ARIZONA DEPARTMENT OF
ECONOMIC SECURITY
Family Assistance Administration (DES/FAA)

Arizona Health Care Cost Containment System (AHCCCS)

Name _____

Date of Birth _____

HEAplus Application ID: _____

Date of Application _____

TEAR OFF AND KEEP PAGES F AND G FOR YOUR RECORDS.
This document is to only be used to meet the signature requirement of the above identified HEAplus application ID when the application could not be signed electronically.

Sign the Application

The application is not valid until it is signed. All unrelated adults without a child in common must sign the application.

Otherwise, the application must be signed by one of the following:

- The applicant or the applicant's designee (we must have documentation showing this person is authorized to act on the applicant's behalf); or
- The applicant's spouse, if married and living within the same household; or
- The parent/legal guardian of a minor child.

Penalty Warning

The information provided on this form may be verified by federal, state, and local officials. If any information is inaccurate, you may be denied benefits.

- You must not knowingly withhold or give false information with the intent to receive or to continue receiving DES and/or AHCCCS benefits to which you are not entitled.
- You will be required to pay back to DES and/or AHCCCS any benefits you receive as a result of withholding or giving false information and you will be subject to criminal prosecution.
- It is fraud for any person to knowingly withhold information with the intent to receive or continue to receive benefits to which he/she is not eligible.

Any person found guilty of fraud may be subject to fines, criminal prosecution, imprisonment or other penalties as provided for by applicable State and Federal laws.

Release of Information

I authorize DES and/or AHCCCS to investigate and contact any sources necessary to establish eligibility and the accuracy of financial information that pertains to eligibility.

Assignment of Rights to Other Benefits for Medical Care

I understand that if I am or members of my household are approved for DES and/or AHCCCS benefits, DES and/or AHCCCS can collect payment from any other parties who may be responsible for paying for my/our health costs. This includes:

- Private or employer-sponsored health insurance (not including Medicare)
- Persons, such as an absent spouse or parent, who are legally responsible for providing medical support
- Private or employer-sponsored disability insurance

- Private or employer-sponsored accident insurance
- Insurance claims, jury awards, or legal settlements resulting from injuries

I understand that DES and/or AHCCCS cannot collect more than the costs paid by DES and/or AHCCCS. I also understand that I must give information about other responsible parties and take any action needed to receive medical support. This includes establishing paternity of my children, unless I can prove good cause not to do so.

I understand that DES and/or AHCCCS and/or their contractors will release information to DES/Division of Child Support Services (DCSS), for a parent of a child who does not live in the home and the child has AHCCCS or private health insurance. DCSS may use this information to get a medical support order.

Assignment of Rights to Other Benefits for Cash Assistance

State and federal law (A.R.S. 46-407) provide that the legal rights to child support and spousal maintenance must be assigned to the State of

Arizona for all persons receiving Cash Assistance. I understand:

- While receiving Cash Assistance, the State has the right to keep child support or spousal maintenance collections, including support or spousal maintenance that was owed while Cash Assistance was paid.
- When Cash Assistance stops, current support payments will be paid to me. The state may continue to collect any assigned back payments for support (assigned arrears) owed before and during the time I received Cash Assistance.
- Child support payments will be used to pay back the state for Cash Assistance paid to me or anyone on my application.
- The State will not keep more from my collected current support or assigned arrears than the total amount of Cash Assistance I received.
- Also the State will not keep any arrears that are more than the total amount of Cash Assistance I received.

Statement of Truth

By signing this application:

- I agree I have read and understand the rules

and penalties on Page G and my rights and responsibilities on Page F (see attached). I have also provided Social Security Numbers for each applicant that has a Social Security Number.

- I agree I have read and understand the assignment or rights to other benefits for Medical Care above.
- I agree I have read and understand the assignment of support rights for Cash Assistance above.
- I agree that certain Nutrition Assistance and/or Cash Assistance household members will cooperate with the work programs, which includes looking for work and accepting training and/or a job. If anyone does not, or will not, look for work, attend training, or accept a job, my benefits may be reduced or stopped.
- I agree to cooperate with Arizona or Federal personnel in the completion of a quality control review on my eligibility for benefits.
- In the event DES or its agents engage in child support enforcement activities involving me, I understand the Assistant Attorneys General and Deputy County Attorneys handling the cases represent DES, and not me or my children.

- If my child support case goes to court, I understand certain personal information contained in this application or my DES records may be released to the court and other parties to the case and becomes a public record document.
- I also hereby agree to accept service of process by first class mail with regard to any paternity or child support proceeding initiated by DES and its agents.
- I understand that my records will be kept confidential and will only be released for purposes authorized by federal and state law.

I swear under penalty of perjury that the statements and documents provided about me and persons in my home, that relates to my eligibility for benefits, is true and correct to the best of my knowledge, and that I have not withheld any information. I swear under penalty of perjury that any photocopied information I have provided are the same as the original documents.

Signature of Applicant:

_____ Date _____

Signature of Spouse:

_____ Date _____

Signature of Other Adult in Household:

_____ Date _____

Signature of Authorized Representative:

_____ Date _____

Signature of Witness (if signed with mark):

_____ Date _____

Authorized Representative

This section is OPTIONAL. You may authorize someone else to represent you in the application process. DES and/or AHCCCS cannot release any information about your eligibility without your written consent.

Representative's Name:

_____

Is representative your legal guardian?
☐ Yes ☐ No

Representative's Mailing Address:

_____

City _____

State _____ ZIP Code _____

Representative's Phone Number:

_____

This number is: ☐ Home ☐ Cell ☐ Work
☐ Message ☐ Other: _____

Representative's Other Phone Number:

_____

This number is: ☐ Home ☐ Cell ☐ Work
☐ Message ☐ Other: _____

What is the representative's preferred SPOKEN language?

☐ English ☐ Spanish ☐ Other: _____

What is the representative's preferred WRITTEN language?

☐ English ☐ Spanish ☐ Other: _____

My representative would like to get information about this application by:

Email: ☐ Yes ☐ No

Email address: _____

Text: ☐ Yes ☐ No

Number to text (standard text rates apply):

_____

If 'Yes' is not marked for Email or Text, all information for this application will be sent via U.S. Mail to the mailing address provided.

By signing below I, the customer, give permission for the person listed above as my representative to act on my behalf in the process of qualifying me for AHCCCS Medical Assistance, help with Medicare costs, Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control. I, therefore:

- Give permission for my representative to complete and sign my application.
- Give permission for my representative to provide

any documents requested, including personal information.

- Give permission to my representative to sign on my behalf to permit other people, businesses, or agencies to give personal information about me to DES and/or AHCCCS, including protected health information needed to determine if I am disabled.
- Agree to give information about my personal circumstances to my representative.
- Agree to allow my representative to assign all my rights to medical reimbursement claims to AHCCCS on my behalf.

By signing below I, the representative, agree to act on the customer's behalf. I also agree to:

- Provide only truthful and complete information under penalty of perjury.
- Fill in and sign needed forms.
- Obtain and give to DES and/or AHCCCS all information needed to determine if the customer can qualify for help with healthcare costs, help with Medicare costs, Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control, such as the customer's Social Security number, income, assets, citizenship, residency, medical insurance,

and information about the customer's spouse, minor children, and parents (if the customer is a minor child).

- Tell DES and/or AHCCCS right away if the customer:
- Has an increase or decrease in income;
- Has an increase or decrease in assets;
- Changes ownership of assets, including opening or closing financial accounts;
- Has a change in address; or
- Has a change in health insurance or the amount of premiums paid.

If I am determined eligible, this authorization will stay in effect until I or my representative tells you to stop it. This authorization will expire when my application for assistance is withdrawn or denied, or when my eligibility ends. However, this authorization will continue during any time while I am contesting my eligibility in an administrative hearing or court proceeding.

Signature of Applicant*:*

_____ Date _____

Signature of Representative*:*

_____ Date _____

Voter Registration

Tell us if any person over the age of 18 listed on this application would like to register to vote. If 'Yes,' we will mail a voter registration form.

You may also access a voter registration form at www.azsos.gov/election/voterinformation.htm. If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. Your answer to this question will not impact the programs you are eligible for.

Would any person on this application over the age of 18 like to register to vote?

☐ Yes ☐ No ☐ Already registered to vote

If YES is not checked, all persons over the age of 18 on this application will be considered to have decided not to register to vote at this time.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to vote, or your right to choose your own

political party or other political preference, you may file a complaint with:

State Election Director
Secretary of State's Office
1700 West Washington
Phoenix, AZ 85007
602-542-8683

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What is expected of me?

For all programs:

- You must provide DES and/or AHCCCS with the needed information to correctly determine your eligibility and authorize DES and/or AHCCCS to investigate and contact any sources necessary to confirm the accuracy of the information for your eligibility.
- If you are approved for benefits, you will get a letter telling you what changes you must report. You MUST report your changes timely.

Program-specific expectations:

If applying for help with AHCCCS Medical Assistance, help with Medicare costs, and/or Cash Assistance, you must take necessary steps to obtain any annuities, pensions, retirement and disability benefits to which you may be entitled, including, but not limited to, Social Security benefits, Railroad retirement, Veterans benefits and unemployment compensation.

For AHCCCS Medical Assistance and/or Cash

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Assistance, you must give us any information you have about an absent parent. If you have reason for not providing this information (such as adoption pending, abuse, incest, neglect, etc.) you may claim good cause. You must cooperate with the Division of Child Support Services (DCSS) to establish paternity, unless you can prove good cause.

What is expected of me?

You have the RIGHT to:

- Courteous and professional treatment.
- Be treated fairly and equally regardless of race, color, religion, national origin, sex, age, disability, or political beliefs.
- Apply for benefits and be given a letter that tells you if you are eligible or not, and/or get a letter before your benefits are reduced or stopped.
- Review DES and AHCCCS policy manuals that show the rules and regulations of AHCCCS Medical Assistance, Medicare Savings Program, Nutrition Assistance, Cash Assistance, and Tuberculosis Control if you want to know the

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reason for our decision.

- Talk about your case with a worker or supervisor.
- Have all information you give regarding your eligibility kept private according to state and federal law.
- Ask for a fair hearing if you disagree with your application being denied, your benefits ended, or are being reduced, or if a decision is not made on your application within the allowable number of days and the delay is due to DES or AHCCCS.
- Look at your file before a fair hearing.
- Bring an attorney or any other person to a fair hearing.

To file a discrimination complaint, contact:

USDA, Director
Office of Civil Rights
Room 326-W, Whitten Building
1400 Independence Avenue, S.W.
Washington, D.C. 20250-9410

1-202-720-5964 (voice and TDD)

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Attention: Regional Manager
U.S. Department of Health and Human Services
Office for Civil Rights/Region IX
50 United Nations Plaza, Room 322
San Francisco, CA 94102

1-800-368-1019 (voice)
1-415-437-8311 (TDD)

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The USDA is an equal opportunity provider and employer • DES/TANF Agencies are Equal Opportunity Employers/Programs • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. To request this document in alternative format or for further information about this policy, contact your local office; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request. Disponible en español en línea o en la oficina local.

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What are the Rules and Penalties?

If you, your representative, or any household member hides information or gives false information on purpose to get or continue to get Nutrition Assistance and/or Cash Assistance benefits that you are not entitled to, that person will be subject to:

- Criminal Prosecution
- Fines
- Imprisonment
- Other penalties provided for by state and federal laws

If you get Nutrition Assistance and/or Cash Assistance, you must follow the rules below:

- Do not make false statements or hide information. If you are not truthful, you may have to pay back DES for benefits you receive and you may be taken to court.
- Do not do anything dishonest to get benefits that you are not supposed to get.
- Do not buy, sell, trade, exchange or otherwise

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transfer your or someone else's Nutrition Assistance benefits or EBT card.

- Do not buy containers with deposits for the purpose of discarding the product and returning the containers to get cash refund deposits.
- Do not sell products bought with Nutrition Assistance benefits to exchange them for cash or items other than eligible food.
- Do not buy products originally bought with Nutrition Assistance benefits to exchange those products for cash or items other than eligible food.
- Do not steal Nutrition Assistance or Cash Assistance benefits.
- Do not use your Nutrition Assistance benefits to buy non-food items such as alcohol and tobacco.
- Do not alter an EBT card.
- Do not use someone else's EBT card unless you are an authorized user approved by DES.

If you knowingly break the rules and get Nutrition Assistance and/or Cash Assistance benefits, we will disqualify you from getting benefits for:

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- 12 months for the first violation
- 24 months for the second violation
- Permanently for the third violation

You or a household member will not be eligible to get Nutrition Assistance and/or Cash Assistance benefits if you or the household member:

- Is a fleeing felon or probation/parole violator.
- Has been convicted of using or getting Nutrition Assistance benefits in a transaction involving the sale of firearms, ammunition or explosives. This person can never get Nutrition Assistance benefits again.
- Has been found guilty of using or getting Nutrition Assistance benefits in a transaction involving the sale of a controlled substance. This person is not eligible to get Nutrition Assistance benefits for 2 years for the first violation and permanently for the second violation.
- Has committed and was convicted of a federal or state felony on or after August 23, 1996 for the possession, use or distribution of a controlled substance.

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- Has been found by a court of law to have given false identification or residence information in order to get benefits in more than one case. This person is not eligible to get benefits for 10 years.
- Refuses to sign and comply with the Personal Responsibility Agreement (PRA). We give you the PRA during the interview process.
- Is an adult recipient (18 years or older) of Cash Assistance when any of the following apply:
  - The recipient does not return the completed Illegal Drug Use Statement. We send the Illegal Drug Use Statement by U.S. Mail after Cash Assistance has been approved.
  - The recipient fails to take a required drug test.
  - The recipient fails the drug test.

You must pay DES back for any Nutrition Assistance and/or Cash Assistance benefits you received for which your household was not eligible. You can make a repayment agreement. If you do not keep your repayment agreement, we may reduce your Nutrition Assistance and/or Cash Assistance benefits, take your income tax refunds,

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or take other legal action, including taking the amounts from your earnings.

The following additional penalties apply to the Nutrition Assistance Program:

- An additional disqualification, of up to 18 months, may be ordered by a court.
- Any participant or household member who makes false statements or hides information can be fined up to $250,000.00, imprisoned for up to 20 years, or both.
- You and/or your household members may be subject to further prosecution under federal laws.