or anyone in your household pay someone to care for a child or a disabled or elderly adult so that a household member can work, attend training or school, or look for work? **YES** ❐ **NO** ❐

If yes, name of person or daycare center _____ Telephone number _____
Address _____
Does anyone help pay these costs? **YES** ❐ **NO** ❐ If yes, who? _____

CHILD SUPPORT ENFORCEMENT REQUIREMENTS FOR MEDICAID AND TEA APPLICANTS

TRANSITIONAL EMPLOYMENT ASSISTANCE (TEA) – I understand that if I accept TEA cash assistance, by state law, I will have assigned all rights, title and interest in any support that I have in my own behalf or in behalf of any other person for whom I am receiving TEA. I understand that all support payments including those received by me directly from the absent parent, are to be paid to the Office of Child Support Enforcement. I understand that this assignment ends when I no longer receive TEA except as to any unpaid support obligation that has accrued at the time my TEA case is closed. I also understand that as a condition of eligibility for TEA, I must cooperate with the Office of Child Support Enforcement in establishing paternity and obtaining child support.

MEDICAID – As a condition of eligibility for Medicaid, each applicant or recipient must cooperate with the Office of Child Support Enforcement (OCSE) in establishing paternity and obtaining medical support for each child who has a parent absent from the home. All other OCSE services, including collection of child support payments from the absent parent, will be provided unless OCSE receives a written notice from me that I do not want these services.

ASSIGNMENTS OF MEDICAL PAYMENTS BY MEDICAID APPLICANTS

I authorize any holder of medical or other information about me to release information needed for a Medicaid claim to DHS. I further authorize release of any information to other parties who may be liable for my medical expenses. As an eligibility condition, I automatically assign my rights to any settlement, judgment, or award which may be obtained against any third party to DHS to the full extent of any amount which is paid by DHS on my behalf. I authorize and request that funds, settlement or other payments made by or on behalf of third parties, including tortfeasors or insurers arising out of a Medicaid claim, be paid directly to DHS. My application for Medicaid benefits shall in itself constitute an assignment by operation of law and shall be considered a statutory lien of any settlement, judgment, or award received by me from a third party. A third party is any person, entity, institution, organization or other source which may be liable for any injury, disease, disability, or death sustained by me or others named herein, including estates of such individuals. I also assign all rights in any settlement made by me or on my behalf arising out of any claim to the extent of medical expenses paid by DHS, whether or not a portion of such settlement is designated for medical expenses. Any such funds received by me shall be paid to DHS. A copy of this authorization may be used in place of the original.

SIGNATURE

READ THE FOLLOWING INFORMATION CAREFULLY BEFORE YOU SIGN THIS APPLICATION.

- I understand that I must help establish my eligibility by providing as much information as I can about my circumstances.
- I authorize DCO to obtain information from other state agencies and other sources to confirm the accuracy of my statements.
- I understand that no person may be denied Medicaid, Food Stamp, or TEA benefits on the grounds of race, color, sex, age, handicap, religion, national origin, or political belief.
- I understand that I may request a hearing from DHS if a decision is not made on my case within the proper limit or if I disagree with the decision.
- I authorize DHS to examine all records of mine or records of those who receive or have received Medicaid benefits through me to investigate whether or not any person has committed Medicaid fraud, or for use in any legal administrative or judicial proceeding.
- I understand that TEA cash assistance will be limited to twenty-four months of my lifetime.
- If I am a TEA or Medicaid recipient, I agree to notify the DHS County Office within 10 days if I or any of my dependents cease to live in my home, if I move, if I become employed or my earnings change, or if any other changes occur in my circumstances.
- If I receive Food Stamp benefits, I understand that I may be required to submit a quarterly report. If I am not required to submit a quarterly report, I agree to report changes in my circumstances within 10 days.
- If I am applying for Food Stamp benefits, I understand that by my signature I am work-registering all non-exempt members of my household. I understand that I will receive a notice telling me which household members are work-registered.
- I understand the questions on this application and the penalties for hiding information or giving false information.
- I certify, under penalty of perjury, that my answers are correct and complete to the best of my knowledge and that all household members are either U.S. citizens or aliens with legal immigration status.
- I understand that if I receive benefits for which I am not eligible because I withheld information or provided inaccurate information, such assistance will be subject to recovery by DCO, that any assistance I receive in the future may be reduced to recover this overpayment, and that I may be subject to prosecution for fraud and fined and/or imprisoned.

Sign Here _____ **Today's Date** _____

Sign Here _____ **Today's Date** _____

Witness if signed with an X _____ **Today's Date** _____

ATTENTION TEA APPLICANTS:
Please review and sign the Personal Responsibility Agreement on the back of this page. Thank you.

COUNTY USE ONLY

PERSON INTERVIEWED: _____ INTERVIEWED BY _____ DATE _____

(Complete this page only if you are applying for TEA benefits.)

Personal Responsibility Agreement

I understand public assistance is temporary as I seek to become self-supportive and economically independent. I understand that it is my responsibility to find and keep a job and to secure all other potential sources of income for the support of myself and my dependent children.

In return for public assistance, I agree to be held responsible for:

1. Looking for employment or following up on job referrals required by my caseworker before, during, and after approval of my application for assistance.

2. Cooperating with my caseworker in developing and following my Employment Plan. DHS has informed me that the supportive services described in the attached information will be available to me as needed to comply with my Employment Plan.

3. Accepting full or part-time employment that may be offered.

4. Not voluntarily terminating employment.

5. Ensuring that my children receive their age appropriate childhood immunizations. (I understand that I will receive guidance from my caseworker on how to achieve this without cost to myself.)

6. Ensuring that my school age children attend school.

7. If I am an unmarried minor parent, I will reside in the household of a parent, legal guardian, other adult relative, or in an approved adult-supervised living arrangement unless my caseworker approves other living arrangements. I understand that I should tell my caseworker right away if circumstances occur that require an alternative living arrangement.

8. Cooperating with the Office of Child Support Enforcement in seeking child support payments and/or establishing paternity.

I understand that in some circumstances the agency may determine that I had good cause for not complying with the above requirements and in certain unique circumstances I may be granted an extension or exemption of a specific program requirement.

Parent/Caretaker Relative Signature	Date
Parent/Caretaker Relative Signature	Date
Minor Parent Signature (if appropriate)	Date
Case Worker's Signature	Date