FAA-1821A FORXLP (5-22)

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:

See pages 31-37 for USDA/EOE/ADA disclosures

- **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**
- **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:

FAA-1821A FORXLP (5-22)

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 has concern for your well-being. This person can assist you in the application process. If you would like someone to be your Authorized Representative, you must complete the *Nutrition Assistance Authorized*

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Representative Request (FAA-1826A) form at the end of the application.

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 about you:

Your Name *(Last, First, Middle)*:

Date of Birth:

Social Security Number:

Home Address:

City:

State:

ZIP Code:

Mailing Address *(if different)*:

City:

State:

ZIP Code: _____

Telephone or Message Number:

What language do you want us to use when we speak to you?

What language do you read?

Does this person have a visual impairment that requires an alternative format for printed letters?

☐ Yes ☐ No

☐ **Larger print letters sent by U.S. Mail will be provided in 24 point font.**

☐ **Readable PDF sent by secure email. Email address:**

☐ **Other: the alternative format is not listed.**

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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

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

2) Are you or anyone in your household working?

☐ **Yes, please see the cover page of this application for further instructions.**

☐ **No, provide the month and year you last received income from working or self-employment.**

_____

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

Last Name, First Name, M. I.	Social Security Number	Date of Birth	Gender

Race	Ethnicity	U.S. Citizen	Relationship to You
		☐ Yes ☐ No	
		☐ 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

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

6) Has anyone received lottery or gambling winnings of $3750 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:

_____

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

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 $:

<u>SIGN THE APPLICATION:</u>
(This application is not valid without a signature)

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 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. I also swear under penalty of perjury that the statements regarding felony convictions and compliance with probation/parole are true and correct. I agree to cooperate with Arizona or Federal personnel in the completion of a Quality Control review of my eligibility for benefits.

By signing below, I give the person listed above to act on my behalf as my representative.

Signature of Applicant:

_____

Date: _____

Signature of Witness *(if signed with mark)*:

_____

Date: _____

NOTICE OF NON-DISCRIMINATION

The Department of Economic Security (DES) comply with applicable Federal civil rights laws and do not discriminate on the basis of race,

color, national origin, age, disability, or sex. DES do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. DES provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, and

other formats). DES provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Health-e-Arizona Plus Customer Support Center at 1-855-432-7587 (TTY: 711).

Also, under the Food Stamp Act and United States Department of Agriculture (USDA)

policy, DES is prohibited from discriminating on the basis of religion or political beliefs.

If you believe that DES failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance. You can file a grievance in person or by mail, fax, or email. Your grievance must be in writing and must be submitted within

180 days of the date that the person filing the grievance becomes aware of what is believed to be discrimination.

Submit your DES discrimination complaint/ grievance to: Arizona Department of Economic Security, Director's Office, 010A, P. O. Box 6123 Phoenix, Arizona 85005-6123.

DHHS: Write DHHS, 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 (TDD).

USDA: You may complete the USDA Program Discrimination Complaint Form, found online at https://www.usda.gov/oascr/program-discrimination-complaint-filing, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the

information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Center for Civil Rights Enforcement, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. You may also call 202-720-5964 (voice and TDD).

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Family Assistance Administration

NUTRITION ASSISTANCE (NA) AUTHORIZED REPRESENTATIVE REQUEST

Case Name

Case Number

See pages 17-19 for USDA/EOE/ADA disclosures

You may choose an Authorized Representative, an adult non-household member, to help you with the requirements of applying for or getting benefits. An Authorized Representative is a friend, relative or other person who has a concern for your well-being. An Authorized Representative is a person you choose. We will not choose one for you. The person you choose

must agree to help you. An agency cannot act as an authorized representative, but an individual at the agency can act as your representative. This individual will be able to assist you in the following ways:

- **Complete your application, forms, and other department paperwork for you.**
- **Complete eligibility interviews in person or on the telephone**

for you.

- **Provide your proof of income, resources, and other case information.**
- **Report and verify changes in your case circumstances for you.**
- **Receive your notices and other mail from the department for you.**

AUTHORIZED REPRESENTATIVE INFORMATION

I want the person named below as my Authorized Representative:

Person's Name *(Last, First, M.I.)*

Person's Phone Number *(include area code)*

☐ **Home** ☐ **Cell**

☐ **Message** ☐ **Work**

Person's Mailing Address *(No., Street)*

City _____

State _____

ZIP Code _____

My Authorized Representative's preferred language is:

Spoken: ☐ **English** ☐ **Spanish** ☐ **Other:**

Written: ☐ **English** ☐ **Spanish** ☐ **Other:**

This person is known to me as *(Your relationship to this person)*

AUTHORIZED REPRESENTATIVE AUTHORIZATION

Please read carefully. Your signature below means you have read, understand, and accept these statements.

Applicant:

I certify that I have read and understand the information on this form.

I certify that the person I chose to be my Authorized Representative is an adult who is sufficiently aware of my family's financial and other household circumstances to give any information required by the Department of Economic Security.

I understand that if my NA Authorized Representative is currently serving an NA intentional program violation (IPV):

- ☐ **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.**

I understand that I am responsible for any incorrect information given by my representative.

I understand that I may be fined, prosecuted, or imprisoned for any program fraud committed by my representative.

I understand that the person I named as my Authorized Representative will continue to act for me

until I revoke, in writing, permission to represent me.

Authorized Representative:

I certify that I have read and understand the information on this form.

I agree to accept the duties on this form.

I understand that I must give proof of my identity to act as an Authorized Representative.

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

Please provide your date of birth _____

and check one of the following boxes:

☐ **I am currently serving a disqualification for a NA IPV.**

☐ **I am not currently serving a disqualification for NA for an IPV.**

I understand that the Department of Economic Security (DES) has the authority to discontinue my ability to act as an Authorized Representative if it is determined that I am not acting in the best interest of the

household I am assisting.

I understand that I may be held personally liable if it is found that I, as an Authorized Representative, am responsible for causing an overpayment to the household that I represent.

I understand that I will be required to update my information with the Department of Economic Security (DES) each time the household

I assist applies for a renewal of Nutrition Assistance (NA) benefits.

If I am determined eligible, this NA 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.

Applicant's Signature:

_____

Date: _____

Authorized Representative's Signature:

_____

Date: _____

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

ARIZONA DEPARTMENT OF ECONOMIC SECURITY

NATIONAL VOTER REGISTRATION ACT

VOTER PREFERENCE QUESTION

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency. If you are not registered to vote where

See page 9 for EOE/ADA disclosures

you live now, would you like to apply to register to vote here today?

☐ **Yes** ☐ **No**

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

If you mark 'yes' or neither box is checked, a voter registration form will be provided to you. If you would like help filling

out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the form in private. You may take the form with you and mail it to the County Recorder yourself or you may complete the form here and provide it to the front desk.

Whether or not you choose to register to vote, your choice is confidential. It

will be used only for voter registration purposes. This form will be kept separate from any assistance-related documents. Any voter registration forms and attachments received by the Department of Economic Security will be routed to the County Recorder's office.

NOTE: Free language assistance for DES services is available upon request.

Signature of Client:

_____

Date: _____

(or initials of staff person when client doesn't want to sign the form)

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 or in applying 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 Services Director - Office of the Secretary of State
1700 West Washington St.
Phoenix, Arizona 85007 -
(602) 542-8683 or (877) 843-8683

Official Use Only

Complete the Method of Encounter for every covered transaction.

Method of Encounter:

☐ **In person (face to face)**

☐ **Remote (telephone, online, drop-off)**

When the response to the question "Would you like to apply to register to vote here today?" above, is "Yes" or neither box is checked, please answer the two questions below:

Question 1. What was the customer's Voter Preference Question Response?

☐ **Yes**

☐ **Neither box checked**

Question 2. The Voter Registration form (DES-1232A) was provided:

☐ **In person**

☐ **By U.S. mail**

☐ **Through an online method**

Equal Opportunity Employer / Program • Auxiliary aids and services are available upon request to individuals with disabilities • TTY/TDD Services 7-1-1 • Disponible en español en línea o en la oficina local