

Arizona Department of Economic Security

Application for

**AHCCCS Health Insurance, Cash Assistance/Temporary Assistance for Needy Families,
Food Stamp Benefits, and General Assistance**

How do I apply for assistance?

For Food Stamp benefits, see YOUR FOOD STAMP RIGHTS, page C.

For Cash Assistance, General Assistance, and AHCCCS Health Insurance, we will accept your application if it contains your name, address (if you have one), and a signature. This information will establish your application filing date.

IF YOU NEED HELP IN FILLING OUT THIS FORM, PLEASE CHECK THE TYPE OF HELP YOU NEED ON PAGE 1 OF THE APPLICATION.

All sections of the application must be completed before we can determine eligibility for the assistance for which you are applying. You may complete the application before the interview; or, if you need help, the application can be completed during the interview.

You may bring, mail, or fax your application to any DES Family Assistance Administration (FAA) or Tribal Temporary Assistance for Needy Families (TANF) office.

When we receive your application, an appointment date and time for your interview will be scheduled.

You may be required to show proof of the information you give us. We will give you a list of information we need. If you need help, let us know and we will help you get this information.

IF YOU NEED A LANGUAGE INTERPRETER OR ACCOMMODATIONS FOR A DISABILITY, PLEASE CHECK THE TYPE OF HELP YOU NEED ON PAGE 1 OF THE APPLICATION.

For Food Stamp benefits and AHCCCS Health Insurance, you may assign a representative to apply for and be interviewed for you. Complete the Representative section of the application. Be sure your representative knows your situation. You will be responsible for any missing or wrong information given by your representative. (See page 1)

Grandparents, other relatives, and non-relatives applying ONLY for children that are not their own: You only need to answer the questions as they apply to the child(ren). For example, the questions on income, resources, etc., all apply to the child(ren) and not to yourself, unless you are applying for Food Stamp benefits or want Cash Assistance or AHCCCS Health Insurance for yourself.

The USDA is an equal opportunity provider and employer ♦ DES/TANF Agencies are Equal Opportunity Employers/Programs

In accordance with Federal law and U.S. Department of Agriculture policy, the State of Arizona Department of Economic Security (DES) is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political beliefs, or disability.

Under the Americans with Disabilities Act (ADA), 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 that 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. This document is available in alternative formats by calling or contacting your case worker.

How long does it take before I know if I am eligible?

- We must determine if you qualify for Food Stamp benefits within **30** days.
- We must determine if you qualify for AHCCCS health Insurance within **45** days.
- We must determine if you qualify for Cash Assistance within **45** days.
- We must determine if you qualify for General Assistance and Tuberculosis Control within **60** days.

To receive assistance, do I have to give you my Social Security Number?

Federal Law requires that you provide a Social Security number for anyone who is requesting AHCCCS Health Insurance, Cash Assistance, or Food Stamp benefits. [42 U.S.C. § 1320b-7 and 42 U.S.C. § 405(c)(2)(C)].

If you or anyone you are applying for does not provide a Social Security number, the persons who do not provide a Social Security number will not be eligible for benefits. If you or anyone you are applying for does not have a Social Security number, we will refer you to the Social Security Office to apply for one. For the purposes of Federal Emergency Medical Services, immigrants who are not legally able to get a Social Security number are not required to provide one.

If you are not applying for benefits for yourself, you do not have to give us your Social Security number. However, it may reduce the total amount of Food Stamp and Cash Assistance benefits for the person(s) applying because we will not consider your needs when determining benefit amounts.

We will not use your Social Security number as your case number or AHCCCS identification number.

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

You need to tell us about the citizenship and immigration status for:

- you, if you are applying for yourself.
- all persons that you are applying for.

Giving us the citizenship and immigration status for all persons who are eligible for benefits allows us to give you the highest amount of benefits you are eligible to receive.

Under federal law, certain non-citizens (such as refugees or political asylees) may qualify for AHCCCS health insurance or Food Stamps. For those lawfully admitted non-citizens, United States Citizenship and Immigration Service (USCIS) guidelines state that use of these benefits will not affect your ability to become a Lawful Permanent Resident.

What does the Department of Economic Security do with the information you give?

The collection of this information, including the Social Security number of each person you are applying for, is authorized under the Food Stamp Act of 1977, as amended, 7 U.S.C. 2011-2036.

We use your information, including Social Security Numbers to:

- Verify identity.
- Verify income and assets.
- Verify other health insurance.
- Prevent duplicate benefits.
- Establish and enforce child support and medical support orders.
- Computer match with state and federal agencies and our other programs to verify information.
- Collect money we overpaid you in the form of benefits.
- Share with other government agencies and their contractors to assess program management and compliance.

Your information may be given to law enforcement officials for the purpose of arresting persons fleeing to avoid the law.

YOUR FOOD STAMP RIGHTS

Where do you get an application?

You can get an application:

- At any Department of Economic Security (DES), Family Assistance Administration (FAA) local office
- On DES' web site at www.azdes.gov/faa or
- You can ask DES to mail or fax an application to you.

Where do you apply?

- You can turn in an application any time by mail, fax, or in person at any DES local office.
- You have a right to get an application and turn it in the same day.

How do you file an application?

- You should fill out as much of the application as you can.
- If you need help filling out the application, you should ask DES for help.
- You can file an application with only your name, address, and the signature of a responsible household member or your authorized representative.
- You may turn the application in, mail it, or fax it to any DES office.

What does DES do with your application?

- DES will review the information on your application.
- DES will set you an appointment to discuss the information on the application.
- DES will give you an interview date and time that is best for you and your family.
- DES will let you know the date, time, and place of your interview.
- If you cannot come to the office for an interview, ask DES to set up a telephone or home interview for you.

Who is eligible for emergency Food Stamp benefits?

- If you have little or no money, you may be eligible for emergency Food Stamp benefits.
- DES will use the information on the application to decide if you can get emergency Food Stamp benefits, so be sure to answer the Emergency Food Stamp benefit questions, 3 - 9 on page 1 of the application.

How long can DES take to decide if you are eligible for Food Stamp benefits?

- DES must make a decision on your Food Stamp application within thirty (30) days from the date they get your application.
- If you are eligible for emergency Food Stamp benefits, DES FAA will put Food Stamp benefits on your Electronic Benefit Transfer (EBT) card within seven (7) days from the date your application was filed.
- Before your eligibility for Food Stamp benefits ends, FAA will tell you that it is time to reapply so your Food Stamp benefits can continue without a break.

What if DES doesn't decide your application on time?

If your Food Stamp application is not decided within the time show above, or you have questions, you should:

- Call the FAA Customer Service Unit at 602-542-9935 or 1-800-352-8401.
- Contact your FAA local office during normal business hours.
- Contact FAA via the internet at www.azdes.gov/faa

RIGHTS AND RESPONSIBILITIES

Your Rights

You have the right to:

- Talk about your case with your worker or the supervisor if you are not happy with our decision.
- Be told in writing before your benefits are reduced or stopped.
- Have the information you gave used only as authorized by law.
- Ask for a fair hearing, verbally or in writing, for any action or failure to take action by the Department/TANF agency.
- Look at your file before the fair hearing.
- Bring an attorney or any other person to the fair hearing.
- Request a Claim for Good Cause for not giving us information about an absent parent if giving us the information might put you, your family or anyone you are applying for in danger.

In accordance with Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discrimination in all its programs and activities on the basis of race, color, national origin, sex, age, disability, political beliefs, sexual orientation, and marital or family status.

To file a complaint of discrimination, contact USDA or HHS. Write or call:

USDA, Director
Office of Civil Rights
Room 326-W, Whitten Building
1400 Independence Ave., SW
Washington, D.C. 20250-9410

Attention: Regional Manager
U.S. Department of Health and Human Services
Office for Civil Rights/Region IX
50 United Nations Plaza, Room 322
San Francisco, CA 94102

(202) 720-5964 (voice and TDD)

1-800-368-1019 (voice)
1-415-437-8311 (TDD)

NOTE: If your child is approved for Cash Assistance or Food Stamps, he/she is eligible for free school breakfast and lunch through the National School Lunch Program. Ask your child's school about this benefit.

Your Responsibilities

- You must report changes in your household, your worker will explain your change reporting requirements and provide you with a change report form.
- Everyone receiving benefits must cooperate with state and federal personnel in the completion of a Quality Control (QC) review of eligibility.
- You are responsible for the use of your Electronic Benefit Transfer (EBT) card and Personal Identification Number (PIN). Your Food Stamp, Cash Assistance and General Assistance benefits will not be replaced if your account is used with your card or your representative's card and the proper PIN.

When you do not access your Food Stamp, Cash Assistance and/or General Assistance benefits that are in your EBT account within a 90-day period, and you have an overpayment, these benefits can be used to pay back any overpayment. Contact the Office of Accounts Receivable and Collections at (602) 252-0024 or 1-800-236-1475.

- All adult household members and minor parents who are eligible for Food Stamp, Cash Assistance, or General Assistance benefits must be fingerprint imaged. (*Exceptions may apply.*)

PENALTIES

If you, your representative or any household member knowingly withholds information or gives false information with the intent to get or continue to get Food Stamp, Cash Assistance, AHCCCS Health Insurance or General Assistance benefits, that person will be subject to criminal prosecution, fines, imprisonment or other penalties provided for by state and federal laws.

If you get Cash Assistance, Food Stamp benefits, or AHCCCS Health Insurance, you must follow the rules for telling us about changes, and the rules below:

- **Do not** make false statements or hide information. This is an Intentional Program Violation (IPV). If you are not truthful, the Department can take back money overpaid to you, and you may be taken to court.
- **Do not** do anything dishonest to get Cash Assistance, Food Stamp or AHCCCS Health Insurance benefits that you are not supposed to get.
- **Do not** give or sell your AHCCCS ID card to anyone.
- **Do not** alter or use someone else's EBT card for your household.
- **Do not** use your Food Stamp benefits to buy non-food items such as alcohol and tobacco.
- If you knowingly hold back or give false information so you can receive or continue receiving AHCCCS Health Insurance, or if something you tell us on this application is incorrect, we may deny or stop AHCCCS Health Insurance. If you and/or your representative knowingly provide false information, you and/or your representative will be subject to criminal prosecution, which could result in fines, imprisonment and/or other penalties under state or federal laws. You may also be required to pay AHCCCS for AHCCCS Health Insurance you received while you were not eligible.
- **If you knowingly break the rules and get Cash Assistance and/or Food Stamp benefits, you will be disqualified from receiving Cash Assistance and/or Food Stamp benefits for:**
 - 12 months for the first violation
 - 24 months for the second violation
 - Permanently for the third or any other violations
- **The following additional penalties apply to the Food Stamp Program:**
 - An additional disqualification, of up to 18 months, may be ordered by a court.
 - Any participant or family member who commits an Intentional Program Violation (IPV) can be fined up to \$250,000.00, imprisoned up to 20 years, or both.
 - An individual may be subject to further prosecution under federal laws.
- **An individual will not be eligible to get Food Stamp or Cash Assistance benefits if the individual is:**
 - Convicted of using or getting Food Stamp benefits in a transaction involving the sale of firearms, ammunition or explosives. This individual can never get Food Stamp benefits again.
 - A fleeing felon, or probation or parole violator.
 - Found guilty of having used or received Food Stamp benefits in the sale of a controlled substance. This individual is not eligible to participate for 2 years for the first violation and permanently for the second violation.
 - An individual who has committed **and** been convicted of federal or state felonies on or after 8/23/96 for possession, use or distribution of illegal drugs. This does not apply to General Assistance applicants.
 - Found to have given false identification or residence information in order to get benefits in more than one case. This individual is not eligible to get benefits for 10 years.
 - Refusing to sign and comply with the Personal Responsibility Agreement (PRA). (For Cash Assistance only)

If you do not cooperate with Child Support Enforcement, your Cash Assistance and Food Stamp benefits may be reduced or stopped. You may also be disqualified from AHCCCS Health Insurance. Your children will **NOT** be disqualified from AHCCCS Health Insurance if you do not cooperate.

You must pay back to the DES/TANF Agency any Food Stamp, Cash Assistance, or General Assistance benefits received for which your household was not eligible. You can make a repayment agreement. If you do not keep your repayment agreement, the State may reduce benefits, federal benefits or earnings, income tax refunds, or take other legal action.





**ARIZONA
DEPARTMENT OF ECONOMIC SECURITY**

**Agency use only
Date Stamp**

PLEASE COMPLETE IN BLUE OR BLACK INK.

I need: a language interpreter, type of language _____
 accommodations for a disability help in filling out this form

I am applying for:

 AHCCCS Health Insurance I do not want AHCCCS Health Insurance
 Cash Assistance (CA)/Temporary Assistance for Needy Families (TANF)
 Food Stamp benefits (FS)  General Assistance

CASE #

Legal Name (Last, First, Middle)

Maiden name, alias or other name(s) used

Residential Address (No., Street, City, State, ZIP) (If rural, give directions)

Mailing Address (No., Street, City, State, ZIP)

Phone Number

()

Message Number

()

1. Are you able to come into the office for an interview? If no, please explain. Yes No

2. Do you need a special appointment? Yes No

If yes, write down the days and times that are best for you. Yes No

Food Stamp benefits

You may qualify for EMERGENCY benefits. Please answer the following questions.

3. Do you, or anyone you are applying for, receive Tribal Food Distribution? Yes No

4. What is the **TOTAL** amount of income, before deductions, that you, or anyone you are applying for, expect to receive this month? \$ _____

5. What is the **TOTAL** amount that you, and everyone you are applying for, have in cash, checking, and savings accounts? \$ _____

6. What is the **TOTAL** monthly housing costs (rent, mortgage) that you pay? \$ _____

7. What is the **TOTAL** monthly utility costs (gas, electric, etc.) that you pay? \$ _____

8. Are you, or anyone you are applying for, a Migrant Seasonal Farm Worker? Yes No

9. Do you, and everyone you are applying for, live in a shelter? Yes No

This completes the **EMERGENCY FOOD STAMP** questions. Now, continue to answer the additional questions on the following pages for each type of assistance your are applying for.

If you are applying for Cash Assistance, Food Stamp benefits and/or AHCCCS Health Insurance and you want to allow someone else to represent you, complete the following section:

Representative's Name (Last, First, Middle)

Representative's Home Address (No., Street, City, County, State, ZIP)

Representative's Mailing Address (No., Street, City, County, State, ZIP)

Representative's Home Telephone No.

()

Representative's Second Telephone No.
(work, message, cell)

()

Representative's Other Telephone No.
(work, message, cell)

()

By signing below, I:

- Give permission for my representative to complete and sign my application;
- Give permission for my representative to provide any documents requested, including personal information;
- Give permission to my representative to sign on my behalf to permit other people, businesses, or agencies to give personal information about me to AHCCCS;
- Give permission for AHCCCS or DES to tell my representative about my eligibility; and
- Agree to give personal information to my representative.

Signature of Applicant (not needed if the applicant has a legal guardian or is unable to sign due to being incapacitated)

Date

If you are applying for Food Stamp benefits and/or Cash or General Assistance and you want to allow someone to have access to your benefits in your Electronic Benefits Account (EBT), you will need to complete the following section to assign an EBT Representative.

EBT Representative's Name (Last, First, Middle)	EBT Representative's Date of Birth
EBT Representative's Home Telephone No. () () ()	EBT Representative's Second Telephone No. (work, message, cell) () () ()

10. Complete the following for you and everyone who lives with you.

Name Last, First, M.I.	Relation- ship to you? (If not related write NR)	Check (✓) Benefits applying for				Social Security Number (for you and anyone you are applying for)	Date of Birth	Sex – M or F	*Race/Ethnicity	Place of Birth (state or country)	Y or N			
		Food Stamp	AHCCCS Health Insurance	Cash/TANF GATC	None						US Citizen?	Disabled?	In School?	Shots Current?
	SELF													

*Race/Ethnicity is optional. Please indicate (in the above grid) all that apply.
 AI – American Indian or Alaska Native; NH – Native Hawaiian or other Pacific Islander; AS – Asian; WH – White; BL – Black or African American; HI – Hispanic/Latino

ANSWER THE FOLLOWING QUESTIONS FOR ANY OF THE FOLLOWING ASSISTANCE PROGRAMS.

- AHCCCS Health Insurance
 Cash Assistance
 Food Stamp benefits
 General Assistance

11. If you are currently receiving AHCCCS Health Insurance, Cash Assistance, Food Stamp benefits, or General Assistance, has any of the information changed since your last interview or reported change? Yes No
 If yes, please explain: _____
12. Have you, or anyone you are applying for, received benefits in any other state? Yes No
 If yes, please explain: _____ Last received: _____
13. Do you, or anyone you are applying for, own, lease, or maintain a home outside Arizona? Yes No
14. Do you, or anyone you are applying for, own or have their name on any of the following:
- Bank (checking, savings), credit union accounts, IRA, Keogh, 401K: Total amount: \$ _____ Yes No
- Stocks, bonds, money market accounts, CDs, trust funds, life insurance: Value: \$ _____ Yes No
- Real property (land or buildings) anywhere: Value: \$ _____ Yes No
- Vehicles (cars, trucks, boats, RVs, motorcycles, etc.): How many? _____ Yes No
- Other: _____ Value: \$ _____ Yes No

15. Are you, or anyone you are applying for, working and/or self-employed? Yes No

This includes all income, wages, salaries, tips, or commissions from any type of work whether full or part time, temporary, seasonal, or training.

Person Working	Employer's Name and Phone Number	Hours Per Week	Hourly Pay	How Often Paid (Weekly, bi-weekly)

16. Do you, or anyone you are applying for, receive or expect to receive money from any of the following:

- | | | | | | |
|---------------|--|---------------------|--|----------------------------|--|
| Child Support | <input type="checkbox"/> Yes <input type="checkbox"/> No | Social Security/SSI | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scholarships, grants/loans | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Disability | <input type="checkbox"/> Yes <input type="checkbox"/> No | Retirement/Pension | <input type="checkbox"/> Yes <input type="checkbox"/> No | Any government check | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tribal Money | <input type="checkbox"/> Yes <input type="checkbox"/> No | Unemployment | <input type="checkbox"/> Yes <input type="checkbox"/> No | Worker's Comp/Industrial | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| BIA/GA | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gifts/Loans | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Person Receiving the Money	Source	How Often Received	Amount

17. Do you, or anyone you are applying for, **expect to receive** money from any other source? Yes No

If yes, from where _____


18. Do you, or anyone you are applying for, **pay** for the care of a child or disabled adult in order to work, look for work, attend training, or school? Yes No

19. Do you, or anyone you are applying for, **pay** court ordered child support? Yes No

If yes, indicate amount \$ _____

20. Does your monthly income, cash and bank account balances **cover** your monthly rent, mortgage, utilities, and child support payments? Yes No

AHCCCS Health Insurance

 **ANSWER THESE ADDITIONAL QUESTIONS IF YOU ARE APPLYING FOR AHCCCS HEALTH INSURANCE**

21. Are you, or anyone you are applying for, pregnant? Yes No

If yes, who? _____ Number of babies expected? _____ Due date _____

22. Are you, or anyone you are applying for, hospitalized? Yes No

If yes, who? _____ Name of hospital _____

23. How long have you, and anyone you are applying for, lived in Arizona? _____

24. Tell us the date you, and anyone you are applying for, moved to Arizona. _____

25. Why did you, and anyone you are applying for, move to Arizona? _____

26. Is Arizona your permanent home state and the home state of the person(s) you are applying for? Yes No

If no, explain _____

27. Were you, or anyone you are applying for, in Arizona's Foster Care or Young Adult Program on your/their 18th birthday? Yes No

28. Do you, or anyone you are applying for, have any injury or illness due to an accident or medical malpractice within the last three years? Yes No

29. Do you, or anyone you are applying for, have a chronic illness (medical condition that requires frequent and ongoing treatment and that if not properly treated will seriously affect the person's overall health)? Yes No
30. Do you, or anyone you are applying for, have health insurance other than AHCCCS? Yes No
31. Do you, or anyone you are applying for, have any medical expenses this month or from the month before this application? Yes No

AHCCCS Health Insurance and/or Cash Assistance



ANSWER THESE ADDITIONAL QUESTIONS FOR AHCCCS HEALTH INSURANCE AND/OR CASH ASSISTANCE



32. Are both parents of any child(ren) living in the home? Yes No
- If no, does the absent parent have insurance coverage for the child(ren)? Yes No
- Complete the following for all absent parents **NOT** in the home or deceased.

Child's Name	Absent Parent Information			
	Name	Address	Social Security Number	Date of Birth

Food Stamp Benefits



ANSWER THESE ADDITIONAL QUESTIONS FOR FOOD STAMP BENEFITS

33. Is there anyone who lives with you who buys and cooks food on their own? Yes No
- If yes, complete the following:

Name	Age	Relationship to you	Does this person give you, or anyone you are applying for, any money?	Does this person pay any portion of the bills for you, or anyone you are applying for?
			<input type="checkbox"/> Yes <input type="checkbox"/> No Explain / Amount	<input type="checkbox"/> Yes <input type="checkbox"/> No Type of bill

34. Are you, or anyone you are applying for, disabled or elderly, have any medical expenses? Yes No



General Assistance

ANSWER THESE ADDITIONAL QUESTIONS FOR GENERAL ASSISTANCE

35. Do you, or anyone in your home, have a disability that prevents you from working? Yes No
36. Have you, or anyone you are applying for, applied for disability benefits? Yes No

Declarations

Assignment of Support Rights for Cash Assistance:

Federal law and state law (at 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 that this means that while I receive, or anyone on my application receives Cash Assistance, the State has the right to keep support or spousal maintenance collections, including collections for support of spousal maintenance that were owed before Cash Assistance was paid. I understand that when I and the persons on my application stop receiving Cash Assistance, current support payments will be paid to me; however, the State may continue to collect any assigned arrears (for support or spousal maintenance that were owed before and during the time I received Cash Assistance). The child support and spousal maintenance collections will be used to pay back the State for Cash Assistance paid to me or anyone on my application.

I also understand that I have a right to claim Good Cause for non-cooperation with Child Support Enforcement if establishing or enforcing support would bring harm to me or any child in my custody. I may claim Good Cause by telling my Cash Assistance or Child Support worker the facts justifying good cause and signing the Claim of Good Cause at any time I am receiving Cash Assistance.

In the event the Department of Economic Security or its agent engages in child support enforcement activities involving me, I understand that the Assistant Attorneys General and Deputy County Attorneys handling the cases represent DES and not me or my child(ren). If my child support case goes to court, I understand that certain personal information contained in this application or my DES records may be released to the court and other party to the case and become 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.

Assignment of Rights to Other Coverage for Medical Care:

I understand that if I am or members of my family are approved for AHCCCS Health Insurance benefits, AHCCCS can collect payment from any other parties who may be responsible for paying for my/our health care costs. This includes (1) private or employer-sponsored health insurance (not including Medicare), (2) persons, such as an absent spouse or parent, who are legally responsible for providing medical support, (3) private or employer-sponsored disability insurance, (4) private or employer-sponsored accident insurance, (5) insurance claims, jury awards, or legal settlements resulting from injuries.

I understand that AHCCCS cannot collect more than the costs paid by 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.

By Signing this Application

- I assign my rights to payment for my health care costs to AHCCCS as provided above.
- I register certain Cash Assistance or Food Stamp household members for work programs. I understand there may be exceptions. I can talk about this with my worker. I understand these members must look for and accept training and/or a job. If anyone does not or will not work or train, benefits may be reduced or stopped.
- I authorize DES and their contractors to contact my current or past employers to get wage information, financial institutions to get asset and property information and other persons or institutions to get information that relates to my eligibility. DES may treat a photocopy or facsimile (FAX) of my signature below as my original signature.
- I state that I have received the "Assistance Programs in Arizona, What You Need to Know" brochure, PAF-001-A. If I have any questions about this brochure, I can contact my worker.
- I state that I have received the "Your Change Reporting Requirements" pamphlet, PAF-558. I have been advised of my change reporting requirements.
- I understand that DES and their contractors will verify the alien status of the household members for whom I am applying. The information that DES and their contractors get from the BCIS may affect these members' eligibility for benefits.
- I understand that I must tell DES and provide proof to receive deductions, when applicable, for the following expenses; child support paid, court ordered child support, child/dependent care expenses, rent or mortgage payments, utility or other shelter costs, and medical expenses.

Statement of Truth

I swear under penalty of perjury that the statements made about persons in my home, income, assets, property and all other information I have given DES and their contractors that relates to my eligibility for benefits is true and correct to the best of my knowledge, and that I have not withheld any information. I swear I have honestly reported my intent to reside in Arizona, my citizenship, and both the citizenship status and intent to reside in Arizona for everyone I am applying for.

Applicant's Signature _____ Date _____

Signature of other Adult Household Member
(required for AHCCCS Health Insurance) _____ Date _____

Representative/Witness Signature _____ Date _____

Agency Use Only

Signature of DES or TANF agency employee who helped complete the application _____

Interviewer's Signature _____ Date _____

Arizona Department of Economic Security

Authorization for Release of Information

I authorize the release of information requested by the Department of Economic Security or its agents to verify my financial information, where I live, and members of my household. DES will only use the information in the administration of any public assistance programs for which I have applied. DES will not release this information to any other person or agency outside of the DES or its agents. This release of information remains in effect while I am an applicant or recipient of public assistance, and for any later investigations of my eligibility and receipt of benefits.

Persons or organizations that may be contacted include, but are not limited to: local governments, public assistance program contractors and grantees, health care providers, tax assessors, financial institutions, Native corporations, stock brokerage firms, landlords, employers, school authorities, and private individuals.

A copy of this release is as valid as the original

Your Signature

Signature of Other Adult Household Member

Printed Name

Printed Name

Address

Address

Phone Number

Phone Number

Date

Date

Arizona Department of Economic Security

Request for Contact Persons and Organizations

We often need to contact persons or organizations that can verify financial information and the information listed below to determine your eligibility for public assistance. When we contact these persons or organizations, we tell them your name, title and that we work for the Department of Economic Security. We are prohibited by law from telling them anything about you or about your assistance case.

The information we most often need to verify is where you live, who lives with you and your household's income and resources. We may also ask for information about absent parents for Cash Assistance and AHCCCS Health Insurance.

Please provide the information requested below:

Name of someone who knows you well _____

Relationship to you _____

Mailing Address _____

Daytime Telephone Number _____

Name of someone who knows you well _____

Relationship to you _____

Mailing Address _____

Daytime Telephone Number _____

Name of Landlord _____

Mailing Address _____

Daytime Telephone Number _____

Financial Institution (Bank, Credit Union) _____

Mailing Address _____

Daytime Telephone Number _____

Employer _____

Mailing Address _____

Daytime Telephone Number _____

Release of AHCCCS health insurance eligibility to Jobs private contractors

Jobs contracts with workers to assist qualified Cash Assistance applicants in moving from public assistance to employment. By signing this application:

- I AGREE to give Jobs private contractors access to AHCCCS health insurance eligibility information contained on the same computer screens as my other benefit eligibility information for as long as I receive public benefits. I understand the AHCCCS eligibility information includes case notes made during interviews with eligibility workers and may contain personal medical information. I also understand that neither DES, nor AHCCCS can deny me medical benefits based on whether I agree to allow the Jobs private contractors access to my AHCCCS application information. I understand that I may revoke this authorization at any time by calling 602-542-5472.
- By agreeing to allow the Jobs private contractor access to my medical information, if the Jobs private contractor discloses my medical information to another person, my medical information will not be protected by the federal privacy rules covering AHCCCS. State law and the contract between Jobs private contractors and DES require that medical information be kept private.

I can prevent the Jobs private contractors from seeing my medical information by initialing and dating here: _____ (Initials) _____ (Date) because I do NOT agree to authorize the release of information to the Jobs private contractors.