COMBINED APPLICATION FOR STATE AND COUNTY MEDICAL ASSISTANCE

Mark the Type of Application (select only one) :			
☐ Emergency 31-Day	☐ Non-Emergency 10-Day Prior	☐ Additional Request	☐ 180-Day Delayed (Justification Must be Attached)

County Date Stamp:

By signing below, I acknowledge that by completing this application form, it will be used to determine eligibility for BOTH County Indigent Medical Assistance and Idaho Department of Health and Welfare Health Coverage Assistance. I also accept and acknowledge that I have read, understand, and will comply with rules promulgated by the Idaho Department of Health & Welfare and the Board of the Catastrophic Health Care Cost Program. I hereby swear or affirm that all information submitted under cover of this application is true and correct, pursuant to Title 31, Chapter 35, Idaho Code.

Printed Name of Patient/Applicant _____ Patient/Applicant's Signature _____ Date _____

****** IF BY A THIRD PARTY APPLICANT ON BEHALF OF THE APPLICANT:***

Printed Name of Third Party Applicant _____ Date _____ Name of Facility _____

Signature of Third Party Applicant _____ Phone _____ Address of Facility _____

IMPORTANT NOTICE: If you need any of the following assistance, please ask. These services are free:

- Language interpreter. (Nosotros proveemos los servicios de un intérprete, sin costo alguno.) Call 2-1-1 or 1-800-926-2588 or TDD 208-332-7205).
- Help filling out this form.
- Accommodation for a disability.

INSTRUCTIONS: Read all questions and instructions carefully. Answer each question as completely as possible. If you need to provide more information than space allows, attach extra sheets.

What is your preferred language? Spoken _____ Written _____

Do you want an interpreter if you are interviewed? One will be provided at no cost to you. ☐ No ☐ Yes

¿Usted necesita a intérprete si usted tiene una entrevista? Uno estará disponible en ningún costo para usted. ☐ No ☐ Sí

List an alternate contact person in the event we are unable to reach someone listed on this application.

First Name	Last Name	Phone Number	Relationship to Patient

Tell us what **Medical Services** you are requesting: _____

Diagnosis: _____

PROVIDER NAME, ADDRESS, & PHONE	DATES OF SERVICE	TYPE OF SERVICE	AMOUNT
	FROM: TO:		
	FROM: TO:		
	FROM: TO:		
	FROM: TO:		
	FROM: TO:		

Tell Us Who You Are

*** If you need to provide more information, please attach extra sheets.**

ATTENTION:
This combined application will be used to determine your program eligibility. Complete the application in its entirety and attach extra sheets if more space is needed.

List every person living in your home.

Add an additional sheet if you need to include more household members. Social Security numbers and citizenship status are required for those applying for services. Use the code key to indicate your Marital Status and Race. **NOTE:** Your responses to Race are optional.

Mark the appropriate box for the patient and anyone applying for Health Coverage.

Race Codes:	
White	WH
Black	BL
Asian	AS
American Indian/Alaska Native	AL
Native Hawaiian/Pacific Island	HP
Hispanic/Latino	HL

Marital Status Codes:	
Married	MA
Never Married	NM
Divorced	DI
Separated	SE
Widowed	WI

YOURSELF / APPLICANT — ☐ **Mark here if this is the Patient** — ☐ **Mark here if you are applying for Health Coverage for this person.**

First Name	Middle Initial	Last Name	Date of Birth	Social Security #	Relationship
					SELF

Former Names, if any	Sex ☐M ☐F	Pregnant? ☐Yes ☐No Due Date	Race	Marital Status	U.S. Citizen? ☐Yes ☐No Alien ID #

Student? ☐Yes ☐No Grade: ☐Full Time ☐Part Time Name of School:	Primary Doctor / Clinic (first & last name)	Phone Number	Sponsor Name

Birth Country	Birth State (if U.S.)	Enrolled Native American Tribe member? ☐Yes ☐No Name of Tribe:

Are you a Veteran? ☐Yes ☐No	VA ID#: Type of Discharge:	Registered to Vote? ☐Yes ☐No State/County?	Licensed to Drive? ☐Yes ☐No State?

Do you plan to file a federal tax return for the CURRENT YEAR? ☐Yes. Complete questions a, b, and c. ☐No. Skip to question c.

a. Filing jointly with a spouse? ☐Yes ☐No If yes, name of spouse:

b. Claiming dependents? ☐Yes ☐No If yes, name of dependents:

c. Claimed as a dependent on someone's tax return who does not live at the address(es) listed on page 2 of this application? ☐Yes ☐No

Daytime Phone Number Type: (work, home, cell)	Message Phone Number Type: (work, home, cell)	Email Address

Physical Address	City	State	Zip Code	County	From (date):	To:
						Present
Mailing Address, if different	City	State	Zip Code	County	From (date):	To:
						Present

CO-APPLICANT / SPOUSE / SIGNIFICANT OTHER — ☐ **Mark here if this is the Patient** — ☐ **Mark here if you are applying for Health Coverage for this person.**

First Name	Middle Initial	Last Name	Date of Birth	Social Security #	Relationship

Former Names, if any	Sex ☐M ☐F	Pregnant? ☐Yes ☐No Due Date	Race	Marital Status	U.S. Citizen? ☐Yes ☐No Alien ID #

Student? ☐Yes ☐No Grade: ☐Full Time ☐Part Time Name of School:	Primary Doctor / Clinic (first & last name)	Phone Number	Sponsor Name

Birth Country	Birth State (if U.S.)	Enrolled Native American Tribe member? ☐Yes ☐No Name of Tribe:

Does this person plan to file a federal tax return for the CURRENT YEAR? ☐Yes. Complete questions a, b, and c. ☐No. Skip to question c.

a. Filing jointly with a spouse? ☐Yes ☐No If yes, name of spouse:

b. Claiming dependents? ☐Yes ☐No If yes, name of dependents:

c. Claimed as a dependent on someone's tax return who does not live at the address(es) listed on page 2 of this application? ☐Yes ☐No

Daytime Phone Number Type: (work, home, cell)	Message Phone Number Type: (work, home, cell)	Email Address

Physical Address	City	State	Zip Code	County	From (date):	To:
						Present
Mailing Address, if different	City	State	Zip Code	County	From (date):	To:
						Present

Tell Us About the People Who Live With You

*** If you need to provide more information, please attach extra sheets.**

OTHER (child, roommate, parent, etc.)	☐ **Mark here if this is the Patient**	☐ **Mark here if you are applying for Health Coverage for this person.**			
First Name	Middle Initial	Last Name	Date of Birth	Social Security #	Relationship
Former Names, if any	Sex ☐M ☐F	Pregnant? ☐Yes ☐No Due Date	Race	Marital Status	U.S. Citizen? ☐Yes ☐No Alien ID #
Student? ☐Yes ☐No Grade: ☐Full Time ☐Part Time Name of School:	Primary Doctor / Clinic (first & last name)		Phone Number	Sponsor Name	
	Birth Country	Birth State (if U.S.)	Enrolled Native American Tribe member? ☐Yes ☐No Name of Tribe:		

Does this person plan to file a federal tax return for the CURRENT YEAR? ☐Yes. Complete questions a, b, and c. ☐No. Skip to question c.

a. Filing jointly with a spouse? ☐Yes ☐No If yes, name of spouse:

b. Claiming dependents? ☐Yes ☐No If yes, name of dependents:

c. Claimed as a dependent on someone's tax return who does not live at the address(es) listed on page 2 of this application? ☐Yes ☐No

	☐ **Mark here if this is the Patient**	☐ **Mark here if you are applying for Health Coverage for this person.**			
First Name	Middle Initial	Last Name	Date of Birth	Social Security #	Relationship
Former Names, if any	Sex ☐M ☐F	Pregnant? ☐Yes ☐No Due Date	Race	Marital Status	U.S. Citizen? ☐Yes ☐No Alien ID #
Student? ☐Yes ☐No Grade: ☐Full Time ☐Part Time Name of School:	Primary Doctor / Clinic (first & last name)		Phone Number	Sponsor Name	
	Birth Country	Birth State (if U.S.)	Enrolled Native American Tribe member? ☐Yes ☐No Name of Tribe:		

Does this person plan to file a federal tax return for the CURRENT YEAR? ☐Yes. Complete questions a, b, and c. ☐No. Skip to question c.

a. Filing jointly with a spouse? ☐Yes ☐No If yes, name of spouse:

b. Claiming dependents? ☐Yes ☐No If yes, name of dependents:

c. Claimed as a dependent on someone's tax return who does not live at the address(es) listed on page 2 of this application? ☐Yes ☐No

	☐ **Mark here if this is the Patient**	☐ **Mark here if you are applying for Health Coverage for this person.**			
First Name	Middle Initial	Last Name	Date of Birth	Social Security #	Relationship
Former Names, if any	Sex ☐M ☐F	Pregnant? ☐Yes ☐No Due Date	Race	Marital Status	U.S. Citizen? ☐Yes ☐No Alien ID #
Student? ☐Yes ☐No Grade: ☐Full Time ☐Part Time Name of School:	Primary Doctor / Clinic (first & last name)		Phone Number	Sponsor Name	
	Birth Country	Birth State (if U.S.)	Enrolled Native American Tribe member? ☐Yes ☐No Name of Tribe:		

Does this person plan to file a federal tax return for the CURRENT YEAR? ☐Yes. Complete questions a, b, and c. ☐No. Skip to question c.

a. Filing jointly with a spouse? ☐Yes ☐No If yes, name of spouse:

b. Claiming dependents? ☐Yes ☐No If yes, name of dependents:

c. Claimed as a dependent on someone's tax return who does not live at the address(es) listed on page 2 of this application? ☐Yes ☐No

	☐ **Mark here if this is the Patient**	☐ **Mark here if you are applying for Health Coverage for this person.**			
First Name	Middle Initial	Last Name	Date of Birth	Social Security #	Relationship
Former Names, if any	Sex ☐M ☐F	Pregnant? ☐Yes ☐No Due Date	Race	Marital Status	U.S. Citizen? ☐Yes ☐No Alien ID #
Student? ☐Yes ☐No Grade: ☐Full Time ☐Part Time Name of School:	Primary Doctor / Clinic (first & last name)		Phone Number	Sponsor Name	
	Birth Country	Birth State (if U.S.)	Enrolled Native American Tribe member? ☐Yes ☐No Name of Tribe:		

Does this person plan to file a federal tax return for the CURRENT YEAR? ☐Yes. Complete questions a, b, and c. ☐No. Skip to question c.

a. Filing jointly with a spouse? ☐Yes ☐No If yes, name of spouse:

b. Claiming dependents? ☐Yes ☐No If yes, name of dependents:

c. Claimed as a dependent on someone's tax return who does not live at the address(es) listed on page 2 of this application? ☐Yes ☐No

Tell Us About Residency for the Patient

*** If you need to provide more information, please attach extra sheets**

Start with the current Address and work backward for five (5) years.

Physical Address	City	State	Zip Code	County	From (date):	To:
☐ Own? ☐ Rent?	Landlord's Name			Landlord's Phone Number		
Physical Address	City	State	Zip Code	County	From (date):	To:
☐ Own? ☐ Rent?	Landlord's Name			Landlord's Phone Number		
Physical Address	City	State	Zip Code	County	From (date):	To:
☐ Own? ☐ Rent?	Landlord's Name			Landlord's Phone Number		
Physical Address	City	State	Zip Code	County	From (date):	To:
☐ Own? ☐ Rent?	Landlord's Name			Landlord's Phone Number		

Current Services and Health Coverage

*** If you need to provide more information, please attach extra sheets.**

Please check any Programs from the list below that you are currently receiving assistance from. Your answer to this question will not affect your eligibility for benefits.

☐ Other State's Assistance Programs | Children's or Adult Developmental Disabilities ☐ Infant and Toddler
☐ Children's or Adult Mental Health Foster Care or Adoption Assistance

Has anyone in your home *ever* received assistance from another state? ☐ Yes ☐ No
If yes, from where? City _____ State _____ County _____ When? _____

List anyone in your home that:

	NAME OF HOUSEHOLD MEMBER	DATE APPLICATION FILED	CURRENT STATUS OF APPLICATION
Has a disability			
Receives or has applied for Social Security			
Receives or has applied for Medicare			
Has applied for Health Coverage in the past Year			
Has applied for Crime Victims in the past year			
Needs medical assistance at home			
Lives with a relative who provides medical care			
Lives in a medical care facility	Name of Facility:		

Are you a dependent of a full-time State employee? ☐ Yes ☐ No

Does anyone applying for state **Department of Health and Welfare** Health Coverage need help paying medical bills from the last three months? ☐ Yes ☐ No If Yes, who? _____

List gross income amount (before taxes) received by your family in each of the last three months.

$	$	$
Last Month	Two Months Ago	Three Months Ago

Would you like Healthy Connections to choose a doctor for you? ☐ Yes ☐ No

Do you have health insurance that covers inpatient/outpatient hospital, physician's medical and surgical, lab, and x-ray services? ☐ Yes ☐ No

List everyone in your household who has had health insurance in the past six (6) months.

NAME OF PERSON(S) INSURED	DATE INSURANCE ENDED	REASON INSURANCE ENDED	NAME OF INSURANCE COMPANY	TYPE OF COVERAGE & POLICY NUMBER

If insurance ended due to loss of employment, have you received notification of COBRA? | Yes | | No
Does anyone in your household have access to any health insurance coverage not listed above? Yes No

Legal Information

*** If you need to provide more information, please attach extra sheets.**

Has anyone in your household been convicted of a felony involving drugs? ☐ Yes ☐ No
If Yes, who: _____ Year: _____
Is anyone fleeing to avoid felony prosecution or jail time? ☐ Yes ☐ No If Yes, who: _____
Is anyone currently violating conditions of probation or parole? ☐ Yes ☐ No If Yes, who: _____
Has anyone been disqualified from public assistance due to an intentional program violation? ☐ Yes ☐ No
If Yes, who: _____ Year: _____ Where: _____

List any pending actions (such as lawsuits, inheritance, accident claim, insurance settlement, etc.) that may result in the receipt of money by anyone in your household.

NAME OF HOUSEHOLD MEMBER	TYPE OF ACTION	BEGINNING DATE OF ACTION	CURRENT STATUS OF ACTION	CLAIM NUMBER

List the name, address, and phone number of your attorney.

Full Name	Address (Street, City, State, Zip)	Phone Number

List anyone in your household who has *ever* been disqualified from an assistance program.

NAME OF HOUSEHOLD MEMBER	NAME OF PROGRAM	DATE DISQUALIFIED	REASON

General Information

*** If you need to provide more information, please attach extra sheets.**

Do you have any children in your home? | Yes | | No
If YES, do any of them have a parent NOT living with them? Yes No

** If you answered "yes" you will be required to give information about the non-custodial parent(s) to Child Support Services and open a Child Support case unless you fear harm to yourself or your children. If you have questions about child support cooperation, please call 1-800-356-9868 for more information.

CHILD'S NAME	NON-CUSTODIAL PARENT'S NAME	NON-CUSTODIAL PARENT'S SSN	NON-CUSTODIAL PARENT'S DOB

List each person in your household that pays or receives child support.

NAME	PAYS/RECEIVES	AMOUNT

List everyone in your home who PAYS child or adult care expenses due to work or school.

Name:	**Reason for Care:** ☐Work ☐Work Search ☐School	Name of Child/Adult in Care:	Amount Paid: $ How Often?
Name of Care Provider:	Do you get help paying for care? ☐No ☐Yes	If yes, how much do you receive? $	
	Name of Person / Agency paying:		
Name:	**Reason for Care:** ☐Work ☐Work Search ☐School	Name of Child/Adult in Care:	Amount Paid: $ How Often?
Name of Care Provider:	Do you get help paying for care? ☐No ☐Yes	If yes, how much do you receive? $	
	Name of Person / Agency paying:		

Tell Us About Your Income and Resources * If you need to provide more information, please attach extra sheets.

Earned Income: List all employment information for each person in your household.

Patient/Applicant			**Spouse/Significant Other/Co-Applicant**		
Current Employer Name:		Phone No:	Current Employer Name:		Phone No:
Address (street, city, state, zip)			Address (street, city, state, zip)		
Hours per Week:	Hourly Rate:	Monthly Gross:	Hours per Week:	Hourly Rate:	Monthly Gross:
List Dates of Employment: From: To:			List Dates of Employment: From: To:		
Previous Employer Name:		Phone No:	Previous Employer Name:		Phone No:
Address (street, city, state, zip)			Address (street, city, state, zip)		
Hours per Week:	Hourly Rate:	Monthly Gross:	Hours per Week:	Hourly Rate:	Monthly Gross:
List Dates of Employment: From: To:			List Dates of Employment: From: To:		
Other Household Member			**Other Household Member**		
Current Employer Name:		Phone No:	Current Employer Name:		Phone No:
Address (street, city, state, zip)			Address (street, city, state, zip)		
Hours per Week:	Hourly Rate:	Monthly Gross:	Hours per Week:	Hourly Rate:	Monthly Gross:
List Dates of Employment: From: To:			List Dates of Employment: From: To:		
Other Household Member			**Other Household Member**		
Current Employer Name:		Phone No:	Current Employer Name:		Phone No:
Address (street, city, state, zip)			Address (street, city, state, zip)		
Hours per Week:	Hourly Rate:	Monthly Gross:	Hours per Week:	Hourly Rate:	Monthly Gross:
List Dates of Employment: From: To:			List Dates of Employment: From: To:		

Is the income provided above reflective of what you expect to earn for the entire calendar year (Jan. through Dec. of the current year)? ☐ Yes ☐ No

If **No**, provide us with your anticipated annual gross income (weekly amount before taxes x 4.3 x 12= annual gross income): $_____

Is anyone in the household self-employed? ☐ Yes ☐ No Who? _____

Name of Business _____ Years in Business _____

Unearned Income Is anyone receiving income from the following sources? Check all that apply.

- ☐ Social Security / SSI / SSD
- ☐ Veteran's Benefits
- ☐ Food Stamps
- ☐ Cash Assistance / TAFI
- ☐ Worker's Compensation
- ☐ Child Support
- ☐ Alimony
- ☐ Employer Disability
- ☐ Crime Victims
- ☐ Unemployment
- ☐ Energy Assistance
- ☐ School Financial Aid
- ☐ Retirement
- ☐ Tribal/BIA Assistance
- ☐ Commodities
- ☐ Rental / Escrow
- ☐ Inheritance / Trust
- ☐ Loans / Gifts
- ☐ Insurance Settlements
- ☐ Church
- ☐ Income Tax Refunds/Earned Income Credit
- ☐ Interest/Dividends
- ☐ Other

Please provide details for any unearned income marked above.

SOURCE OF UNEARNED INCOME	PERSON RECEIVING INCOME	AMOUNT	HOW OFTEN RECEIVED?

ASSETS

*** If you need to provide more information, please attach extra sheets.**

List all assets for anyone in your household. Include anything you have or your name appears on, even as a co-signer.

ITEM	HAVE IT? (CHECK)	ITEM DESCRIPTION / ACCOUNT NUMBERS	OWNER(S) / NAME(S) ON ACCOUNT	BANK NAME / ITEM OR ACCOUNT LOCATION	VALUE / AMOUNT	AMOUNT OWED
Cash						
Checking Acct.						
Savings Acct.						
Line of Credit						
CDs / Mutual Funds						
Stocks / Bonds						
Trusts / Annuities						
Retirement (IRA, 401K, etc.)						
Credit Cards						
Credit Cards						
Other Financial						
Home / Residence						
Land						
Rental Property						
Vehicle(s)						
Vehicle(s)						
Recreational Vehicles (Camper, Trailer, ATVs, etc.)						
Livestock / Tools of Trade						
Mining Claims						
Burial Plots / Burial Funds						
Life Insurance						
Other						

List anyone in your household who has sold, transferred or given away any cash, property, or assets in the past 5 years.

NAME OF PERSON(S)	DATE OF TRANSACTION	WHAT ASSETS	$$ RECEIVED	FAIR MARKET VALUE

Tell Us About Your Expenses

*** If you need to provide more information, please attach extra sheets.**

List all expenses for anyone in your household. Include anything you have or your name appears on, even as a co-signer.

ITEM	MONTHLY AMOUNT	BALANCE OWED	NAME(S) ON ACCOUNT	PAID TO:	OFFICE USE ONLY
Rent or Mortgage Subsidized? ☐Yes ☐No					
2nd Mortgage					
Space Rent					
Food					
Non-Food					
Electricity					
Heat – (Source?)					
Water / Sewer / Trash					
Telephone (Base Rate)					
Health / Accident Insurance					
Home Owners / Renters Insurance					
Life Insurance					
Auto Insurance					
Car Payment					
Fuel					
Alternate Transportation (Bus, Taxi, etc.)					
Hospitals					
Doctors					
Medications					
Dental					
Property Taxes					
Payroll Taxes (for business owners or self-employed)					
Education Expenses					
Child Care Subsidized? ☐Yes ☐No					
Dues and Tithing					
Child Support					
Garnishment					
Fines					
Other					
Other					
TOTAL EXPENSES					

Patient Rights and Responsibilities for State and County Assistance

The Applicant must read, or have read to them by the third party applicant, and initial each of the following statements acknowledging they understand and accept these rights and responsibilities.

For State Assistance:

_____ My signature certifies that the information on this application is true and accurate. I could be sanctioned and required to return any benefit I receive if my information is not true. Sanctions may include administrative, civil or criminal actions against me, including prosecution.

_____ I consent to the gathering, use and disclosure of my information by the Idaho Department of Health and Welfare or its designees. I understand the information is needed for the purpose of providing benefits or services, obtaining payment for my benefits or services, and for normal business operations of the Department.

_____ I consent to the gathering and use of income data, including information from tax returns for determining eligibility for help paying for health coverage in future years (up to 5 years). I will receive notice when this occurs, be able to make changes, and may opt out at any time.

_____ I have the right to revoke this consent, in writing, at any time except to the extent the Department has already used and disclosed my information in reliance on this consent. If I revoke this consent, the Department may not provide further benefits or services.

_____ I will be notified of the right to appeal Department decisions and I can contact the Department for information on the appeal process.

_____ My signature indicates I have received a copy of the Department Privacy Practices.

_____ If I am determined eligible for Health Coverage Assistance, the plan I will be enrolled in is dependent on my individual needs.

_____ By applying for benefits for a minor child, a medical support case must be opened, when applicable. If I am receiving benefits for myself, failure to cooperate with Child Support Services may result in a loss or decrease of my benefits.

_____ My signature certifies that the listed citizenship/immigration status is correct for each person applying.

_____ If I am determined eligible for Health Coverage Assistance, I may be responsible for paying part of the cost of my/my child's health coverage, and I will be notified of my co-pay amount.

_____ My signature or the signature of my representative authorizes State offices to communicate with insurance companies related to my/my child's medical assistance.

_____ I have the right to choose a Healthy Connections Primary Care Doctor, to request referrals for services, and to change the doctor/clinic if my circumstances change.

_____ If I receive Medicaid after age 55, my estate may be subject to recovery of medical expenses paid on my behalf, and that any transfer of assets may be set aside by a court if I do not receive adequate value.

_____ If a third party is responsible for my/my child's disease or injury, I give to Medicaid any rights I may have, or may acquire in the future, to be compensated by the responsible party for any medical benefits I receive for myself/my children.

_____ If I receive Health Coverage Assistance, I am required to report specific mandatory changes that are required for that program outlined in the Approval Notice.

_____ I may be required to cooperate with state or federal reviewers who are making sure my benefits are correct. I may not be eligible to receive benefits if I do not cooperate.

_____ If I am determined eligible to receive an Advance Payment of Premium Tax Credit (APTC) and use these funds towards the purchase of a Qualified Health Plan (QHP), any discrepancies between my reported income, which was used to determine eligibility, and the amount of the tax credit, will be reconciled with the final income reported on my taxes at the end of the calendar year. The IRS will be responsible for conducting this reconciliation, and any discrepancies may result in an adjustment of the tax credit, including entitlement to additional funds or re-payment of funds overpaid to me.

For County Assistance:

_____ An automatic lien will attach to my real and personal property, insurance benefits, and any additional resources or assets I own.

_____ I must complete the entire application within the timelines allowed by law.

_____ I must cooperate with the investigation of my application by providing documentation and submitting to an interview.

_____ I am obligated to reimburse the county for any assistance requested and provided on my behalf.

_____ I must notify the county if I receive resources after filing an application with the county.

_____ To assist in determining my eligibility, I consent to the gathering, use, and disclosure of my personal and financial information by the county.

_____ A provider may file an application on my behalf as a third party applicant.

_____ I will be notified of the county's decisions and that I may appeal an adverse decision of the Board of County Commissioners within 28 days of the date of determination.

_____ I may seek judicial review of the county's final determination denying my application.

_____ If I fail to cooperate with the county, make a material misstatement or material omission, my application will be denied and I will be ineligible for non-emergency services for up to two (2) years.

_____ If I do not provide required material information or if I divest myself of resources within one (1) year prior to filing an application in order to become eligible for county assistance, my application will be denied.

_____ If I am sanctioned by federal or state authorities and lose medical benefits, I will be ineligible for county assistance for the period of the sanction.

_____ If I give false or misleading information to a hospital, county, to its agent, or to any person in order to receive county assistance, or fail to disclose resources or benefits available to me as payment or reimbursement, I will be guilty of a misdemeanor and punishable under the law.

Signature (must be completed)

I acknowledge that I have read and reviewed the Rights and Responsibilities for State and County assistance with the patient.

Printed Name of Patient/Applicant	Signature of Patient/Applicant	Date
Printed Name of Third Party Applicant	Signature of Third Party Applicant	Date

RELEASE OF INFORMATION

Patient's Name: _____ **County:** _____

Applicant's Name: _____ **Co-Applicant's Name:** _____

I/we authorize and request any hospital, doctor, or other person that has provided care to the above named patient ("Providers") to release medical records to representatives of the State or the County as the records are pertinent to the investigation and eligibility determination of medical indigency pursuant to Chapter 35, Title 31 Idaho Code. I acknowledge that some records pertaining to treatment I have received for which I am seeking payment from the State or the County may include information that is protected under the Federal Law. Specific authorization is given to release information concerning a federal-assisted drug or alcohol abuse program, drug-alcohol abuse information, mental health information, HIV information, or any other information that may be protected by law. I understand that I am waiving the confidentiality of such records for the limited purpose of this application for medical indigency and any supplements or amendments thereto. I acknowledge that the State or the County may disclose any information received to my providers participating in the medical indigency process and to representatives of the State Catastrophic Health Care Cost Program. I acknowledge that the purpose of the release is to determine whether or not I meet the statutory requirements for medical indigency assistance from the State or the County.

Federally protected records obtained as authorized by this release will be maintained in accordance with federal confidentiality regulations (Title 42CFR) which prohibits re-disclosure.

I/we also request my/our relatives, banker(s), credit union(s), financial or investment institution(s), physician(s), hospital(s), creditor(s), credit reporting agencies, and any other persons or organizations including the State Department of Health and Welfare, Social Security Administration, Public Health Districts, Veterans Administration, Crime Victims Compensation Program, Idaho Industrial Commission, utility companies or departments, law enforcement agencies, courts, Idaho Department of Labor, or employer(s), having any information concerning me/us or my/our circumstances to provide the information to such representative of the State or the County, inasmuch as it is pertinent to this application.

I/we hereby authorize the State or the County and its representatives to release pertinent information regarding this application, the contents thereof and action taken thereon to all parties of interest as provided by Chapter 35, Title 31, Idaho Code. I/we acknowledge that my/our medical indigency application waives any confidentiality granted by state law to the extent necessary to carry out the intent of Idaho Code 31-3504 regarding such applications. I/we hereby authorize a copy of this agreement to be used when necessary and give it full force as the original.

I/we understand that I/we may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that unless consent is sooner revoked; this release is valid as long as it is pertinent to this application, post-application reimbursement, or collection activity.

_____ _____
Signature of Patient Date

_____ _____
Signature of Applicant Date

_____ _____
Signature of Co-Applicant Date

STATE OF IDAHO)
):SS.
County of _____)

On this _____ day of _____, 20_____, _____ personally appeared before me and proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to this instrument and acknowledged to me that he/she/they executed the same.

Subscribed and sworn before me:

_____
Notary Public for the State of Idaho

(SEAL)

Residing In: _____
My Commission Expires On: _____

This authorization conforms to the regulations promulgated under Section 333 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, and Section 408 of the Drug Abuse Offense and Treatment Act of 1972 and the Health Insurance Portability and Accountability Act of 1996.

REQUIRED INFORMATION

The following information is required when applying for assistance. <u>You must provide</u> proof of ALL income, resources, assets, benefits, and expenses of ALL household members. Failure to provide verification of all items listed may result in denial of your application. <u>Bring your verifications with you to your scheduled interview.</u> (The documentation should include your name, your monthly payment amount, and the balance owing. If you get a monthly billing statement for the expense, bring in the statement for the most recent month. Otherwise, bring in the applicable lease or contract agreement).

<u>IDENTIFICATION:</u>

- **Picture ID** (Driver's license, school I.D., etc.) for <u>All</u> members of the household
- **Social Security cards** for <u>All</u> members of the household
- **Citizenship and Residency Documentation** for <u>All</u> members of the household (VISA, Resident Alien Card, etc.)
- **Veteran's Status** (DD214, military discharge papers)

<u>INCOME / ASSETS / BENEFITS</u>:

- **Verification of all household income for the past six (6) months** <u>including but is not limited to</u>:

Wage Stubs/ Employer Earning Statements	Health Insurance or Life Insurance	Rental Income/ Escrow Income
Self-Employment Records (i.e. Year-to-date Profit and Loss Statement)	Survivor Benefits	Land-Trust Payments/ Per-Capita Payments
Unemployment Benefits	Food Stamps Benefits	Garnishment Income
Retirement Pension	TAFI Benefits	Investment Income
IRA or other Retirement Income	ICCP Benefits	Cash Settlement Payments
Worker's Compensation	SSI/ SSD/ Social Security Retirement	School Financial Aid/ Scholarships/ Loans
Crime Victims Compensation	Alimony	Family Financial Assistance
Veteran Disability/ Pension	Child Support	Other

- **Federal** and **State tax returns** for the most recent year filed
- **Bank / Credit Union / Investment Income statements** for all checking, savings, money market accounts, IRAs, certificates of deposit, stocks, bonds, mutual funds, real estate, retirement investments etc. (If you don't have these, please get a print-out from your bank/credit union, brokerage firm / investment house)
- **Verification of any assistance received from other agencies or assistance programs** <u>including, but not limited to:</u>

Energy Assistance	SEICCA	Aid for Friends
Subsidized Housing	Project Share	Salvation Army
Phone Assistance	Church Assistance	St. Vincent DePaul

<u>EXPENSES:</u>

- **Provide all medical bills (immediately, upon receipt) to the county for which assistance is requested.**
- **Proof of *all* monthly household expenses and *all* outstanding debts** <u>including, but not limited to</u>:

Rental Lease	Water/sewer/garbage	Child Support	Transportation
Lot Space Lease	Telephone	Child Care	Taxes
Mortgage	Food	Medications	Court-Ordered Fines
Heating	Non-Food Grocery	Insurance	Loan Payments
Electricity	Car payment	Doctor / Hospital	Other

- **<u>ALSO:</u> Any and all other information** requested by the Idaho Department of Health and Welfare and/or the County Indigent Program.

DO I HAVE TO BE A CITIZEN?

According to the U.S. Citizenship and Immigration Services, if you do NOT have a green card, members of your family who are eligible can use non-cash benefits, including Health Coverage, Food Stamps, WIC, housing assistance, energy benefits, job training, child care, disaster relief, public health assistance, etc., without hurting your chances of getting a green card, becoming a U.S. citizen, or sponsoring relatives in the future.

DO I HAVE TO RELEASE MY SOCIAL SECURITY NUMBER (SSN) AND CITIZENSHIP STATUS?

Some family members of applicants may choose not to apply for Health and Welfare services. In that case, they do not have to provide a SSN or citizenship or immigration status. Benefits to applicants will not be delayed or denied because some family members do not apply.

Anyone who applies for services, except child care, must have a SSN or apply for one. If you want Emergency Health Coverage only or you are a victim of domestic violence, you may not have to give a SSN or immigration status. You only have to give us citizenship or immigration status information for persons who want help, except when applying for child care.

We can help you apply for a SSN, and benefits will not be denied or delayed while the application is being processed. We need the SSN to help you establish paternity, get Child Support, and change or enforce Child Support orders, including medical insurance coverage for a child. SSN's will not be given to the U.S. Citizen and Immigration Services.

IS THERE EQUAL OPPORTUNITY FOR APPLICANTS?

In accordance with federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, the Department of Health and Welfare 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:

USDA, Director, Office of Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410 (800) 795-3272 (Voice) (202) 720-6382 (TTY) USDA & HHS are equal opportunity providers and employers.	U.S. Department of Health & Human Services Room 506 F, 200 Independence Avenue, SW Washington, D.C. 20201 ocrcomplain@hhs.gov (202) 619-0403 (Voice) (202) 619-3257 (TTY)

IDAHO HEALTH COVERAGE CHOICE

If you are eligible for Health Coverage Assistance, you have the right to choose the plan that is based on your health needs. Idaho Health Coverage offers the Health Coverage Basic Plan and the Health Coverage Enhanced Plan to meet different health needs.

- **The Health Coverage Basic Plan** is for low-income children and working-age adults with average health needs. This plan provides complete health, prevention, and wellness benefits for children and adults who don't have special health needs.
- **The Health Coverage Enhanced Plan** is for individuals with disabilities or special health needs. This plan includes all benefits in the Basic Plan, plus additional benefits.

You may choose NOT to enroll in the plan that meets your health needs. You may choose to enroll in Standard Health Coverage instead. Standard Health Coverage does not include prescription drugs, certain prevention and wellness benefits, therapies, dental services, vision services, and other services. If you do not want to enroll in the benefit plan that meets your health needs, you must inform your Self-Reliance worker.