FAA-1821A FORLP (10/24)

Arizona Department of Economic Security
Family Assistance Administration

Elderly Simplified Application Project (ESAP) Nutrition Assistance Application

You may use this application to apply when you and anyone you are applying for are:

- **60 years old or older and**
- **Receive no income from work or self-employment**

If your household meets the criteria above, you qualify for ESAP. The following are the benefits of the program:

- **A shorter and simplified application, verification, and renewal process**

See pages 28-30 for USDA/EOE/ADA disclosures

- **A longer approval period (36 months)**
- **No contact is required half-way through the approval period**
- **A renewal interview may not be needed**

For questions, please contact the ESAP Unit at 1 (855) 234-4960.

Submitting An Application

Submit your application by any of the following ways:

Mail:

Arizona Department of Economic Security Family Assistance Administration
ESAP Unit
P.O. Box 19009
Phoenix, Arizona 85005-9009

Fax:

(602) 257-7035 ATTN: ESAP

Phone:

For assistance in completing the application, call the ESAP Unit at 1 (855) 234-4960.

Authorized Representative

An Authorized Representative is a friend, relative, or other person who knows your circumstances and who can assist you in the application process. If you would like someone to be your Authorized Representative, you must complete the Nutrition Assistance authorized representative information on pages 20 through 27.

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Family Assistance Administration

Elderly Simplified Application Project (ESAP) Nutrition Assistance Application

Note: You can file an application with only your name, address, and the signature of a responsible household member or your authorized representative. Eligibility cannot be determined until you complete a full application.

Agency Use only: **Case Number:**

Application Date: _____

Customer Information

Tell us how we can contact an adult member of your household. If the post office does not deliver mail to where you live, please give us a mailing

address. If you do not have a mailing address to give us, please contact us for help.

Legal Name (First, Middle, Last):

_____

Home Address (include suite number/apartment number):

_____

City: _____

State: _____ **ZIP Code:** _____

Mailing Address (if different):

_____

City: _____

State: _____ **ZIP Code:** _____

Do you live in a shelter? ☐ **Yes** ☐ **No** **If Yes, what kind of shelter?**

_____

Phone Number (Home, Work, Cell, Message):

_____

What is the preferred language you and your household speak?

☐ **English** ☐ **Spanish** ☐ **Other**

What is the preferred language you and your household read?

☐ **English** ☐ **Spanish** ☐ **Other**

I 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.

SIGN THE APPLICATION:

I affirm under penalty of perjury that I will answer the questions on this application about myself and persons on this application applying for benefits truthfully to the best of my knowledge. This includes any information regarding citizenship or alien status. I have not and will not withhold any information. I affirm under penalty of perjury that any photocopied information I provide is the same as the original documents and any documents I provide are true and correct to the best of my knowledge. I also affirm under penalty of perjury that the statements I provide regarding felony convictions and compliance with probation/parole are true and correct. I understand my rights and responsibilities for each program.

Signature of Applicant or Authorized Representative: _____

Date: _____

Signature of Spouse (CA and NA ONLY): _____

Date: _____

Signature of Other Adult in Household: _____

Date: _____

Signature of Witness (if signed with mark): _____

Date: _____

1) Expedited Services:

Your household will be screened for Expedited Nutrition Assistance (NA) benefits and, if eligible, your household will receive NA benefits within seven (7) days from the date of application.

To determine if your household is eligible for Expedited NA benefits, please answer the questions below (A-D):

A) How much is your household's total cash on hand and in a bank account?

$ _____

B) How much money will your household get this month?

$ _____

C) How much is your household's shelter expense?

(Mortgage, rent, lot space rent, list property taxes and property insurance when you pay them separately, homeowner's association fees)

Type of Expense	Who Pays this Expense?	Amount Paid	How Often

D) How much is your household's utility expense?
(Electricity, gas, propane, wood, water, trash, sewer, telephone, etc.)

Type of Expense	Who Pays this Expense?	Amount Paid	How Often

E) How do you heat (central heating, stove, fireplace) or cool (air conditioning, evaporative cooler) your home?

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2) Are you or anyone in your household working?

- ☐ **Yes, STOP, you cannot use this application. See the cover page of this application.**
- ☐ **No, provide the month and year you last received income from working or self-employment.** _____

When applying for Nutrition Assistance (NA) persons in your household may choose not to get NA benefits. These persons are not required to provide a Social Security number or citizenship and immigration information. However, for NA, some persons in the household might be required to be included.

Social Security numbers are verified through computer matching programs and may be shared with federal and state agencies or with private claims/collection agencies. For NA, requesting your Social Security number is authorized under the Food and Nutrition Act of 2008.

Race/Ethnicity: Select one or more answers for each person applying for benefits. This information is used to ensure that program benefits are distributed without regard to race, color, or national origin. This information is optional and does not affect eligibility or benefit level.

3) Tell us about your household: List every person you are applying for. You need to include your spouse, when living with you. Attach a separate sheet if you need more room.

Last Name, First Name, M. I.	Social Security Number	Date of Birth	Gender
Ethnicity Hispanic/Latino	**Race**	**U.S. Citizen**	**Relationship to You**
☐ Yes ☐ No		☐ Yes ☐ No	
Last Name, First Name, M. I.	**Social Security Number**	**Date of Birth**	**Gender**
Ethnicity Hispanic/Latino	**Race**	**U.S. Citizen**	**Relationship to You**
☐ Yes ☐ No		☐ Yes ☐ No	

Last Name, First Name, M. I.	Social Security Number	Date of Birth	Gender
Ethnicity Hispanic/Latino	**Race**	**U.S. Citizen**	**Relationship to You**
☐ Yes ☐ No		☐ Yes ☐ No	

4) If you or anyone you are applying for is not a U.S. Citizen, do you want to provide their immigration status?

☐ **Yes** ☐ **No** **If Yes, who:**

_____

Immigration status:

_____

Type of document:

☐ **Yes** ☐ **No** **If Yes, who:**

Immigration status:

Type of document:

☐ **Yes** ☐ **No** **If Yes, who:**

Immigration status:

Type of document:

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5) List everyone living in your house that you do

not buy and cook your meals with. Attach a separate sheet if you need more room.

Last Name, First Name, M. I.	Date of Birth	Relationship to You

6) Has anyone received lottery or gambling winnings of $4500 or more in a single game this month?

☐ **Yes** ☐ **No** **If Yes, who:**

_____

When: _____

Gross amount: $ _____

How much is left? $ _____

7) Are you or anyone you are applying for:

A) Receiving or expecting to receive Nutrition Assistance from another state this month?

☐ **Yes** ☐ **No** **If Yes, who:**

_____

State: _____

B) Currently living in an assisted living facility or a group home?

☐ **Yes** ☐ **No** **If Yes, who:**

_____

Name of the Facility:

C) Receiving Tribal Food Distribution?
☐ **Yes** ☐ **No** **If Yes, who:**

D) Been convicted of a felony offense for possession, use, or distribution of a controlled substance on or after August 23, 1996?
☐ **Yes** ☐ **No** **If Yes, who:**

E) Running from the law on felony charges or in violation of probation or parole?
☐ **Yes** ☐ **No** **If Yes, who:**

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8) Do you or anyone you are applying for receive

money from any source? ☐ Yes ☐ No
If Yes, list each type below.

Example: Social Security income, Veteran's Administration income, Child Support, monetary gifts, contributions from others, Unemployment, Railroad Retirement, Dividends, Interest, and any other income.

Type of Income	Who Receives It?	Monthly Amount Before Deductions

9) Are you or anyone you are applying for paying any of the expenses listed below? You must provide proof to be given the deduction.

A) Out-of-pocket medical expenses that when added together are more than $35.00 per month. Example: prescriptions, doctor visits, hospital bills, health insurance, Medicare premiums, transportation, etc.

☐ Yes ☐ No If Yes, list each type below.

Type of Medical Expense	Who Pays this Expense?	Amount Paid	How Often

B) Legally obligated Child Support for someone not living in your house. Example: A copy of a court order and proof of payment or a statement from a Child Support Agency.

☐ Yes ☐ No If Yes, who:

_____

Amount paid per month $:

_____

C) Care of an incapacitated adult? Example: A letter or a statement from your care provider or care facility.

☐ Yes ☐ No If Yes, who:

_____

Amount paid per month $:

_____

Authorized Representative

This section is OPTIONAL. You may authorize someone else to represent you in the application process. DES cannot release any information about your eligibility, unless you give us written permission.

Representative's Name

Is representative your legal guardian?

☐ **Yes** ☐ **No**

Is the representative acting on behalf of an organization?

☐ **Yes** ☐ **No**

Name of Organization:

Representative's Mailing Address

City: _____

State: _____ **ZIP Code:** _____

Representative's Phone Number:

_____

This number is:

☐ **Home** ☐ **Cell** ☐ **Work** ☐ **Message**

☐ **Other:** _____

What is the representative's preferred language to speak?

☐ **English** ☐ **Spanish**

☐ **Other:** _____

What is the representative's preferred language to read?

☐ **English** ☐ **Spanish**

☐ **Other:** _____

This section must also be completed when requesting a Nutrition Assistance (NA) Authorized Representative:

I understand that if my NA Authorized Representative is

currently disqualified from NA for an intentional program violation (IPV), they cannot act as an NA Authorized Representative. (when this happens, check one of the following boxes):

☐ **I will select another person to serve as my NA Authorized Representative.**

☐ **This is the only person that is available to be my NA Authorized Representative.**

Signature of Applicant:

_____

Date: _____

I understand that if I am disqualified from NA for an intentional program violation (IPV), I cannot act as an NA Authorized Representative unless there is no one else available to represent this person.

Please provide your date of birth

_____ and check one of the following boxes: *(this is the NA Authorized Representative's date of birth)*

☐ **I am currently serving a disqualification for a Nutrition Assistance IPV.**

☐ **I am not currently serving a disqualification for a Nutrition Assistance IPV.**

Signature of Representative:

_____

Date: _____

When a legal guardian has been appointed for the only adult applicant in the household, the applicant's signature is not required for the legal guardian to be appointed as the authorized representative. Only the authorized representative's signature is needed.

Authorized Representative Authorization

Applicant:

By signing below, I (the customer) give permission for the person listed on the previous page to act on my behalf as my representative. That person is allowed to help me in the process of qualifying for Nutrition Assistance. I do give permission and agree that my representative may do all the following on my behalf:

- **Complete and sign my application.**
- **Provide any documents requested, including personal information.**
- **Sign on my behalf to permit other people, businesses, or agencies to give personal information about me to DES, including protected health information needed to determine if I am disabled.**

I also agree to give information about my personal circumstances to my

representative. And agree to allow my representative to assign all my rights to child support and spousal maintenance on my behalf.

Authorized Representative:

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 all information needed to determine if the customer can qualify for help with Nutrition Assistance, such as the customer's Social Security number, income, assets, citizenship, residency, and information about the customer's spouse).**
- **Tell DES right away if the customer has an/a:**

- **Increase or decrease in income;**
- **Increase or decrease in assets;**
- **Change in ownership of assets, including opening or closing financial accounts;**
- **Change in address; or**
- **Change in the amount of premiums paid.**

- **Maintain confidentiality of any information regarding the applicant or beneficiary provided by the agency.**

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: _____

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.

Do Not Send Applications Here

USDA Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter

must be submitted to:

1. **mail:**
   Food and Nutrition Service, USDA
   1320 Braddock Place, Room 334
   Alexandria, VA 22314; or
2. **fax:**
   (833) 256-1665 or
   (202) 690-7442; or
3. **email:**
   FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.

Do Not Send Applications Here

To request this document in alternative format or for further information about this policy, contact your local office; TTY/TDD Services: 7-1-1. • Disponible en español en línea o en la oficina local.