

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 **complete** your application fill out pages 3 to 6. You can **start** 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).

Premium Payment Program

If you or your child qualifies for Medicaid, you may be eligible for reimbursement of your health insurance premiums. To apply go to <http://hrsa.dshs.wa.gov/PremiumPymt/>, or call us at 1-877-562-3022, ext 15473.

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:
<ul style="list-style-type: none">• Decide who is eligible for our programs.• Collect overpayments of food assistance.• Manage our programs.• Make sure we follow the law.	<ul style="list-style-type: none">• 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. Medicare Savings Program is exempt. 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, 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

Check this box if you need help filling out this form.

1. FIRST NAME MIDDLE INITIAL LAST NAME	SIGNATURE (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)	

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

- | | |
|---|--|
| <input type="checkbox"/> Cash | <input type="checkbox"/> Food |
| <input type="checkbox"/> Medical | <input type="checkbox"/> Drug or Alcohol Treatment |
| <input type="checkbox"/> Help with medical bills (from last three months) | <input type="checkbox"/> Nursing Home |
| <input type="checkbox"/> Assisted Living Facility / Adult Family Home | <input type="checkbox"/> Medicare Savings Program |
| <input type="checkbox"/> Psychiatric Indigent Inpatient (PII) | <input type="checkbox"/> Hospice |
| <input type="checkbox"/> Healthcare / Workers with Disabilities (HWD) | <input type="checkbox"/> In-Home Long Term Care Services |
| <input type="checkbox"/> Other (please list): _____ | |

7. EMAIL ADDRESS

9. I or someone in my household (check all that apply): Are in a domestic violence situation

Can't work because of health problems Have a disability Are pregnant; 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 a phone interview. Please call me at: _____

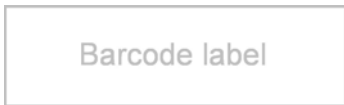
17. I need an interpreter. I speak: _____ or sign; translate my letters into: _____

18. 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		<input type="checkbox"/>		<input type="checkbox"/>		
				<input type="checkbox"/>		<input type="checkbox"/>		
				<input type="checkbox"/>		<input type="checkbox"/>		
				<input type="checkbox"/>		<input type="checkbox"/>		
				<input type="checkbox"/>		<input type="checkbox"/>		
				<input type="checkbox"/>		<input type="checkbox"/>		
				<input type="checkbox"/>		<input type="checkbox"/>		

19. 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.



I. General Information

1. In the past 30 days, I got cash, food, or medical assistance 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 is in school: Yes No Who: _____
5. Someone is temporarily out of my home: Yes No Who: _____
6. I or someone I'm applying for served in the military: Yes No Who: _____
7. Someone is the dependent or spouse of someone (living or deceased) who served in the military: Yes No
8. 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
9. I am living in: My own house or apartment Group Home Other: _____
 Facility (list type): _____ Date entered: _____
10. I am: Single Married Divorced Separated Widowed
 In a Registered Domestic Partnership

II. Medical and Health Insurance Information

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 (Check all that apply): Medicare (not DSHS medical) Tricare
 Long-Term Care Insurance Indian Health Services Other Health Insurance: _____

III. Resources (Not needed for Children's Medical, Pregnancy Medical, 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
- Savings bonds
- Bonds
- Mutual funds
- Stocks
- Annuities
- Trusts
- IRA
- 401K
- Retirement fund
- Houses, including the one you live in
- Condominium
- Land
- Sales contracts
- Building
- Life estate
- Life insurance
- Burial funds, prepaid plans
- College funds
- Time-share
- 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
			<input type="checkbox"/>	<input type="checkbox"/>	\$
			<input type="checkbox"/>	<input type="checkbox"/>	\$

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

APPLICANT'S NAME	SOCIAL SECURITY NUMBER	CLIENT IDENTIFICATION NUMBER
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IV. 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 _____ EMPLOYER'S NAME AND PHONE NUMBER _____ START DATE _____	GROSS AMOUNT RECEIVED (DOLLAR AMOUNT BEFORE TAXES) \$ _____ every: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Two weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Month Hours per week: _____ Pay dates (e.g., 1 st and 15 th , or every Friday): _____
Is this job self-employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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

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

	WHO GETS THE INCOME?	GROSS MONTHLY AMOUNT	WHO GETS THE INCOME?	GROSS MONTHLY 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 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 Medicaid Long Term Care benefits, you must name the State of Washington as a remainder beneficiary of the annuity.

VII. Monthly Expenses Attach Proof

RENT \$	MORTGAGE \$	SPACE RENT \$	CONDOMINIUM FEES \$
HOMEOWNER'S INSURANCE \$	PROPERTY TAXES \$	PROPERTY ASSESSMENTS \$	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):

<input type="checkbox"/> Child or Adult Dependent Care (including transportation costs)	Monthly amount: \$	Who pays:
<input type="checkbox"/> Medical bills for persons with disabilities or age 60 + (including transportation costs)	Monthly amount: \$	Who pays:
<input type="checkbox"/> 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

NAME	RELATIONSHIP	TELEPHONE NUMBER
STREET ADDRESS	CITY	STATE
		ZIP CODE
MAILING 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 and follow reporting requirements.
- Provide proof I am eligible.
- Assign certain rights to child support and medical support, to the State of Washington when I receive Temporary Assistance for Needy Families (TANF). Assign third party payments for medical care to the State of Washington when I receive medical care benefits. However, I can ask DSHS not to pursue child support, medical support, or third party payments for medical care, 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.

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	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	