SNAP & WIC FOOD ASSISTANCE PROGRAMS

12/4/17

RESOURCE GUIDES

The following resource guides go in-depth about the eligibility requirements for the SNAP Food Stamps program and the Women, Infant and Child (WIC) program.

SNAP & WIC Food Assistance programs

RESOURCE GUIDES

SNAP: DEPARTMENT OF CHILDREN AND FAMILIES FOOD ASSISTANCE GUIDE

Information: The Food Assistance Program helps provide healthy food to people with low-income levels. The amount of assistance provided is based upon the number of people living in the household and gross income brought in after certain expenses are subtracted from disposable income.

Contact Information

Phone: 352-955-5338
Mailing Office:

ACCESS Central Mail Center
P.O. Box 1770
Ocala, FL 34478-1770

Call Center:
Agents available
8am to 5pm Mon-Fri
1-866-762-22371

Link to Website: http://www.myflfamilies.com/service-programs/access-florida-food-medical-assistance-cash/food-assistance-and-suncap

Step-by-Step Food Stamps Eligibility Guidelines

In order to receive assistance, all individuals must meet these guidelines:

1. *Proof of identity (license, passport etc.)*
2. *Adult's age 18-50 years of age who have no dependent children under them may qualify for 3-months of assistance within a 3-year period as long as they are not working or in a work program.*
3. *Your household must pass a gross income equal or less than 200% of the Federal Poverty Level Households who become disqualified must have a net income less than 100% of the FPL. Senior citizens 60 or older must only meet the **monthly** net income limit.*
4. *Individuals must live in the State of Florida*
5. *Individuals must be a U.S Citizen or have a certified noncitizen status*
6. *Individuals must have a valid SSN (Social Security Number) or show proof they have applied for one*
7. *Individuals must pay Child Support Payments regularly (if applicable)*

8. *Most food assistance households may have assets such as vehicles, bank accounts, or property and still get help. Households with a disqualified member must meet an asset limit of $2,250 or $3,250 effective October 1, 2014 (if the household contains an elderly or disabled member).*
9. *Change Reporting- households must report when the total monthly gross income exceeds 130% of the FTL when able-working adults fall below 20 hours a week. Must be reported within 10 days to keep eligibility.*
10. *YOU ARE INELIGIBLE IF YOU MEET ONE OF THE FOLLOWING: running convicted felon, participated in drug trafficking, noncitizen, break SNAP rules on purpose, and some students who attend universities may become ineligible for food assistance benefits.*

-Foods you can buy with food stamps include: breads, cereals, fruits, vegetables, meats, fish, poultry, dairy, and plants and seeds but not any nonfood items or hot food.

Complete the application below and send to mailing address or apply online.

ACCESS FLORIDA APPLICATION

☒ Before You Begin

You are ready to start your application. Here is some important information when applying and what to expect.

Applying for Benefits

You may apply for help by giving us just your name, address, and signing your application. We encourage you to answer as many questions as you can, and sign your application today. This will allow us to help you more quickly. If you need help in completing this application or need interpreter services, there may be Community Partners in your area who can help. Visit our website at www.myflorida.com/accessflorida or contact our Customer Call Center at 1-866-762-2237 for more information. You may apply faster online at www.myflorida.com/accessflorida.

Processing Your Application

Processing begins with the date we receive your signed application. It may take 7 to 30 days to process your food assistance application. Expedited households may get food assistance benefits within seven days. Your answers on the application will decide if your household meets expedited food assistance criteria. Expedited households must have: 1. Monthly gross income less than $150 and liquid assets less than $150; 2. Monthly gross income plus liquid assets less than the household rent or mortgage plus utility costs; or, 3. Be a destitute migrant or seasonal farmworker with liquid assets less than $100. Applications for Medical Assistance and Temporary Cash Assistance may take 30 to 45 days, and Medical Assistance applications may take longer if we need to determine if someone is disabled. You may check the status of your application by visiting the ACCESS Florida website at http://www.myflorida.com/accessflorida and click on the "My ACCESS Account" link.

An Application for Assistance may be submitted to any Department of Children and Families Economic Self-Sufficiency Services office in the State of Florida by you, or by someone acting for you, in person, by mail, by facsimile (FAX), or electronically through the internet. Applications received during normal business hours are considered received the same day. When an application is received after normal business hours, it will be considered received on the first business day following its receipt. Food assistance benefits start from the date of application if the applicant meets all eligibility requirements, completes the interview, and provides all necessary eligibility information by the 30th day after the date of application. The household has the right to file an application form on the same day it contacts DCF, in an office, by phone, fax, in person, or electronically. Applicants do not have to complete the interview prior to filing the application. Receiving food assistance does not affect other program time limits. For an individual applying for food assistance and SSI at the same time, the filing date is the date of release from the institution or the actual date of receipt if filed after release. The collection of information on the application, including the SSN of each household member, is authorized under the Food and Nutrition Act of 2008 as amended, 7 U.S.C. 2011-2036. The information will be used to determine whether your household is eligible, or continues to be eligible to participate in food assistance. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management. The household cannot be denied food assistance benefits solely because of the denial of other program benefits.

Head of Household

The household may select an adult parent of children (of any age) living in the household, or an adult who has parental control over children (under 18 years of age) living in the household, as the head of household provided all adult household members agree to the selection. Households may select the head of household at application, at each review, or when there is a change in household composition. If all adult household members do not agree to the selection, or decline to select an adult parent as the head of household, the state agency may designate the head of household or permit the household to make another selection. If the household does not consist of adult parents and children or adults who have parental control of children living in the household, the state agency shall designate the head of household or permit the household to do so.

Social Security Number

We may treat household members who are ineligible, or who are not applying for benefits, as non-applicants. Non-applicants, or persons applying only for Emergency Medical Assistance for Aliens, Refugee Cash Assistance, or Refugee Medical Assistance, do NOT need to give a Social Security Number (SSN). If you were not eligible for an SSN because of your immigration status, you may be eligible for a non-work SSN. If you need an SSN, we can help you apply for one. Non-applicants do NOT need to give proof of immigration status. Noncitizens who are applying for benefits will have their immigration status verified with the U.S. Citizenship and Immigration Services (USCIS). We will not tell USCIS about the immigration status of those living in your household who are not applying for benefits.

Important Information for Immigrants

Applying for or receiving Food Assistance (SNAP) benefits or Medical Assistance will not affect you or your family members' immigration status or ability to get permanent resident status (green card). Receiving Temporary Cash Assistance or long term institutional care, such as nursing home benefits might create problems with getting that status, especially if the benefits are your family's only income.

Public Assistance Fraud / Notice of Penalties
If you are found guilty (by a state or federal court, or an administrative disqualification hearing, or sign a hearing waiver) of intentionally making a false or misleading statement, concealing or withholding facts in order to receive or in an attempt to receive food assistance or Temporary Cash Assistance (TCA) or committing any act that violates the Food and Nutrition Act of 2008, food assistance regulations, or any state statute for purposes of using, presenting, transferring, acquiring, receiving, or possessing food assistance benefits, you will be disqualified. You will be ineligible for food assistance or TCA for 12 months for the first violation, 24 months for the second violation, and permanently for the third violation. If you are convicted of trafficking food assistance benefits of $500 or more, you will be disqualified permanently. Trafficking of food assistance includes:

1. Buying, selling, stealing, or exchanging benefits for cash;
2. Exchanging firearms, ammunition, explosives, or illegal drugs for benefits;
3. Buying sodas, water, or other items in a container to get the cash deposit;
4. Buying an item with food assistance and then purposely selling the item for cash; and
5. Trading cash for items paid for with food assistance benefits.

If you are convicted of these acts, depending on the severity, you may be fined up to $250,000, imprisoned for up to 20 years, or both. You may also be subject to prosecution under other applicable Federal and State Laws. You may be barred from receiving food assistance for an additional 18 months if court ordered. If you are convicted by a state or federal court of making a fraudulent statement with respect to identity or residency in order to receive food assistance or TCA in more than one state at the same time, you will be ineligible to participate in the Food Assistance Program or TCA for a period of 10 years.

If you are fleeing to avoid prosecution, custody, or confinement, after conviction for a crime or an attempt to commit a crime, which is a felony, or are in violation of probation or parole imposed under a federal or state law, you are ineligible for food assistance and Temporary Cash Assistance. This information may be disclosed to other federal and state agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law.

If you are found guilty of a drug-trafficking felony after 8/22/96, or convicted by a federal, state, or local court of trading firearms, ammunition, or explosives for food assistance benefits, you are ineligible for food assistance. If you are convicted of using or receiving food assistance benefits in a transaction involving the sale of a controlled substance, you will be ineligible 24 months for the first violation and permanently for the second violation. Households must not use food assistance benefits to purchase nonfood items, pay on credit accounts, pay for food purchased on a credit account, use or possess the Electronic Benefits Transfer (EBT) cards of others, allow unauthorized use of the household's EBT card by non-household members, sell or trade EBT cards, or use someone else's EBT card. If a food assistance claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action.

Income and Eligibility Verification System (IEVS)
We will request information through computer matches in IEVS and may verify the information if we find differences based on the answers you gave on your application. We may use the information found in IEVS to affect your eligibility and level of benefits.

Reporting Requirements
For all programs, households are encouraged to report any change in the household living and/or mailing address. For programs except Food Assistance (SNAP), households must report changes in who lives in the household, employment, and income. Food Assistance (SNAP) households must report when the total monthly household gross income exceeds 130% of the federal poverty level for the household size and when the work hours of able-bodied adults fall below 20 hours per week when averaged monthly, by the 10th of the month after the month of the change. Households receiving Medicaid or Temporary Cash Assistance must report changes within 10 days.

Requesting a Fair Hearing
You have the right to ask for a hearing before a state hearings officer. You can bring with you or be represented at the hearing by a lawyer, relative, friend, or anyone you choose. If you want a hearing, you must ask for the hearing by writing, calling the Customer Call Center, or coming into the office within 90 days from the mailing date of your notice of case action. If you ask for a hearing by the end of the last day of the month prior to the effective date of the adverse action, your benefits may continue at the prior level until the hearing decision. You will be responsible to repay any benefits continued if the hearing decision is not in your favor. If you need information about how to receive free legal advice, you can call the Customer Call Center toll free at 1-866-762-2237 for a listing of free legal agencies in your area.

Medical Assistance Applications
Use this application to see what coverage choices you qualify for such as free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP), affordable private health insurance plans that offer comprehensive coverage to help you stay well, and a new tax credit that can immediately help pay your premiums for health coverage. To complete your application, you may need social security numbers, document numbers for legal immigrants, employer and income information for everyone in your family, policy numbers for current health insurance, and job-related health insurance information. Please send copies not originals.

What Happens Next
Submit your signed application at any Department of Children and Families Economic Self-Sufficiency Services office or mail your application to ACCESS Central Mail Center, P.O. Box 1770, Ocala, FL 34478-1770. You may fax your application to a Customer Service Center in your area. Find a local fax number at http://www.myflfamilies.com/service-programs/access-florida-food-medical-assistance-cash/locate-service-center-your-area.

ACCESS FLORIDA APPLICATION

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

APPLICANT INFORMATION

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

First Middle Last

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

Street Apt. No. City State Zip Code County

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

Street/P. O. Box City State Zip Code

Home or Message Phone Number: **Work Phone Number:** **Cell Phone Number:**

E-Mail Address:

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

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

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

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

STATEMENT OF UNDERSTANDING

I understand that information that I provide with this application, interview, or when requesting other benefits, including computer information matches with other agencies, is subject to verification by DCF and other Federal and State agencies including Division of Public Assistance Fraud (DPAF). I understand and agree to the following: DCF, DPAF, and authorized Federal Agencies may verify the information I give on this form, interview, or when requesting other benefits. Information may be obtained from my past or present employers. My signature authorizes release of such information to DCF and/or DPAF. As a condition of participation in Medicaid, I consent to review and release of all medical records deemed necessary by Medicaid under its auditing and investigatory powers. If any information is incorrect, benefits may be reduced or denied and I may be subject to criminal prosecution or disqualified from the program for knowingly providing incorrect or false information or hiding information. I have read my Rights and Responsibilities. I certify under penalty of perjury that the information on this form is true to the best of my knowledge, including the citizen or noncitizen status of those who are applying for benefits. I hereby acknowledge receipt of the Florida DCF CFOP 60-17, Chapter 1, Attachment 3, Notice of Privacy Practices.

SIGNATURES

Signature of Adult Household Member / Date Signed

Signature of Witness if signed with an "X"

Authorized/Designated Representative – Please print

Name	
Address	Phone Number

Signature of Authorized/Designated Representative

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

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

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

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

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

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

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

SECTION A – List All Adults Living At Your Address

Adult's Legal Name First, Middle, Last	Want to Apply?	Sex	Social Security Number (see instructions above)	Date and Place of Birth*	U.S. Citizen	Ethnicity (see above)	Race (see above)	Marital Status	Attends School/ # Hours / Week/ Last Grade Completed*	Buys and Eats Food with You
1. Relationship to you: **SELF**	☐ Yes ☐ No	☐ F ☐ M			☐ Yes ☐ No USCIS #	☐ A ☐ B	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7		☐ Yes ☐ No # hours per week: * Last Grade Completed:	☐ Yes ☐ No
2. Relationship to you:	☐ Yes ☐ No	☐ F ☐ M			☐ Yes ☐ No USCIS #	☐ A ☐ B	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7		☐ Yes ☐ No # hours per week: * Last Grade Completed:	☐ Yes ☐ No
3. Relationship to you:	☐ Yes ☐ No	☐ F ☐ M			☐ Yes ☐ No USCIS #	☐ A ☐ B	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7		☐ Yes ☐ N # hours per week: * Last Grade Completed:	☐ Yes ☐ No
4. Relationship to you:	☐ Yes ☐ No	☐ F ☐ M			☐ Yes ☐ No USCIS #	☐ A ☐ B	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7		☐ Yes ☐ No # hours per week: * Last Grade Completed:	☐ Yes ☐ No

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

Child's Legal Name First, Middle, Last	Want to Apply?	Sex	Social Security Number (see instructions above)	Date and Place of Birth*	U.S. Citizen	Ethnicity (see page 2)	Race (see page 2)	*Child under Age 5 Immunized	Attends School/ School Name/	*Date To Graduate	Buys and Eats Food with You
1. Relationship to you	☐ Yes ☐ No	☐ F ☐ M			☐ Yes ☐ No USCIS #	☐ A ☐ B	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7	☐ Yes ☐ No	☐ Yes ☐ No School Name:		☐ Yes ☐ No
2. Relationship to you	☐ Yes ☐ No	☐ F ☐ M			☐ Yes ☐ No USCIS #	☐ A ☐ B	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7	☐ Yes ☐ No	☐ Yes ☐ No School Name:		☐ Yes ☐ No
3. Relationship to you	☐ Yes ☐ No	☐ F ☐ M			☐ Yes ☐ No USCIS #	☐ A ☐ B	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7	☐ Yes ☐ No	☐ Yes ☐ No School Name:		☐ Yes ☐ No
4. Relationship to you	☐ Yes ☐ No	☐ F ☐ M			☐ Yes ☐ No USCIS #	☐ A ☐ B	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7	☐ Yes ☐ No	☐ Yes ☐ No School Name:		☐ Yes ☐ No

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Individual	Type of Asset or Insurance	Vehicles Year, Make, Model*	Amount Owed on Vehicle/Property	Location of Asset/Insurance Bank/Company Name and Address	Account # or Insurance ID #	Amount or Value

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

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

If yes, who?

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

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

If yes, who?

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

YOU CAN APPLY TO REGISTER TO VOTE HERE

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

☐ **YES** ☐ **NO**

NOTICE OF RIGHTS

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

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

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

Formal Complaint: If you believe someone has interfered with either your right to apply to register or to decline to register to vote, your right to privacy in deciding whether to apply to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with: Florida Secretary of State, Division of Elections, NVRA Administrator, R.A. Gray Building, 500 S. Bronough Street, Tallahassee, Florida 32399-0250. Forms for filing a complaint are available at http://election.dos.state.fl.us/nvra/index.shtml or call 1-850-245-6200. For complaints not related to voter registration, see "**USDA-HHS NON DISCRIMINATION STATEMENT**" on the last page of this application.
[Authority: National Voter Registration Act (42 U.S.C. 1973 gg); ss. 97.023, 97.058 and 97.0585, F.S.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Type of Expense	Who is Obligated To Pay This Expense	If a Medical Expense, Who Received the Medical Service?	Monthly Amount	Paid to Whom	Date Paid	Still Owed?	For Court Ordered Child Support Only, Name of Child for Whom Support is Paid
						☐ YES ☐ NO	
						☐ YES ☐ NO	
						☐ YES ☐ NO	
						☐ YES ☐ NO	
						☐ YES ☐ NO	

How do you heat or cool your home?

Does anyone help you pay expenses? ☐ **YES** ☐ **NO** **If yes, who?**

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

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

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

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

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

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

☐ Medicaid: _____

☐ Medicare: _____

☐ VA health programs: _____

☐ Employer insurance: _____

Name of Insurance: _____

Name of person insured: _____

Policy number: _____

Is this COBRA coverage? ☐ **YES** ☐ **NO**

Is this a retiree health plan? ☐ **YES** ☐ **NO**

☐ Florida KidCare: _____

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

☐ Peace Corps: _____

☐ Other: _____

Name of Health Insurance: _____

Name of person insured: _____

Policy number: _____

Is this a limited-benefit plan (like school accident policy)?

☐ **YES** ☐ **NO**

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

☐ The cost of an applicant child's health insurance is more than 5% of your family's income.

☐ Domestic violence led to the loss of coverage for an applicant child.

☐ Parent lost a job that provided employer-sponsored coverage for an applicant child.

☐ The coverage does not cover the applicant child's health care needs.

☐ Parent who had the health coverage for an applicant child is deceased.

☐ The employer providing the applicant child's coverage canceled the coverage.

☐ The applicant child's coverage ended because the child reached the maximum lifetime coverage limit or an annual benefit limit.

☐ An applicant child has a medical condition that, without medical care, would cause serious disability, loss of function, or death.

☐ The applicant child's parent canceled COBRA coverage or the COBRA coverage reached its legal limit.

☐ A non-custodial parent dropped the applicant child's coverage.

YOU MAY BE ELIGIBLE FOR REDUCED TELEPHONE RATES

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

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

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible. If you have more people to include, make a copy of this page and attach.

Name First, Middle, Last	Member of a Federally recognized tribe	Has this person ever received a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	
	☐ **YES** ☐ **NO** **If yes, tribe name:**	☐ **YES** ☐ **NO**	If no, is this person eligible to get services from one of these programs? ☐ **YES** ☐ **NO**
	☐ **YES** ☐ **NO** **If yes, tribe name:**	☐ **YES** ☐ **NO**	If no, is this person eligible to get services from one of these programs? ☐ **YES** ☐ **NO**
	☐ **YES** ☐ **NO** **If yes, tribe name:**	☐ **YES** ☐ **NO**	If no, is this person eligible to get services from one of these programs? ☐ **YES** ☐ **NO**
	☐ **YES** ☐ **NO** **If yes, tribe name:**	☐ **YES** ☐ **NO**	If no, is this person eligible to get services from one of these programs? ☐ **YES** ☐ **NO**

*Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income reported on your application that includes money from these sources:

☐ **Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties?** ☐ **YES** ☐ **NO**
If yes, who? **Amount:** $

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

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

AUTHORIZED REPRESENTATIVE

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

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

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

Name: First, Middle, Last: ______________________

Organization Name and ID number (if applicable): ______________________

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

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

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES NON-DISCRIMINATION STATEMENT

No person shall, on the basis of race, color, religion, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to unlawful discrimination under any program or activity receiving or benefiting from federal financial assistance and administered by the Department. To file a complaint, alleging violations of this policy, contact the Office of Civil Rights, Florida Department of Children and Families, 1317 Winewood Boulevard, Tallahassee, Florida 32399-0700 or call 1-850-487-1901, or TDD 1-850-922-9220.

USDA-HHS NON-DISCRIMINATION STATEMENT

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 based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.) should contact the Department of Children and Families, where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. 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 Numbers (click the link for a listing of hotline numbers by State); found online at http://www.fns.usda.gov/snap/contact_info/hotlines.htm. 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). This institution is an equal opportunity provider.