Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587).

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Family Assistance Administration
Arizona Health Care Cost Containment System (AHCCCS)

APPLICATION FOR BENEFITS

Tear off and keep pages A through L for your records.

What is this application for?

Use this application to see if you and members of your household qualify for:

- Free or low-cost insurance from AHCCCS
- Help with your Medicare costs
- Nutrition Assistance
- Cash Assistance/Temporary Assistance for Needy Families (TANF)
- Tuberculosis Control
- A new tax credit that can help pay your health insurance premiums

See pages B and C for a description of each program.

Who can use this application?

An application may be completed by you or anyone you choose who knows or can get the information needed to complete the application for you and your household members. You can use this application to apply for anyone in your household, even if they already have benefits, including health insurance.

Your household includes:

- Your spouse, if married
- Your children under age 22 who live with you
- Your partner who lives with you (but only if you have a child together who needs health insurance or Cash Assistance)
- People you claim on your income tax return even if they do not live with you
- Relatives in your care who are under the age of 19 and live with you
- People who you live with that purchase and prepare food with you

If you want to select a representative to complete your application, complete the Authorized Representative form on page 1 and 2 of the application.

Where else can I apply?

You can apply faster online at www.healthearizonaplus.gov.

You can also apply in person at any local Department of Economic Security (DES)/Family Assistance Administration (FAA) office.

You can find a list of local FAA offices at https://des.az.gov/ or call our 24 hour Interactive Voice Response system at 1-855-HEAPLUS (432-7587).

What if I need help?

If you need help filling out this application, please tell us. If you need a language interpreter or accommodations for a disability, please check the kind of help you need on page 1 of the application.

Online: www.healthearizonaplus.gov
Phone: 1-855-HEA-PLUS (432-7587)
In person: Visit www.des.az.gov to find the office closest to you.

Do you need help with this application? Visit www.healthearizonaplus.gov
or call 1-855-HEA-PLUS (432-7587).

What information do I need to complete this application?

You can file an application with only your name, address, and the signature of a responsible household member or your authorized representative. This will hold your date of application. Eligibility cannot be determined until you complete a full application and an interview for Nutrition Assistance and Cash Assistance. If eligible, benefits are provided from the date the agency receives the application.

Note: When an application if filed while the applicant is in an institution, the filing date will not be the date of application but will be the date that the applicant is released from the institution.

Why do we ask for so much information?

We ask about income and other information to make sure you and members of your household get the correct benefits for your household.
We will keep all information you provide private, as required by law.

What happens next?

Send your signed application to the address on page 28 or take it to your local DES office. If you do not have all of the information available, you can still submit your application and we will help you get the rest of the information.

Program Information:

You can use this application to apply for one or more programs. Each program has a symbol. On the application, look for the symbol for the program(s) you want to apply for and answer those questions. These are the symbols you will see on this application:

= Health Insurance Costs (AHCCCS Medical Assistance, Medicare Savings Program, Tax Credits)

= Nutrition Assistance

= Cash Assistance

= Tuberculosis Control

What are Nutrition Assistance benefits?

Nutrition Assistance benefits help low-income families or individuals buy food for a healthier diet. If you have little or no money, you may be eligible for Emergency Nutrition Assistance benefits. Be sure to answer the Emergency Nutrition Assistance benefits questions on page 3 of this application. If you qualify for Emergency Nutrition Assistance benefits, you can get them within 7 days of your application date.

What is Cash Assistance?

Cash Assistance gives temporary cash benefits to low income families. Parents or relatives of dependent children who are in their care may be eligible.

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587).

What is Tuberculosis Control?

Tuberculosis Control gives cash support to individuals who are determined unable to work by the Department of Health Services as a result of communicable Tuberculosis.

What is AHCCCS Medical Assistance?

AHCCCS stands for Arizona Health Care Cost Containment System, and it is the State of Arizona's Medicaid program. AHCCCS can provide medical benefits and help with Medicare costs to Arizona residents who meet certain income and other eligibility standards. AHCCCS Medical Assistance covers the following medical services:

- Prescription Medication*
- Medical Supplies
- Chemotherapy
- Doctor's Office Visits
- Medically Necessary Transportation
- Emergency Medical Care
- Laboratory and X-ray Services
- Medically Necessary Specialist Care
- Rehabilitation Services
- Hospital Services
- Behavioral Health Care
- 90 days of nursing care
- Dialysis
- Immunizations (shots)

*AHCCCS prescription coverage is limited for people who have Medicare.

What is Medicare Savings Program?

Medicare Savings Program may pay:

- Medicare Part A premium
- Medicare deductibles and copayments
- Medicare Part B premium
- Automatic Extra Help for Medicare Part D prescription expenses

What if I am not eligible for AHCCCS Medical Assistance?

If you are not eligible for AHCCCS Medical Assistance, you may be eligible for federal tax credits to help with your health insurance premiums. If you are not eligible for any programs through AHCCCS, we will send your information to the federal Health Insurance Marketplace to see about health insurance tax credits.

If you are waiting for your application to be processed or you are not eligible for AHCCCS Medical Assistance, you may qualify to receive drug and alcohol and mental health treatment services through other funding sources administered by the Regional Behavioral Health Authority, or RBHA. For more information, contact the RBHA in your area at: Central Arizona – (602) 586-1841 or toll-free (800) 564-5465; Northern Arizona – (800) 640-2123; or Southern Arizona – (866) 495-6738.

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587).

How does AHCCCS Medical Assistance work?

If you are approved for AHCCCS Medical Assistance, you will receive your health care from an AHCCCS health plan unless:

- You are an American Indian and you choose American Indian Health Program as your health plan.
- You are only asking for help with your Medicare costs. If you are approved for one of the Medicare Savings Programs (QMB), AHCCCS may pay your Medicare premiums and Medicare coinsurance and deductibles.
- AHCCCS can only pay for your emergency services because of your status with United States Citizenship and Immigration Services (USCIS). If you are approved for emergency services only, you may receive medical services from any provider (doctor, hospital, etc.) that has an agreement to bill AHCCCS for covered emergency services.

How much does AHCCCS Medical Assistance cost?

Premiums:

- Most people do not have to pay a monthly premium for AHCCCS Medical Assistance.
- Some people with income too high to qualify for AHCCCS Medical Assistance with no monthly premium may be able to get it by paying a monthly premium. If you have to pay a premium, the premium amounts are:
  - $10 to $35 for customers on the Freedom to Work program.
  - $10 to $70 for customers on the KidsCare program.

Copayments:

- A co-payment is the amount you pay a health care provider when you receive a medical service. Your co-payment amount will vary depending on which AHCCCS program you are enrolled in and the services you need. For some AHCCCS programs, the provider can deny services if the co-payments are not made. Remember to report any changes in income because this may change your co-payment amount. Co-payments for services are:
  - $2.30 to $10 for prescriptions.
  - $0 to $30 for non-emergency use of an emergency room.
  - $3.40 to $5 for outpatient visits for evaluation and management services including doctor's office visits.
  - $2.30 to $3 for physical, occupational or speech therapy.

The following people are never asked to pay co-payments:

- Children under age 19.
- People determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services.
- Individuals through age 20 who receive services from the Children's Rehabilitative Services (CRS) program.
- People who are residing in nursing home or residential facilities such as an Assisted Living Home and only when the acute care member's medical condition would otherwise require hospitalization. The exemption from co-payments is limited to 90 calendar days in a contract year.
- People who receive hospice care.

The following services are always provided at no cost for anyone enrolled in an AHCCCS program:

- Hospitalizations
- Services paid on a fee for service basis
- Emergency services
- Pregnancy related health care including tobacco cessation for pregnant women
- Family planning services

Do I need a Social Security Number?

Federal law requires you give a Social Security number (SSN) for anyone who wants to get AHCCCS Medical Assistance, help with Medicare costs, Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control (42 U.S.C. §1320b-7; 42 U.S.C. §405(c)(2)(C), 7 U.S.C. §§ 2011-2036, and Social Security Act (SSA) of 1935 (Section 1137) as amended by P.L. 98-369).

- If you or anyone you are applying for does not have an SSN, we will refer you to the Social Security office to apply for one. Immigrants who are not legally able to get an SSN are not required to give one or apply for one. Any person you are applying for who is legally able to get an SSN but does not have one or does not apply for one will not be eligible for benefits.
- If you are not applying for benefits for yourself, you do not have to give us your SSN. However, it may reduce the total amount of Nutrition Assistance and/or Cash Assistance benefits for the person you are applying for because we will not include you in the benefit amount.
- We will not use your SSN as your DES or AHCCCS identification number.
- We will not give any SSNs to the United States Citizenship and Immigration Services (USCIS).

We use your information, including your SSN to:

- Verify identity
- Verify income and resources.
- Prevent duplicate benefits.
- Establish and enforce child support.
- Computer match with state, local, and federal agencies and our other programs to verify information. Information available through the Income and Eligibility Verification System (IEVS) will be requested, used and may be verified through collateral contacts when discrepancies are found. This information may affect eligibility and benefit level.
- Collect money we overpaid to you in the form of benefits.
- Share with other government agencies and their contractors to assess Nutrition Assistance and/or Cash Assistance program management and compliance.
- We may give your information to law enforcement officials for the purpose of arresting persons fleeing to avoid the law.

If we are not able to find proof of the information you have given us through the sources available to us, then you must provide proof of the information for us to decide if you are eligible.

DES and/or AHCCCS will keep your information for at least 7 years.

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587).

Do I have to give information about my citizenship and immigration status?

To get the most help, you need to give us information about citizenship and immigration status for each person who is applying for help.

- Giving us the citizenship and immigration status for all people who are eligible for benefits allows us to include them in the Nutrition Assistance and/or Cash Assistance benefit. When you do not give us this information, it will not affect the eligibility of the people you are applying for who have given us verification of their citizenship or qualified non-citizen status, but it may affect the amount of the benefits for these people.
- If you choose not to give us information regarding immigration status but still want AHCCCS Medical Assistance, you may only be eligible for emergency medical services.
- You do not need to give us information about citizenship and immigration status for any person who is not applying.
- Under federal law, certain non-citizens such as refugees or political asylees may qualify for Medical Assistance, Nutrition Assistance, and/or Cash Assistance. For those non-citizens, United States Citizenship and Immigration Services (USCIS) guidelines state that use of these benefits will not affect your ability to become a Lawful Permanent Resident.
- If you are not applying for any benefits or if you chose not to provide citizenship or immigration information, we will not try to find out this information from USCIS.
- We will not report you, a family, or a household member to U.S. Immigration and Customs Enforcement (ICE) unless you inform us that you, your family, or a household member is in the U.S. illegally.
- Households with different immigration statuses may apply for benefits on behalf of U.S. citizen children and other eligible family members.

State agencies must use the Systematic Alien Verification and Eligibility (SAVE) system. The alien status of persons requesting benefits may be subject to verification by USCIS through the submission of information from the application to USCIS. The submitted information received from USCIS may affect the household's eligibility and level of benefits.

Will I Have To Do An Interview?

When applying for AHCCCS Medical Assistance and/or help with Medicare costs, an interview is not needed. When applying for Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control you or your representative must complete an interview in person or by phone. If you need special accommodations for an interview, please tell us on page 1 of the application so we can be ready for your interview.

How Long Does It Take To Find If I Am Eligible After You Receive My Application?

For AHCCCS Medical Assistance and/or help with Medicare costs, we will make a decision within 45 calendar days.

- If you are pregnant, we will make a decision within 20 calendar days.
- If you need a disability determination report, we will make a decision within 90 calendar days.

For Nutrition Assistance, we will make a decision within 30 calendar days.

- If you are eligible for Emergency Nutrition Assistance, we will make a decision within 7 calendar days.

For Cash Assistance, we will make a decision within 45 calendar days.

- If you are a relative or legal guardian applying only for children who are not your own, we will determine if the children qualify within 20 calendar days.

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587).

How Will I Know If I Am Eligible?

If you are approved, you will receive a letter explaining the benefits you are eligible for and the amount of benefits you will get, or you will be provided information on AHCCCS medical coverage.

If you are denied, we will send you a letter explaining the reason for our decision.

How Can I Get My Benefits When My Application Is Approved?

If you are approved for AHCCCS Medical Assistance and/or help with Medicare costs, you will get an approval letter. You will get your AHCCCS ID card from your enrollment plan 10 to 14 business days after you get your approval letter. If you need medical services before you get your AHCCCS ID card, contact your enrollment plan.

If you are approved for Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control, you will get an Electronic Benefit Transfer (EBT) card. This card works like a debit card. You will get a pamphlet with instructions on how to use your card. It can take up to 48 hours for the benefits to be available after approval. You can call the Customer Service number on the back of the card to check the balance of your benefits.

Important: It is illegal to use your EBT card to do any of the following:

- Withdraw Cash Assistance benefits at ATMs located inside liquor stores, casinos, and horse or dog racing facilities.
- Make purchases at Point of Sale machines located inside liquor stores, casinos, horse or dog racing facilities, adult entertainment establishments, or Medical Marijuana Dispensaries (A.R.S. §46-297)
- To use your EBT card to purchase lottery tickets.
- Pay for food purchased on credit with SNAP benefits.
- If you request more than two EBT replacement cards in a 12 month period, you will be required to contact DES to answer questions to determine whether fraud is being committed.
- If you use more than 10% of your Cash Assistance balance on out-of-state purchases in a 6 month period, you will be required to contact DES to answer questions to determine whether fraud is being committed.
- If you lose your EBT card you may have to pay for a new one.

What is expected of me?

For all programs:

- **You must provide DES and/or AHCCCS with the needed information to correctly determine your eligibility and authorize DES and/or AHCCCS to investigate and contact any sources necessary to confirm the accuracy of the information for your eligibility.**
- If you are approved for benefits, you will get a letter telling you what changes you must report. You MUST report your changes timely.

Program-specific expectations:

If applying for help with AHCCCS Medical Assistance, help with Medicare costs, and/or Cash Assistance, you must take necessary steps to obtain any annuities, pensions, retirement and disability benefits to which you may be entitled, including, but not limited to, Social Security benefits, Railroad retirement, Veterans benefits and unemployment compensation.

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587).

For AHCCCS Medical Assistance and/or Cash Assistance, you must give us any information you have about an absent parent. If you have reason for not providing this information (such as adoption pending, abuse, incest, neglect, etc.) you may claim good cause. You must cooperate with the Division of Child Support Services (DCSS) to establish paternity, unless you can prove good cause.

For Nutrition Assistance and/or Cash Assistance you must tell us about your expenses and provide proof to receive deductions, for the following expenses: court ordered child support paid, child/adult dependent care expenses, medical expenses, transportation costs to and from the provider of medical care or daily care of a child/adult dependent, rent or mortgage payments, utility or other shelter costs.

What are my rights?

You have the RIGHT to:

- Courteous and professional treatment.
- Be treated fairly and equally regardless of race, color, religion, national origin, sex, age, disability, or political beliefs.
- Apply for benefits and be given a letter that tells you if you are eligible or not, and/or get a letter before your benefits are reduced or stopped.
- Review DES and AHCCCS policy manuals that show the rules and regulations of AHCCCS Medical Assistance, Medicare Savings Program, Nutrition Assistance, Cash Assistance, and Tuberculosis Control if you want to know the reason for our decision.
- Talk about your case with a worker or supervisor.
- Ask for a legal review of your case if you disagree with a decision or action taken by DES. This review is called an Appeal. You can ask for an Appeal on any DES decisions, actions, or inaction, which may or may not affect the participation of the household in any program.
- Ask for an appeal if a request for supplemental or replacement benefits is denied or is not acted on in a timely manner.
- Ask for an appeal if an overpayment determination or amount of an overpayment is disputed.
- Ask for an appeal if a change is not acted on.
- Ask for an appeal if you disagree with a decision made on your application or if a decision is not made on your application within the allowable number of days and the delay is due to DES or AHCCCS.
- Look at your file before the appeal.
- Bring an attorney or any other person to the appeal.
- Have all information you give regarding your eligibility kept private according to state and federal law.
- File for Nutrition Assistance benefits separately or at the same time you apply for other programs listed on the application. All Nutrition Assistance applications, regardless of whether they are joint applications or separate applications, must be processed for Nutrition Assistance purposes in accordance with procedural, timeliness, notice and appeal requirements. No household shall have its Nutrition Assistance benefits denied solely on the basis that another program applied for has been denied. A separate determination for Nutrition Assistance must be completed. When another program that is applied for is denied, a new application for Nutrition Assistance shall not be required. Eligibility shall be determined based on Nutrition Assistance processing time frames from the date the joint application was initially accepted by the State agency.

Do you need help with this application? Visit www.healthearizonaplus.gov
or call 1-855-HEA-PLUS (432-7587).

What are the rules and penalties?

If you, your representative, or any household member hides information or gives false information on purpose to get or continue to get Nutrition Assistance and/or Cash Assistance benefits that you are not entitled to, that person will be subject to:

- **Criminal prosecution**
- **Fines**
- **Imprisonment**
- **Other penalties provided for by state and federal laws**

If you get Nutrition Assistance and/or Cash Assistance, you must follow the rules below:

- It is mandatory for you to cooperate with a fraud investigation. For Cash Assistance, failure to cooperate may result in case closure and the termination of benefits within ten (10) days from the agency's notice of termination.
- Do not make false statements or hide information. If you are not truthful, you may have to pay back DES for benefits you receive and you may be taken to court.
- Do not do anything dishonest to get benefits that you are not supposed to get.
- Do not buy, sell, trade, exchange or otherwise transfer yours or someone else's Nutrition Assistance benefits or EBT card.
- Do not buy containers with deposits for the purpose of discarding the product and returning the containers to get cash refund deposits.
- Do not sell products bought with Nutrition Assistance benefits to exchange those products for cash or items other than eligible food.
- Do not steal Nutrition Assistance or Cash Assistance benefits.
- Do not use your Nutrition Assistance benefits to buy non-food items such as alcohol or tobacco.
- Do not alter an EBT card.
- Do not use someone else's EBT card unless you are an authorized user approved by DES.

You or a household member will not be eligible to get Nutrition Assistance and/or Cash Assistance benefits if you or the household member:

- **Has been convicted of or found guilty in a court of law of using or getting Nutrition Assistance benefits in a transaction involving the sale of firearms, ammunition or explosives. This person can never get Nutrition Assistance benefits again.**
- Has their Cash Assistance benefits sanctioned. You or the household member will be sanctioned 50% for the first occurrence and 100% for the second occurrence if any adult has voluntarily quit a job without good cause or has sold, possessed or used a controlled substance in violation of A.R.S. Title 13.
- **Has been found guilty of using or getting Nutrition Assistance benefits in a transaction involving the sale of a controlled substance. This person is not eligible to get Nutrition Assistance benefits for 2 years for the first violation and permanently for the second violation.**
- **Knowingly breaks the rules to get Nutrition Assistance benefits. We will disqualify you from getting Nutrition Assistance benefits for 12 months for the first offense, 24 months for the second offense and permanently for the third offense. In addition, you can be fined up to $250,000, imprisoned up to 20 years or both. You and/or your household members may be subject to further prosecution under Federal laws, and an additional disqualification of up to 18 months may be ordered by a court.**

- **Has been found by a court of law to give false identification or residence information to get benefits in more than one case, they will not be eligible for benefits for 10 years.**
- **Has been found guilty by a court of law of having trafficked benefits for a total amount of $500 or more, you will be permanently ineligible to participate in the Program upon the first occasion of such violation.**
- **Knowingly breaks the rules to get Cash Assistance benefits. We will disqualify you from getting Cash Assistance benefits for 6 months for the first offense, 12 months for the second offense and permanently for all other offenses.**
- Is a fleeing felon or probation/parole violator.
- When convicted of the following crimes and are not in compliance with the terms of the sentence, is a fleeing felon, or is a parole or probation violator:
  - Aggravated sexual abuse
  - Murder
  - Sexual Exploitation and other abuse of children involving sexual assault
- Has committed and was convicted of a federal or state felony on or after August 23, 1996 for the possession, use or distribution of a controlled substance. If the person with the felony drug conviction agrees to random drug testing and they meet at least one additional requirement, they may be eligible to receive Nutrition Assistance.
- For Nutrition Assistance the following applies:
  A person who is convicted of a felony offense which has as an element of the offense "the use or possession of a controlled substance," may be eligible for Nutrition Assistance if the person agrees to random drug testing and meets at least one of the following:
  - Is currently accepted for treatment in a substance abuse treatment program but is on a waiting list. The person remains enrolled in the treatment program and enters the treatment program at the first available opportunity.
  - Is currently accepted for treatment, and is participating in a substance abuse treatment program.
  - Has successfully completed a substance abuse treatment program after the offense in question.
  - Is determined by a licensed medical provider to not need substance abuse treatment.
  - If on probation/parole for a felony drug conviction, is in compliance with the terms of probation/ parole.
- For Cash Assistance, if you refuse to sign and comply with the Personal Responsibility Agreement (PRA). We give you the PRA during the interview process.
  - Is an adult recipient (18 years or older) of Cash Assistance when any of the following apply:
    - The recipient does not return the completed Illegal Drug Use Statement. We send the Illegal Drug use Statement by U.S. Mail after Cash Assistance has been approved.
    - The recipient fails to take a required drug test.
    - The recipient fails the drug test.
- End for the CA Drug Conviction Sanction
  - The person who is convicted August 9, 2017 or later, can end the sanction for others in the household when they agree to random drug testing and meet at least one of the following criteria:
- Successfully completes, or is accepted into, a substance abuse treatment program. The person also meets this criteria if they are either of the following:
  - Currently accepted for treatment in a substance abuse treatment program but is on a waiting list. The person remains enrolled in the treatment program and enters the treatment program at the first available opportunity.
  - Currently accepted for treatment, and is participating in a substance abuse treatment program.

- Is determined by licensed medical provider to not need substance abuse treatment.
- If applicable, is in compliance with all terms of probation related to the conviction they were sanctioned for.

As part of the change reporting requirements, all households must report when any household member receives lottery or gambling winnings of $3500 or more.

You must pay DES back for any Nutrition Assistance and/or Cash Assistance benefits you received for which your household was not eligible. You can make a repayment agreement. If you do not keep your repayment agreement, we may reduce your Nutrition Assistance and/or Cash Assistance benefits, take your income tax refunds, or take other legal action, including taking the amounts from your earnings.

Health insurance Tax Credit Information

If you are not eligible for help with health insurance costs, you may be eligible for federal tax credits to help with your health insurance premiums. If you are not eligible for any programs through AHCCCS, we will send your information to the Federal Health Insurance Market place to see about health insurance tax credits.

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587).

How to choose a health plan

You need to choose a health plan that serves your county.

- All AHCCCS health plans provide the same covered medical services.
- Before choosing a health plan, check with your doctor, pharmacy or hospital to see if they work with the plan that you want. If you want more information about the doctors, specialists or hospitals that work with a health plan that serves your county, call the number listed below for the health plan or visit the plan's website.
- American Indian members may choose from American Indian Health Program or an AHCCCS health plan.
- If you do not choose a health plan, one will be assigned to you.
- If you have been enrolled in an AHCCCS health plan within the past 90 days, you may be enrolled with your previous health plan.
- If you need help selecting a health plan you may visit www.azahcccs.gov/choice; or speak to a Beneficiary Support Specialist by calling (602) 417-7100.

North • Apache • Coconino • Mohave • Navajo • Yavapai	• American Indian Health Program • Care1st Health Plan • Health Choice Arizona
Central • Maricopa • Gila • Pinal, excluding ZIP codes 85542, 85192, and 85550	• American Indian Health Program • Arizona Complete Health - Complete Care Plan (formerly Health Net Access) • Banner-University Family Care • Care1st Health Plan • Magellan Complete Care • Mercy Care • Health Choice Arizona • UnitedHealthcare Community Plan
South • Cochise • Graham • Greenlee • La Paz • Pima • Santa Cruz • Yuma • ZIP codes 85542, 85192, and 85550	• American Indian Health Program • Arizona Complete Health - Complete Care Plan (formerly Health Net Access) • Banner-University Family Care • UnitedHealthcare Community Plan (Pima County Only)

Health Plan Name	Phone Number	Website
American Indian Health Program	Maricopa County: 602-417-7100 All other counties: 1-800-334-5283	www.azahcccs.gov/AmericanIndians/AIHP/
Arizona Complete Health - Complete Care Plan (formerly Health Net Access)	1-888-788-4408	www.azcompletehealth.com/completecare
Banner-University Family Care	1-800-582-8686	www.bannerufc.com/acc
Care1st Health Plan	1-866-560-4042	www.care1staz.com
Magellan Complete Care	1-800-424-5891	www.mccofaz.com
Mercy Care	1-800-624-3879	www.mercycareaz.org
Health Choice Arizona (formerly Health Choice AZ)	1-800-322-8670	www.HealthChoiceAZ.com
UnitedHealthcare Community Plan	1-800-348-4058	www.uhccommunityplan.com

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587).

Arizona Department of Economic Security/Family Assistance Administration (DES/FAA)
Arizona Health Care Cost Containment System (AHCCCS)

APPLICATION FOR BENEFITS

For Agency use
Date: _____
Case# _____

Contact Information:

Tell us how we can contact an adult member of your household.

Name (First, Middle, Last): _____

Home Address (include suite number/apartment number): _____

City: _____ State: _____ Zip Code _____

Mailing Address (if different): _____

City: _____ State: _____ Zip Code _____

Do you live in a shelter? ◯ Yes ◯ No If Yes, what kind of shelter? _____

Phone Number: _____

What is the preferred language you and your household speak?

◯ English ◯ Spanish ◯ Other _____

What is the preferred language you and your household read?

◯ English ◯ Spanish ◯ Other _____

I would like to get information about this application by:

Email: ◯ Yes ◯ No Email address: _____

Text: ◯ Yes ◯ No Number to text (standard text rates apply): _____

If 'Yes' is not marked for Email or Text, all information for this application will be sent via U.S. Mail to the mailing address provided.

I need the following help with this application (check all that apply):

☐ Reading/understanding this application ☐ Filling out this application

☐ American Sign Language ☐ Language Interpreter

☐ Other: _____ What language? _____

I have an impairment that requires the following accommodations for this application (check all that apply):

☐ Hearing ☐ Speaking ☐ Visual ☐ Writing ☐ Walking ☐ Other: _____

Does the customer, authorized representative, or legal guardian have a visual impairment that requires an alternative format for printed letters? ◯ Yes ◯ No

If yes, who needs the accommodation: _____

If yes, what kind of alternative format do you need? Please choose one option:

◯ Letters in HEAplus account (note: this person must have an HEAplus account)

◯ Readable PDF sent by secure email

◯ Large print: larger print letters sent by U.S. mail will be provided Arial 24 point font.

◯ Other: _____

We can accept your application if it contains at least your name, address and signature. Please sign in this box →	Signature: _____

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587).

Food Preparation. Tell us how your household buys and prepares food.

Does anyone at your address buy and prepare his/her own food separate from others in the household?
◯ Yes ◯ No If **Yes**, tell us about the people who buy and prepare their own food using the table below.

Name (first & last)	Age	Relationship to MAIN CONTACT	Does this person pay expenses?	What expenses?

Authorized Representative:

This section is OPTIONAL. You may authorize someone else to represent you in the application process. DES and/or AHCCCS cannot release any information about your eligibility, unless you give us written permission.

Representative's Name: _____

Is representative your legal guardian? ◯ Yes ◯ No Representative's date of birth _____

Representative's Mailing Address: _____

City: _____ State: _____ Zip Code _____

Representative's Phone Number: _____

This number is: ☐ Home ☐ Cell ☐ Work ☐ Message ☐ Other: _____

What is the representative's preferred language to speak?
◯ English ◯ Spanish ◯ Other _____

What is the representative's preferred language to read?
◯ English ◯ Spanish ◯ Other _____

My representative would like to get information about this application by:

Email: ◯ Yes ◯ No Email address: _____

Text: ◯ Yes ◯ No Number to text (standard text rates apply): _____

If 'Yes' is not marked for Email or Text, all information for this application will be sent via U.S. Mail to the mailing address provided.

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587).

<table>
<tr>
<td>By signing below, I (the customer) give permission for the person listed above to act on my behalf as my representative. That person is allowed to help me in the process of qualifying for help with insurance and Medicare costs, Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control. I do give permission and agree that my representative may do all the following on my behalf:
Complete and sign my application.
Provide any documents requested, including personal information.
Sign on my behalf to permit other people, businesses, or agencies to give personal information about me to DES and/or AHCCCS, including protected health information needed to determine if I am disabled.
I also agree to give information about my personal circumstances to my representative and agree to allow my representative to assign all my rights to medical reimbursement claims to AHCCCS on my behalf.</td>
<td>By signing below, I (the representative) agree to act on the customer’s behalf. I also agree to:
Provide only truthful and complete information under penalty of perjury.
Fill in and sign needed forms.
Obtain and give to DES and/or AHCCCS all information needed to determine if the customer can qualify for help with insurance and Medicare costs, Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control, such as the customer’s Social Security number, income, assets, citizenship, residency, medical insurance, and information about the customer’s spouse, minor children, and parents (if the customer is a minor child).
Tell DES and/or AHCCCS right away if the customer has an/a:
Increase or decrease in income;
Increase or decrease in assets;
Change in ownership of assets, including opening or closing financial accounts;
Change in address; or
Change in health insurance or the amount of premiums paid.</td>
</tr>
<tr>
<td colspan="2">If I am determined eligible, this authorization will stay in effect until I or my representative tells you to stop it. This authorization will expire when my application for assistance is withdrawn or denied, or when my eligibility ends. However, this authorization will continue during any time while I am contesting my eligibility in an administrative hearing or court proceeding.</td>
</tr>
<tr>
<td>Signature of Applicant: _____ Date: _____</td>
<td>Signature of Representative: _____ Date: _____</td>
</tr>
</table>

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587).

Release of Information to Hospitals/Hospital Agents/Organizations/Agencies:

This section is OPTIONAL. You may give permission to DES and AHCCCS to release information about you or a family member's eligibility. AHCCCS and DES cannot share any information about you or your family members without your written permission.

Name of Hospital/Hospital's Agent/Organization/Agency: _____

Contact Person: _____

Phone Number: _____

Mailing Address: _____

City: _____ State: _____ Zip Code _____

I give permission for DES and/or AHCCCS staff to tell the hospital, hospital agent, organization, or agency listed above:
That I have applied for help with insurance costs;
The information or proof needed to see if I can get help with insurance costs, and
If approved for help with insurance costs, the effective date of my eligibility, the redetermination date, and the category of assistance that I was approved for.
If denied for help with insurance costs, the reason I was denied.

Signature of Applicant: _____ Date: _____

Access to Electronic Benefit (EBT) Account:

This section is OPTIONAL. You may choose a person, called an Alternate Cardholder, to get your benefits for you. If you need an Alternate Cardholder, choose a person you trust. Remember that lost or stolen benefits will not be replaced.

EBT Representative's (Rep) Name: _____

EBT Rep's Date of Birth: _____

EBT Rep's Mailing Address: _____

City: _____ State: _____ Zip Code _____

EBT Rep's Phone Number: _____

Signature of Applicant: _____ Date: _____

Emergency Nutrition Assistance:

Answer the following questions if you or your household want to be considered for emergency Nutrition Assistance:

What is the total amount of income before deductions you expect to get this month? $ _____

What is the total amount of cash on hand and money in your checking & savings account? $ _____

What are the total monthly housing costs (rent, mortgage, taxes homeowner's insurance, etc.)? $ _____

What are the total monthly utility costs (gas, electric, water, etc.)? $ _____

What are the monthly telephone costs? $ _____

Is anyone a migrant or seasonal farm worker? ◯ Yes ◯ No

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587).

Household Information:

Tell us about each person in your household, starting with you. See page A for a definition of whom you must include. If you are a representative, tell us about who you are representing and others in the household.

Name Last, First, M.I. (List name as shown on SSN card)	Applying for?					Relationship to Main Contact (1.)	Marital Status (never married, married, divorced, or widowed)	Date of Birth	Social Security Number (If not applying, optional)	Gender M=Male F=Female
	Help with Health Insurance	Help with Medicare costs	Nutrition Assistance	Cash Assistance	Tuberculosis Control					
1.	☐	☐	☐	☐	☐	Main Contact				
2.	☐	☐	☐	☐	☐					
3.	☐	☐	☐	☐	☐					
4.	☐	☐	☐	☐	☐					
5.	☐	☐	☐	☐	☐					
6.	☐	☐	☐	☐	☐					

Have any of the people listed above ever used another name, (i.e. alias, maiden name, suffix)?

If yes, who? _____

Other Name(s): _____

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587).

Citizenship Information:

Complete ONLY for each person applying. If a person is not applying for benefits, skip this section for that particular person. For those applying, you may need to provide proof of citizenship.

Is the main contact a U.S. citizen or U.S. national? (see page F for more information)

○ Yes ○ No ○ Choose not to answer

If the main contact is NOT a U.S. Citizen, what is their immigration status?

- ☐ Lawful Permanent Resident
- ☐ Asylee
- ☐ Special Immigrant Juvenile Status Applicant
- ☐ Deferred Action Status
- ☐ Legalization under LIFE Act
- ☐ Legalization under IRCA Act
- ☐ Applicant for Asylum, LPR or Withholding Deportation
- ☐ Lawful Temporary Resident
- ☐ Refugee
- ☐ Battered Spouse, Child, Parent
- ☐ Non Immigrant Status
- ☐ Victim of Trafficking
- ☐ Withholding of Deportation
- ☐ Conditional Entrant granted before 1980
- ☐ Non-immigrant Status
- ☐ Cuban-Haitian Entrant
- ☐ Remove/Suspension of Deportation
- ☐ Temporary Protection Status
- ☐ Paroled into United States
- ☐ Order of Supervision
- ☐ Other: _____
- ☐ I do not want to provide this information

What immigration document does MAIN contact have?

☐ Permanent Resident Card ☐ I- 94 ☐ Visa ☐ Foreign Passport ☐ None

☐ Other: _____ Immigration document Number: _____

Has the Main Contact lived in the U.S. since August 22, 1996? ○ Yes ○ No

Is **PERSON 2** a U.S. citizen or U.S. national? (see page F for more information)

○ Yes ○ No ○ Choose not to answer

If PERSON 2 is NOT a U.S. Citizen, what is their immigration status?

- ☐ Lawful Permanent Resident
- ☐ Asylee
- ☐ Special Immigrant Juvenile Status Applicant
- ☐ Deferred Action Status
- ☐ Legalization under LIFE Act
- ☐ Legalization under IRCA Act
- ☐ Applicant for Asylum, LPR or Withholding Deportation
- ☐ Lawful Temporary Resident
- ☐ Refugee
- ☐ Battered Spouse, Child, Parent
- ☐ Non Immigrant Status
- ☐ Victim of Trafficking
- ☐ Withholding of Deportation
- ☐ Conditional Entrant granted before 1980
- ☐ Non-immigrant Status
- ☐ Cuban-Haitian Entrant
- ☐ Remove/Suspension of Deportation
- ☐ Temporary Protection Status
- ☐ Paroled into United States
- ☐ Order of Supervision
- ☐ Other: _____
- ☐ I do not want to provide this information

What immigration document does PERSON 2 have?

☐ Permanent Resident Card ☐ I- 94 ☐ Visa ☐ Foreign Passport ☐ None

☐ Other: _____ Immigration document Number: _____

Has PERSON 2 lived in the U.S. since August 22, 1996? ◯ Yes ◯ No

Is **PERSON 3** a U.S. citizen or U.S. national? (see page F for more information)

◯ Yes ◯ No ◯ Choose not to answer

If PERSON 3 is NOT a U.S. Citizen, what is their immigration status?

☐ Lawful Permanent Resident	☐ Lawful Temporary Resident	☐ Non-immigrant Status
☐ Asylee	☐ Refugee	☐ Cuban-Haitian Entrant
☐ Special Immigrant Juvenile Status Applicant	☐ Battered Spouse, Child, Parent	☐ Remove/Suspension of Deportation
☐ Deferred Action Status	☐ Non Immigrant Status	☐ Temporary Protection Status
☐ Legalization under LIFE Act	☐ Victim of Trafficking	☐ Paroled into United States
☐ Legalization under IRCA Act	☐ Withholding of Deportation	☐ Order of Supervision
☐ Applicant for Asylum, LPR or Withholding Deportation	☐ Conditional Entrant granted before 1980	☐ Other: _____

☐ I do not want to provide this information

What immigration document does PERSON 3 have?

☐ Permanent Resident Card ☐ I- 94 ☐ Visa ☐ Foreign Passport ☐ None

☐ Other: _____ Immigration document Number: _____

Has PERSON 3 lived in the U.S. since August 22, 1996? ◯ Yes ◯ No

Is **PERSON 4** a U.S. citizen or U.S. national? (see page F for more information)

◯ Yes ◯ No ◯ Choose not to answer

If PERSON 4 is NOT a U.S. Citizen, what is their immigration status?

☐ Lawful Permanent Resident	☐ Lawful Temporary Resident	☐ Non-immigrant Status
☐ Asylee	☐ Refugee	☐ Cuban-Haitian Entrant
☐ Special Immigrant Juvenile Status Applicant	☐ Battered Spouse, Child, Parent	☐ Remove/Suspension of Deportation
☐ Deferred Action Status	☐ Non Immigrant Status	☐ Temporary Protection Status
☐ Legalization under LIFE Act	☐ Victim of Trafficking	☐ Paroled into United States
☐ Legalization under IRCA Act	☐ Withholding of Deportation	☐ Order of Supervision
☐ Applicant for Asylum, LPR or Withholding Deportation	☐ Conditional Entrant granted before 1980	☐ Other: _____

☐ I do not want to provide this information

What immigration document does PERSON 4 have?

☐ Permanent Resident Card ☐ I- 94 ☐ Visa ☐ Foreign Passport ☐ None

☐ Other: _____ Immigration document Number: _____

Has PERSON 4 lived in the U.S. since August 22, 1996? ◯ Yes ◯ No

Is **PERSON 5** a U.S. citizen or U.S. national? (see page F for more information)

◯ Yes ◯ No ◯ Choose not to answer

If PERSON 5 is NOT a U.S. Citizen, what is their immigration status?

☐ Lawful Permanent Resident	☐ Lawful Temporary Resident	☐ Non-immigrant Status
☐ Asylee	☐ Refugee	☐ Cuban-Haitian Entrant
☐ Special Immigrant Juvenile Status Applicant	☐ Battered Spouse, Child, Parent	☐ Remove/Suspension of Deportation
☐ Deferred Action Status	☐ Non Immigrant Status	☐ Temporary Protection Status
☐ Legalization under LIFE Act	☐ Victim of Trafficking	☐ Paroled into United States
☐ Legalization under IRCA Act	☐ Withholding of Deportation	☐ Order of Supervision
☐ Applicant for Asylum, LPR or Withholding Deportation	☐ Conditional Entrant granted before 1980	☐ Other: _____

☐ I do not want to provide this information

What immigration document does PERSON 5 have?

☐ Permanent Resident Card ☐ I- 94 ☐ Visa ☐ Foreign Passport ☐ None

☐ Other: _____ Immigration document Number: _____

Has PERSON 5 lived in the U.S. since August 22, 1996? ◯ Yes ◯ No

Is **PERSON 6** a U.S. citizen or U.S. national? (see page F for more information)

◯ Yes ◯ No ◯ Choose not to answer

If PERSON 6 is NOT a U.S. Citizen, what is their immigration status?

☐ Lawful Permanent Resident	☐ Lawful Temporary Resident	☐ Non-immigrant Status
☐ Asylee	☐ Refugee	☐ Cuban-Haitian Entrant
☐ Special Immigrant Juvenile Status Applicant	☐ Battered Spouse, Child, Parent	☐ Remove/Suspension of Deportation
☐ Deferred Action Status	☐ Non Immigrant Status	☐ Temporary Protection Status
☐ Legalization under LIFE Act	☐ Victim of Trafficking	☐ Paroled into United States
☐ Legalization under IRCA Act	☐ Withholding of Deportation	☐ Order of Supervision
☐ Applicant for Asylum, LPR or Withholding Deportation	☐ Conditional Entrant granted before 1980	☐ Other: _____

☐ I do not want to provide this information

What immigration document does PERSON 6 have?

☐ Permanent Resident Card ☐ I- 94 ☐ Visa ☐ Foreign Passport ☐ None

☐ Other: _____ Immigration document Number: _____

Has PERSON 6 lived in the U.S. since August 22, 1996? ◯ Yes ◯ No

Federal Income Tax Filing:

Tell us NEXT YEAR'S tax filing information for everyone applying:

Main Contact	Plan to file Federal income tax return? ◯ Yes ◯ No	Filing Status: ☐ Head of Household ☐ Qualifying Widow(er) ☐ Single ☐ Married-Filing Separate Return ☐ Married-Filing Joint Return Spouse's name: _____
	Will claim dependents on own tax return? ◯ Yes ◯ No If yes, list dependents' names:	
	Claimed as dependent on someone else's tax return? ◯ Yes ◯ No If yes, name of tax filer claiming this person: _____	
Person 2	Plan to file Federal income tax return? ◯ Yes ◯ No	Filing Status: ☐ Head of Household ☐ Qualifying Widow(er) ☐ Single ☐ Married-Filing Separate Return ☐ Married-Filing Joint Return Spouse's name: _____
	Will claim dependents on own tax return? ◯ Yes ◯ No If yes, list dependents' names:	
	Claimed as dependent on someone else's tax return? ◯ Yes ◯ No If yes, name of tax filer claiming this person: _____	

Person 3

Plan to file Federal income tax return?
◯ Yes ◯ No

Filing Status:
☐ Head of Household ☐ Qualifying Widow(er)
☐ Single ☐ Married-Filing Separate Return
☐ Married-Filing Joint Return
Spouse's name: _____

Will claim dependents on own tax return? ◯ Yes ◯ No
If yes, list dependents' names:

Claimed as dependent on someone else's tax return?
◯ Yes ◯ No
If yes, name of tax filer claiming this person: _____

Person 4

Plan to file Federal income tax return?
◯ Yes ◯ No

Filing Status:
☐ Head of Household ☐ Qualifying Widow(er)
☐ Single ☐ Married-Filing Separate Return
☐ Married-Filing Joint Return
Spouse's name: _____

Will claim dependents on own tax return? ◯ Yes ◯ No
If yes, list dependents' names:

Claimed as dependent on someone else's tax return?
◯ Yes ◯ No
If yes, name of tax filer claiming this person: _____

Person 5

Plan to file Federal income tax return?
◯ Yes ◯ No

Filing Status:
☐ Head of Household ☐ Qualifying Widow(er)
☐ Single ☐ Married-Filing Separate Return
☐ Married-Filing Joint Return
Spouse's name: _____

Will claim dependents on own tax return? ◯ Yes ◯ No
If yes, list dependents' names:

	Claimed as dependent on someone else's tax return? ◯ Yes ◯ No If yes, name of tax filer claiming this person: _____	
Person 6	Plan to file Federal income tax return? ◯ Yes ◯ No	Filing Status: ☐ Head of Household ☐ Qualifying Widow(er) ☐ Single ☐ Married-Filing Separate Return ☐ Married-Filing Joint Return Spouse's name: _____
	Will claim dependents on own tax return? ◯ Yes ◯ No If yes, list dependents' names:	
	Claimed as dependent on someone else's tax return? ◯ Yes ◯ No If yes, name of tax filer claiming this person: _____	

Prior Medical Expenses:

		Who?	Month(s)?
Does anyone applying for benefits also need help with medical bills in any of the last three months?	◯ Yes ◯ No		
Is the person needing help with medical expenses pregnant or had a pregnancy end in the last 5 months?	◯ Yes ◯ No		
Does anyone in this application have Medicare and want help paying their Medicare Part B premium for any of the last three months?	◯ Yes ◯ No		

Deceased Applicant:

		Who?	Date Deceased
Is anyone you are applying for Deceased?	◯ Yes ◯ No		

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587).

Temporary Absence: Tell us about any people who are temporarily living outside of your home who are expected to return.

Name (first & last)	Date Left	Expected Return Date	Temporary Address	Why are they out of the home?

Residency for All Applicants: Tell us about residency. You may need to provide proof of residency.

Is each person applying for benefits a resident of Arizona?	◯ Yes ◯ No	Who is not? _____
Did any of the persons applying for benefits move to Arizona within the last four months?	◯ Yes ◯ No	If yes, who? _____ Date moved _____

Questions for All Applicants:

Is anyone applying for benefits currently in jail, prison or detention center?	◯ Yes ◯ No	If yes, who? _____
Has anyone applying for benefits been released from a jail, prison or detention center within the last four months?	◯ Yes ◯ No	If yes, who? _____ Release Date _____

Foster Care and Adult with Child:

Was anyone in Arizona Foster Care on their 18th birthday?	◯ Yes ◯ No	Who? _____
Was anyone in Arizona Tribal Foster Care on their 18th birthday?	◯ Yes ◯ No	Who? _____ What Tribe? _____
Does any adult live with at least one child under age 19 and is the main caretaker of the child?	◯ Yes ◯ No	Who? _____

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587).

Race/Ethnicity: Select one or more answers for each person applying for benefits. This information is optional and does not affect eligibility.

Race														If Hispanic/Latino, check ethnicity:							
Person	American Indian/ Alaskan Native	Asian Indian	Black or African American	Chinese	Filipino	Guamanian or Chamoro	Japanese	Korean	Native Hawaiian	Other Asian	Other Pacific Islander	Samoan	Vietnamese	White	Mexican	Mexican American	Chicano/a	Puerto Rican	Cuban	Other
Main Contact	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Person 2	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Person 3	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Person 4	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Person 5	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Person 6	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

American Indian and Alaskan Native Persons: Complete this section if anyone applying is an American Indian or Alaska Native.

Person	Enrolled in Federally Recognized Tribe?	Name of Tribe	Received services from • Indian Health Service; • a tribal health program; • urban health program; • through a referral from one of these programs?	If no, is the person eligible to receive services?
	◯ Yes ◯ No		◯ Yes ◯ No	
	◯ Yes ◯ No		◯ Yes ◯ No	
	◯ Yes ◯ No		◯ Yes ◯ No	

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587).

Person	Enrolled in Federally Recognized Tribe?	Name of Tribe	Received services from • Indian Health Service; • a tribal health program; • urban health program; • through a referral from one of these programs?	If no, is the person eligible to receive services?
	◯ Yes ◯ No		◯ Yes ◯ No	
	◯ Yes ◯ No		◯ Yes ◯ No	
	◯ Yes ◯ No		◯ Yes ◯ No	

Person	Living on a Reservation?	Name of Reservation	Tribal Census Number
	◯ Yes ◯ No		
	◯ Yes ◯ No		
	◯ Yes ◯ No		
	◯ Yes ◯ No		
	◯ Yes ◯ No		
	◯ Yes ◯ No		

Help with Health Insurance Costs, Help with Medicare Costs, and Cash Assistance Questions:

Is anyone you are applying for pregnant?	◯ Yes ◯ No	Who?	Number of Babies Due	Expected Due Date

For anyone applying under age 19, are both of his/her parents living in the home?

◯ Yes ◯ No If no, complete the information below

Child's Name:	Parent's Name:	Social Security Number:	Date of Birth:
	Mailing Address:	City, State:	Zip Code:
	Phone number:	Reason parent is absent: ☐ Deceased ☐ Out of Home ☐ Unknown	

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587).

Child's Name:	Parent's Name:	Social Security Number:	Date of Birth:
	Mailing Address:	City, State:	Zip Code:
	Phone number:	Reason parent is absent: ☐ Deceased ☐ Out of Home ☐ Unknown	

Has anyone ever received Supplemental Security Income (SSI)?
◯ Yes ◯ No Who? _____

Does anyone have Medicare coverage?	◯ Yes ◯ No	Who?	Medicare Claim or Railroad Number: _____ ☐ Part A ☐ Part B ☐ Part D
		Who?	Medicare Claim or Railroad Number: _____ ☐ Part A ☐ Part B ☐ Part D

Potential Benefits:

Has anyone you are applying for, their spouse or deceased spouse worked for: • A government agency; or • An employer with a pension plan	◯ Yes ◯ No	If yes, who? _____ Employer Name: _____

Is anyone you are applying for:
• A person who served in the U.S. military;
• A widow or widower of a person who served in the U.S. military; or
• A child of a deceased person who served in the U.S. Military and is:
  ○ Not married, and
  ○ Under age 18, or
  ○ Under age 23 and is attending school, or
  ○ Determined to have a permanent disability before age 18
• A child (as defined above) or a spouse of a person who served in the U.S. Military who has a service connected disability
	◯ Yes ◯ No	If yes, provide the following information:
		Veteran Name: _____
		Veteran SSN: _____
		Serial Service Number: _____
		Branch of Service: _____
		Veteran's Date of Birth: _____
		VA Claim Number: _____
		Dates of Service: _____

Is anyone you are applying for out of work because of an injury or illness received at work and may qualify for Worker's Compensation?	◯ Yes ◯ No	
Is anyone you are applying for out of work because of an injury or illness and may qualify for Short-Term Disability or Long-Term Disability Payments through their employer or other company?	◯ Yes ◯ No	

Has anyone you are applying for lost employment in the past six months? When the answer is yes, you may be required to apply for Unemployment Benefits.	◯ Yes ◯ No	

Nutrition Assistance and Cash Assistance Expenses:

Do you or anyone in your household pay for the care of a child or an adult with a disability in order to work, look for work, attend training, or school?	◯ Yes ◯ No	If yes, who pays? _____ Amount paid? $ _____ How often paid? _____
Do you or anyone in your household have transportation costs to travel to or from the person or agency that provides after school care or adult care?	◯ Yes ◯ No	If yes, who pays? _____ Amount paid? $ _____ How often paid? _____
Do you or anyone in your household pay court-ordered child support?	◯ Yes ◯ No	If yes, who pays? _____ Amount paid? $ _____ How often paid? _____

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587).

Employment: Tell us about everyone's employment, including self-employment and rental income. You may need to provide proof of income. If self-employed, please attach the most recent federal tax forms: 1040, SE and applicable schedules such as C, C-EZ, E,F, and K1. If you do not have these tax forms, attach proof of business income and expenses for at least the last and current calendar month.

Does anyone in this application work?

◯ Yes ◯ No If yes, give employment information below.

Who	Employer's Name and Phone Number	How often paid? Weekly, biweekly, semi-monthly, monthly	Date last paid	Gross amount per paycheck (before deductions)	How many hours worked per week?

Did anyone leave a job in the last 30 days?	◯ Yes ◯ No	If yes, who? _____
Is ANYONE listed in this application self-employed?	◯ Yes ◯ No	If yes, who? _____ Type of work: _____ Annual Gross income (before business expenses). $ _____ Annual business expense: $ _____
Is more than one person self-employed?	◯ Yes ◯ No	If yes, who? _____ Type of work: _____ Annual Gross income (before business expenses). $ _____ Annual business expense: $ _____
If self-employed, has business been in existence for at least 12 months?	◯ Yes ◯ No	If no, date business started: _____

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587).

Other Income: Check YES or NO for each income type. You may need to provide proof of income.

Type of Income	Yes or No
Is anyone in the household an owner or member of a franchise, corporation or limited liability corporation?	◯ Yes ◯ No
Social Security Benefits	◯ Yes ◯ No
Supplemental Security Income (SSI Cash)	◯ Yes ◯ No
Retirement/pension	◯ Yes ◯ No
Unemployment	◯ Yes ◯ No
Disability / worker's compensation	◯ Yes ◯ No
Child support ☐ Court ordered ☐ Other: _____	◯ Yes ◯ No
Spousal maintenance (alimony)	◯ Yes ◯ No
Veterans benefits	◯ Yes ◯ No
Gift, contributions or loans	◯ Yes ◯ No
Tribal money ☐ Gaming ☐ Other: _____	◯ Yes ◯ No
Rental income	◯ Yes ◯ No
Per capita payments from natural resources, usage rights, leases or royalties	◯ Yes ◯ No
Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land	◯ Yes ◯ No
Other: _____	◯ Yes ◯ No
Check here if no other income ☐	

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587).

If you checked YES for any of the income types on the previous page, provide additional information below. If there is not enough space to list all income types, attach a piece of paper with the additional information.

Type of income:	Who receives?	Amount	How often received?	Who pays the income?

Expected Income Changes:

In the next twelve (12) months, does anyone in the household expect income changes because of seasonal work or contract employment? Please tell us only about the changes that happen regularly

◯ Yes ◯ No

If Yes, who? _____

How many sources are expected to change? _____

Name of sources: _____

Amount expected to make in the next 12 months $ _____

_____

Does anyone in the household expect changes in income for any other reason in the next twelve (12) months?

◯ Yes ◯ No

If Yes, who? _____

Please explain: _____

Allowed deductions from taxes/income: Tell us if anyone has the following expenses that can be taken for taxes. Do not include self-employment expenses.

Expense	Who has the expense?	Amount	How Often?
Deductions from pay for expenses like retirement and insurance taken out before taxes			
Student Loan Interest			
Spousal Maintenance (Alimony)			
Other Type:			

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587).

Questions for All Applicants:

Is any adult you are applying for not able to work because of a medical or mental condition that has lasted or may last 12 months, or might result in death?	◯ Yes ◯ No	If yes, who? _____ Date of last day worked? _____ Expected return date? _____
Does any child you are applying for have a physical or mental condition that is disabling and has lasted or may last 12 months, or result in death?	◯ Yes ◯ No	If yes, who? _____ When did the condition begin? _____
Is anyone you are applying for under age 65, have a disability expected to last at least 12 months and is working?	◯ Yes ◯ No	If yes, who? _____
Does anyone you are applying for need help with activities of daily living (bathing, dressing, etc.) through personal assistance, services, nursing home, or other medical facility?	◯ Yes ◯ No	If yes, who? _____
Does anyone you are applying for have a legal guardian?	◯ Yes ◯ No	If yes, who? _____ Name of the legal guardian: _____

Nutrition Assistance and Cash Assistance:

Is anyone you are applying for a migrant or seasonal farm worker?	◯ Yes ◯ No	If yes, type of farm worker? _____
Is this person under contract or agreement to begin employment within 30 days?	◯ Yes ◯ No	
Is this person working a minimum of 30 hours a week?	◯ Yes ◯ No	If yes, who? _____
Are you or anyone you are applying for on strike?	◯ Yes ◯ No	If yes, who? _____
Are you or anyone you are applying for a boarder?	◯ Yes ◯ No	If yes, who? _____
Are the persons you are applying for homeless?	◯ Yes ◯ No	If yes, who? _____
Has anyone you are applying for been determined to be blind or have a disability by: • The Social Security Administration (SSA), or • The Veterans Administration (VA)?	◯ Yes ◯ No	If yes, who? _____
Has anyone you are applying for had a felony conviction for possession, use, or distribution of a controlled substance on or after August 23, 1996?	◯ Yes ◯ No	City/state of conviction: _____ Date of conviction: _____ Type of conviction: _____

If you have a felony drug conviction and would like to get Nutrition Assistance or Cash Assistance, do you agree to random drug testing?	◯ Yes ◯ No	
Is anyone you are applying for: • Running from the law on any felony charges, or • In violation of probation or parole?	◯ Yes ◯ No	If yes, who? _____
Has anyone you are applying for been convicted of any of the following felonies and is in violation of probation or parole: • Aggravated sexual abuse • Murder • Sexual Exploitation and other abuse of children involving sexual assault	◯ Yes ◯ No	If yes, who? _____
Has anyone been found to have committed a Nutrition Assistance or Cash Assistance Intentional Program Violation in Arizona or any other state?	◯ Yes ◯ No	If yes, who? _____ What State? _____

Questions for All Applicants:

Is anyone on this application attending school?

◯ Yes ◯ No **If yes**, complete grid below:

Who	Name of School	Address	Full/part time	Grade	Start date	Graduation date

Nutrition Assistance and Cash Assistance:

Are the persons you are applying for living in Government assisted housing?	◯ Yes ◯ No
What are your monthly housing costs?	Rent or Mortgage $ _____ Taxes $ _____ Insurance $ _____
What are the total monthly utility costs?	Gas $ _____, Electric $ _____ Water $ _____, Other $ _____

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587).

Other Benefits and Expenses: Answer the following questions about receiving benefits from other states and expenses for anyone disabled or is 60 or older.

Has anyone on the application received Nutrition Assistance from another state?	◯ Yes ◯ No	If yes, who? _____ When did benefits stop? _____ Name of state/country? _____
Has anyone on the application received Cash Assistance benefits from another state?	◯ Yes ◯ No	If yes, who? _____ When did benefits stop? _____ Name of state/country? _____
Does anyone receive Tribal Food Distribution?	◯ Yes ◯ No	If yes, who? _____ When did benefits stop? _____ Name of Tribe? _____
Is anyone on the application living in an assisted living facility or group home?	◯ Yes ◯ No	If yes, who? _____
Is anyone disabled or 60 or older?	◯ Yes ◯ No	If yes, who? _____
Does this person have any paid or unpaid medical expenses, even if they have medical insurance?	◯ Yes ◯ No	Average Total Monthly Medical Expenses $ _____

Cash Assistance Questions

Are you requesting an additional 12 months of Cash Assistance?	◯ Yes ◯ No	
Is any adult in the household currently sanctioned for Jobs Program noncompliance?	◯ Yes ◯ No	
Do all children in the household who are ages 6-15 have a school attendance record of at least 90%, unless the child was excused pursuant to A.R.S. §15-802?	◯ Yes ◯ No	
Has anyone you are applying for received Cash Assistance this month?	◯ Yes ◯ No	If yes, who? _____ When did benefits stop? _____ Name of state/country? _____
Do all children under age 19 have current immunizations (shots)?	◯ Yes ◯ No	If No, who does not? _____

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587).

Nutrition Assistance and Cash Assistance:

Does anyone you are applying for have any type of bank account? ◯ Yes ◯ No
If Yes, what is the total value? _____
Who owns the account? _____

Does anyone you are applying for have cash, uncashed checks, or money on a pre-paid debit card? ◯ Yes ◯ No
If Yes, what is the total value? _____

Does anyone you are applying for have a retirement account or an annuity? ◯ Yes ◯ No
If Yes, what is the total value? _____
Who is the owner? _____
Name of financial Institution: _____

Do you or anyone in your household own or have their name on stock, bonds, money market accounts, Certificates of Deposit (CDs), trust funds, or life insurance? ◯ Yes ◯ No
If Yes, what is the total value? _____
Who is the owner? _____
Name of financial Institution: _____

Does anyone you are applying for own any other land or buildings? ◯ Yes ◯ No
If Yes, what is the total value? _____
Who is the owner? _____
Name of Mortgage Company: _____

No Income: Answer the following questions if you have no income.

How do you pay your bills?

- ☐ Living with Friends
- ☐ Working odd jobs
- ☐ Using money from savings or checking accounts
- ☐ Living off credit cards
- ☐ Other: _____

Monthly Income: $ _____

Check the box below and answer questions for all that apply:

- ☐ You receive loans from people. Amount: $ _____
  When does it need to be paid back? _____
- ☐ Someone gives you money. Amount: $ _____
- ☐ Someone pays your bills directly. Amount: $ _____
  Which Bills? _____
- ☐ You work in exchange for rent
  Number of Hours worked per week: _____ Monthly Rent _____

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587).

Medical Assistance Questions:

Do any applicants have an injury or illness due to an accident or medical malpractice? ◯ Yes ◯ No

If Yes, who? _____

Are any applicants currently admitted to a hospital? ◯ Yes ◯ No

If Yes, who? _____

Name of the Hospital: _____

Health Insurance Coverage:

Do any applicants have health insurance other than AHCCCS or Medicare?

If Yes, provide details below. ◯ Yes ◯ No

Who is the policy holder? _____

Name of Insured	Name of Insurance Provider	Policy Number	Coverage Effective Date

Does any child under age 19 in this application qualify for health benefits (even if they choose not to enroll) through the State of Arizona because:

- A parent or step parent (in or out of the home) works for an employer (state or other public agency) that offers health insurance coverage through the State of Arizona and is eligible to get health insurance coverage; **OR**
- The child or child's spouse works for an employer (state or other public agency) that offers health insurance coverage through the State of Arizona and is eligible to get health insurance coverage?

◯ Yes ◯ No

If Yes, who? _____

Have any children under the age of 19 lost health insurance coverage in the last 90 days? If Yes, provide the information requested below. ◯ Yes ◯ No

Child(ren) who lost health insurance coverage	
Name of Policy Holder	
Name of Insurance Company	
Group Number	
Policy Number	
Insurance Company Phone Number	
Coverage End Date	

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587).

Why did the health insurance coverage stop?

- ☐ Cost too much money.
- ☐ Coverage was through Medicare/Chip, or through Advance Premium Tax Credits (APTC), or Cost Sharing Reductions.
- ☐ Job changed or ended.
- ☐ Divorce or death of parent.
- ☐ Employer stopped offering coverage for dependents.
- ☐ Other: _____

If the health insurance cost too much:

- ☐ The monthly premium to cover one person is: $ _____
- ☐ The monthly premium to cover family is: $ _____
- ☐ Was approved for APTC because employer-sponsored insurance was determined to be unaffordable.

Do any children under the age of 19 you are applying for have a chronic illness? ◯ Yes ◯ No

(Medical condition that requires frequent and ongoing treatment and that if not properly treated will seriously affect the person's overall health).

If Yes, who? _____

Health Plan Choice: Please see page L for enrollment plan choices for everyone applying for Medical Assistance.

	Name	Health Plan Choice
Person 1:		
Person 2:		
Person 3:		
Person 4:		
Person 5:		
Person 6:		

Insurance from Jobs: Tell us about health insurance that may be offered through a job.

Is anyone eligible for health insurance coverage offered by an employer, or will you become eligible for coverage in the next 60 days?	◯ Yes ◯ No ◯ I do not know If **YES**, answer the questions below. If **NO** or **I DO NOT KNOW**, go to the next section.

Tell us about the job that offers health insurance coverage. If there are plans offered by more than one employer and you need more space, please attach additional pages. If you need help with the information, contact the employer.

Employee Name: _____ Employee SSN: _____

Employer Name: _____

Employer Identification Number (EIN): _____

Employer Address: _____

City: _____ State: _____ Zip Code _____

Whom may we contact about employment health insurance coverage at this job?

_____

If you are in a waiting or probationary period for insurance offered by an employer, when can you enroll in coverage? _____

Who is eligible for coverage from this job? _____

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

◯ Yes ◯ No ◯ I do not know

If **YES**, answer the questions below. If **NO** or **I DO NOT KNOW**, go to the next section.

For the lowest-cost plan that meets the minimum value standard* offered only to the employee (does not include family plans):

If the employer has wellness programs, provide the premium that the employee would pay if employee received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs:

How much does the employee have to pay in premiums for that plan? _____

How often will the employee have to pay the premium?

☐ Weekly ☐ Twice a month ☐ Every 2 Weeks ☐ Monthly ☐ Quarterly ☐ Yearly

☐ I do not know ☐ Other: _____

What changes will the employer make for the new plan year (if known)?

☐ Employer will not 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 does the employee have to pay in premiums for that plan? _____

How often will the employee have to pay the premium?

☐ Weekly ☐ Twice a month ☐ Every 2 Weeks ☐ Monthly ☐ Quarterly ☐ Yearly

☐ I do not know ☐ Other: _____

* An employer-sponsored health plan meets “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.

Renewal of Tax Credit Coverage in Future Years:

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

Yes, renew my eligibility for the next:

☐ 5 years ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 years

No, do not use my information from tax returns to renew my coverage ☐

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587).

Who Can Sign the Application?

For Medical Assistance the following people may sign the application:

- The applicant or the applicant's designee (we must have documentation showing this person is authorized to act on the applicant's behalf); or
- An adult who is in the customer's MAGI budget group,
- The parent/legal guardian of a minor child.

For Nutrition Assistance, Cash Assistance and Tuberculosis Control, the following people must sign the application:

- The applicant, a responsible household member, or a person representing the applicant

The application is not valid until it is signed

Penalty Warning

The information provided on this form may be verified by federal, state, and local officials. If any information is inaccurate, you may be denied benefits.

- **You must not knowingly withhold or give false information with the intent to receive or to continue receiving DES and/or AHCCCS benefits to which you are not entitled.**
- **You will be required to pay back to DES and/or AHCCCS any benefits you receive as a result of withholding or giving false information and you will be subject to criminal prosecution.**
- **It is fraud for any person to knowingly withhold information with the intent to receive or continue to receive benefits to which they are not eligible. Any person found guilty of fraud may be subject to fines, criminal prosecution, imprisonment or other penalties as provided for by applicable State and Federal laws.**

Release of Information

I authorize DES and/or AHCCCS to investigate and contact any sources necessary to establish eligibility and the accuracy of financial information that pertains to AHCCCS and DES programs or benefits eligibility.

Assignment of Rights to Other Benefits for Medical Care

I understand that if I am or members of my household are approved for DES and/or AHCCCS benefits, DES and/or AHCCCS can collect payment from any other parties who may be responsible for paying for my/our health costs. This includes:

- Private or employer-sponsored health insurance (not including Medicare)
- Persons, such as an absent spouse or parent, who are legally responsible for providing medical support
- Private or employer-sponsored disability or accident insurance
- Insurance claims, jury awards, or legal settlements resulting from injuries

I understand that DES and/or AHCCCS cannot collect more than the costs paid by DES and/or AHCCCS.

I also understand that I must give information about other responsible parties and take any action needed to receive medical support. This includes establishing paternity of my children, unless I can prove good cause not to do so.

I understand that DES and/or AHCCCS and/or their contractors will release information to DES/ Division of Child Support Services (DCSS), for a parent of a child who does not live in the home and whose child has AHCCCS or private health insurance. DCSS may use this information to get a medical support order.

Assignment of Rights to Other Benefits for Cash Assistance

State and federal law (A.R.S. 46-407) provide that the legal rights to child support and spousal maintenance must be assigned to the State of Arizona for all persons receiving Cash Assistance. I understand:

- While receiving Cash Assistance, the State has the right to keep child support or spousal maintenance collections, including support or spousal maintenance that was owed while Cash Assistance was paid.
- When Cash Assistance stops, current support payments will be paid to me. The state may continue to collect any assigned back payments for support (assigned arrears) owed before and during the time I received Cash Assistance.
- Child support payments will be used to pay back the state for Cash Assistance paid to me or anyone on my application.
- The State will not keep more from my collected current support or assigned arrears than the total amount of Cash Assistance I received.
- The State will not keep any arrears that are more than the total amount of Cash Assistance I received.

Declarations and Statement of Truth

By signing this application:

- I agree I have read and understand the rules and penalties on page I-K included with the application. I have read and understand my rights and responsibilities, and provided Social Security numbers for each applicant that has a Social Security number.
- I agree I have read and understand the assignment of rights to other benefits for Medical Assistance.
- I agree I have read and understand the assignment of support rights for Cash Assistance above.
- I agree that certain Nutrition Assistance or Cash Assistance household members will cooperate with the work programs, which includes looking for work and accepting training and/or a job. If anyone does not, or will not, look for work, attend training, or accept a job, my benefits may be reduced or stopped.
- I agree to cooperate with Arizona or Federal personnel in the completion of a quality control review on my eligibility for benefits.
- In the event DES or its agents engage in child support enforcement activities involving me, I understand the Assistant Attorneys General and Deputy County Attorneys handling the cases represent DES, and not me or my children.
- If my child support case goes to court, I understand certain personal information contained in this application or my DES records may be released to the court and other parties to the case and becomes a public record document.
- I also hereby agree to accept service of process by first class mail with regard to any paternity or child support proceeding initiated by DES and its agents.
- I understand that my records will be kept confidential and will only be released for purposes authorized by federal and state law.
- I understand that I may be required to pay a premium if enrolled in the KidsCare or Freedom to Work program.

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587).

SIGN THE APPLICATION:

I swear under penalty of perjury that the statements and documents provided about myself and persons in my home, that relates to my eligibility for benefits, including any information regarding citizenship or alien status, is true and correct to the best of my knowledge, and that I have not withheld any information. I swear under penalty of perjury that any photocopied information I have provided are the same as the original documents. For Nutrition Assistance and Cash Assistance, I also swear under penalty of perjury that the statements regarding felony convictions and compliance with probation/parole are true and correct.

Signature of Applicant: _____ Date: _____

Signature of Spouse (CA and NA ONLY): _____ Date: _____

Signature of Other Adult in Household: _____ Date: _____

Signature of Authorized Representative: _____ Date: _____

Signature of Witness (if signed with mark): _____ Date: _____

Submit your signed application along with any supporting documents to the following address:

Arizona Department of Economic Security
Family Assistance Administration
P.O. Box 19009
Phoenix, Arizona 85005-9009

Note: You can file an application with only your name, address, and the signature of a responsible household member or your authorized representative. Eligibility cannot be determined until you complete a full application.

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex, and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination against its customers, employees, and applicants for employment on the bases on race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)
If you wish to file a Civil Rights program complaint of discrimination with USDA, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing, or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

Do you need help with this application? Visit www.healthearizonaplus.gov
or call 1-855-HEA-PLUS (432-7587).

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish, or call the State Information/Hotline https://www.fns.usda.gov/search?keywords=hotline.
To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

USDA and HHS are equal opportunity providers and employers. Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact your local office manager TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request. • Disponible en español en línea o en la oficina local.

NOTICE OF NON-DISCRIMINATION

The Arizona Health Care Cost Containment System (AHCCCS) and the Department of Economic Security (DES) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AHCCCS and DES do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. AHCCCS and DES provide free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, and other formats). AHCCCS and DES provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Health-e-Arizona Plus Customer Support Center at 1-855-432-7587 (TTY: 711). Also, under the Food Stamp Act and USDA policy, DES is prohibited from discriminating on the basis of religion or political beliefs.

If you believe that AHCCCS or DES failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance. You can file a grievance in person or by mail, fax, or email. Your grievance must be in writing and must be submitted within 180 days of the date that the person filing the grievance becomes aware of what is believed to be discrimination.

Submit your AHCCCS grievance to: General Counsel, AHCCCS Administration, Office of Administrative Legal Services, MD 6200, 701 E. Jefferson, Phoenix, AZ 85034 Fax: 602 253 9115 Email: EqualAccess@azahcccs.gov. You can also file an AHCCCS civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail at

U.S. Department of Health and Human Services; 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201; or by phone: 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html.

Submit your DES discrimination complaint/grievance to: Arizona Department of Economic Security, Director's Office, 010A, P. O. Box 6123 Phoenix, Arizona 85005-6123.

DHHS: Write DHHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D. C. 20201 or call 202-619-0403 (voice) or 202-619-3257 (TDD).

USDA: You may complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. You may also call 202-720-5964 (voice and TDD).

AVISO DE NO DISCRIMINACIÓN

El programa de seguro médico público estatal *Arizona Health Care Cost Containment System (AHCCCS)* y el Departamento de Seguridad Económica *(Department of Economic Security / DES)* cumplen con las leyes federales vigentes de derechos civiles y no discriminan por motivo de raza, color, origen nacional, edad, discapacidad o sexo. Las agencias *AHCCCS y DES* no excluyen a las personas ni las tratan de manera distinta por motivo de raza, color, origen nacional, edad, discapacidad o sexo. Las agencias *AHCCCS y DES* proporcionan ayudas y servicios gratuitos a las personas con discapacidades para comunicarse efectivamente con nosotros, tales como intérpretes de idioma de señas calificados e información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles y otros formatos). Las agencias *AHCCCS y DES* proporcionan servicios gratuitos de idiomas para las personas cuyas lenguas vernáculas no sean el inglés, tales como intérpretes calificados e información escrita en otros idiomas. Si necesitara estos servicios, comuníquese con el Centro de Servicios a Clientes de *Health-e-Arizona Plus* al 1-855-432-7587 (TTY: 711). Además, de conformidad con la Ley General de las Estampillas Para Alimentos *(Food Stamp Act)* y la política de la Secretaría Federal de Agricultura de los Estados Unidos *(United States Department of Agriculture)*, se le prohíbe al DES discriminar por motivo de creencias religiosas o políticas.

Si le pareciera que las agencias *AHCCCS o DES* no le proporcionaron estos servicios o discriminaron de cualquier otra manera por motivo de raza, color, origen nacional, edad, discapacidad o sexo, podrá presentar una querella. Podrá presentar la querella en persona, por correo, por fax o por correo electrónico *(email)*. Su querella deberá constar por escrito y deberá presentarse en los 180 días siguientes a la fecha en la que la persona que presente la querella se percatara de lo que le pareciera un discrimen.

Presente su querella contra AHCCCS a:
General Counsel
AHCCCS Administration
Office of Administrative Legal Services
MD 6200
701 E. Jefferson St.
Phoenix, AZ 85034

Por fax al 602 253 9115; por correo electrónico *(email)* mediante EqualAccess@azahcccs.gov.

También podrá presentar una querella de derechos civiles contra *AHCCCS* ante la Oficina de Derechos Civiles de la Secretaría Federal de Salud y Servicios Humanos *(U.S. Department of Health and Human Services, Office for Civil Rights)* electrónicamente mediante el Portal de Querellas de la Oficina de Derechos Civiles *(Office for Civil Rights Complaint Portal)*, disponible mediante https://ocrportal.hhs.gov/ocr/portal/lobby.jsf; o por correo a:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

O por teléfono al 1-800-368-1019, 800-537-7697 (TDD). La forma de querella está disponible mediante http://www.hhs.gov/ocr/office/file/index.html.

Presente su querella por discrimen contra *DES* a:
Arizona Department of Economic Security, Director's Office, 010A, P. O. Box 6123 Phoenix, Arizona 85005-6123.

Ante la Secretaría Federal de Salud y Servicios Humanos *(DHHS)*:
Escriba a: *DHHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D. C. 20201;* o llame al 202-619-0403 (por voz) ó al 202-619-3257 (TDD).

Ante la Secretaría Federal de Agricultura *(USDA)*: Podrá rellenar la *Forma de querella por discrimen en programas de la Secretaría de Agricultura de los EE. UU.* *(USDA Program Discrimination Complaint Form)* por Internet en http://www.ascr.usda.gov/complaint_filing_cust.html o en cualquier oficina de USDA, o llamar al (866) 632-9992 para pedir la forma. También podrá escribir una carta que contenga toda la información que se solicita en la forma. Envíenos su forma rellenada o carta de querella por correo a: *U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410*; por fax al (202) 690-7442; o por correo electrónico *(email)* a program.intake@usda.gov. También pudiera llamar al 202-720-5964 (voz y TDD).

English	If you speak English, language assistance services, free of charge, are available to you. Call 1-855-432-7587 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-432-7587 (TTY: 711).
Navajo	Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dę́ę́', t'áá jiik'eh, éí ná hóló̜, koji̜' hódíílnih 1-855-432-7587（TTY: 711）
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 1-855-432-7587（TTY：711）。
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-432-7587 (TTY:711).
Arabic	ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-885-432-7587 (رقم هاتف الصم والبكم:711).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-432-7587 (TTY:711).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-432-7587 (TTY: 711) 번으로 전화해 주십시오.
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-432-7587 (ATS : 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-432-7587 (TTY: 711).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-432-7587 (телетайп: 711).
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。1-855-432-7587（TTY: 711）まで、お電話にてご連絡ください。
Serbo-Croatian/Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-432-7587 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).
Syriac/Assyrian	ܙܘܗܪܐ: ܐܢ ܐܢܬܘܢ ܟܐ ܡܡܠܠܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܨܝܬܘܢ ܕܡܣܬܥܝܢܝܬܘܢ ܒܚܠܡܬܐ ܕܥܘܕܪܢܐ ܕܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ 1-855-432-7587 (TTY: 711)).
Persian/Farsi	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY:711) 1-855-432-7587 تماس بگیرید.
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-432-7587 (TTY:711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-432-7587 (TTY: 711).

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587).

Voter Registration: Tell us if any person over the age of 18 listed on this application would like to register to vote

If you are not registered to vote where you live now, would you like to apply to register to vote here today? Please go to the last attached page of this application, which is the "Offer of Voter Registration" form. Read the information, check "Yes" or "No," and then sign and date the form where indicated.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

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.

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 to vote, or your right to choose your own political party or other political preference, you may file a complaint with the State Election Director, Secretary of State's Office, 1700 West Washington, Phoenix, AZ 85007, 602-542-8683.

You may also get a voter registration form at www.azsos.gov/election/voterinformation.htm.

OFFER OF VOTER REGISTRATION FORM

The Offer of Voter Registration form is on the last page.

Please read the form and answer "Yes" or "No."

Sign and date the form under "Signature of Client"

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587).

FAA-1699A FORENG (12-19)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY

OFFER OF VOTER REGISTRATION

Applying to register to vote or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

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

IF YOU DO NOT MARK EITHER LINE, YOU WILL BE CONSIDERED TO HAVE DECIDED TO REGISTER TO VOTE AT THIS TIME.

If you would like help 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. You may take the form with you and mail it to the county recorder yourself or you may complete the registration here and deposit it in the box provided.

If you choose to register to vote here, the information regarding the agency where the registration took place will remain confidential and will be used only for voter registration purposes. If you choose not to register to vote at this time, that information will remain confidential and will be used only for voter registration purposes.

_____ _____

Signature of Client *(or initials of staff person)* Date

If you believe that someone has interfered with your right to register to vote or to decline to register to vote, your right to privacy in deciding whether to register to vote 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:

State Election Services Director
Office of the Secretary of State
1700 West Washington St.
Phoenix, Arizona 85007
(602) 542-8683 or (877) 843-8683

FAA-1699A FORSPA (12-19) ARIZONA DEPARTMENT OF ECONOMIC SECURITY

PROPOSICIÓN DE INSCRIPCIÓN DE VOTANTE

La cantidad de ayuda que esta oficina le va a proveer no será afectada por su decisión de inscribirse para votar o de no inscribirse para votar.

Si usted no esta inscrito para votar donde usted vive ahora, ¿le conviniera solicitar inscripción para votar hoy día aquí mismo? ◯ Sí ◯ No

SI USTED NO MARCA NINGUNA DE LAS RESPUESTAS, SE CONSIDERARÁ QUE USTED HIZO LA DECISIÓN DE INSCRIBIRSE PARA VOTAR HOY DÍA.

Si usted necesita ayuda para completar el formulario de inscripción de votante, nosotros estamos dispuestos a ayudarle. La decisión de solicitar o aceptar ayuda es suya. Se le permite completar el formulario de solicitud en privado. Usted tiene la opción de llevarse el formulario consigo y regresarlo por correo al registrador del condado o usted puede completar su inscripción aquí y depositarlo en el depósito que se proporciona.

Si usted se decide a inscribirse para votar, la información tocante la oficina donde se efectuó el inscripción permanecerá confidencial y se usará únicamente para los propósitos de inscripción de votantes.

Firma del Cliente *(o iniciales del miembro del personal)* Fecha

Si usted cree que alguien se ha impedido con su derecho de inscribirse para votar o de no inscribirse para votar, su derecho a privacidad en decidiendo de inscribirse o en solicitar inscripción para votar, o su derecho de seleccionar su propio partido político u otra preferencia política, usted puede entablar su queja con:

State Election Services Director
Office of the Secretary of State
1700 West Washington St.
Phoenix, Arizona 85007
(602) 542-8683 or (877) 843-8683