

**ARIZONA DEPARTMENT  
OF ECONOMIC SECURITY  
Family Assistance  
Administration (DES/FAA)  
Arizona Health Care Cost  
Containment System  
(AHCCCS)**

**APPLICATION SIGNATURE  
PAGES**

**DECLARATIONS FOR  
MEDICAL ASSISTANCE,  
NUTRITION ASSISTANCE  
AND CASH ASSISTANCE**

**See pages 57-59 for USDA/EOE/ADA disclosures**

**Please read the following before you sign your application:**

- **What is expected of me?**
- **What are my rights?**
- **What are the rules and penalties?**
- **Assignment of Rights to Other Benefits**

**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 and give us proof of the changes.**

# **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 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.**

- **For Nutrition Assistance and /or Cash Assistance you must tell us and provide proof to receive deductions for the following expenses: court ordered medical child support paid, child/adult dependent**

**care expenses,  
medical expenses,  
transportation costs to  
and from the provider  
of medical care or daily  
care of a child/adult  
dependent, rent or  
mortgage payments,  
utility or other shelter  
costs.**

**What are my rights?**

**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 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 an appeal 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 an appeal**
- **Bring an attorney or any other person to an appeal.**

- **File for Nutrition Assistance benefits separately or at the same time you apply for other programs listed on the application. All Nutrition Assistance applications, regardless of whether they are joint applications or separate applications, must be processed for Nutrition Assistance purposes in accordance with procedural, timeliness, notice and**

**an appeal requirements. No household shall have its Nutrition Assistance benefits denied solely on the basis that another program applied for has been denied. A separate determination for Nutrition Assistance must be completed. When another program that is applied for is denied, a new application for Nutrition Assistance shall not be**

**required. Eligibility shall be determined based on Nutrition Assistance processing time frames from the date the joint application was initially accepted by the State agency.**

**To file a discrimination complaint, contact:**

**U.S. Department of Health  
and Human Services  
Director, Office for Civil  
Rights**

**Room 515-F**

**200 Independence  
Avenue, S.W. Washington,  
DC 20201**

**1-202-619-0403 (Voice)**

**1-800-537-7697 (TTY)**

---

**Form: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html)**

**U.S. Department of  
Agriculture Director,  
Office of Adjudication  
1400 Independence  
Avenue, SW Washington,  
DC 20250-9410**

**Fax: 1-202-690-7442**

**E-mail: [program.intake@usda.gov](mailto:program.intake@usda.gov)**

**For help filling out the form, you may call:**

**1-866-632-9992 (Toll-free Customer Service)**

**1-800-877-8339 (Local or Federal Relay)**

**1-866-377-8642 (Relay Voice Users)**

**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 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:**

- **For Cash Assistance, it is mandatory for you to cooperate with a fraud investigation. Failure to cooperate may result in case closure and the termination of benefits within ten (10) days from the agency's notice of termination.**
- **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 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.**

**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 or found guilty in a court of law 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.**

- **Cash Assistance benefits will be sanctioned 50% for the first occurrence and 100% for the second occurrence if any adult has voluntarily quit a job without good cause or has sold, possessed or used a controlled**

**substance in violation of ARS Title 13. See End for the Cash Assistance Drug Conviction Sanction.**

- **Knowingly breaks the rules to get Cash Assistance benefits. We will disqualify you from getting Cash Assistance benefits for 6 months for the first offense, 12 months for the second offense and permanently for all other offenses.**



- **Knowingly breaks the rules to get Nutrition Assistance benefits. We will disqualify you from getting Nutrition Assistance benefits for 12 months for the first offense, 24 months for the second offense and permanently for the third offense. In addition, you can be fined up to \$250,000, imprisoned up to 20 years or both. You and/or your**

**household members may be subject to further prosecution under Federal laws and an additional disqualification, of up to 18 months, may be ordered by a court.**

- **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. See Nutrition**

## **Assistance Drug Conviction Exception below.**

- **Has been found by a court of law to give 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.**
- **If a court of law finds you guilty of having trafficked benefits for an aggregate amount**

**of \$500 or more, you will be permanently ineligible to participate in the Program upon the first occasion of such violation.**

- **State agencies must use the Systematic Alien Verification and Eligibility (SAVE) system. The alien status of persons requesting benefits may be subject to verification by USCIS through the submission of information from the**

**application to USCIS, and that the submitted information received from USCIS may affect the household's eligibility and level of benefits.**

- **For Cash Assistance, if you refuse 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.**

- **Nutrition Assistance  
Drug Conviction  
Exception:**

**A person who is convicted of a felony offense which has as an element of “the use or possession of a controlled substance,” may be eligible for Nutrition Assistance if the person agrees to random drug testing and meets at least one of the following:**

- **Is currently accepted for treatment in a substance abuse**

**treatment program but is on a waiting list. The person remains enrolled in the treatment program and enters the treatment program at the first available opportunity.**

- **Is currently accepted for treatment and is participating in a substance abuse treatment program.**
- **Has successfully completed a substance**



**abuse treatment program after the offense in question.**

- **Is determined by a licensed medical provider to not need substance abuse treatment.**
- **If on probation for a felony drug conviction, is in compliance with the terms of probation.**

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

# **End for the Cash Assistance Drug Conviction Sanction**

**The person who is convicted August 9, 2017 or later, can end the sanction when they agree to random drug testing and meet at least one of the following criteria:**

- Successfully completes, or is accepted into, a substance abuse treatment program. The person also meets this**

**criteria if they are either of the following:**

- **Currently accepted for treatment in a substance abuse treatment program but is on a waiting list. The person remains enrolled in the treatment program and enters the treatment program at the first available opportunity.**
- **Currently accepted for treatment, and**

**is participating in a substance abuse treatment program.**

- **Is determined by licensed medical provider to not need substance abuse treatment.**
- **If applicable, is in compliance with all terms of probation related to the conviction they were sanctioned for.**

**The person convicted of the felony drug conviction will be permanently disqualified. The remaining budgetary unit member's benefits may be restored the following month after the sanction is ended.**

**End for Cash Assistance  
Voluntary Quit Sanction  
Customer's benefits  
will be returned to the  
previous benefit level  
for the following month  
after the minimum one**

**month sanction has been imposed.**

## **PENALTY WARNING**

**The information provided 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.**

**Assignment of Rights to Other Benefits:**

**For AHCCCS Medical Assistance:**

**I understand that if I am or members of my**

**household are approved for Medical Assistance, 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 AHCCCS cannot collect more than the costs paid by 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 who does not live in the home and whose child has AHCCCS or private health insurance. DCSS may use this information to get a medical support order.**

**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.**

**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.**

## **Statement of Truth**

**By signing this application:**

- I agree I have read and understand the rules and penalties. I have read and understand my rights and what is expected of me, and provided Social Security numbers for each applicant who has a Social Security number.**

- **I agree I have read and understand the assignment of 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 understand that I may be required to pay a premium if enrolled in the KidsCare or Freedom to Work program.**

**I swear under penalty of perjury that the statements and documents provided about myself and persons in my home, that relates to my eligibility for benefits, including any information**

**regarding citizenship and/or alien status, 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**

**Important! Only the applicant or the applicant's authorized representative can sign**

**this application.**

**Applicant 1**

---

**Date** \_\_\_\_\_

**Applicant 2**

---

**Date** \_\_\_\_\_

**Witness (if applicable  
signed with a mark)**

---

**Date** \_\_\_\_\_

---

**Customer Name**

---



# **Health-e-Arizona PLUS Application ID**

---

**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.**