



## EqualityCare (Medicaid) Aged, Blind, or Disabled Programs Application Packet

This application is available in Spanish. Call 1-800-457-3659.  
Esta solicitud está disponible en español. Llame al 1-800-457-3659.

This packet provides information needed to assist you when applying for Wyoming **EqualityCare (Medicaid)** Aged, Blind, or Disabled Programs.

In addition to completing the EqualityCare (Medicaid) Application for Aged, Blind, or Disabled programs, an interview is required when applying for most programs. To schedule an interview, contact your local Department of Family Services (DFS) Field Service Office.

The following items are included in this packet:

- Application for EqualityCare (Medicaid) Aged, Blind, or Disabled Programs
- EqualityCare (Medicaid) Application Checklist for Aged, Blind, or Disabled Programs
- EqualityCare (Medicaid) Application Information for Aged, Blind, or Disabled Programs
- List of Department of Family Services (DFS) Field Service Office Locations

Additional information on Wyoming EqualityCare (Medicaid) Long Term Care programs is available at:

- Wyoming Department of Health, EqualityCare Eligibility: <http://health.wyo.gov/EqualityCare>.

Appointment Date: \_\_\_\_\_  
Appointment Time: \_\_\_\_\_

Benefit Specialist: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

\*If you have any questions or problems making your appointment, contact me at the phone number above.

# **EqualityCare (Medicaid) Application Checklist for Aged, Blind, or Disabled Programs**

Please provide verification for all items listed below, **if applicable**. Copies are okay, and a worker can help you make copies or assist with obtaining verifications, if needed. If you are married, verification of the same items will be required for your spouse. An interview will be required for most programs and additional items may be requested during the interview.

## **Personal Information**

- U.S. Citizenship (U.S. Passport, WY Driver's License, Certificate of Naturalization or Birth Certificate)
- Identity (U.S. Passport, U.S. issued Driver's License or ID Card, or Certificate of Naturalization)
- Social Security Number or proof of application for Social Security Number
- Power of Attorney, Guardianship, or Conservator documents
- Alien Status, Permanent Resident Card or USCIS Record
- Health insurance card(s) including Medicare card

## **Income and Resource Information**

- Income, including, but not limited to, pay stubs, self employment, social security, retirement/pension, unemployment benefits, veteran's benefits, interest, dividends or contributions
- Current (within last 30 days) statements for all bank accounts, savings, checking, CD or retirement accounts. This would include IRAs and 401(k) accounts
- Statements for all life insurance policies or annuities showing ownership, face value and current cash surrender value
- Copies of all stocks or bonds
- Vehicle titles or registrations for all licensed or unlicensed vehicles and verification of amounts owed
- Deeds for all real property, tax assessment, and verification of amounts owed
- Mineral rights owned and any current leases
- Prepaid funeral arrangements; including funeral or burial accounts, mausoleums or plots
- Trust documents for any trusts for you or your spouse
- List of contents for safe deposit box
- Documentation of any transfers made by you, your spouse, or anyone acting on your behalf, in the past 60 months. This would include, but is not limited to gifts, transfers, or sale of properties

## **Liability Information**

- Health insurance premiums
- Medical bills for the last 3 months (if any)

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## **EqualityCare (Medicaid) Application Information for Aged, Blind, or Disabled Programs**

### **EqualityCare INFORMATION:**

EqualityCare is the name chosen by the Wyoming Department of Health (WDH) for Medicaid. This application can be used to apply for Aged, Blind, or Disabled programs for individuals in need of professional care provided at home, in a nursing home, hospital or intermediate care facility. This application can be used for individuals who:

- Are aged, blind, or disabled
- Need help paying their Medicare premium
- Are in nursing homes or assisted living facilities
- Need nursing home level of care, but wish to remain in their home and receive specialized services.
- Need Hospice care
- Need inpatient hospital care (for stays of 30 days or longer)
- Are employed and have a disability

This application can also be used to apply for the Prescription Drug Assistance Program (PDAP).

If you are receiving Supplemental Security Income (SSI) you are automatically eligible for Medicaid and do not need to complete an application. Contact your local Department of Family Services (DFS) Field Service Office for more information.

If you do not have a Social Security Number (SSN), ask your eligibility worker about how to get one.

Eligibility is determined by DFS and is generally based on family income and sometimes resources and/or healthcare needs. If you have questions, or need help completing or understanding this application, contact your local DFS Field Service Office.

If you are only applying for an EqualityCare Family and Children's program, including the Pregnant Women's program, please complete the Wyoming Healthcare Coverage Application, which can be completed online at [www.healthlink.wyo.gov](http://www.healthlink.wyo.gov).

If you need more information about Medicaid programs that are available, please visit: [www.health.wyo.gov/EqualityCare](http://www.health.wyo.gov/EqualityCare).

## RIGHTS AND RESPONSIBILITIES:

If you do not speak English, or if you are blind, hard of hearing or deaf, you can have interpretation services provided for you at no cost.

- **Citizenship/Immigration Status** – Your signature certifies that the citizenship/immigration status is correct for each person applying. You do not have to give information about citizenship or immigration status of family members who are not applying for healthcare benefits. Your records will be kept confidential and will only be released for purposes authorized by federal and state law. Information you provide on this application will NOT be shared with the U.S. Citizenship and Immigration Services (USCIS) formerly known as Immigration and Naturalization Service (INS).
- **Release of Medical Information** – The WDH or its representative must be able to obtain medical records from providers if necessary. Your signature authorizes your medical providers to release any medical records to the WDH or its representative.
- **Social Security Numbers** – Social Security Numbers (SSNs) are required only for individuals who are applying for benefits. SSNs will be used to check the identity of household members to prevent duplicate participation. SSNs will also be used in computer matching, program reviews, and/or audits to make sure your household is eligible for this program. We will be comparing what you tell us with information on record with agencies such as the Department of Employment, Internal Revenue Service, Social Security Administration, Vital Statistics, Worker’s Compensation, Child Support Enforcement, the Department of Revenue and Taxation, and the Department of Transportation. All persons in your home, who are applying for or receiving benefits, will be included in the computer matches. The information received may affect your eligibility and benefits. If you do not have a SSN for yourself or a household member, DFS can help you apply for one.
- **Civil Rights** – None of the programs this application is used for will exclude, deny benefits to, or otherwise discriminate against any person on the grounds of race, color, sex, religion, political belief, or national origin, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits of any of its programs and activities or in employment. For further information about this policy contact your local DFS Field Service Office or the Office of Civil Rights at 1-800-368-1019.
- **Administrative Hearings** – You may request a conference with your local DFS Field Service Office if you disagree with decisions made regarding this application. You may also request a conference with the DFS Field Service Office due to any changes to your benefits. If you still don’t agree after the conference, you may request an administrative hearing, which may be granted if requested within 90 days from the date the Notice of Adverse Action was generated. In order to receive continued benefits under the same program, you must request the administrative hearing within ten days of the date the adverse action was generated. You can request to have your local DFS Field Service Office help you arrange the conference and hearing. You may represent yourself at these meetings, or you may choose a friend, relative, lawyer, or other person to represent you. You will pay all legal charges if you hire a lawyer. If you want to discuss our

decision or ask any questions about how an administrative hearing works, contact your local DFS Field Service Office. You may also call your local Legal Services Office to find out if free legal advice is available.

- **Reporting Responsibilities** – You are responsible for reporting changes to the information provided on this application within 10 days of identifying the change. Verification of these changes will be required. Changes in the following will need to be reported to DFS:

1) Income, 2) Resources, 3) Address, 4) Household Members, 5) Medical Insurance

If you expect any of the above items to change or they have already changed, call, write or complete a Change Report form and submit along with verification of the change.

- **Medical Support** – If you receive EqualityCare (Medicaid) and also get money for the same medical bills, or the medical bills are paid by another insurance company or third party, you must give the money to the WDH. The state may collect from any potentially liable third party, insurance company, or from the proceeds of any court settlement or judgment for all medical bills. You are obligated to repay the state for 100% of the medical bills paid from any settlement or judgment prior to receiving any of the money or other benefits from the settlement or judgment.
- **Estate Recovery** – The WDH will pursue recovery of medical care costs paid by the EqualityCare (Medicaid) program from the estate of an EqualityCare recipient who was age 55 years or older when they received medical assistance or who was an inpatient in a medical institution when they received medical assistance.
- **Verification of Application Information** – Any false statements you make on this application and failure on your part to report any change in circumstance which would affect your eligibility for payment from Wyoming EqualityCare (Medicaid), constitutes a crime. You could be prosecuted under Wyoming criminal laws for this crime. Your signature (or the signature of your representative) authorizes State and Federal officials to get and use computerized and other information about you to determine if you are eligible for benefits. Computer matches will be conducted against the information provided on your application. Identification of false information provided may occur through these computer matches. You must cooperate fully with state and local workers if your application is selected for review.
- **Application Processing** – Your application will be approved or denied within 45 days from the date of application unless waiting for third party verification, in which case, the decision will be made within 60 days. If you are waiting for a disability determination, a decision will be made within 90 days from the date of application.

**DO NOT** risk losing your benefits or cause an overpayment by not notifying DFS of the change.

## Department of Family Services Field Service Office Locations

Albany County DFS  
2020 Grand Ave., Ste 400  
Laramie WY 82070  
307-745-7324

Big Horn County DFS  
616 2nd Ave., North  
Greybull WY 82426  
307-765-9453

Campbell County DFS  
1901 Energy Ct., Ste 300  
Gillette WY 82716  
307-682-7277

Carbon County DFS  
215 W Buffalo St., Ste 359  
Rawlins WY 82301  
307-328-0612

Converse County DFS  
219 N Russell Ave.  
Douglas WY 82633  
307-358-3138

Converse County DFS  
925 W Birch St.  
Glenrock WY 82637  
307-436-9068

Crook County DFS  
102 N 5th St.  
Sundance, WY 82729  
307-283-2014

Eastern Shoshone  
42 Black Coal Rd.  
Ft Washakie, WY 82514  
307-332-0207

Fremont County DFS  
201 N 4th St.  
Lander WY 82520  
307-332-4038

Fremont County DFS  
120 N 6th St., East  
Riverton WY 82501  
307-856-6521

Goshen County DFS  
1618 E M St.  
Torrington WY 82240  
307-532-2191

Hot Springs County DFS  
403 Big Horn St.  
Thermopolis WY 82443  
307-864-2158

Johnson County DFS  
381 N Main St.  
Buffalo WY 82834  
307-684-5513

Laramie County DFS  
1510 E. Pershing Blvd.  
Cheyenne WY 82002  
307-777-7921

Lincoln County DFS  
1100 Pine Ave.  
Kemmerer WY 83101  
307-877-6670

Lincoln County DFS  
631 N Washington St.  
Afton WY 83110  
307-886-9232

Natrona County DFS  
851 Werner Ct., Ste 200  
Casper WY 82601  
307-473-3900

Niobrara County DFS  
905 S Main St.  
Lusk WY 82225  
307-334-2153

Northern Arapahoe  
St. 325 Left Hand Ditch Rd.  
Unit 9334  
Arapahoe, WY 82510  
307-857-1692

Park County DFS  
1301 Rumsey Ave.  
Cody WY 82414  
307-587-6246

Park County DFS  
109 W 14<sup>th</sup> St.  
Powell WY 82435  
307-754-2245

Platte County DFS  
1556 Progress Ct.  
Wheatland WY 82201  
307-322-3790

Sheridan County DFS  
111 E Works St.  
Sheridan WY 82801  
307-672-2404

Sublette County DFS  
11 N Sublette Ave., B 1070  
Pinedale WY 82941  
307-367-4124

Sweetwater County DFS  
2451 Foothill Blvd., Ste 103  
Rock Springs WY 82901  
307-362-5630

Teton County DFS  
115 W Snow King Ave.  
Jackson WY  
307-733-7757

Uinta County DFS  
350 City View Dr., Ste 206  
Evanston WY 82930  
307-789-2756

Uinta County DFS  
225 W Owen  
Mountain View WY 82939  
307-786-4011

Washakie County DFS  
1700 Robertson Ave.  
Worland WY 82401  
307-347-6181

Weston County DFS  
2013 W Main St., Ste 101  
Newcastle WY 82701  
307-746-4657

## EqualityCare (Medicaid) Application for Aged, Blind, or Disabled Programs

Please read all questions carefully and complete each section to the best of your knowledge. Print your answers and sign the application using dark ink. You may have someone help you complete the application.

Once complete, take or mail the application to your local Department of Family Services (DFS) Field Service Office. An interview may be required to complete the application process. The address and phone number of your local DFS Field Service Office can be found on the list included in this packet, at <http://dfsweb.state.wy.us/dfs/dfs-in-your-community.html> or by calling 1-800-457-3659.

Some information on this application must be verified for each person applying. Please see the checklist on page two (2) of this packet for a list of documents you should bring to your scheduled interview.

<b>Applicant Information:</b>					
Last Name:		First Name and Middle Initial:		Social Security Number: - -	
Your Address:		City:	State:	Zip Code:	
Mailing Address (If different):		City:	State:	Zip Code:	
Home Phone Number: ( )		Cell Phone/Message Number: ( )		Work Phone Number: ( )	
Email Address:		What is Your Preferred Language?		Place of Birth: City/State _____/_____/_____	
Birth Date: ____/____/____ MM / DD / YYYY	Race and Ethnicity (Optional): <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Other _____		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other _____
Do you live in Wyoming or intend to live in Wyoming within the next 45 days? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you a US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, provide Permanent Resident Alien Registration #		Date of Entry into the US ____/____/____ MM / DD / YYYY
<b>Do you have a legal (court-appointed) guardian and/or Power of Attorney?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No					

**Tell us About Your Spouse, Child(ren), or Parents Living in the Household:**

<p><b>Last Name, First Name, Middle Initial</b></p> <p>Last _____</p> <p>First _____</p> <p>MI _____</p> <p>Month Day Year</p> <p><b>Date of Birth</b> ____/____/____</p> <p><b>SSN:</b> ____-____-____</p>	<p><b>Applying for benefits?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Sex</b></p> <p><input type="checkbox"/> M <input type="checkbox"/> F</p> <p><b>Place of Birth:</b></p> <p>_____/____</p> <p>City State</p>	<p><b>Relationship to You?</b></p> <p><input type="checkbox"/> Spouse  <input type="checkbox"/> Child  <input type="checkbox"/> Step-Child  <input type="checkbox"/> Sibling  <input type="checkbox"/> Parent  <input type="checkbox"/> Step-Parent  <input type="checkbox"/> Other: _____</p>	<p><b>Race &amp; Ethnicity (Optional)</b></p> <p><input type="checkbox"/> White  <input type="checkbox"/> American Indian or Alaska Native  <input type="checkbox"/> Black  <input type="checkbox"/> Native Hawaiian or Pacific Islander  <input type="checkbox"/> Asian  <input type="checkbox"/> Hispanic or Latino  <input type="checkbox"/> Other: _____</p>	<p><b>US Citizen?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please provide:</p> <p><b>A #</b> _____          (Alien Registration Number)</p> <p>and</p> <p>Month Day Year</p> <p><b>Date of Entry</b> ____/____/____</p>
<p><b>Last Name, First Name, Middle Initial</b></p> <p>Last _____</p> <p>First _____</p> <p>MI _____</p> <p>Month Day Year</p> <p><b>Date of Birth</b> ____/____/____</p> <p><b>SSN:</b> ____-____-____</p>	<p><b>Applying for benefits?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Sex</b></p> <p><input type="checkbox"/> M <input type="checkbox"/> F</p> <p><b>Place of Birth:</b></p> <p>_____/____</p> <p>City State</p>	<p><b>Relationship to You?</b></p> <p><input type="checkbox"/> Spouse  <input type="checkbox"/> Child  <input type="checkbox"/> Step-Child  <input type="checkbox"/> Sibling  <input type="checkbox"/> Parent  <input type="checkbox"/> Step-Parent  <input type="checkbox"/> Other: _____</p>	<p><b>Race &amp; Ethnicity (Optional)</b></p> <p><input type="checkbox"/> White  <input type="checkbox"/> American Indian or Alaska Native  <input type="checkbox"/> Black  <input type="checkbox"/> Native Hawaiian or Pacific Islander  <input type="checkbox"/> Asian  <input type="checkbox"/> Hispanic or Latino  <input type="checkbox"/> Other: _____</p>	<p><b>US Citizen?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please provide:</p> <p><b>A #</b> _____          (Alien Registration Number)</p> <p>and</p> <p>Month Day Year</p> <p><b>Date of Entry</b> ____/____/____</p>
<p><b>Last Name, First Name, Middle Initial</b></p> <p>Last _____</p> <p>First _____</p> <p>MI _____</p> <p>Month Day Year</p> <p><b>Date of Birth</b> ____/____/____</p> <p><b>SSN:</b> ____-____-____</p>	<p><b>Applying for benefits?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Sex</b></p> <p><input type="checkbox"/> M <input type="checkbox"/> F</p> <p><b>Place of Birth:</b></p> <p>_____/____</p> <p>City State</p>	<p><b>Relationship to You?</b></p> <p><input type="checkbox"/> Spouse  <input type="checkbox"/> Child  <input type="checkbox"/> Step-Child  <input type="checkbox"/> Sibling  <input type="checkbox"/> Parent  <input type="checkbox"/> Step-Parent  <input type="checkbox"/> Other: _____</p>	<p><b>Race &amp; Ethnicity (Optional)</b></p> <p><input type="checkbox"/> White  <input type="checkbox"/> American Indian or Alaska Native  <input type="checkbox"/> Black  <input type="checkbox"/> Native Hawaiian or Pacific Islander  <input type="checkbox"/> Asian  <input type="checkbox"/> Hispanic or Latino  <input type="checkbox"/> Other: _____</p>	<p><b>US Citizen?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please provide:</p> <p><b>A #</b> _____          (Alien Registration Number)</p> <p>and</p> <p>Month Day Year</p> <p><b>Date of Entry</b> ____/____/____</p>

**Note:** Additional Household Members can be listed on the last page of this application.

**Provide Medical and Insurance Information for Anyone in the Household Applying for EqualityCare (Medicaid):**

**Is anyone in your household pregnant?**  Yes  No

Name of household member:	Is this their first pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Due Date: ____/____/____ MM/DD/YYYY
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**Is there a household member applying for EqualityCare (Medicaid) who is currently receiving or entitled to Medicare?**  Yes  No

Name of household member:	Medicare Number:
Name of household member:	Medicare Number:

**Is there a household member applying for EqualityCare (Medicaid) who is currently covered by other insurance or has other insurance available to them?**

Yes  No

Name of household member:	Group/Policy Number:	Type of Insurance Policy:	Amount of Monthly Premium:
Name of insurance company:	Date Insurance Began: ____/____/____ MM/DD/YYYY	<input type="checkbox"/> Long Term Care <input type="checkbox"/> Disability <input type="checkbox"/> Accident <input type="checkbox"/> Health <input type="checkbox"/> Other _____	\$
Name of household member:	Group/Policy Number:	Type of Insurance Policy:	Amount of Monthly Premium:
Name of insurance company:	Date Insurance Began: ____/____/____ MM/DD/YYYY	<input type="checkbox"/> Long Term Care <input type="checkbox"/> Disability <input type="checkbox"/> Accident <input type="checkbox"/> Health <input type="checkbox"/> Other _____	\$
Name of household member:	Group/Policy Number:	Type of Insurance Policy:	Amount of Monthly Premium:
Name of insurance company:	Date Insurance Began: ____/____/____ MM/DD/YYYY	<input type="checkbox"/> Long Term Care <input type="checkbox"/> Disability <input type="checkbox"/> Accident <input type="checkbox"/> Health <input type="checkbox"/> Other _____	\$

<b>Has anyone in the household, who is applying for EqualityCare (Medicaid), been covered by health insurance or long term care insurance that ended in the last three (3) months?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
Type of Insurance: <input type="checkbox"/> Health <input type="checkbox"/> Long Term Care	Date Insurance Ended: ____/____/_____ MM / DD / YYYY	For LTC Insurance, reason insurance ended:
Type of Insurance: <input type="checkbox"/> Health <input type="checkbox"/> Long Term Care	Date Insurance Ended: ____/____/_____ MM / DD / YYYY	For LTC Insurance, reason insurance ended:
<b>Does anyone in your household, who is applying for EqualityCare (Medicaid), have unpaid medical bills within 3 months of the date of application?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of Household Member:	Date(s) of Service:	
Name of Household Member:	Date(s) of Service:	
<b>Are any of the household members applying for EqualityCare (Medicaid) currently in a medical facility or long term care facility, or do they plan to live in a long term care facility?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
Type of Facility: <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Home <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Other: _____	Name of Facility:	Entry Date: ____/____/_____ MM / DD / YYYY
<b>Has anyone in your household served in the Armed Forces?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of Household Member:		
<b>Are you a dependent of a Veteran?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
Relationship to Veteran: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent	Name of Veteran:	Veteran's Claim Number:

**Tell us About Resources Belonging to Household Members:**

Type	Y	N	Household Member(s)	Amount	Financial Institution/ Company Name	Account Number
Cash on hand				\$		
Checking Account				\$		
Checking Account				\$		
Checking Account				\$		
Savings Account				\$		
Savings Account				\$		
Savings Account				\$		
Credit Union Account				\$		
Nursing Home Account				\$		
Certificate of Deposit				\$		
Stocks/Bonds/Annuities				\$		
IRA/401K/Keogh/Pension Plan				\$		
Burial Funds/Trusts				\$		

Type	Y	N	Household Member(s)	Amount	Financial Institution/ Company Name	Account Number
Pooled Trust						
Special Needs Trust						
Any Other Trust						
Life Insurance						
Other Resources						

Type	Y	N	Household Member	Value
Automobile				\$
Automobile				\$
Automobile				\$
Recreational Vehicle				\$
Crops/Equipment				\$
Tractors				\$
Livestock				\$
Property/Real Estate				\$
Life Estate				\$

Type	Y	N	Household Member	Value
Burial Space(s)				\$
Contract for Deed and/or Promissory Note				\$
Safety Deposit Box				\$
Other Resources				\$

**Has anyone in the household sold, transferred, traded, or given away any items of value in the past 60 months?**  Yes  No

Examples: trusts, real estate, automobiles, burial spaces

Name of Household Member(s):	Date(s) Item(s) Sold/Transferred/ Traded/Given Away: ____/____/____ MM / DD / YYYY	Item(s) Sold/Transferred/Traded/Given Away:
Value: \$	Amount(s) Received From Sale, Trade, or Transfer: \$	Name of Person(s) the Item(s) was Sold/Transferred/Traded/Given Away to:

Does anyone in your household have a Companion or Care Contract in place?

Yes  No

**Does anyone give you money on a monthly basis to pay your expenses?**  Yes  No

Name of Person Providing Payment:	Amount of Monthly Payment Provided: \$
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**Has any household member received or are they expecting to receive a one-time payment, i.e., a settlement, inheritance, retroactive payment, etc.?**  Yes  No

Name of Household Member:	When: ____/____/____ MM / DD / YYYY	Amount: \$
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**Tell us About Anyone in Your Household who has Income:**

Who has this Income?	Is this Person a Full-Time Student?	Type of Income (Check all that apply)	Employer Name	Gross Total Income this Month (Income before taxes and deductions are taken out)	Claim #s (Enter all that apply)
Last _____ First _____ MI _____	<input type="checkbox"/> Yes <input type="checkbox"/> No  If Yes, Grade: _____	<input type="checkbox"/> Self-Employment <input type="checkbox"/> Wages <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Unemployment <input type="checkbox"/> Trust Fund Monies <input type="checkbox"/> Veteran's Benefits <input type="checkbox"/> SSA/SSI <input type="checkbox"/> Pension <input type="checkbox"/> Other _____		\$	
Last _____ First _____ MI _____	<input type="checkbox"/> Yes <input type="checkbox"/> No  If Yes, Grade: _____	<input type="checkbox"/> Self-Employment <input type="checkbox"/> Wages <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Unemployment <input type="checkbox"/> Trust Fund Monies <input type="checkbox"/> Veteran's Benefits <input type="checkbox"/> SSA/SSI <input type="checkbox"/> Pension <input type="checkbox"/> Other _____		\$	
Last _____ First _____ MI _____	<input type="checkbox"/> Yes <input type="checkbox"/> No  If Yes, Grade: _____	<input type="checkbox"/> Self-Employment <input type="checkbox"/> Wages <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Unemployment <input type="checkbox"/> Trust Fund Monies <input type="checkbox"/> Veteran's Benefits <input type="checkbox"/> SSA/SSI <input type="checkbox"/> Pension <input type="checkbox"/> Other _____		\$	
Last _____ First _____ MI _____	<input type="checkbox"/> Yes <input type="checkbox"/> No  If Yes, Grade: _____	<input type="checkbox"/> Self-Employment <input type="checkbox"/> Wages <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Unemployment <input type="checkbox"/> Trust Fund Monies <input type="checkbox"/> Veteran's Benefits <input type="checkbox"/> SSA/SSI <input type="checkbox"/> Pension <input type="checkbox"/> Other _____		\$	

**Complete this section if you are assisting someone else with this application:**

Name:	Relationship: <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Sibling <input type="checkbox"/> Friend <input type="checkbox"/> Guardian <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Other _____
Phone Number: (    )	Address:

**Applicant or Authorized Representative's Statement of Understanding and Agreement** - I do allow any person having this information about me or other household members to give any requested information, including confidential information, to any authorized agent of the State of Wyoming or the federal government. This information will be used for the purpose of determining eligibility for the programs for which I am applying. I also agree to provide information necessary to verify any statement given on this application, to update information promptly and to cooperate fully with all officials of the State of Wyoming in investigations and prosecution of actions based upon this application or the information it contains. A copy of this authorization is as valid as the original.

I certify that the information given on this form is true and correct. I realize if I give information that is not true OR if I withhold information, I can be lawfully punished for fraud or perjury. I have also read and understand the Rights and Responsibilities listed at the beginning of this application. I declare the identity of minors named on this form to be true and correct.

Signature of Applicant or  
Authorized Representative: \_\_\_\_\_ Date \_\_\_\_\_

Signature of Eligibility Worker: \_\_\_\_\_ Date \_\_\_\_\_

Please feel free to use the back of this page for additional information or comments.

