Washington State Department of Social & Health Services

Eligibility Review

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 cash or food assistance?

- **Complete** the attached review. You can **start** the process today by submitting the review in-person at a local community services office. The review must have your name, address, and signature or the signature of your authorized representative. If you don't have an address, contact your local office for resources to acquire a mailing address. Attach more sheets if you need more space.
- 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.
- Take your review to a local office. See www.dshs.wa.gov for locations.
- Fax your review to 1-888-338-7410.
- Mail your review to one of the following:

DSHS
CSD-Customer Service Center
PO Box 11699
Tacoma, WA 98411-6699

DSHS
Home and Community Services – Long Term Care Services
PO Box 45826
Olympia, WA 98504-5826

- You can also fill out this review online at www.washingtonconnection.org
- **This Eligibility Review form can only be used to renew coverage for the Washington Apple Health programs listed on this form. For other health care coverage you must apply either online at www.wahealthplanfinder.org, by calling 1-855-923-4633, or by using the HCA Application for Health Care Coverage (HCA 18-001).**

How soon can I receive help with food and cash?

If you need food assistance right away, fill in Questions 1 through 14 and take this form to your local office.

We decide if you are eligible for food assistance *within 7 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 assistance usually starts the day we receive your application. Cash assistance usually starts 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 Nutrition Act of 2008 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 (202) 720-5964 (voice and TDD). 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 immigration status of anyone who applies. We have health care coverage that may 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 Washington Apple Health. TANF, or food assistance. We may also need SSNs of parents and spouses who live with you but don't apply. We have health care coverage 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 Washington Apple Health

U.S. citizens must prove citizenship and identity to receive Washington Apple Health. 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).

Repaying the State for Medical and Long Term Care

- By law, if you are age 55 or older AND receive Washington Apple Health or long-term care services, The Health Care Authority (HCA) may recover from your estate (assets you own at the time of your death) to repay HCA for the costs of medical assistance, medical services, and long-term care. Medicare Savings Program is exempt. HCA 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, Medicaid Personal Care, Nursing Home services, adult day health, private duty nursing, four DDA HCBS waivers: Basic, Basic Plus, Core, and Community Protection, and other services provided by Home and Community Services and the Developmental Disabilities Administration.
- 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, HCA 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. HCA 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.

Privacy and Your Cash and Food Assistance

The Food and Nutrition Act of 2008, as amended permits the department to collect the information we ask for on the application, including the SSN of each household member. Providing the requested information is voluntary. However, failure to provide a SSN or proof of application for a SSN without a good reason will result in the denial of Basic Food benefits to each individual failing to provide a SSN We verify some of this information with computer matching programs, including the federal Income and Eligibility Verification System (IEVS).

Information reported to the Department of Social and Health Services may affect eligibility for health care coverage administered by the Health Care Authority and the Health Benefit Exchange.

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.

Washington State Department of Social & Health Services

Eligibility Review

Ask us if you need help filling out this form.

1. FIRST NAME MIDDLE INITIAL LAST NAME	SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTATIVE (REQUIRED)	2. CLIENT ID NUMBER (IF KNOWN)
3. STREET ADDRESS WHERE YOU LIVE CITY STATE ZIP CODE		4. HOME/PREFERRED PHONE NUMBER
5. MAILING ADDRESS (IF DIFFERENT) CITY STATE ZIP CODE		6. OTHER PHONE NUMBER(S)
		7. EMAIL ADDRESS

8. I am applying for (check all that apply):

- ☐ Cash
- ☐ Health Care coverage for the aged, blind, or disabled
- ☐ Medicare Savings Program
- ☐ Assisted Living Facility / Adult Family Home
- ☐ In-Home Long Term Care Services
- ☐ Food
- ☐ Nursing Home
- ☐ Hospice
- ☐ Healthcare / Workers with Disabilities (HWD)

9. I or someone in my household (check all that apply): ☐ Are in a domestic violence situation ☐ Have a disability ☐ Can't work because of health problems ☐ Are pregnant; name: _____ due date: _____

10. How much money do you expect your household to get this month? $_____

11. How much money does your household have in cash and bank accounts? $_____

12. How much does your household pay for rent or mortgage? $_____

13. What utilities does your household pay for? ☐ Heating/cooling ☐ Telephone ☐ Other: _____

14. Is anyone in your household a seasonal or migrant farm worker? ☐ Yes ☐ No

15. If applying for food assistance, how many people in your household do you buy and prepare food for? _____

FOR OFFICE USE ONLY – Household eligible for expedited service: ☐ **Yes** ☐ **No** **Screener's Initials:** _____ **Date:** _____

16. ☐ I need an interpreter. I speak: _____ or ☐ sign; translate my letters into: _____

17. List everyone in your household even if you are not applying for them (attach additional sheets, if necessary).

NAME (FIRST, MIDDLE, LAST)	SEX M OR F	HOW IS THIS PERSON RELATED TO YOU?	DATE OF BIRTH	CHECK IF YOU WANT BENEFITS FOR THIS PERSON	OPTIONAL FOR NON-APPLICANTS			
					SOCIAL SECURITY NUMBER	CHECK IF U.S. CITIZEN	RACE (SEE SAMPLES BELOW)	TRIBE NAME (For American Indians, Alaska Natives)
		Myself		☐		☐		
				☐		☐		
				☐		☐		
				☐		☐		
				☐		☐		
				☐		☐		
				☐		☐		

18. My ethnic background is Hispanic or Latino: ☐ Yes ☐ No

Race and Ethnic background information is voluntary. For Food Assistance the USDA requires us to answer for you if no information is provided. **Race examples:** White, Black or African American, Asian, Native Hawaiian, Pacific Islander, American Indian, Alaska Native, or any combination of races.

APPLICANT'S NAME	SOCIAL SECURITY NUMBER	CLIENT IDENTIFICATION NUMBER

I. General Information

1. In the past 30 days, I received cash, food, or health care coverage from another state, tribe, or other source. ☐ Yes ☐ No
2. Someone I'm applying for lives outside Washington State: ☐ Yes ☐ No Who: _____
3. I or someone in my household is a sponsored alien: ☐ Yes ☐ No Who: _____
4. I or someone in my household age 16 or older is in high school or a GED Program: ☐ Yes ☐ No Who: _____
5. I or someone in my household is attending college or trade school: ☐ Yes ☐ No Who: _____
6. Someone is temporarily out of my home: ☐ Yes ☐ No Who: _____
7. I or someone I'm applying for served in the military: ☐ Yes ☐ No Who: _____
8. Someone is the dependent or spouse of someone (living or deceased) who served in the military: ☐ Yes ☐ No
9. I am or someone I'm applying for is fleeing from the law to avoid going to court or jail for a felony crime: ☐ Yes ☐ No
10. I am living in: ☐ My own house or apartment ☐ Group Home ☐ Other: _____ ☐ Facility (list type): _____ Date entered: _____
11. I am: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ In a Registered Domestic Partnership

II. Health Insurance Information (Not needed for Basic Food)

I, my spouse, or someone in my household (check appropriate box):

1. Plan to enter, are in, or recently left a medical facility (such as a hospital or nursing home)..... ☐ Yes ☐ No
2. Have health insurance: ☐ Yes ☐ No; check all that apply: ☐ Medicare (not Washington Apple Health) ☐ Tricare ☐ Long-Term Care Insurance ☐ Indian Health Services ☐ Other Health Insurance:

III. Resources (Not needed for HWD, or Basic Food) Attach Proof

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
- Checking accounts
- Savings accounts
- CDs
- Money market account
- Bonds
- Trusts
- IRA / 401k
- Retirement fund
- Mutual funds / stocks
- Sales contracts
- Land
- Life estate
- Houses, including the one you live in
- Condominium
- Building / time – share
- Life insurance
- Burial funds, prepaid plans
- College funds
- Business equipment
- Farm equipment
- Livestock

Please list the resources you, your spouse, or anyone you are applying for owns or is buying:

RESOURCE	WHO OWNS	LOCATION	VALUE	WHO OWNS	LOCATION	VALUE
			$			$
			$			$
			$			$
			$			$
			$			$
			$			$

2. I, my spouse, or someone I'm applying for have cars, trucks, vans, boats, RVs, trailers, or other motor vehicles:

YEAR (E.G., 1980)	MAKE (E.G., FORD)	MODEL (E.G., ESCORT)	CHECK IF LEASED	CHECK IF VEHICLE IS USED FOR MEDICAL PURPOSES	AMOUNT OWED
			☐	☐	$
			☐	☐	$

3. I, my spouse, or someone I'm applying for has sold, traded, given away, or transferred a resource in the last two years (including trusts, vehicles or life estates): ☐ Yes ☐ No If yes, what: _____ when: _____

APPLICANT'S NAME	SOCIAL SECURITY NUMBER	CLIENT IDENTIFICATION NUMBER

IV. Annuities (Investments made by any household member to receive regular payments now or in the future.)

WHO OWNS THE ANNUITY?	COMPANY OR INSTITUTION?	AMOUNT OR VALUE	MONTHLY INCOME	DATE PURCHASED
		$	$	
		$	$	
		$	$	

If you, or your spouse, have an interest in an annuity and you accept Washington Apple Health Long Term Care, SSI Related or CN coverage, you must name the State of Washington as a remainder beneficiary of the annuity.

V. Earned Income Attach Proof

1. I, my spouse, or someone I'm applying for had a job that ended in the past 60 days: ☐ Yes ☐ No
2. I, my spouse, or someone I'm applying for has income from work: ☐ Yes ☐ No If yes, please complete this section:

WHO EARNS THIS INCOME	GROSS AMOUNT RECEIVED (DOLLAR AMOUNT BEFORE DEDUCTIONS)
EMPLOYER'S NAME AND PHONE NUMBER	$_____every: ☐ Hour ☐ Week ☐ Two weeks ☐ Twice a month ☐ Month
START DATE	Hours per week: _____
Is this job self-employment? ☐ Yes ☐ No	Pay dates (e.g., 1st and 15th, or every Friday):

WHO EARNS THIS INCOME	GROSS AMOUNT RECEIVED (DOLLAR AMOUNT BEFORE DEDUCTIONS)
EMPLOYER'S NAME AND PHONE NUMBER	$_____every: ☐ Hour ☐ Week ☐ Two weeks ☐ Twice a month ☐ Month
START DATE	Hours per week: _____
Is this job self-employment? ☐ Yes ☐ No	Pay dates (e.g., 1st and 15th, or every Friday):

VI. Other Income (Use for all household members) Attach Proof

- Unemployment benefits
- Social Security income
- Tribal income
- Gaming income
- Educational benefits (student loans, grants, work - study)
- Supplemental Security income (SSI)
- Child Support or spousal maintenance
- Railroad benefits
- Rental income
- Retirement or pension
- Veteran Administration (VA) or military benefits
- Labor and Industries (L&I)
- Trusts
- Interests / Dividends

UNEARNED INCOME TYPE	WHO GETS THE INCOME?	GROSS MONTHLY AMOUNT	WHO GETS THE INCOME?	GROSS MONTHLY AMOUNT
		$		$
		$		$
		$		$
		$		$
		$		$
		$		$
		$		$
		$		$
		$		$
		$		$

VII. Monthly Expenses (Attach Proof)

RENT	MORTGAGE	SPACE RENT	HOMEOWNER'S INSURANCE	PROPERTY TAXES	OTHER FEES
$	$	$	$	$	$

Another person or agency, such as subsidized housing, helps me pay either all or part of these expenses: ☐ Yes ☐ No
If yes, who: _____ What expense: _____ Amount they pay: $ _____

I, my spouse, or someone in my household pay or are supposed to pay (check all that apply):

☐ Child or Adult Dependent Care (including transportation costs)	Monthly amount: $	Who pays:
☐ Medical bills for persons with disabilities or age 60 + (including transportation costs and health insurance premiums)	Monthly amount: $	Who pays:
☐ Child support	Monthly amount: $	Who pays:

If you do not report any of the above listed expenses, we will consider this as a statement by your household that you do not want to receive a deduction for this expense.

VIII. Authorized Representative

An Authorized Representative is someone you allow DSHS to talk with about your benefits. You can name someone, but you do not have to.

Do you have an Authorized Representative? ☐ Yes ☐ No
Is this person your legal guardian? ☐ Yes ☐ No
Does this person have Power of Attorney? ☐ Yes ☐ No

You may need to complete the Authorized Representative form (DSHS 14-532) if you are renewing your health care coverage.

NAME	RELATIONSHIP	TELEPHONE NUMBER

MAILING ADDRESS	CITY	STATE	ZIP CODE

Declaration and Signatures

For cash, all adults (or authorized representatives) in the household must sign.
For food assistance or health care coverage the applicant (or authorized representative) must sign.

I understand I must:

- Give correct information and follow reporting requirements.
- Provide proof I am eligible.
- Assign certain rights to child support to the State of Washington when I receive Temporary Assistance for Needy Families (TANF). However, I can ask DSHS not to pursue child support if it would endanger me or my children.
- Cooperate with food assistance work requirements.

If I don't do these things, I may be denied benefits or have to pay them back.

I understand I can be criminally prosecuted if I willfully make a false statement or fail to report something I should report.

I authorize DSHS to contact other persons or agencies when necessary to help me get proof that I am eligible.

For cash and food, 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. For health care coverage, I have read or had explained to me my rights and responsibilities and received a copy of the Client Rights and Responsibilities, HCA 18-003, **I certify or declare under penalty of perjury under the laws of the State of Washington that the information I gave in this application, including the information concerning citizenship and alien status of the members applying for benefits, is true and correct.**

APPLICANT'S SIGNATURE	DATE	PRINTED NAME OF APPLICANT	CITY AND STATE WHERE SIGNED
OTHER ADULT APPLICANT'S SIGNATURE	DATE	PRINTED NAME OF OTHER ADULT	CITY AND STATE WHERE SIGNED
HELPER OR REPRESENTATIVE'S SIGNATURE	DATE	PRINTED NAME OF REPRESENTATIVE	CITY AND STATE WHERE SIGNED
WITNESS' SIGNATURE IF SIGNED WITH AN "X"	DATE	PRINTED NAME OF WITNESS	