

Application for Benefits

If you need help reading or completing this form, please ask us for help.

Keep this page for your records.

How do I apply for benefits?

- To <u>complete</u> your application fill out pages 3 to 6. You can <u>start</u> your application today by giving the receptionist your name, address, and signature on page 3. If you don't have an address, tell the receptionist or call your local office.
- Attach more sheets if you need more space.
- Take or mail pages 3 to 6 to your local office. Keep pages 1 and 2 for your records.
- You may get more benefits or get them sooner if you start, complete, and give us your application and any other information we ask for as soon as you can. We may also share this information with Federal and state officials.

How soon can I receive help with food and cash?

If you need food benefits right away, fill in Questions 1 through 14 on page 3 take this form to the receptionist.

We decide if you are eligible for food assistance within 5 days if you show proof of your identity and meet one of the following:

- Your household will have less than \$150 gross income and less than \$100 liquid resources this month.
- Your household's income and resources are less than your monthly rent and utilities.
- Your household includes a destitute migrant or seasonal farm worker.

Benefits are issued by the day after we decide you are eligible. Food benefits usually start the day we receive your application. Cash benefits usually start the day we have all the information to decide you are eligible.

Civil Rights

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 discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs. To file a complaint of discrimination, contact USDA or HHS. Write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). Write HHS, 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 (TTY). USDA and HHS are equal opportunity providers and employers.

Immigration Status and Social Security Numbers

You may be able to get assistance for some people you live with even if others you live with can't get help because of immigration status. You must tell us the status of anyone who applies. We have medical programs that cover some people who can't prove they are in the country legally.

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

We use SSNs to check identity, verify eligibility, prevent fraud, and collect claims. We exchange information with other agencies to manage our programs and follow the law. We may also give this information to law enforcement agencies trying to catch fleeing felons.

Citizenship and Identity for Medicaid

U.S. citizens must prove citizenship and identity to receive Medicaid. We will work with you to obtain the proof. If we require a document that will cost you money, we will send for it and pay the cost. We don't need proof for anyone in your household who receives Medicare, Social Security Disability Insurance (SSDI) based on their own disability or Supplemental Security Income (SSI). Proof includes but isn't limited to:

Proof of Citizenship	Proof of Identity
• U.S. passport.	State driver's license.
Certificate of Naturalization or Citizenship.	State identity or military ID card with picture.
Tribal membership card with picture.	U.S. American Indian/Alaska Native tribal document.
Official state/county U.S. birth certificate.	Completed Citizenship Documentation and Identity Declaration form for children under 16.

Privacy and Food Assistance

The current Food Stamp Act permits the department to collect the information we ask for on the application. We verify some of this information with computer matching programs.

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

Food Assistance Penalty Warning

We do send information about persons applying for Food Assistance to other Federal agencies to check that the information is correct. If any information is incorrect, the persons who apply may not get Food Assistance. If a person provides information that they know is incorrect, they could be criminally prosecuted. Penalties for intentionally breaking Food Assistance rules vary from disqualification from the program, to fines, or possibly imprisonment.

Repaying the State for Medical and Long Term Care

- By law, if you are age 55 or older AND receive Medicaid or long-term care services, DSHS may recover from your
 estate (assets you own at the time of your death) to repay DSHS for the costs of medical assistance, medical services,
 and long-term care. DSHS may recover the costs for state-only funded long-term care services received at any age.
 This is called ESTATE RECOVERY. Tribal lands may be exempt from recovery.
- Long-Term Care services include COPES, OBRA, Medicaid Personal Care, Nursing Home services, adult day health, private duty nursing, four DDD HCBS waivers: Basic, Basic Plus, Core, and Community Protection, and other services provided by Home and Community Services and the Division of Developmental Disabilities.
- Estate recovery doesn't occur until after your death and the death of your surviving spouse, if any. If you have dependent heirs, estate recovery may be delayed for some hardship reasons.
- If you are permanently living in a nursing home or other medical facility, DSHS may file a lien against your property to repay the costs of medical assistance, medical services, and long-term care you received. If you return home, DSHS will release the lien. DSHS won't file a lien against your home if:
 - Your spouse lives there.
 - Your child who is blind, disabled, or under 21 lives there.
 - Your sibling who has an equity interest in the home lives there and has lived there for at least one year immediately before you entered the facility.



Application for Benefits

If you need help filling out this form, please check this box.

F	OR OFFICE	USE ONLY
DATE	RECEIVED	INITIALS

	RST NAME MIDDLE INITIAL LAST NAME SIGNATURE (REQUIRED) 2. CLIENT ID NUMBER (IF KNOWN)							
3. STREET ADDRESS WHE	RE YOU	J LIVE CI	TY	STATE	ZIP COI	DE	4. HOME/PR	EFERRED PHONE NUMBER
5. MAILING ADDRESS (IF D	IFFERE	ENT) CI	TY	STATE	ZIP COI	DE	6. OTHER PH	HONE NUMBER(S)
8. I am applying for (check all that apply): Cash Food Medical Drug or Alcohol Treatment Nursing Home Assisted Living Adult Family Home In-Home Care Other (please list):								
9. How much money	do you	expect your	household to	o get this mo	nth?	\$		<u> </u>
10. How much money	does y	our househo	ld have in ca	sh and bank	accounts?	\$		<u> </u>
11. How much does yo	ur hou	sehold pay f	or rent or mo	ortgage?		\$		<u> </u>
12. What utilities does								r:
13. Is anyone in your h			=					ad farO
14. If applying for food				-	-			
								Date:
15. I need a phone inter16. ☐ I need an inter	erview. oreter.	Please call I speak:	me at:	or 🗌 s	ign; transla	ite my le	tters into:	
17. List everyone in yo	ur hou		if you are no		them (atta			
SEX HOW IS CHECK IF OPTIONAL FOR NON-APPLICANTS								
NAME	_	THIS	DATE OF	YOU WANT	CHECK			
NAME (FIRST, MIDDLE, LAST)	M OR F		DATE OF BIRTH		CHECK IF IN SCHOOL	SOCIA	L SECURITY JMBER	CHECK IF U.S. CITIZEN PLACE OF BIRTH (CITY/STATE)
	M OR	THIS PERSON RELATED	_	YOU WANT BENEFITS FOR THIS	IF IN	SOCIA	L SECURITY	CHECK IF U.S. CITIZEN PLACE OF BIRTH
	M OR	THIS PERSON RELATED TO YOU?	_	YOU WANT BENEFITS FOR THIS	IF IN	SOCIA	L SECURITY	CHECK IF U.S. CITIZEN PLACE OF BIRTH (CITY/STATE)
	M OR	THIS PERSON RELATED TO YOU?	_	YOU WANT BENEFITS FOR THIS	IF IN	SOCIA	L SECURITY	CHECK IF U.S. CITIZEN PLACE OF BIRTH (CITY/STATE)
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	M OR	THIS PERSON RELATED TO YOU?	_	YOU WANT BENEFITS FOR THIS	IF IN	SOCIA	L SECURITY	CHECK IF U.S. CITIZEN PLACE OF BIRTH (CITY/STATE)
	M OR	THIS PERSON RELATED TO YOU?	_	YOU WANT BENEFITS FOR THIS PERSON	IF IN SCHOOL	SOCIA	L SECURITY	CHECK IF U.S. CITIZEN PLACE OF BIRTH (CITY/STATE)
	M OR F	THIS PERSON RELATED TO YOU? Myself	BIRTH	YOU WANT BENEFITS FOR THIS PERSON	IF IN SCHOOL	SOCIAI	L SECURITY JMBER	CHECK IF U.S. CITIZEN PLACE OF BIRTH (CITY/STATE)
18. I or someone in my	M OR F	THIS PERSON RELATED TO YOU? Myself ehold have a Domestic	(check all the violence situ	YOU WANT BENEFITS FOR THIS PERSON	IF IN SCHOOL	social Ni cy; due c t type):	L SECURITY JMBER date:	CHECK IF U.S. CITIZEN PLACE OF BIRTH (CITY/STATE)
18. I or someone in my Medical emerg 19. In the past 30 days	M OR F / house ency [s, I got	THIS PERSON RELATED TO YOU? Myself ehold have a Domestic cash, food, o	(check all the violence situation medical as	YOU WANT BENEFITS FOR THIS PERSON	IF IN SCHOOL	cy; due cottype):	L SECURITY JMBER date: ource: Ye	CHECK IF U.S. CITIZEN PLACE OF BIRTH (CITY/STATE)
18. I or someone in my Medical emerg 19. In the past 30 days 20. I am or someone I'	M OR F	THIS PERSON RELATED TO YOU? Myself ehold have a Domestic cash, food, colying for is flee	(check all the violence situate medical asseing from the	YOU WANT BENEFITS FOR THIS PERSON	IF IN SCHOOL	cy; due cout type):	date:	CHECK IF U.S. CITIZEN PLACE OF BIRTH (CITY/STATE)
18. I or someone in my Medical emerg 19. In the past 30 days	house ency [s, I got m applood as	THIS PERSON RELATED TO YOU? Myself ehold have a Domestic cash, food, colying for is fleesistance if yellowed in the person of the color of the col	(check all the violence situation medical as eeing from the you don't ar atino:	YOU WANT BENEFITS FOR THIS PERSON	IF IN SCHOOL	cy; due count or j	date: ource: Yeal for a felonoranswer for	CHECK IF U.S. CITIZEN PLACE OF BIRTH (CITY/STATE)

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			I. Ge	neral Information			
1. Someone I'm applying for lives outside Washington State:							
		II.	Medical and H	lealth Insurance I	nformation		
I, my spouse, or someone in my household (check appropriate box): 1. Can't work because of health problems							
III. Resources (Not needed for Children's Medical, Pregnancy Medical, HWD, or Basic Food) A resource is anything you own or are buying that can be sold, traded, or converted into cash or money held by others. A resource does not include personal property such as furniture, or clothing. Examples of resources are: Cash Mutual funds Houses, including the one you live in Savings accounts Annuities Condominium College funds Trusts Land Money market account Resource you, your spouse, or anyone you are applying for owns or is buying: RESOURCE WHO OWNS LOCATION VALUE WHO OWNS LOCATION VALUE WHO OWNS LOCATION VALUE WHO OWNS LOCATION VALUE Life estate VALUE WHO OWNS LOCATION VALUE Life or converted into cash or money held by others. A resources or money held by others. A resources are: Life insurance Life insurance Duilding the one you live in Surial funds, prepaid plans College funds Time-share Business equipment Farm equipment Livestock Livestock							
				\$ \$ \$			\$ \$ \$
				\$			\$
				\$			\$
				\$			\$
				\$			\$
				\$			\$
				\$			\$
				\$			\$
2. I, my spouse, or se	omeone I	m applyi	ing for have car	rs, trucks, vans, bo	ats, RVs, trailers,	or other m	otor vehicles:
YEAR (E.G., 1980) MAKE (E.G.	G., FORD)	MODEL	(E.G., ESCORT)	CHECK IF LEASED	CHECK IF VEHICL FOR MEDICAL PI		AMOUNT OWED
							\$
							\$
				, traded, given awa ☐ No If yes, what			in the last five years

APPLICANT'S NAME	SOCIAL SECURITY NUMBER CLIENT IDENTIFICATION					
	ome					
1. I, my spouse, or someone I'm applying for quit a	a job within	the pa	ast 60 days: 🔲 Y	es 🗌 No		
2. I, my spouse, or someone I'm applying for has in	ncome fror					
WHO MAKES THIS INCOME		GROS	SS AMOUNT RECEIVEI every	•	,	
EMPLOYER'S NAME AND PHONE NUMBER		Ψ		Twice a mor		
START DATE			s per week:			
		Pay	dates (e.g., 1 st and	15", or every Fric	lay):	
Is this job self-employment? Yes No		CDOC	CO AMOUNT DECENTE	O (DOLL AD AMOUNT	DEFORE TAVECY	
WHO MAKES THIS INCOME			S AMOUNT RECEIVER every	: Hour W	,	
EMPLOYER'S NAME AND PHONE NUMBER				Twice a mor		
START DATE			s per week:			
		Pay	dates (e.g., 1 st and	15", or every Fric	lay):	
Is this job self-employment? Yes No						
V. Other Incom	e (Use for WHO GET		ousehold member GROSS MONTHLY	s) WHO GETS THE	GROSS MONTHLY	
	INCOM		AMOUNT	INCOME?	AMOUNT	
Unemployment benefits			\$		\$	
Social Security			\$		\$	
Supplemental Security income (SSI)		\$			\$	
Child support or spousal maintenance		\$			\$	
Retirement or pension			\$		\$	
Veterans Administration (VA) or military benefits			\$		\$	
Labor & Industries (L&I) or insurance benefits			\$		\$	
Trusts		\$			\$	
Interest			\$		\$	
Railroad benefits		\$		\$		
Rental income			\$		\$	
Other:		\$			\$	
Other:		\$			\$	
VI. Annuities (Investments made by any hous					•	
WHO OWNS THE ANNUITY? COMPANY OR INSTITUTE	IUTION?	\$		MONTHLY INCOME \$	DATE PURCHASED	
		\$		\$		
		\$		\$		
If you, or your spouse, have an interest in an annui	ty and you	accer	ot Medicaid Long T	erm Care benefits	s, you must name	

VII. Monthly Expenses							
RENT ¢	MORTGAG	E	SPACE REN	IT		CONDOMINIUM FEES	
HOMEOWNER'S INSURANCE \$	\$ PROPERTY \$	Y TAXES	PROPERTY	ASSESSMI	ENTS	S OTHER FEES \$	
Utilities (check all that apply): Heating (gas, electric, oil) Electricity (not heat) Phone Water, sewer, garbage							
Another person or agency, su	ch as subs	idized housing, he	elps me pay eit	ther all or	part of the	ese expenses: Yes No	
If yes, who:	,	What expense:			Amoun	it they pay: \$	
I, my spouse, or someone in I	ny househ	old pay or are sup	posed to pay (check all	that apply	/):	
☐ Child care or dependent of	are	Monthly amount:	\$		Who pays:		
☐ Child support		Monthly amount: \$			Who pays:		
☐ Medical bills		Monthly amount:	\$		Who pay	/s:	
		VIII. Authoriz	ed Represen	tative			
you do not have to. Do you ls this	u have an A person you	ne you allow DSHS Authorized Repres ur legal guardian? have Power of At RELATIONSHIP	entative?	bout your Yes Yes Yes Yes	☐ No ☐ No ☐ No	You can name someone, but	
STREET ADDRESS		CITY		STATE		ZIP CODE	
Declaration and Signatures							
If applying for cash or medical for adults, all adults in the household must sign. If applying for food assistance or medical for children, the applicant must sign. I understand I must: Give correct information. Report the changes listed in my approval letter. Provide proof I am eligible. DSHS may help me get the proof or contact other persons or agencies for it. Assign certain rights to child support to the State of Washington when I receive Temporary Assistance to Needy Families (TANF). Assign my rights to medical care support and third party payments for medical care to the State of Washington when I receive medical care benefits. Cooperate with food assistance work requirements							
If I don't do these things, I ma	y be denie	d benefits or have	to pay them b	ack.			
I understand I can be criminally prosecuted if I willfully: Make a false statement. Fail to report something I should report.							
I have read or had explained to me my rights and responsibilities and received a copy of the Client Rights and Responsibilities, DSHS 14-113. I certify or declare under penalty of perjury under the laws of the State of Washington that the information I gave in this application is true and correct.							
APPLICANT'S SIGNATURE		DATE PRI	NTED NAME OF	APPLICANT	Γ (CITY AND STATE WHERE SIGNED	
OTHER ADULT APPLICANT'S SIGN	IATURE	DATE PRII	NTED NAME OF	OTHER ADI	ULT (CITY AND STATE WHERE SIGNED	
HELPER OR REPRESENTATIVE'S	SIGNATURE	DATE PRI	NTED NAME OF	REPRESEN	ITATIVE (CITY AND STATE WHERE SIGNED	
WITNESS' SIGNATURE IF SIGNED	WITH AN "X"	DATE PRI	NTED NAME OF	WITNESS			