Washington State Department of Social & Health Services

Application for Benefits

If you need help reading or completing this form, please ask us for help.
Keep this page for your records.

How do I apply for benefits?

- To **complete** your application fill out pages 3 to 6. You can **start** your application today by giving the receptionist your name, address, and signature on page 3. If you don't have an address, tell the receptionist or call your local office.
- Attach more sheets if you need more space.
- Take or mail pages 3 to 6 to your local office. Keep pages 1 and 2 for your records.
- You may get more benefits or get them sooner if you start, complete, and give us your application and any other information we ask for as soon as you can. We may also share this information with Federal and state officials.

How soon can I receive help with food and cash?

If you need food benefits right away, fill in Questions 1 through 14 on page 3 take this form to the receptionist.

We decide if you are eligible for food assistance *within 5 days* if you show proof of your identity *and* meet one of the following:

- Your household will have less than $150 gross income and less than $100 liquid resources this month.
- Your household's income and resources are less than your monthly rent and utilities.
- Your household includes a destitute migrant or seasonal farm worker.

Benefits are issued by the day after we decide you are eligible. Food benefits usually start the day we receive your application. Cash benefits usually start the day we have all the information to decide you are eligible.

Civil Rights

In accordance with Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs. To file a complaint of discrimination, contact USDA or HHS. Write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). Write HHS, 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 (TTY). USDA and HHS are equal opportunity providers and employers.

Immigration Status and Social Security Numbers

You may be able to get assistance for some people you live with even if others you live with can't get help because of immigration status. You must tell us the status of anyone who applies. We have medical programs that cover some people who can't prove they are in the country legally.

Under Federal Law (42 CFR § 435.910, 45 CFR §205.52, 7 CFR §273.6), you must give us the Social Security Number (SSN) for anyone you live with who applies for Medicaid, TANF, or food assistance. We may also need SSNs of parents and spouses who live with you but don't apply. We have medical programs for some people who don't have SSNs.

We use SSNs to check identity, verify eligibility, prevent fraud, and collect claims. We exchange information with other agencies to manage our programs and follow the law. We may also give this information to law enforcement agencies trying to catch fleeing felons.

Citizenship and Identity for Medicaid

U.S. citizens must prove citizenship and identity to receive Medicaid. We will work with you to obtain the proof. If we require a document that will cost you money, we will send for it and pay the cost. We don't need proof for anyone in your household who receives Medicare, Social Security Disability Insurance (SSDI) based on their own disability or Supplemental Security Income (SSI). Proof includes but isn't limited to:

Proof of Citizenship	Proof of Identity
• U.S. passport. • Certificate of Naturalization or Citizenship. • Tribal membership card with picture. • Official state/county U.S. birth certificate.	• State driver's license. • State identity or military ID card with picture. • U.S. American Indian/Alaska Native tribal document. • Completed Citizenship Documentation and Identity Declaration form for children under 16.

Privacy and Food Assistance

The current Food Stamp Act permits the department to collect the information we ask for on the application. We verify some of this information with computer matching programs.

We use this information to:	We may give this information to:
• Decide who is eligible for our programs. • Collect overpayments of food assistance. • Manage our programs. • Make sure we follow the law.	• Federal and state agencies for official use. • Law Enforcement agencies pursuing people who are fleeing to avoid the law. • Private collection agencies to collect food assistance overpayments.

Food Assistance Penalty Warning

We do send information about persons applying for Food Assistance to other Federal agencies to check that the information is correct. If any information is incorrect, the persons who apply may not get Food Assistance. If a person provides information that they know is incorrect, they could be criminally prosecuted. Penalties for intentionally breaking Food Assistance rules vary from disqualification from the program, to fines, or possibly imprisonment.

Repaying the State for Medical and Long Term Care

- By law, if you are age 55 or older AND receive Medicaid or long-term care services, DSHS may recover from your estate (assets you own at the time of your death) to repay DSHS for the costs of medical assistance, medical services, and long-term care. DSHS may recover the costs for state-only funded long-term care services received **at any age**. This is called ESTATE RECOVERY. Tribal lands may be exempt from recovery.
- Long-Term Care services include COPES, OBRA, Medicaid Personal Care, Nursing Home services, adult day health, private duty nursing, four DDD HCBS waivers: Basic, Basic Plus, Core, and Community Protection, and other services provided by Home and Community Services and the Division of Developmental Disabilities.
- Estate recovery doesn't occur until after your death and the death of your surviving spouse, if any. If you have dependent heirs, estate recovery may be delayed for some hardship reasons.
- If you are permanently living in a nursing home or other medical facility, DSHS may file a lien against your property to repay the costs of medical assistance, medical services, and long-term care you received. If you return home, DSHS will release the lien. DSHS won't file a lien against your home if:
    - ♦ Your spouse lives there.
    - ♦ Your child who is blind, disabled, or under 21 lives there.
    - ♦ Your sibling who has an equity interest in the home lives there and has lived there for at least one year immediately before you entered the facility.

Washington State Department of Social & Health Services

Application for Benefits

☐ **If you need help filling out this form, please check this box.**

FOR OFFICE USE ONLY
DATE RECEIVED **INITIALS**

1. FIRST NAME MIDDLE INITIAL LAST NAME	SIGNATURE (REQUIRED)	2. CLIENT ID NUMBER (IF KNOWN)
3. STREET ADDRESS WHERE YOU LIVE CITY STATE ZIP CODE		4. HOME/PREFERRED PHONE NUMBER
5. MAILING ADDRESS (IF DIFFERENT) CITY STATE ZIP CODE		6. OTHER PHONE NUMBER(S)
		7. EMAIL ADDRESS

8. I am applying for (check all that apply):
☐ Cash ☐ Food ☐ Medical ☐ Drug or Alcohol Treatment
☐ Nursing Home ☐ Assisted Living ☐ Adult Family Home ☐ In-Home Care
☐ Other (please list): _____

9. How much money do you expect your household to get this month? $_____

10. How much money does your household have in cash and bank accounts? $_____

11. How much does your household pay for rent or mortgage? $_____

12. What utilities does your household pay for? ☐ Heating/cooling ☐ Telephone ☐ Other: _____

13. Is anyone in your household a seasonal or migrant farm worker? ☐ Yes ☐ No

14. If applying for food assistance, how many people in your household do you buy and prepare food for? _____

FOR OFFICE USE ONLY – Household eligible for expedited service: ☐ Yes ☐ No Screener's Initials: _____ Date: _____

15. I need a phone interview. Please call me at: _____

16. ☐ I need an interpreter. I speak: _____ or ☐ sign; translate my letters into: _____

17. List everyone in your household even if you are not applying for them (attach additional sheets, if necessary).

NAME (FIRST, MIDDLE, LAST)	SEX M OR F	HOW IS THIS PERSON RELATED TO YOU?	DATE OF BIRTH	CHECK IF YOU WANT BENEFITS FOR THIS PERSON	CHECK IF IN SCHOOL	OPTIONAL FOR NON-APPLICANTS	
						SOCIAL SECURITY NUMBER	CHECK IF U.S. CITIZEN PLACE OF BIRTH (CITY/STATE)
		Myself		☐	☐		☐
				☐	☐		☐
				☐	☐		☐
				☐	☐		☐
				☐	☐		☐
				☐	☐		☐
				☐	☐		☐
				☐	☐		☐

18. I or someone in my household have a (check all that apply): ☐ Pregnancy; due date: _____
☐ Medical emergency ☐ Domestic violence situation ☐ Disability (list type):

19. In the past 30 days, I got cash, food, or medical assistance from another state or source: ☐ Yes ☐ No

20. I am or someone I'm applying for is fleeing from the law to avoid going to court or jail for a felony crime: ☐ Yes ☐ No

21. **OPTIONAL. For food assistance if you don't answer, the USDA requires us to answer for you.**
My ethnic background is Hispanic or Latino: ☐ Yes ☐ No

22. I consider my race to be (check all that apply): ☐ White ☐ Black or African American ☐ Asian
☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native; tribe name: _____
☐ Other (list):

I. General Information

1. Someone I'm applying for lives outside Washington State: ☐ Yes ☐ No Who: _____
2. I or someone in my household is a sponsored alien: ☐ Yes ☐ No Who: _____
3. Someone is temporarily out of my home: ☐ Yes ☐ No Who: _____
4. I or someone I'm applying for served in the military: ☐ Yes ☐ No Who: _____
5. Someone is the dependent or spouse of someone (living or deceased) who served in the military: ☐ Yes ☐ No
6. I am living in: ☐ My own house or apartment ☐ Group Home ☐ Other: _____
   ☐ Facility (list type): _____ Date entered: _____
7. I am: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

II. Medical and Health Insurance Information

I, my spouse, or someone in my household (check appropriate box):

1. Can't work because of health problems ..... ☐ Yes ☐ No
2. Had an accident requiring medical care ..... ☐ Yes ☐ No
3. Plan to enter, are in, or recently left a medical facility (such as a hospital or nursing home) ..... ☐ Yes ☐ No
4. Have unpaid medical bills ..... ☐ Yes ☐ No
5. Need help with unpaid medical bills for any of the past three months ..... ☐ Yes ☐ No
6. Have health insurance (Check all that apply): ☐ Medicare (not DSHS medical) ☐ Tricare
   ☐ Long-Term Care Insurance. ☐ Other Health Insurance: _____

III. Resources (Not needed for Children's Medical, Pregnancy Medical, HWD, or Basic Food)

A resource is anything you own or are buying that can be sold, traded, or converted into cash or money held by others. A resource does not include personal property such as furniture, or clothing. Examples of resources are:

- Cash
- Checking accounts
- Savings accounts
- CDs
- Money market account
- Savings bonds
- Bonds
- Mutual funds
- Stocks
- Annuities
- Trusts
- IRA
- 401K
- Retirement fund
- Houses, including the one you live in
- Condominium
- Land
- Sales contracts
- Building
- Life estate
- Life insurance
- Burial funds, prepaid plans
- College funds
- Time-share
- Business equipment
- Farm equipment
- Livestock

Please list the resources you, your spouse, or anyone you are applying for owns or is buying:

RESOURCE	WHO OWNS	LOCATION	VALUE	WHO OWNS	LOCATION	VALUE
			$			$
			$			$
			$			$
			$			$
			$			$
			$			$
			$			$
			$		1	$
			$			$
			$			$

2. I, my spouse, or someone I'm applying for have cars, trucks, vans, boats, RVs, trailers, or other motor vehicles:

YEAR (E.G., 1980)	MAKE (E.G., FORD)	MODEL (E.G., ESCORT)	CHECK IF LEASED	CHECK IF VEHICLE IS USED FOR MEDICAL PURPOSES	AMOUNT OWED
			☐	☐	$
			☐	☐	$

3. I, my spouse, or someone I'm applying for has sold, traded, given away, or transferred a resource in the last five years (including trusts, vehicles or life estates): ☐ Yes ☐ No If yes, what: _____ when: _____

APPLICANT'S NAME	SOCIAL SECURITY NUMBER	CLIENT IDENTIFICATION NUMBER

IV. Earned Income

1. I, my spouse, or someone I'm applying for quit a job within the past 60 days: ☐ Yes ☐ No
2. I, my spouse, or someone I'm applying for has income from work: ☐ Yes ☐ No If yes, please complete this section:

WHO MAKES THIS INCOME EMPLOYER'S NAME AND PHONE NUMBER START DATE Is this job self-employment? ☐ Yes ☐ No	GROSS AMOUNT RECEIVED (DOLLAR AMOUNT BEFORE TAXES) $_____every: ☐ Hour ☐ Week ☐ Two weeks ☐ Twice a month ☐ Month Hours per week: _____ Pay dates (e.g., 1st and 15th, or every Friday):
WHO MAKES THIS INCOME EMPLOYER'S NAME AND PHONE NUMBER START DATE Is this job self-employment? ☐ Yes ☐ No	GROSS AMOUNT RECEIVED (DOLLAR AMOUNT BEFORE TAXES) $_____every: ☐ Hour ☐ Week ☐ Two weeks ☐ Twice a month ☐ Month Hours per week: _____ Pay dates (e.g., 1st and 15th, or every Friday):

V. Other Income (Use for all household members)

	WHO GETS THE INCOME?	GROSS MONTHLY AMOUNT	WHO GETS THE INCOME?	GROSS MONTHLY AMOUNT
Unemployment benefits		$		$
Social Security		$		$
Supplemental Security income (SSI)		$		$
Child support or spousal maintenance		$		$
Retirement or pension		$		$
Veterans Administration (VA) or military benefits		$		$
Labor & Industries (L&I) or insurance benefits		$		$
Trusts		$		$
Interest		$		$
Railroad benefits		$		$
Rental income		$		$
Other:		$		$
Other:		$		$

VI. Annuities (Investments made by any household member to receive regular payments now or in the future.)

WHO OWNS THE ANNUITY?	COMPANY OR INSTITUTION?	AMOUNT OR VALUE	MONTHLY INCOME	DATE PURCHASED
		$	$	
		$	$	
		$	$	

If you, or your spouse, have an interest in an annuity and you accept Medicaid Long Term Care benefits, you must name the State of Washington as a remainder beneficiary of the annuity.

VII. Monthly Expenses

RENT	MORTGAGE	SPACE RENT	CONDOMINIUM FEES
$	$	$	$
HOMEOWNER'S INSURANCE	PROPERTY TAXES	PROPERTY ASSESSMENTS	OTHER FEES
$	$	$	$

Utilities (check all that apply): ☐ Heating (gas, electric, oil) ☐ Electricity **(not heat)** ☐ Phone ☐ Water, sewer, garbage

Another person or agency, such as subsidized housing, helps me pay either all or part of these expenses: ☐ Yes ☐ No

If yes, who: _____ What expense: _____ Amount they pay: $ _____

I, my spouse, or someone in my household pay or are supposed to pay (check all that apply):

☐ Child care or dependent care	Monthly amount: $	Who pays:
☐ Child support	Monthly amount: $	Who pays:
☐ Medical bills	Monthly amount: $	Who pays:

VIII. Authorized Representative

An Authorized Representative is someone you allow DSHS to talk with about your benefits. You can name someone, but you do not have to.

Do you have an Authorized Representative? ☐ Yes ☐ No
Is this person your legal guardian? ☐ Yes ☐ No
Does this person have Power of Attorney? ☐ Yes ☐ No

NAME	RELATIONSHIP	TELEPHONE NUMBER

STREET ADDRESS	CITY	STATE	ZIP CODE

Declaration and Signatures

If applying for cash or medical for adults, all adults in the household must sign.

If applying for food assistance or medical for children, the applicant must sign.

I understand I must:

- Give correct information.
- Report the changes listed in my approval letter.
- Provide proof I am eligible. DSHS may help me get the proof or contact other persons or agencies for it.
- Assign certain rights to child support to the State of Washington when I receive Temporary Assistance to Needy Families (TANF).
- Assign my rights to medical care support and third party payments for medical care to the State of Washington when I receive medical care benefits.
- Cooperate with food assistance work requirements

If I don't do these things, I may be denied benefits or have to pay them back.

I understand I can be criminally prosecuted if I willfully:

- Make a false statement.
- Fail to report something I should report.

I have read or had explained to me my rights and responsibilities and received a copy of the Client Rights and Responsibilities, DSHS 14-113. **I certify or declare under penalty of perjury under the laws of the State of Washington that the information I gave in this application is true and correct.**

APPLICANT'S SIGNATURE	DATE	PRINTED NAME OF APPLICANT	CITY AND STATE WHERE SIGNED
OTHER ADULT APPLICANT'S SIGNATURE	DATE	PRINTED NAME OF OTHER ADULT	CITY AND STATE WHERE SIGNED
HELPER OR REPRESENTATIVE'S SIGNATURE	DATE	PRINTED NAME OF REPRESENTATIVE	CITY AND STATE WHERE SIGNED
WITNESS' SIGNATURE IF SIGNED WITH AN "X"	DATE	PRINTED NAME OF WITNESS	