RECERTIFICATION FORM

Supplemental Nutrition Assistance Program (SNAP), Medicaid, Cash Assistance

Si Ud. necesita este formulario en español, comuníquese con su trabajador(a).
Answer all the questions on the form. You must sign and date the last page of the Recertification Application in order for it to be valid.
If you would like to receive another type of help you do not already get, please contact your caseworker and ask for a HSD100 application form.

Section 1: Address

Please write in your current address and mailing address. Is this a new address? ☐ YES ☐ NO

Home address - No. & Street/R. Rt. /Apt. No.	City	State	Zip Code	Date of change
Mailing address if Different - No. & Street/R. Rt./Apt. No.	City	State	Zip Code	Telephone Number

Section 2. Tell us About the People who live with You:

Please list everyone that lives in your household even if you do not want to apply for them. You only have to give U.S. Citizenship and Social Security Numbers for those household members that you are applying for. An SSN is optional for people not applying for medical assistance, but providing an SSN can speed up the application process. You do not need to be a U.S. Citizen to apply. Receiving SNAP/food, energy or medical assistance will not prevent you from becoming a lawful permanent resident or U.S. Citizen. Non-citizen immigrants not requesting assistance for themselves do not need to give immigration status information, Social Security Numbers, or other similar proofs; however, they must give proof of income and things they own because part of their income and things they own may count towards the household's eligibility for assistance. Certain benefits may be available for people without a Social Security Number; ask ISD. If needed, please use an additional sheet of paper for additional household members who do not fit on this page.

List the names and information for yourself and all the people who live with you:						Fill out this section only for each person applying for benefits.				
Name (First and Last)	Relationship	Sex M/F	Date of Birth	Ethnicity Hispanic Y/N (Optional)	Race (Optional) 1-5	Tribal Affiliation	SSN #	Citizenship Immigration Status 1-15 (see below)	Will you file Federal income taxes for the current year? Y/N	Will you claim this person on your current year's tax return? Y/N
1.	(Self)									
2.										
3.										
4.										
5.										
6.										
7.										
8.										

Race: For each person applying for help, choose from the numbers below that best describes their Race and **write the numbers above.**

1 - American Indian Alaskan Native
2 - Asian
3 - Black or African American
4 - Native Hawaiian or Pacific Highlander
5 - White

Citizenship/Immigration Status: For each person applying for help, choose from the numbers below that best describes their U.S Citizenship or Immigration Status and **write the numbers above.**

1 – U.S Citizen
2 – Lawful Perm Resident (LPR)
3 – Refugee
4 – Asylee
5 – Cuban Haitian Entrants
6 – Amerasians
7 – Paroled to U.S. – 1 year
8 – Withholding of Deportation/Removal
9 – Battered Woman/Children
10 – Veterans, Active Duty Military
11 – Hmong or Laotian Tribe
12 – Human Trafficking Victim
13 – Lawfully Residing Pregnant Woman
14 - Lawfully Residing Child
15 - Other

Is anyone in your household pregnant?	☐ YES ☐ NO	If YES, who? _____
Do all persons purchase and prepare meals together?	☐ YES ☐ NO	
Is any household member imprisoned (detained or jailed)?	☐ YES ☐ NO	If, YES, Who? _____ Where? _____ Date of imprisonment_____ Date of release_____

Section 3: Has there been a change in Federal income Tax filing information? ☐ YES ☐ NO
IF YES: Please list all individuals who will file their own taxes listed in Section 2. *The applicant can still get Medicaid if they do not file Federal tax returns. (Medicaid Only)

Tax Payer 1 Name: _____
Who will they claim from section 2? _____

Tax Payer 2 Name: _____
Who will they claim from section 2? _____

Tax Payer 3 Name: _____
Who will they claim from section 2? _____

Section 4: Has anyone moved out of your home? ☐ YES ☐ NO If YES, complete the information in this section.

Name	Explain why no longer in your home

Section 5: Is there a new applicant who is attending school? ☐YES ☐ NO
Has there been a change in student status for any current household members? ☐YES ☐ NO
IF YES: Please complete the information below.

Name of Person in School	Name of School	Attending Boarding school	Grade Level	Part-time or Full-time	Graduation Date
		☐YES ☐ NO			
		☐YES ☐ NO			
		☐YES ☐ NO			
		☐YES ☐ NO			

Section 6: Has there been a change in the amount of income your household gets from work? ☐ YES ☐ NO
Do you have a new employer? ☐ YES ☐ NO
IF YES: Please complete the information below.
SNAP: Provide proof of income for last 30 days ONLY if your employer has changed or if your monthly income has increased or decreased by more than $50 per month.
Other programs: Provide proof of all new or different income for last 30 days.

Name of person working:_____ Place of work:_____ Date this job started:_____	**How often are you paid?** ☐Once a month ☐ Weekly	☐ Bi-Weekly ☐ Twice a month ☐ Other: _____
Name of person working:_____ Place of work:_____ Date this job started:_____	**How often are you paid?** ☐Once a month ☐ Weekly	☐ Bi-Weekly ☐ Twice a month ☐ Other: _____

Section 7: Has there been a change in household income from a source other than work? ☐ YES ☐ NO
IF YES: Please complete the information below.
SNAP: Provide proof of income for last 30 days ONLY if the source of income has changed or if the amount of monthly income has increased or decreased by more than $50 per month.
Other programs: Provide proof of all new or different income for last 30 days.

List all checks/money received by you or any other household members. Examples - Social Security SSI, VA, unemployment benefits, workers compensation, child support, military allotments, contributions, dividends, grants, loans, BIA-GA, Individual Indian Monies, and any other money/monies received from any other source.

Household Member Who Gets Money	Who Provides or the Source of this Money	Amount of Income	How often is Income Received? (Monthly, Weekly, etc.)	When did this income start?

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Section 8: Have your resources changed? ☐ YES ☐ NO IF YES: Please complete the information in this section.

Resources are things like cash, money in savings account, stocks, bonds, camper trailers, boats, recreational vehicles (RV's), land your household owns but does not live on, cash settlements, or anything else that can be sold or turned into cash. Complete the section below and send in proof of these resources. Use an extra sheet of paper if needed to explain.

Name of person	Type of Property/Savings	$ Value	Year / Make / Model

MEDICAID ONLY: Did you or anyone living with you transfer anything of value to others in the last 5 years (60 months)?

Item transferred	Transferred to whom?	$ Value	Date of transfer

Section 9: Shelter Costs – Have your bills changed? ☐ YES ☐ NO

IF YES: Please complete the information in this section. If you do not report any of the expenses listed below, you will not receive a deduction for these expenses. **Institutional Care Medicaid ONLY:** Please complete the information in this section if your bills have increased or decreased per month or if you have moved and provide proof.

Housing:
- ☐ Rent or Home Mortgage $ _____
- ☐ Rent includes Utilities $_____
- ☐ HUD Housing/Section 8 $ _____
- ☐ Living with Relatives or Friends $ _____
- ☐ Home Insurance $_____
- ☐ Own my Home $_____
- ☐ Taxes $_____
- ☐ Housing is Supplied Free of Charge

Utilities:
- ☐ Included in Rent
- ☐ Gas/Butane
- ☐ Electric
- ☐ Telephone
- ☐ Water
- ☐ Trash/Sewer
- ☐ Purchase Pellets
- ☐ Purchase Wood

Low Income Home Energy Assistance Program (LIHEAP): Has LIHEAP or anyone else helped you pay for heating or cooling costs within the past year at your current address? ☐Yes ☐ No

Section 10: Has the amount of Child Support you pay changed? ☐ YES ☐ NO (SNAP, Cash, and Institutional Care Medicaid only)

Has the amount of Spousal Support you pay changed? ☐ YES ☐ NO (Institutional Care Medicaid only)

IF YES: Please complete the information in this section.

Are you, or is anyone in your household, paying court ordered support to someone living outside your household? ☐YES ☐ NO
If YES: Please complete the section below.

Who pays? _____
To whom? Name:_____
Telephone:_____
Address: _____

How much? $ _____
How often? _____
Did the amount you are court-ordered to pay change? ☐ YES ☐ NO
If yes, you must show proof of the court order to pay support and all payments that were made in the last three months.

Section 11: Has there been a change in Dependent Care? ☐ YES ☐ NO (SNAP or Cash only)

IF YES: Please complete the information in this section. If you do not report any of the expenses listed below, you will not receive a deduction for these expenses.

Do you or someone in your household pay someone to care for your children or a disabled or elderly person so you can work, attend school, or look for work? ☐YES ☐ NO

For whom? _____
How much? $_____
How often? (Monthly, Weekly, etc.)_____

Name of caregiver or day care center: _____
Mileage Round Trip for Dependent Care: _____
Telephone Number: _____
Do you get help to pay for childcare? ☐YES ☐ NO

Section 12: Have Medical Expenses for People who are Disabled or Over the Age of 60 changed? ☐ YES ☐ NO (SNAP and Institutional Care Medicaid) IF YES: Please complete the information in this section.

These expenses include medical bills not covered by insurance, prescriptions, health insurance premiums or other medical services. **For SNAP: You must give your caseworker proof if the amount increased by $25 or more. For Institutional Care Medicaid: You must give your caseworker proof of all expenses.**

Amount paid or owed per month: $ _____ Do you receive a Medicare Prescription Card? ☐YES ☐ NO

Section 13: Is there a new applicant with health insurance? ☐YES ☐ NO

Does any household member have changes to their health insurance? ☐YES ☐ NO (Medicaid only)

Who lost health insurance? _____, _____, _____ Who has health insurance? _____, _____, _____
Who is the primary policy holder? _____, _____
When did the insurance begin? _____ What is the policy number? _____ **Attach a copy of the card(s) if possible.**

Section 14: Information About Penalties (SNAP and Cash only)

If you do the following:	You will lose benefits for:
▪ Hide information or make false statements ▪ Use EBT cards that belong to someone else ▪ Use Food Stamp Benefits to buy alcohol or tobacco ▪ Trade or sell benefits or EBT cards	▪ 12 months for the first time ▪ 24 months for the second time ▪ Permanently for the third time
▪ Trade Food Stamp Benefits for controlled substances; such as drugs	▪ 24 months for the first time, and ▪ Permanently for the second time
▪ Trade Food stamps Benefits for firearms, ammunition or explosives ▪ Trade, buy or sell Food Stamp Benefits of $500 or more	▪ Permanently
▪ Give false information about who you are and where you live so you can get extra Food Stamp Benefits	▪ 10 years for each time

You can also be fined up to $250,000 or put in jail for up to 20 years, or both, for doing these things. You could also be charged under other state or federal laws.

Section 15: Your Signature

You must sign this form to make this report valid. Your report will not be processed unless signed. Your signature also is an indication of the following:

- I understand that making false statements or hiding information could mean State and Federal penalties and I have given HSD true, correct and complete information.
- The filing date is different if the household is in an institution and applying for SNAP and SSI at the same time. The filing date will be the date of release from the institution.
- I am declaring the identity of the children under age 16 for whom I am applying.
- I will give proof of things I report to HSD. If you need help, the Department has the responsibility to help you. I will let HSD contact other people, and companies to get proof.
- I will let HSD give limited information to approved agencies which give other related help for which I may be eligible.
- I understand that if I receive benefits for which I am not eligible, that I may have to pay HSD back for those benefits.
- I know that HSD will check the information that I give. HSD may use computers or other means to check the information on this form.
- I know that HSD will check the immigration status of people who apply for or get benefits. I understand that immigration status for any household member that I am applying for may be subject to verification by USCIS (INS), and that it may affect the household's eligibility and level of benefits.
- I understand that I must cooperate with Quality Control (QC). QC is a part of HSD. QC reviews cases to make sure we determine who can get help correctly.
- I have been given an information sheet explaining my rights and responsibilities including, expedited SNAP/food assistance, SNAP/food penalties and program violations, fair hearing rights and more. I understand that these will also be explained to me during my appointment for an interview.
- TRUSTS - I understand that if I, or the person(s) for whom I am applying, have set up a trust, or are the beneficiaries of a trust, I must give HSD a copy of the trust document, including all attachments and related information. HSD will analyze the trust to see if it affects the Medicaid benefits for which I am applying.
- ESTATE RECOVERY- I understand that, after my death, HSD can file a claim against my estate to recover the amounts that the state pays or paid on my behalf for medical assistance provided under the Medicaid program. This process is called "Estate Recovery." "Estate Recovery" is required by federal and state law. "Estate Recovery" is required where Medicaid recipients are fifty-five (55) years of age or older and the state makes medical assistance payments on their behalf for nursing facilities services, home and community based services, and/or related hospital and prescription drug services. The amount recovered by HSD will not exceed the amount of medical assistance payments made on behalf of the Medicaid recipient. Some exclusion's may apply.
- I understand that I must give HSD any money I receive for medical services which have already been paid for by Medicaid. If I fail to do so, I, or the person(s) for whom I am applying, may lose Medicaid coverage for at least one year AND until the amount owed to Medicaid has been paid back in full.
- A person who is applying for or receiving Medicaid Assistance shall assign to HSD all rights against any and all individuals for medical support or payments for medical expenses paid on the applicants' or client's behalf and the behalf of any other person for whom application is made or assistance is received.
- I, as the Authorized Representative, affirm and agree to be legally bound to maintain the confidentiality of any information regarding the applicant or beneficiary, shall not reassign any provider claims, if applicable, and shall adhere to all requirements set forth in 42 CFR 435.923(d).
- I affirm under penalty of perjury that the statements made about persons in my home, income, resources, property and all other information I have given HSD are true and correct.

Sign Here _____ Today's Date _____ Telephone Number (daytime) _____

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