Department of Children & Families — Acceptance Test — ACCESS Florida

English Español Kreyòl Help

Welcome to FLORIDA Department of Children & Families (DCF) ACCESS Florida Online Application System

If you need help paying for food or medical bills or need cash, you may apply for benefits online. What would you like to do? Choose the button next to your choice then click Continue. Choose only one option.

- **Apply for benefits.**
  Choose this if you have not recently applied for benefits in Florida or you want to apply for additional benefits. Do not choose this if you have recently applied and are waiting for a notice letter of approval or denial for benefits. If you are waiting for a decision on your recent application, please use My ACCESS Account to check the status of your application.

  Note: If you need to complete a review and are not able to create or log into your account, you may choose "Apply for benefits". We will process this as a review.

- **Complete an unfinished application.**
  Choose this option to continue an application that you started earlier and have not completed the Electronic Signature.
- **Add comments to an application that has been submitted using an Electronic Signature.**
  Choose this option if you recently completed the Electronic Signature on an Application and need to change an address or other information. You will be able to make changes until processing begins on your case.
- **My ACCESS Account and eligibility reviews.**
  Check Case Status or Benefit Information.
  Report Changes for your household.
  Apply for Additional Benefits.
  Submit a Review to continue to receive benefits.
  Request Closure of case.

You may need the following information for all individuals for whom you are applying.

- ✔ Social Security number and date of birth.
- ✔ Income information such as job, child support or any other sources.
- ✔ Resource or asset information such as checking, savings accounts, vehicles, homes, land or life insurance.
- ✔ Housing expenses such as rent or utilities.
- ✔ Health insurance information.
- ✔ All U.S. citizens applying for, or receiving Medicaid, including children, are required to provide proof of U.S. citizenship and identity.

When completed, click the Continue button below.

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Benefit Choices

Choose for whom you are applying:

- ○ I am applying for myself
- ○ I am applying for myself and my family
- ○ I am applying for another individual (not myself)

Choose all programs for which you would like to apply:

☐ **All Programs**

All Programs includes Food Assistance, Cash and Medicaid.

☐ **Food Assistance**

The Food Assistance Program helps low-income households to buy nutritious food. A food assistance household is normally a group of people who live together and buy food and prepare meals together.

Cash Assistance:

The Temporary Cash Assistance (TCA) program gives cash assistance to low income families with children, women in the 9th month of pregnancy, or women in the 6th month of pregnancy who are not able to work.

- ☐ Cash assistance for myself or myself and my family
- ☐ Cash assistance for a child the court placed with me
- ☐ Cash assistance for a child that is not mine but is related to me
- ☐ Cash assistance for refugees or some legal noncitizens who just came to the United States

☐ **Medicaid**

The Medicaid Program gives medical coverage to low income individuals and families. Medicaid services in Florida are administered by the Agency for Health Care Administration.

☐ **Nursing Home Medicaid Coverage**

Nursing Home Medicaid coverage gives medical assistance including the cost of care for individuals placed in nursing homes.

☐ **HCBS/Waivers**

Home and Community Based Services (HCBS) Medicaid Waiver Programs give Medicaid services to individuals at risk of placement in a nursing home. These programs give additional services not available through regular Medicaid.

☐ **Hospice**

The Hospice Medicaid program gives health care services to terminally ill individuals when they no longer choose to get medical treatment to cure an illness or disease. Hospice Medicaid Services can be given in an individual's home or in a nursing facility.

☐ **Medicare Savings Program**

Medicare savings Programs are Medicaid programs that help Medicare beneficiaries of modest means pay all or some of Medicare cost sharing amounts (i.e., premiums, deductible and co-payments). Programs considered Medicare Savings Programs include Qualified Medicare Beneficiary, Special Low-income Medicare Beneficiary, Qualifying individuals 1, and Qualified Working and Disabled Individuals.

☐ **Simplified Eligibility for Pregnant Women**

Simplified Eligibility for Pregnant Women (SEPW) is a Medicaid program for women who are pregnant.

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Medicaid

What would you like to do? Choose the button next to your choice then click Continue. Choose only one.

○ Check here if you are applying for Medicaid for anyone 19 years of age or older (adult).

○ Click here if you are applying for Florida KidCare or Medicaid for a child. Florida KidCare is the state's children's health insurance program for uninsured children under age 19. You would only select this option if you are applying only for children under the age of 19.

If you select this option you will leave the Department of Children and Families' website and be directed to the website for the Florida KidCare Program. The Florida KidCare website has information about the Florida Kidcare Program and an on-line application for medical assistance for your children.

Only select this option if you are not interested in applying for other benefits offered by the Department of Children and Families.

You may call 1-888-540-5437 for questions about the KidCare program.

When completed, click the Continue button below.

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Relative Caregiver Program Eligibility Requirements

- The following requirements only apply if the child(ren) you are applying for was placed in your home by court order. You may apply and receive cash assistance for related children even if they were not placed in your home by a court. To continue with the application process, click on the "Continue" button below.

Please read the program requirements listed herein.

- I must be taking care of children under age 18 who are related to me.
- There must be a Florida court order by a judge finding the children were abandoned, abused or neglected. The child(ren) who I am applying for has been placed in my custody by a Florida juvenile court judge.
- I understand that the Department's Office of Family Safety will do a home study to be sure that the children in my custody are safe from abuse or neglect. If there are problems in my home, the Department may be court ordered by a judge to supervise them or even remove them from my home.
- I must have an interview and provide all the requested documentation the Department needs to decide if I meet the requirements for Temporary Cash Assistance. If it is hard for me to get the requested documentation, I understand that I can ask my caseworker to help me.
- If I receive Temporary Cash Assistance, I cannot also receive Relative Caregiver benefits in the same month. If I meet technical and financial requirements, I can ask to receive Temporary Cash Assistance while the request for Relative Caregiver eligibility is being processed. If I am eligible for Temporary Cash Assistance, I will not receive the increased Relative Caregiver benefit until the first month after the Department stops my Temporary Cash Assistance.
- I understand that the Relative Caregiver payment is to cover the cost of the child's basic needs such as food, clothing, shelter, school supplies, and personal items like toiletries, entertainment, etc.

When completed, click the Continue button below.

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Important Information When Applying and What to Expect.

Applying for Benefits
You may apply for help by giving us just your name, address, and signing your application. You may click on the "Apply" button after you confirm your address. **We encourage you to answer as many questions as you can, and sign your application today. This will allow us to help you more quickly.**

Pre-screening Tool
Before completing your application, you may answer a few questions to see if you or your household might be eligible for benefits. Complete the questions based on your current circumstances. Estimates are allowed when answering the questions. Please remember the tool is not an application for benefits. If the tool says your household may not be eligible; you may still complete an application. We will make a determination of eligibility based on your application. If you want to use the Pre-screening Tool, **click on this link**.

Processing Your Application
Your application is date stamped the day we get a signed application. The date stamp will be the next business day if we get your application after hours on a weekend or holiday. We will begin working on your application as soon as we get it. It may take 7 to 30 days to process your food assistance application. Expedited household may get food assistance benefits within seven days. Your answers on the application will decide if your household meets expedited food assistance criteria. Applications for Medicaid and Temporary Cash Assistance may take 30 to 45 days, and Medicaid applications may take longer if we need to determine if someone is disabled. You may check the status of your application by visiting the ACCESS Florida website at **http://www.myflorida.com/accessflorida** and click on the "My ACCESS Account" link.

Online Application Process
If you chose to complete the online application, you will be able to back up and check your answers at any point during the application process. At the end of the application process you will be shown a "Case Summary" page which will allow you to check the information you gave on the online application. If you want a copy of the Case Summary for your records, you must have a working printer attached to your computer.

Social Security Number
We may treat household members who are ineligible, or who are not applying for benefits, as non-applicants. Non-applicants, or persons applying only for Emergency Medicaid for Aliens, Refugee Cash Assistance, or Refugee Medical Assistance, do **NOT** need to give a Social Security Number (SSN). If you were not eligible for an SSN because of your immigration status, you may be eligible for a non-work SSN. If you need an SSN, we can help you apply for one. Non-applicants do **NOT** need to give proof of immigration status. Non-citizens who are applying for benefits will have their immigration status verified with the U.S. Citizenship and Immigration Services (USCIS). We will not tell USCIS about the immigration status of those living in your household who are not applying for benefits.

Important Information for Immigrants
Applying for or receiving food assistance benefits or Medicaid will not affect you or your family members' immigration status or ability to get permanent resident status (green card). Receiving Temporary Cash Assistance or long term institutional care, such as nursing home benefits might create problems with getting that status, especially if the benefits are your family's only income.

Public Assistance Fraud
Answers you give may be confirmed by DCF and other Federal and State groups like Public Assistance Fraud (PAF). You may be accused of a crime if you give answers that are not true to get benefits. If you are caught giving answers that are not true or you are not telling us something so you can get benefits, you will

not be able to get benefits for 12 months the first time, 24 months for the second time, and permanently for the third time. You may also be fined up to $250,000, put in prison, or both.

Income and Eligibility Verification System (IEVS)
We will request information through computer matches in IEVS and may verify the information if we find differences based on the answers you gave on your application. We may use the information found in IEVS to affect your eligibility and level of benefits.

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ACCESS Online User Sign-up

This is your ACCESS online number. You will need this number and password to complete your unfinished application or add comments after signing your application with an Electronic Signature.

ACCESS Online Number: 800026543

Please create a password. You need a password and the ACCESS online number if you exit and return later. Password must be 6 to 8 characters long.

A password must be entered:

Re-enter the password:

Warning! By using this government computer system, you are agreeing to system checking for law enforcement and others. Misuse of this computer system may result in criminal prosecution and penalties.

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Applicant Information

You are now ready to begin your application.
Enter the following contact information for the head of the household.

Enter the full name of the Head of Household. By Head of the Household we mean the responsible adult that lives in the household. Do not enter a child here. If you are completing the application for someone that does not live with you, enter their name. (Do not use nicknames). If you are completing the application for someone else and you do not live in their household, we will ask for your name and address when you complete the Electronic Signature.

First name | Middle initial | Last name | Suffix

Enter the address where the people you are applying for live. Do not enter a Post Office Box. Enter the **Living address** of the household. By living address we mean the address where the household lives, even if they do not receive mail there. If the person(s) you are applying for are homeless and receive their mail through General Delivery, enter Generel Delivery in the Living Address.The person(s) you are applying for must be a Florida resident to receive assistance from Florida.

Address line 1 | Address line 2

City | State (Florida) | Zip

Do the people you are applying for get mail at a different address from the one listed above? If 'Yes', enter the mailing address below. Yes ○ No ○

Address line 1 | Address line 2

City | State | Zip

In what language do you prefer your notice letters? ◉ English ○ Spanish ○ Creole

Home phone | Work phone

Cell phone

By entering your email address you are saying it is okay for the department to send emails to you about your case.

Email address | Retype email address

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Address Validation

The addresses that you entered are being validated through the United States Post Office. If the addresses are not valid, you may not get mail from us or your benefits may be delayed.

Living address:

	The living address that you entered has been validated and standardized with the United States Post Office.
1940 N Monroe	1940 N Monroe St
Tallahassee , FL , 32303 -0000	Tallahassee , FL , 32303 -0000
Select this option if you would like to correct the address that you entered. ○	Select this option if you want to use this address. ○

Continue

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Name Change

Mary Smith

Household living address Change

1940 N Monroe St , Tallahassee , FL , 32303

Mailing address Change

Not entered

Contact information Change

Home phone:
Cell phone:
Work phone:
Email address:

Notice language Change

English

Who is applying (Change)	Type of benefits selected (Change)
☑ I am applying for myself	☑ Food Assistance Program
☐ I am applying for myself and my family	☑ Cash assistance for myself or myself and my family
☐ I am applying for another individual (not myself)	☑ Cash assistance for a child the court's placed with me
	☑ Cash assistance for a child that is not mine but is related to me
	☑ Cash assistance for Refugees
	☑ Medicaid
	☑ Nursing Home Medicaid Coverage
	☑ HCBS/Waivers
	☑ Hospice
	☑ Medicare Savings Program
	☑ Simplified Eligibility for Pregnant women

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Household List

Add, remove or make changes to the information about the people you are applying for. Add all people in the home even if you are not applying for them

Anyone who is living in your household and is not eligible or is not applying for benefits may be treated as a non-applicant. Non-applicants or persons applying only for Emergency Medicaid, Refugee Cash Assistance, or Refugee Medical Assistance are NOT required to provide a Social Security Number (SSN). If you were not eligible for an SSN because of your immigration status, you may be eligible for a non-work SSN. If you need an SSN, we can help you apply for one. Non-applicants are NOT required to provide proof of immigration status. Noncitizens who are applying for benefits will have their immigration status verified with the U.S. Citizenship and Immigration Services (USCIS). We will not tell USCIS about the immigration status of those living in your household who are not applying for benefits.

If you, or the people you are applying for do not have an SSN please leave the SSN field blank. Do not make up an SSN.

Please use the legal name of the individual (do not use nicknames).

First name	Mary	Middle initial	
Last name	Smith	Suffix	
Social Security Number			
Date of birth (mm/dd/yyyy)			
Sex			
Marital status			
Living arrangement			
Race			
Ethnic Background			
Country of Birth			
Is this person applying for benefits?	○ Yes ○ No		
Do you want to add another person?	○ Yes ○ No		

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Rights and Responsibilities

Please carefully read the Rights and Responsibilities information below. Use the scroll bar on the right side of the form to view all of the information.

Rights and Responsibilities

YOU HAVE THE RIGHT TO:

- Apply for assistance and to have a determination of your eligibility made without regard to race, color, sex, age, disability, religion, national origin, or political belief. (If you have a disability that limits you in a major life activity, please tell us so we can make reasonable accommodations to help you.)
- Turn in your request for assistance the same day you get it. You may turn in your request in person, through someone else, through the mail or by fax. You may turn in an incomplete request, as long as it has your name and address, and is signed by you or another responsible member

☐ **Yes, I have read and understand the Rights and Responsibilities.**

When completed, click the Continue button below.

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HIPAA Statement

Please carefully read the HIPAA information below. Use the scroll bar on the right side of the form to view all of the information.

CFOP 60-17
Chapter 1, Attachment 2
June 2, 2008

MANAGEMENT AND PROTECTION OF PERSONAL HEALTH INFORMATION POLICY

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. ***Please review it carefully.***

I. Our Duties As They Relate to Your Protected Health Information (PHI). Our records about you contain health information that is very personal. The confidentiality of this personal information is protected by federal and state law. We have a duty to safeguard your Protected Health Information (PHI) which includes individually identifiable information about:

- your past, present, or future health or condition,
- provision of health care to you,
- payment for the health care considered PHI

☐ **Yes, I have read and understand the HIPAA statement.**

When completed, click the Continue button below.

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Household Relationships

Please choose how these people in your household are related using the drop down box.

				Buys and eats food with you?	
Mary Smith	is the	Select Relation	of Allie Smith	Yes	No
Mary Smith	is the	Select Relation	of Bobby Smith	Yes	No
Allie Smith	is the	Select Relation	of Bobby Smith	Yes	No

When completed, click the Continue button below.

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Please answer the following for each individual for whom you are applying. If a statement does not apply to anyone in the household, choose "No One".

Choose everyone who is a citizen of the United States.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who is a Florida resident.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who has ever used a different Social Security number or a different name, such as a maiden or married name.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who has served in the United States Military.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who has been out of the U.S. in the last 30 days.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who is pregnant.

☐ Mary Smith

Choose everyone who is attending school, including college and technical school.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who is fleeing the law due to a felony or probation or parole violation.

☐ Mary Smith ☐ No One

Choose everyone who has been convicted of a drug trafficking felony.

☐ Mary Smith ☐ No One

Choose everyone who has been convicted of receiving food assistance, temporary cash assistance or Medicaid in more than one state at the same time.

☐ Mary Smith ☐ No One

Choose everyone who has received Food Assistance, Cash or Medicaid assistance from another state or source.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

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Please answer the following for each individual for whom you are applying. If a statement does not apply to anyone in the household, choose "No One".

Choose everyone who has a disability or needs help in finding out if a disability exists.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who is in renal dialysis.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who is applying for or getting Hospice.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith

Choose everyone who is applying for or getting HCBS/Waiver.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith

Choose everyone who got SSI benefits in the past but is not receiving them now.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose any children limited or prevented in any way in ability to do things most children of the same age can do.

☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose any children that need or get special therapy such as physical, mental health, occupational, speech therapy, treatment or counseling for emotional, developmental or behavioral problems.

☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose any children that need or use more medical care, mental health or educational services than usual for children of the same age.

☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose all children who are current with their immunization (shot) requirements.

☐ Bobby Smith ☐ No One

Choose all children who you would like to get child health check up services.

☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone a judge has declared an adult.

☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who is a foster child.

☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who is a victim of human trafficking or a family member of a trafficking victim.

☐ Mary Smith ☐ No One

When completed, click the Continue button below.

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Certification of Identity

Statement of proof of identity for children under age 16. For each child under 16 we will request that you certify their identity.

Please review the information for the child below and click on the "Certify Now" button if you are able to confirm their identity. We must have this information to approve them for Medicaid.

If you do not wish to confirm identity by clicking on the "Certify Now" button, you may turn in another type of verification such as a student ID card, or state issued ID card.

Legal name	Date of birth	Country of Birth
Allie Smith	4/12/2001	United States
Bobby Smith	2/18/2010	United States

I certify that I am the parent, guardian, or representative of the above child and also certify under penalty of perjury that the above child(ren) are who I claim them to be.

Certify Now

When completed, click the Continue button below.

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Absent Parent Details

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Please complete the following for all of the absent parent(s) of the child(ren) for whom you are applying. A child is anyone in the household under 21 years of age that has never been married or is under 18 years of age and has not been declared an adult by a judge (emancipated minor). An absent parent is a parent who does not live with the children. You can choose more than one child for each absent parent. If you do not know the name of the absent parent, enter unknown for the last name. If the mother and father are absent from the home, complete an absent parent screen for each. If there is more than one possible father, complete a screen for each.

Complete the following for each parent who is not in the household:

First name MI Last name Suffix

Sex Race

Is this the child's legal parent?

○ Yes ○ No

This person is the parent of ☐ Allie Smith ☐ Bobby Smith

Do you want to get Child Support Enforcement services for this child or child(ren) if not approved for benefits?

○ Yes ○ No

Choose the reason the parent is not in the home.

Below, tell us what you know about the absent parent:

Date of birth Social Security Number

Phone number Place of birth

Address where the absent parent lives:

Address line 1 Address line 2

City State Zip

Address where the absent parent gets mail if different than the living address:

Address line 1 Address line 2

City State Zip

Information about the absent parent's employer:

Name

Phone number

Address line 1

Address line 2

City

State

Zip

Information about the absent parent's medical insurance:

Policy number

Carrier name

Are the above child(ren) included on the medical insurance? ○ Yes ○ No

Do you want to add another absent parent? ○ Yes ○ No

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Long Term Care Details

Nursing Home, HCBS or Hospice care has been requested. Enter as much of the information below as you can. If you do not know, leave the field blank.

You reported Nursing Home, HCBS or Hospice care for **Mary Smith**.

Facility or provider name:

Facility or provider address line 1:

Facility or provider address line 2:

City: State: Zip:

Phone:

Does **Mary Smith** want their spouse or dependents to have part of their income to meet the familys needs? ○ Yes ○ No ○ Not Sure

Is **Mary Smith** receiving hospice care in a nursing facility? ○ Yes ○ No ○ Not Sure

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Additional Long Term Care Details

Additonal nursing home information is needed. Enter as much of the information below as you can. If you do not know, leave the field blank.

Provider Number:

County of placement:

Date of admission: (mm/dd/yyyy)

Date of discharge: (mm/dd/yyyy)

Does **Mary Smith** have food or housing expenses during the month of admission to or discharge from a nursing facility? ○ Yes ○ No ○ Not Sure

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Prior Residence Information

You have reported that someone for whom you are applying is in a nursing home or will be going into a nursing home. Please complete as much information as possible.

What was **Mary Smith**'s address before entering the nursing home?

Address line 1: Address line 2:

City State Zip

County

Please name a contact person who can verify information:

First name Middle initial Last name Suffix

Relationship:

Address line 1: Address line 2:

City State Zip

Phone number:

When completed, click the Continue button below.

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Noncitizen Details

Enter details for persons who are not citizen's of the United States.

Please complete the following information for **Mary Smith.**

What date did **Mary Smith** enter the United States? Note: If you cannot remember the date give us your best guess. (mm/dd/yyyy)

What is **Mary Smith** 's U.S. Citizenship and Immigration Services (USCIS) number? If you do not know or do not have a USCIS number for this person, please enter "unknown".

What date was **Mary Smith** 's document issued by USCIS? Note: If you cannot remember the date give us your best guess. (mm/dd/yyyy)

If **Mary Smith** is an asylee, what date was asylum granted? Note: If you cannot remember the date give your best guess. (mm/dd/yyyy)

Does **Mary Smith** have a sponsor? ○ Yes ○ No

Noncitizens who are ineligible for regular Medicaid may qualify for Emergency medical assistance.

Has **Mary Smith** had a medical emergency in the U.S. in the past 3 months? ○ Yes ○ No

Please give the following medical emergency information:

Type of medical emergency

Date of medical emergency (mm/dd/yyyy)

When completed, click the Continue button below.

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Sponsor Details

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You reported that **Mary Smith** has a sponsor. Give the following sponsor information.

Sponsor Type Sponsor ID

Sponsor Name (Only needed if Sponsor ID answer is Other)

Address line 1

Address line 2

City State Zip

When completed, click the Continue button below.

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Alias Name/or Social Security Number (SSN) Details

An alias is any name or Social Security number that a person has used in the past. For example, a maiden or married name or a different Social Security number.

Please tell us about the other names or SSNs used by **Mary Smith**.

Enter names used in the past. (such as a maiden or married name)

First name | Middle initial | Last name | Suffix

Name type

Enter the Social Security number used in the past:

Social Security Number | SSN type

Has **Mary Smith** used any other names or Social Security numbers? ○ Yes ○ No

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You reported that **Mary Smith** was out of the U.S. in the past 30 days. Enter the details below.

Date that **Mary Smith** left the U.S. (mm/dd/yyyy)

Date that **Mary Smith** returned to the U.S. (mm/dd/yyyy)

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Please complete the following pregnancy details for **Mary Smith**. You may have to give proof of pregnancy from a health professional.

Click here to view or print the Health Insurance for Pregnant Women Brochure.

Expected due date: (mm/dd/yyyy)

Number of babies expected:

Does **Mary Smith** have Medicaid? Yes No

If no, has **Mary Smith** applied for Medicaid? Yes No

Does the father of the unborn live in the household? Yes No

If yes, enter the father's name:

Has a healthy Start Screening been done? Yes No

Please ask your doctor for a Healthy Start Screening.

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Click here to read or print the Notice of Learnfare Requirements.

Please answer the following school questions for **Allie Smith**.

School name:

School district:

School type:

Student is attending:

If attending High School or equivalent, enter the expected graduation date. (mm/dd/yyyy)

If attending an institute of higher learning is this person participating in a Work Study Program ○ Yes ○ No

Education Level

Has anyone attended a school conference for **Allie Smith** ○ Yes ○ No

If yes, who attended the conference?

Date of last school conference for **Allie Smith** (mm/dd/yyyy)

When completed, click the Continue button below.

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Disability Details

A disability is a condition that may prevent a person from working and be expected to last for a continuous period of at least 12 months.

Click here to read or print the Authorization to Disclose Information form

Click here to read or print the Statement of the Need for Care form

Please complete the following disability information for **Mary Smith** .

Has Disability been decided for **Mary Smith** ? ○ Yes ○ No

Has **Mary Smith** ever applied for and been denied disability (SSI or SSDI) by the Social Security Administration (SSA) because medical conditions were not met? ○ Yes ○ No

If yes, please enter the denial date. Note:If you cannot remember the date, give us your best guess.(mm/dd/yyyy)

Is the denial currently under appeal with Social Security Administration(SSA)? ○ Yes ○ No

Does **Mary Smith** have a new condition since the denial or a condition that SSA did not know about when they denied the disability? ○ Yes ○ No

Did **Mary Smith** ever get and then stop getting disability for any reason? ○ Yes ○ No

Is **Mary Smith** able to purchase and prepare meals? ○ Yes ○ No

Will **Mary Smith** 's incapacity or disability last for more than 30 days? ○ Yes ○ No

Will **Mary Smith** 's incapacity or disability last for more than 12 months? ○ Yes ○ No

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Supplemental Security Income (SSI) Details

You reported that **Mary Smith** got SSI in the past but is not getting it now. Please answer the questions below.

Did **Mary Smith** ever get SSI and SSA benefits at the same time?	○ Yes ○ No
Did **Mary Smith** get SSI in the month before getting Social Security benefits?	○ Yes ○ No
Has **Mary Smith** been entitled to Social Security widow (widower) benefits?	○ Yes ○ No
Has **Mary Smith** been required by Social Security to file for widow (widower) benefits?	○ Yes ○ No
Is **Mary Smith** getting Social Security benefits under a parents coverage?	○ Yes ○ No
Does **Mary Smith** get Social Security benefits due to a change in definition of childhood disability?	○ Yes ○ No
Did **Mary Smith** get SSI benefits prior to age 60?	○ Yes ○ No

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Disability Pamphlet

Please carefully read the Disability information below.

ARE YOU DISABLED AND APPLYING FOR MEDICAID?

Notification of Disability Information and Request Form.

What to provide with your application for Medicaid.

What is Medicaid? Medicaid is a state run medical assistance program for needy individuals and families with limited income. If you are under age 65 and have no children, you must be disabled to qualify for Florida Medicaid.

What is Disability? You may be disabled if you have a condition that has affected (or is expected to affect) you ability to work for at least 12 months, or result in death. Children may be considered disabled if they have a medical condition severe enough to be considered a disability for an adult. If you are applying for Medicaid based on your disability, You must apply for all other disability income you may be able to receive, including Social Security Disability Insurance payments. You are not required to apply for Supplemental Security Income (SSI). For more information about Social Security, call 1-800-772-1213 or visit them online at http://ssa.gov.

Who decides if I am disabled? We use the same rules as Social Security to determine disability. If Social Security determines you as disabled, We accept their decision and will automatically consider you as disabled. If you do not have a disability determination from Social Security, we will work with the Division of Disability Determinations(DDD) to have them evaluate your condition based on medical information you provide.

What do I need to provide? If you have determination of disability from Social Security , give us a copy of the letter from them to show the decision and the date your disability began. We need no other medical information. If you do not have a determination of disability from Social Security, You need to provide us information about your condition. We will send the information to DDD for them to evaluate and make a Disability decision.

What information do I need for my interview?

- Dates of treatment.
- Names of all medications from your doctors, therapists, hospitals and clinics.
- Laboratory and test results.
- Information about normal daily activities, interests and hobbies , and how your condition affects them.
- Unpaid Medical bills
- Signed CF-ES 2514 form (Authorization to Disclose Information).

What other information should I provide? In addition to being determined

disabled, you must have income and resources within certain limits to qualify for Medicaid. You must also be a Florida resident and a U.S. citizen or qualified non citizen.

Additional information we need:

- ✔ Social Security number.*
- ✔ Alien registration card, if not a U.S. citizen.*
- ✔ Proof of gross monthly income from all sources.
- ✔ Any letters you received from Social Security about your disability.
- ✔ Proof you have applied for Social Security Disability Insurance payments.*
- ✔ Information about things you own such as bank accounts, stocks , annuities, real property , cars ,etc.

The list above covers the most common types of documentation we need from you to show you are eligible for Medicaid. We may ask you for additional information during the interview or as we proceed your case.

* Not required if you are not a citizen and only applying for Emergency Medical Services to cover periods of emergency services only.

Don't Delay! Don't delay your interview if you don't have all this information. You can provide it later or we can help you get it. Giving us medical records with your application may help us make faster decision, but it is not available, we will still send your availability to the Division of Disability Determinations. You may copy your medical records at a customer service center or fax them to your case processor from one of our gold community partner sites. Lists of service centers and partners are online at http://www.dcf.state.fl/ess/docs/partner_listing.pdf.

Very Important! We handle most interviews by telephone. If you need to reschedule your interview , please call the number on your appointment letter to schedule another interview time. Please understand that rescheduling an interview may cause delay in processing your Medicaid case.

We will make every effort to complete your application within 90 days of the date we receive your application for Medicaid not counting any delays caused by you in getting necessary information to us.

If your case is still pending after 100days, we will review your case and to determine why there is no decision, instruct eligibility staff on what information is missing, and advice them how to obtain the missing information.

If we complete a 100-day review of your case we will send you a special notice telling you the results of our review. We will continue to monitor your case until a final decision is made.

You can file an application online at http://www.dcf.state.fl/ess/ or call 1-866-762-2237 for an application to be mailed by you.

The Department of Children and Families will act on your application without regard to age, race, color, sex, disability, religious creeds, nation origin, marital status, or political beliefs.

☐ **I have read and understand the disability information.**

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Case Information

Would you like to register to vote or update your voter registration record? ○ Yes ○ No

If "Yes", we will send you an application.

If "No", you will be considered to have decided not to register to vote or update your voter registration information.

Checking "Yes" or "No" will not affect your receipt of benefits.

Is anyone in your household a migrant or seasonal farm-worker? ○ Yes ○ No

Discounted Phone Service

Do you want to get a discount of $13.50 per month on your phone service from the Lifeline Assistance Program?

If your application is approved the information, your information can be given to the Public Service commission (PSC) for automatic enrollment in Florida's Lifeline Assistance program. All personal information given to PSC will be kept confidential.

Do you want Lifeline Assistance?
- ○ Yes
- ○ No
- ○ Already receive Lifeline Assistance.

If yes, do you have phone service? ○ Yes ○ No

If you have phone service, whose name is on the phone bill?

○ Mary Smith ○ No One

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Case Details

You said you wanted a discount on your phone service. Answer all of these questions so we can make a referral. If your telephone company is not listed in the drop down box, it does not offer Lifeline at this time.

What is the name of your phone company?

What is your phone number?

Please enter SSN. If SSN is not entered a referral cannot be made for Lifeline Assistance.

Please call your phone company if you have Lifeline questions.

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Migrant Details

Has all of your household income recently stopped? ○ Yes ○ No

Do you have a new source of income? ○ Yes ○ No

When will you get paid from the new source?(mm/dd/yyyy)

Amount you will get?

When completed, click the Continue button below.

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Household List

Change

Name	SSN	Date of birth	Sex	Apply for benefits
Mary Smith	810051100	07/15/1970	Female	Yes
Allie Smith	Not entered	04/12/2001	Male	Yes
Bobby Smith	Not entered	02/18/2010	Male	Yes

Household List Continued

Change

Name	Marital status	Living arrangement
Mary Smith	Single - never married	Nursing home
Allie Smith	Single - never married	Home/apartment/trailer
Bobby Smith	Single - never married	Home/apartment/trailer

Rights and Responsibilities reviewed?	Yes
HIPAA statement reviewed?	Yes

Household Relationships

Change

Name	Relationship	Buys and eats food with you?
Allie Smith (10) is Mary Smith 's (41)	Son	Yes
Bobby Smith (1) is Mary Smith 's (41)	Son	Yes
Mary Smith (41) is Allie Smith 's (10)	Mother	Yes
Bobby Smith (1) is Allie Smith 's (10)	Brother	Yes
Mary Smith (41) is Bobby Smith 's (1)	Mother	Yes
Allie Smith (10) is Bobby Smith 's (1)	Brother	Yes

Household Information

Change

Name	Citizen	Florida resident	Alias/SSN	US Military	Out of U.S.
Mary Smith	No	Yes	Yes	Yes	Yes
Allie Smith	Yes	Yes	No	No	No
Bobby Smith	Yes	Yes	No	No	No

Household Information continued

Change

Name	Pregnancy	School	Fleeing the law due to a felony or probation

			or parole violation
Mary Smith	Yes	No	No
Allie Smith	N/A	Yes	N/A
Bobby Smith	N/A	No	N/A

Household Information continued Change

Name	Convicted of drug trafficking felony	Convicted of receiving benefits in more than one state at the same time	Received Food, Cash or Medicaid assistance from another state or source
Mary Smith	No	No	No
Allie Smith	N/A	N/A	No
Bobby Smith	N/A	N/A	No

Additional Household Information Change

Name	Disability	Renal Dialysis	Hospice	HCBS/Waiver	Received SSI in past but not receiving now
Mary Smith	Yes	No	Yes	Yes	Yes
Allie Smith	No	No	No	No	No
Bobby Smith	No	No	No	No	No

Additional Household Information continued Change

Name	Children limited or prevented in any way in ability to do the things most children of the same age can do	Children that need or get special therapy such as physical, occupational or speech therapy or treatment or counseling for emotional, developmental or behavioral problems.	Children that need or use more medical care, mental health or educational services than usual for children of the same age
Mary Smith	N/A	N/A	N/A
Allie Smith	No	No	No
Bobby Smith	No	No	No

Additional Household Information continued Change

Name	Immunization	Child Health Checkup Services	Emancipated minor	Foster child	Human Trafficking
Mary	N/A	N/A	N/A	N/A	No

Smith					
Allie Smith	N/A	Yes	No	No	N/A
Bobby Smith	Yes	Yes	No	No	N/A

Certification of Identity Change

Name	Certification
Allie Smith	Not certified
Bobby Smith	Not certified

Absent Parent Details Change

Absent parent's name	Child Name	Reason for absence	CSE services
Joe Smith	Allie Smith Bobby Smith	Not entered	Yes

Long Term Care Details Change

Name	Facility
Mary Smith	Shady Pines

Additional Long Term Care Details Change

Name	County of placement	Date of Admission
Mary Smith	Leon	6/1/2011

Prior Residence Information Change

Name	County	Contact person
Mary Smith	Leon	Bruce Smith

Noncitizen Details Change

Name	Date entered the United States	USCIS number	Medical emergency date
Mary Smith	6/1/2010	a941	9/1/2010

Alias Name/or Social Security Number (SSN) Details Change

Name	Alias name	Alias SSN
Mary Smith	MaryEllen Walton	N/A

Household Information Details Change

Name	Date left U.S.	Date returned to U.S.
Mary Smith	6/1/2011	Not entered

Pregnancy Details Change

Name	Due date	Babies expected
Mary Smith	6/1/2012	1

School Details Change

Name	School type	Graduation date
Allie Smith	Elementary	Not entered

Disability Details Change

Name	Disability established
Mary Smith	Yes

Disability pamphlet reviewed? Yes

Supplemental Security Income Details Change

Name	Received SSI and SSA at the same time	Received SSI in month before receiving SSA benefits
Mary Smith	Yes	Yes

Case Information Change

Register to vote	Interested in Lifeline assistance	Migrant or seasonal farm worker
Yes	Yes	Yes

Case Details

Currently have phone service	SSN	Phone service provider	Phone number	Name on the phone bill
Yes	810051100	T-Mobile South LLC (cell phone)	(850)123-4567	Mary Smith

Migrant Details Change

Income terminated	New income source	Paid date	Amount paid
Yes	No	Not entered	Not entered

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Asset Information

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Please answer the following for each individual for whom you are applying. If a statement does not apply to anyone in the household, choose "No One".

IMPORTANT INFORMATION FOR OWNERS OF AN ANNUITY: In accordance with Public Law 109-171, individuals and their spouses who are applying for or receiving Medicaid Institutional Care Program (nursing home care), Hospice, Home and Community Based Services waiver programs, or the Program of All - Inclusive Care for the Elderly must list all annuities they own. Certain annuity purchases or other transactions made on or after 11/01/2007 will be considered a transfer of an asset for less than fair market value unless the annuity names the State of Florida, Agency for Health Care Administration as the first remainder beneficiary (or second remainder beneficiary after the community spouse or minor or disabled child) for the total amount of Medicaid funds paid on the Medicaid recipient's behalf.

Choose everyone who is buying or owns all or part of any liquid asset. Liquid assets are things like cash, bank accounts (checking or savings accounts), stocks, bonds, retirement accounts, trust funds, mutual funds, pre-paid funeral expenses, or certificates of deposit. Include all annuities even if not yet receiving income from them, continuing care retirement, life care community contracts or any other liquid assets not listed.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who has life insurance that has cash value. This does not include a pre-paid funeral plan.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who is buying, owns or co-owns a vehicle with another person. Vehicles include cars, trucks, boats, trailers, campers, motorcycles, and sport vehicles. Vehicle ownership means that your name is on the sale papers or the registration.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who owns all or part of any property. Property is land where you may or may not live. Examples are, homestead property, inherited property, vacant lots, time-shares, rental property, burial plots, or any other property asset not listed.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who owns all or part of any business assets. Examples of business assets are machinery, livestock, supplies, and inventory.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who sold, transferred, or gave away an asset in the last 3 years. This includes closing bank accounts or adding someone to an account

or property title.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who received a cash settlement in the last 3 months or is expecting to receive a cash settlement. Settlements are payments received from accidents, insurance claims, inheritance, lottery winnings or any other type of cash payment.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

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Liquid Asset Details

Liquid assets include cash, bank accounts even if only used to cash checks, (checking or savings accounts), stocks, bonds, retirement accounts, trust funds, mutual funds, pre-paid funeral expenses, or certificates of deposit. Include all annuities even if not yet receiving income from them, continuing care retirement or life care community contracts or any other liquid assets not listed.

You reported liquid assets for **Mary Smith**. Please answer the following questions on liquid assets:

Type of asset:

Value:

Bank name:

Account number, if known:

Are you designating any of this asset for burial? ○ Yes ○ No

If Yes, how much?

Is anyone else a part owner? Choose one of the following:

○ Allie Smith ○ Bobby Smith
○ A person outside of the household
○ Not jointly owned with anyone

If part owner, what percentage does this person own?

Does **Mary Smith** have another liquid asset? ○ Yes ○ No

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Life Insurance Details

Life insurance includes a policy that has cash value like a whole life policy, this does not include a prepaid funeral plan.

You reported life insurance for **Mary Smith**. Please answer the following questions:

Type of insurance

Policy number

What is the policy begin date? Note: If you do not know the exact date, give us your best guess. (mm/dd/yyyy)

Company name

Address line 1

Address line 2

City

State

Zip

Face value:

Cash value:

Loan amount:

Are you designating any of this asset for burial? Yes No

If Yes, how much?

Does **Mary Smith** own another life insurance policy? Yes No

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Vehicle Details

Vehicles are cars, trucks, boats, trailers, campers, motorcycles, and sport vehicles. Vehicle ownership means that your name is on the sale papers as the buyer.

You reported that **Mary Smith** is buying or owns a vehicle. Please answer the following questions:

Type of vehicle:

Year

Make Model

Amount owed Resale value

Does **Mary Smith** have access to and use of this vehicle? Yes No

How is this vehicle used?

Does this vehicle have a current tag? Yes No

Is anyone else a part owner? Choose one of the following:

Allie Smith Bobby Smith

A person outside of the household

Not jointly owned with anyone

If part owner, what percentage does this person own?

Does **Mary Smith** have another vehicle? Yes No

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Real Estate/Property Details

Real estate or property is land that you may or may not be living on; for example, homestead property, inherited property, vacant lot, time-share, rental property, or any other property asset not listed.

You reported property owned by **Mary Smith**. Please answer the following questions about the property below.

Property type

Market value

Property address line1

Amount owed

Property address line2

City State Zip

Does **Mary Smith** have access to and use of this property? ○ Yes ○ No

Are you designating any of this asset for burial? ○ Yes ○ No

If Yes, how much?

Is anyone else a part owner? Choose one of the following:

○ Allie Smith ○ Bobby Smith
○ A person outside of the household
○ Not jointly owned with anyone

If part owner, what percentage does this person own?

Is this property a life estate? ○ Yes ○ No

Is this property under construction or repair? ○ Yes ○ No

Is this property for sale with a signed sales agreement? ○ Yes ○ No

Does this property produce income? (such as farmland or rental property) ○ Yes ○ No

If property produces crops or livestock, is it for home ○ Yes ○ No

use?

Does **Mary Smith** have other real estate or property? ○ Yes ○ No

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Additional Real Estate/Property Details

Please provide more information about the property located at:
800 S monroe

Does the person for whom you are applying have a spouse, minor child or disabled child living in the home? ○ Yes ○ No

Mortgage Holder Name

Address line 1 Address line 2

City State Zip

Did **Mary Smith** retain a life estate in this property? ○ Yes ○ No

Did **Mary Smith** have a life lease? ○ Yes ○ No

Does **Mary Smith** intend to return to this property? ○ Yes ○ No

How long did **Mary Smith** live in the home?
○ Less than one year ○ One year or longer

What is the amount of monthly income produced by this property?

What is the amount of the monthly expenses for this property?

Does **Mary Smith** manage the income producing property? ○ Yes ○ No

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Business Asset Details

Business assets include machinery, livestock, supplies, and inventory.

You reported business assets for **Mary Smith**. Please answer the following questions on business assets:

Type of asset _____ Asset value _____

Are you designating any of this asset for burial? ○ Yes ○ No

If Yes, how much? _____

Is anyone else a part owner? Choose one of the following:

○ Allie Smith ○ Bobby Smith
○ A person outside of the household
○ Not jointly owned with anyone

If part owner, what percentage does this person own? _____

Does **Mary Smith** have another business asset? ○ Yes ○ No

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Asset Transfer Details

Enter details for any asset that has been sold, transferred, traded or given away in the last 3 years. This includes closing of bank accounts or adding someone to an account or property title.

You reported a transfer of assets for **Mary Smith**. Please answer the following questions on the transfer of assets:

What was the asset?

When was the asset sold, traded, transferred, or given away? (mm/dd/yyyy)

What was the value of the asset at the time?

Who was the asset sold, traded, transferred, or given to?

Why was the asset sold, traded, transferred, or given away?

Does **Mary Smith** have another asset transfer to report? ○ Yes ○ No

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You reported cash settlement information for **Mary Smith**.

Please answer the following questions: ○ Expected ○ Received

Type of cash payment received or expected to be received.

Amount of payment received or expected to be received: If unknown, leave blank

Date cash settlement received or expected to be received. Note: If you do not know the exact date, give us your best guess. (mm/dd/yyyy)

Is this payment from a personal injury or wrongful death claim? ○ Yes ○ No

Are you designating any of this asset for burial? ○ Yes ○ No

If Yes, how much?

Does **Mary Smith** have another cash settlement? ○ Yes ○ No

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Asset Summary

Asset Information

Change

Name	Liquid assets	Life insurance	Vehicle	Real estate/property	Business assets
Mary Smith	Yes	Yes	Yes	Yes	Yes
Allie Smith	No	No	No	No	No
Bobby Smith	No	No	No	No	No

Asset Information

Change

Name	Asset transfer	Received cash settlement
Mary Smith	Yes	Yes
Allie Smith	No	No
Bobby Smith	No	No

Liquid Asset Details

Change

Name	Type of asset	Bank or company name	Amount or value
Mary Smith	Cash		$400.00

Life Insurance Details

Change

Name	Type of insurance	Policy number
Mary Smith	Group	1234567

Vehicle Details

Change

Name	Year	Make	Model	Value
Mary Smith	2004	ford	taurus	

Real Estate/Property Details

Change

Name	Property type	Value
Mary Smith	Homestead property	$10,000.00

Business Asset Details

Change

Name	Type of asset	Value
Mary Smith	Bank account	$250.00

Asset Transfer Details

Change

Name	Type of asset	Date transferred	Value
Mary Smith	Life insurance	06/01/2010	$15,000.00

Cash Settlement Details

Change

Name	Type of asset	Amount

Mary Smith	Inheritance

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Employment Information

Choose everyone for whom you are applying who has income from work. Include the income of the individuals applying, including spouses, children up to age 22 and disabled children of any age if they are living in the home. If no one has these types of income, choose "No One".

Choose everyone who is working or about to begin work.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who stopped working in the last 60 days.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who refused a job in the last 60 days.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

If anyone refused a job in the past 60 days, enter the reason. (Maximum 500 characters).

You have 500 characters remaining for your description.

Choose everyone who is on strike.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

If anyone is on strike, enter the date the strike began. (mm/dd/yyyy)

Choose everyone who is self employed.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who receives payment for room and board. Roomers live in your home and pay for a room. Boarders live in your home and pay for a room and meals.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

When completed, click the Continue button below.

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Current Employment Income Details

Enter all income received from a job by everyone for whom you are applying. Please enter Work Study Income also. Provide pay stubs for the last 4 weeks or have the employer complete the Employment Verification form.

Click here to read or print the Income Verification Form.

You reported earned income from a job for **Mary Smith**. Please enter employment information for all jobs for this individual.

Employment begin date: (mm/dd/yyyy)

Number of hours worked per month

Use the drop down box to choose how often this person gets paid.

What is the gross amount of your check before any deductions?

What is the amount of tips or commission received but not included in the pay check?

Enter additional comments about this job. If you chose other, explain how often this person gets paid.

You have **500** characters remaining for your description.

Employer Name and Address Information:

Name

Address line 1

Address line 2

City

State

Zip

Phone Number

Please enter comments about employment.

You have **500** characters remaining for your description.

Does **Mary Smith** have income from any other jobs? ○ Yes ○ No

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Past Employment Income Details

Enter income from jobs that have ended in the past 60 days for all persons for whom you are applying. Provide pay stubs for the last 4 weeks or have the previous employer complete the Employment Verification form.

Click here to read or print the Income Verification Form.

You reported earned income from a job for **Mary Smith** that had ended in the past 60 days. Enter information about all jobs that ended for this person in the past 60 days.

Employment begin date: (mm/dd/yyyy)

Number of hours worked per month

Use the drop down box to choose how often this person gets paid.

What is the gross amount of your check before any deductions?

What is the amount of tips or commission received but not included in the pay check?

Enter additional comments about this job. If you chose other, explain how often this person gets paid.

You have **500** characters remaining for your description.

Employer Name and Address Information:

Name

Address line 1

Address line 2

City

State

Zip

Phone Number

Please enter comments about employment.

You have **500** characters remaining for your description.

What date did this job

Final pay date:

end? (mm/dd/yyyy) (mm/dd/yyyy)

Amount you will get this month:

Amount of pay for next month:

Did **Mary Smith** have any other job income that ended in the past 60 days? ○ Yes ○ No

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Self Employment Income and Expenses Details

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You reported self employment for **Mary Smith**. Enter the details below.

Enter the type of self employment:

Enter the number of hours worked each month:

Is this income from farming? Yes No

Type of income or expense: Choose at least one income or expense type.	**Amount of monthly income or expense:**

Do you want to add another self employment for **Mary Smith** ? Yes No

When completed, click the Continue button below.

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Room and Board Income Details

A roomer is an individual who lives in your home and pays rent for a room. A boarder is an individual who rents a room and pays you for meals.

You reported that **Mary Smith** has income from room and board. Please answer the following questions:

Choose who is paying the room and board.

Choose number of meals provided each day:

Amount received if roomer is paying for room only:

Amount received if boarder is paying for room and meals:

Enter the amount you spend to prepare meals for this individual(s):

Does **Mary Smith** have other room and board income? ○ Yes ○ No

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Employment Summary

Employment Information

Change

Name	Current employment	Past employment	Self employment	Room and board	Strike
Mary Smith	Yes	Yes	Yes	Yes	No
Allie Smith	No	No	No	No	No
Bobby Smith	No	No	No	No	No

Employment Information continued

Change

Name	Refuse a job
Mary Smith	No
Allie Smith	No
Bobby Smith	No

Current Employment Income Details

Change

Name	Employer	Income	Schedule	Comments
Mary Smith	Joe's Place	$500.00	Every Other Week	

Past Employment Income Details

Change

Name	Employer	Income	Schedule	Comments
Mary Smith	Casey's	$400.00	Monthly	

Self Employment Income and Expenses Details

Change

Name	Description	Income	Expense
Mary Smith	DayCare	$600.00	$0.00

Room and Board Income Details

Change

Name	Payer	Room	Room and board
Mary Smith	Mary Smith	$100.00	N/A

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Other Income Information

Please choose everyone for whom you are applying that receives these kinds of income. If no one receives any of these kinds of income choose "No One".

Choose everyone who gets Social Security Income (SSA).

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who gets Supplemental Security Income (SSI).

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who gets Worker's Compensation or Disability/Sick Benefits (Not SSA or SSI).

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who gets income from another agency, assistance from another state or money from another person (not child support).

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who gets Alimony or Child Support.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who gets Unemployment Compensation.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who gets money from dividends, interest income, Qualified Trust or Estate/Trust Fund.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who gets Public Retirement, Railroad Retirement, Civil Service Annuity, Union Funds or Pensions.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who gets Reparation or Black Lung Benefits.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who gets a training allowance or educational stipends.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who receives Veteran's Benefits or Military Allotments.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who gets money from Home Care for the Elderly program.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who gets money from any other source.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who has applied for but not been approved for these benefits.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

When completed, click the Continue button below.

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Qualified Income Trust Information

Please carefully read the Qualified Income Trust Information below:

What is a Qualified Income Trust?

If your income is over the limit to qualify for Medicaid long-term care services (including nursing home care), a Qualified Income Trust (QIT) allows you to become eligible by placing income into an account each month that you need Medicaid. The QIT involves a written agreement, setting up a special account and making deposits into the account.

Who needs a Qualified Income Trust?

You need a QIT if your income before any deductions (such as taxes, Medicare, or health insurance premiums) is over the limit to qualify for the Institutional Care Program (ICP), Institutional Hospice, Program of All-Inclusive Care for the Elderly (PACE) or the Home and Community Based Services(HCBS) waivers.

How do I set up a Qualified Income Trust agreement?

You may obtain professional help to set up the QIT agreement, but it is not required. A QIT agreement must meet specific requirements and be approved by Department of Children and Families legal offices. You must submit a copy of the QIT agreement to an eligibility specialist who will forward it to our legal offices for review.

What items must be included in the Qualified Income Trust agreement?

The QIT agreement must:

- Be irrevocable (cannot be canceled).
- Require that the State will receive all funds remaining in the trust at the time of your death (up to the amount of Medicaid benefits paid on your behalf).
- Consist of your income only. (Do not include or add assets).
- Be signed and dated by you, your spouse, or a person who has legal authority to act on your behalf or who is acting at your request or the request of your spouse.

How does the Qualified Income Trust account work?

After setting up the account, you must make deposits into the QIT account every month for as long as you need Medicaid. This means you may need to make deposits before a Medicaid application is approved if you need Medicaid coverage.

You cannot make deposits for a past or future month. Any income you receive back from the trust to you will be counted as income to you.

If you fail to make a deposit in any given month, or to deposit enough income you will be ineligible for Medicaid payment of long- term care services for the month.

As long as you deposit income into the QIT account in the month it is received, it will not be counted when we determine if you are eligible for Medicaid for that month.

How much income must I deposit into the Qualified Income Trust account?

You must deposit enough income into the QIT account each month so that your income outside the QIT account is within program standards. It is better to deposit more income than take the chance of depositing too little to qualify for Medicaid.

Call (866) 762-2237 or visit

http://www.dcf.state.fl.us/programs/access/docs/ssi_fin_elig_chart.pdf

for information about current income standards

What happens to the income I deposit in the Qualified Income Trust account?

The income you have in and out of the QIT is used to calculate your patient responsibility. If you do have a patient responsibility, you are responsible for paying that amount. If there is money left in the QIT upon your death, it is paid to the State, up to an amount equal to the total medical assistance paid on your behalf by the state while the trust was in effect.

How to pay funds remaining in the QIT to the State?

The QIT trustee or other individual acting on your behalf should contact the long term care facility to see if any refund for the month of death is due back to the trust. The balance of the QIT at the date of death, plus any refund from the long term care facility is to be paid to the State.

Mail a check payable to the "Agency for Health Care Administration" to:

ACS Recovery Services

PO Box 12188

Tallahassee, FL 32317-2188

A brief cover letter or note should state that the payment is for a QIT and include your name, Social Security number, and/or Medicaid ID number. Enclose a copy of the QIT bank statement covering the date of death to confirm the check is for the balance. Also, include documentation of any refunds received from the long term care facility.

Contact ACS at (877) 357-3268 for questions regarding payment of QIT funds to the State.

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Other Income Details

Please tell us about the other types of income that are received by anyone for whom you are applying.

You reported **Social Security Income** for **Mary Smith.** Enter details about this income.

Choose the kind of income being received:

Amount of income:

Use the drop down box to choose how often the individual gets the income.

When did the individual start receiving this income? Note: If you do not know the exact date, give us your best guess. (mm/dd/yyyy)

Does **Mary Smith** get other income from **Social Security Income** ? ○ Yes ○ No

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Application for Other Benefits Details

Enter information about benefits that the individual has applied for but is not yet receiving.

You reported **Mary Smith** applied for, but is not yet receiving other benefits. Please enter information about the benefits.

Choose the type of income or benefits applied for.

Enter the date the benefits were applied for. (mm/dd/yyyy)

Has **Mary Smith** applied for any other benefits? ○ Yes ○ No

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Other Income Information

Change

Name	Social Security Income	Supplemental Security Income	Worker's Compensation or Disability/Sick Benefits	Income from another agency, assistance from another state or money from another person	Alimony or child support
Mary Smith	Yes	No	No	No	No
Allie Smith	No	No	No	No	No
Bobby Smith	No	No	No	No	No

Other Income Information continued

Change

Name	Unemployment Compensation	Dividends, Interest Income, Qualified Trust or Estate/Trust Fund	Public Retirement, Railroad Retirement, Civil Service Annuity, Union Funds or Pensions	Reparation Payment or Black Lung Benefits
Mary Smith	No	No	No	No
Allie Smith	No	No	No	No
Bobby Smith	No	No	No	No

Other Income Information continued

Change

Name	Training Allowance or Educational Stipends	Veteran's Benefits or Military Allotments	Home Care for the Elderly or Disabled Adults	Other source	Application for Other Benefits
Mary Smith	No	No	No	No	Yes
Allie Smith	No	No	No	No	No
Bobby Smith	No	No	No	No	No

Other Income Details

Change

Name	Type	Amount	How often received	Income begin date
Mary Smith	Social Security	$850.00	Monthly	6/1/2010

Application for Other Benefits Details

Change

Name	Type	Date applied
Mary Smith	Dividends	6/1/2011

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Insurance Information

Please tell us if the people you are applying for have Medicare or health insurance. Complete each question for each kind of insurance even if someone outside the household pays all or part of the expense.

Choose everyone that has Medicare. Medicare is an insurance program through the Social Security Administration. Most people who have Medicare have a "Red, White and Blue" card and pay a premium. Medicare is not the same as Medicaid.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Does anyone have or pay for health insurance? Health insurance pays for a doctor, hospital, or any other type of medical service including TRICARE.

○ Yes ○ No

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Medicare Details

Enter information about Medicare, an insurance program through the Social Security Administration.

You reported that **Mary Smith** has Medicare. Please complete the following:

Enter the Medicare number. The number is on the "Red, White and Blue card."

☐ I don't know

Does coverage include Medicare Part A? ○ Yes ○ No

Does coverage include Medicare Part B? ○ Yes ○ No

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Medicare Premium Details

You reported that **Mary Smith** has Medicare. Please complete the following:

How much is the premium for Medicare Part A?

When did the Medicare Part A begin? Note: If you do not know the exact date, give us your best guess.(mm/dd/yyyy)

Who pays the premium?

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You reported health insurance. Enter health insurance information for everyone for whom you are applying even if someone outside the household pays for the insurance.

Choose each individual covered by this health insurance.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith

Type Coverage

Insurance company information:

Name

Address line 1 Address line 2

City State

Zip

Policy Number

Group Number

Group Name

Begin Date (mm/dd/yyyy) Premium amount

Choose who pays for this policy?

○ Mary Smith ○ Allie Smith ○ Bobby Smith ○ Other

Do you want to add another health insurance policy? ○ Yes ○ No

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Health Insurance paid for by someone outside of the household

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You reported that someone outside of the household pays for **Blue Cross** 's insurance. Please enter that person's name and address.

First name | Middle initial | Last name

Address line 1 | Address line 2

City | State | Zip

Is this individual an absent parent? Yes No

Is this court ordered coverage? Yes No Unknown

When completed, click the Continue button below.

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Expense Information

Please tell us about the household expenses of the individuals for whom you are applying. Complete questions for each expense that is paid even if someone outside the household pays all or part of the expense. If no one is billed for or pays any of these expenses, choose "No One".

Choose everyone who is billed for or pays housing costs even if someone outside of the household pays all or part of the expense, including Section 8 and HUD. Housing costs are rent, mortgage, room rent, condominium fees, property taxes, homeowner's insurance, etc.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who is billed for or pays utility costs even if someone outside of the household pays all or part of the expense, including Section 8 and HUD. Utility costs are electricity, phone, coal/wood, fuel oil, gas, trash removal, or water and sewer.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who is billed for or pays child or adult daycare expenses. Daycare expenses are paid for the care of someone in the household so another person in the household can go to work.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who pays room and board expense. This means that you are paying money to rent a room and meals are included.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who pays or is billed for heating or cooling costs.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who is homeless and billed for or pays a housing expense such as shelter, mission or hotel cost.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who pays Support Payments. Support payments are child support or daycare expenses paid by someone in the household for someone who lives outside of the household.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone you are applying for who has any unpaid medical bills in the last three months?

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who has medical expenses such as but not limited to prescriptions, glasses, transportation, doctor visits, dental, health aides, hospitalization, or insurance or Medicare premiums not covered by insurance or another third party.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Choose everyone who is blind and employed with work-related expenses.

☐ Mary Smith ☐ Allie Smith ☐ Bobby Smith ☐ No One

Did anyone that you are applying for receive Low Income Housing Energy Assistance (LIHEAP) in the past 12 months.

○ Yes ○ No

When completed, click the Continue button below.

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Housing Expense Details

Housing expenses include rent, mortgage, condo fees, property taxes, and homeowner's insurance.

You reported expenses for **Mary Smith**. Enter all housing expenses even if someone outside of the home pays all or part of the cost.

Type of housing expense

What is the full monthly amount?

If someone else pays part or all of the expense, enter the name of the person or organization that pays.

How much do they pay?

If Section 8 or HUD pays all or part of the housing, choose which one.
Section 8 ☐ or HUD ☐

Section 8 or HUD, Enter comments about your housing expenses.

You have **500** characters remaining for your description.

Does **Mary Smith** have another housing expense? ○ Yes ○ No

When completed, click the Continue button below.

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Utility Expense Details

Utility costs include electricity, phone, coal/wood, fuel oil, gas, trash removal, or water and sewer.

You reported utility expenses for **Mary Smith**. Enter all housing expenses even if someone outside of the home pays all or part of the cost.

Type of utility expense What is the full monthly amount?

If someone else pays part or all of the expense, enter the name of the person or organization that pays.

How much do they pay?

If Section 8 or HUD pays all or part of the utility expense choose which one.
Section 8 ☐ or HUD ☐

Enter comments about your utility expenses.

You have **500** characters remaining for your description.

Does **Mary Smith** have another utility expense? ○ Yes ○ No

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Child or Adult Daycare Expense Details

Enter all daycare expenses being paid for an individual in the household by anyone for whom you are applying.

Click here to read or print the Verification of Dependent Care Expenses form.

You reported that **Mary Smith** is paying for child or adult daycare expenses.

Paid to: Paid for:

Monthly amount paid:

Name of person caring for the child or adult:

First name Middle initial Last name

Provide caregivers address and phone number:

Address line 1 Address line 2

City State Zip

Phone number

Do you want to add another child or adult daycare expense for **Mary Smith**? Yes No

When completed, click the Continue button below.

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Room and Board Expense Details

By room and board, we mean that you are paying money to rent a room and meals are included.

You reported that **Mary Smith** pays to rent a room which includes meals.

Monthly amount: Number of meals each day:

Room charge included? Yes No

Who does the room and board payment cover?
Mary Smith Allie Smith Bobby Smith

Does **Mary Smith** have another room and board expense? Yes No

When completed, click the Continue button below.

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Support Payment Details

Child support or dependent care expenses. These are expenses paid by someone in the household for an individual who lives outside of the household.

You reported child support or daycare care expenses paid by **Mary Smith**. Please enter the information below.

Enter monthly amount paid:

Payment type:

Is this court ordered?

Is the court ordered amount paid?

Amount of the court order:

Choose the relationship of the dependent to the individual making the payment:

Dependent's name and address:

First name: Middle initial: Last name:

Address line 1:

Address line 2:

City: State: Zip:

Phone number:

Is **Mary Smith** paying any other child support or dependent care expenses? Yes No

When completed, click the Continue button below.

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Past Medical Expense Details

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You reported that Mary Smith has unpaid medical bills from the past 3 months. You may need to provide proof of income, assets and bills for these months.

Choose which of the past 3 months **Mary Smith** has unpaid medical bills.

☐ July ☐ August ☐ September

When completed, click the Continue button below.

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Medical Expense Details

Medical expenses are bills such as but not limited to prescriptions, glasses, transportation, doctor visits, dental, health aides, hospitalization, or insurance or Medicare premiums not covered by insurance or another third party.

You reported that **Mary Smith** has ongoing medical expenses. Please provide the following information for each bill.

Medical expense type:

Total amount billed:

Monthly payment:

Name of the service provider :

Does **Mary Smith** need to add another medical expense? ○ Yes ○ No

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Blind Work Expense Details

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You reported that **Mary Smith** has a blind work related expense. Please complete the following.

Expense type:

Monthly amount:

Does **Mary Smith** have another blind work related expense to add? ○ Yes ○ No

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Expense Summary

Expense Information

Change

Name	Medicare	Housing	Utility	Child/adult daycare
Mary Smith	Yes	Yes	Yes	Yes
Allie Smith	No	No	No	No
Bobby Smith	No	No	No	No

Expense Information continued

Change

Name	Room and board	Heating and cooling costs	Homeless	Support payments
Mary Smith	Yes	Yes	Yes	Yes
Allie Smith	No	No	No	No
Bobby Smith	No	No	No	No

Expense Information continued

Change

Name	Past Medical expense	Medical expense	Blind Work expense
Mary Smith	Yes	Yes	Yes
Allie Smith	No	No	No
Bobby Smith	No	No	No

Health Insurance	Yes
Received low income housing energy assistance (LIHEAP)?	Yes

Health Insurance Details

Change

Name	Type	Expense amount	Other payer
joes smith	Basic medical	$150.00	Yes

Medicare Details

Change

Name	Medicare number	Part A	Part B
Mary Smith	Not entered	Yes	No

Medicare Premium Details

Name	Part A amount	Part B amount
Mary Smith	$150.00	N/A

Housing Expense Details

Change

Name	Expense type	Expense amount	Other payer Comments
Mary Smith	Condo/Maintenance main	$100.00	Not entered

Utility Expense Details Change

Name	Expense type	Expense amount	Other payer	Comments
Mary Smith	Electricity	$55.00	Not entered	

Child or Adult Daycare Expense Details Change

Paid by	Paid for	Provider name	Amount
Mary Smith	Bobby Smith	Jackie House	$150.00

Support Payment Details Change

Paid by	Paid for	Type	Amount
Mary Smith	Dave Smith	Child support	$100.00

Room and Board Expense Details Change

Name	Meals	Room included	Amount
Mary Smith	0	No	$100.00

Past Medical Expense Details Change

Name	Months
Mary Smith	July , August , September

Medical Expense Details Change

Paid by	Type	Provider
Mary Smith	Unpaid High Hospital Bill	Hospital

Blind Work Expense Details Change

Name	Type	Amount
Mary Smith	Bus Trans To/From Work	$50.00

When completed, click the Continue button below.

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Case Summary

Application Summary

Name Change

Mary Smith

Household living address Change

1940 N Monroe St , Tallahassee , FL , 32303

Mailing address Change

Not entered

Contact information Change

Home phone: Cell phone:
Work phone: Email address:

Notice language Change

English

Who is applying (Change)	Type of benefits selected (Change)
☑ I am applying for myself	☑ Food Assistance Program
☐ I am applying for myself and my family	☑ Cash assistance for myself or myself and my family
☐ I am applying for another individual (not myself)	☑ Cash assistance for a child the court's placed with me
	☑ Cash assistance for a child that is not mine but is related to me
	☑ Cash assistance for Refugees
	☑ Medicaid
	☑ Nursing Home Medicaid Coverage
	☑ HCBS/Waivers
	☑ Hospice
	☑ Medicare Savings Program
	☑ Simplified Eligibility for Pregnant women

Household Summary

Household List Change

Name	SSN	Date of birth	Sex	Apply for benefits
Mary Smith	810051100	07/15/1970	Female	Yes
Allie Smith	Not entered	04/12/2001	Male	Yes
Bobby Smith	Not entered	02/18/2010	Male	Yes

Household List Continued Change

Name	Marital status	Living arrangement
Mary Smith	Single - never married	Nursing home
Allie Smith	Single - never married	Home/apartment/trailer
Bobby Smith	Single - never married	Home/apartment/trailer

Rights and Responsibilities reviewed?	Yes
HIPAA statement reviewed?	Yes

Household Relationships Change

Name	Relationship	Buys and eats food with you?
Allie Smith (10) is Mary Smith 's (41)	Son	Yes
Bobby Smith (1) is Mary Smith 's (41)	Son	Yes
Mary Smith (41) is Allie Smith 's (10)	Mother	Yes
Bobby Smith (1) is Allie Smith 's (10)	Brother	Yes
Mary Smith (41) is Bobby Smith 's (1)	Mother	Yes
Allie Smith (10) is Bobby Smith 's (1)	Brother	Yes

Household Information Change

Name	Citizen	Florida resident	Alias/SSN	US Military	Out of U.S.
Mary Smith	No	Yes	Yes	Yes	Yes
Allie Smith	Yes	Yes	No	No	No
Bobby Smith	Yes	Yes	No	No	No

Household Information continued Change

Name	Pregnancy	School	Fleeing the law due to a felony or probation or parole violation
Mary Smith	Yes	No	No
Allie Smith	N/A	Yes	N/A
Bobby Smith	N/A	No	N/A

Household Information continued Change

Name	Convicted of drug trafficking felony	Convicted of receiving benefits in more than one state at the same time	Received Food, Cash or Medicaid assistance from another state or source
Mary Smith	No	No	No
Allie Smith	N/A	N/A	No
Bobby Smith	N/A	N/A	No

Additional Household Information Change

Name	Disability	Renal Dialysis	Hospice	HCBS/Waiver	Received SSI in past but

					not receiving now
Mary Smith	Yes	No	Yes	Yes	Yes
Allie Smith	No	No	No	No	No
Bobby Smith	No	No	No	No	No

Additional Household Information Change

Name	Children limited or prevented in any way in ability to do the things most children of the same age can do	Children that need or get special therapy such as physical, occupational or speech therapy or treatment or counseling for emotional, developmental or behavioral problems.	Children that need or use more medical care, mental health or educational services than usual for children of the same age
Mary Smith	N/A	N/A	N/A
Allie Smith	No	No	No
Bobby Smith	No	No	No

Additional Household Information Change

Name	Immunization	Child Health Checkup Services	Emancipated minor	Foster child	Human Trafficking
Mary Smith	N/A	N/A	N/A	N/A	No
Allie Smith	N/A	Yes	No	No	N/A
Bobby Smith	Yes	Yes	No	No	N/A

Certification of Identity Change

Name	Certification
Allie Smith	Not certified
Bobby Smith	Not certified

Absent Parent Details Change

Absent parent's name	Child Name	Reason for absence	CSE services
Joe Smith	Allie Smith Bobby Smith	Not entered	Yes

Long Term Care Details Change

Name	Facility
Mary Smith	Shady Pines

Additional Long Term Care Details Change

Name	County of placement	Date of Admission
Mary Smith	Leon	6/1/2011

Prior Residence Information Change

Name	County	Contact person
Mary Smith	Leon	Bruce Smith

Noncitizen Details Change

Name	Date entered the United States	USCIS number	Medical emergency date
Mary Smith	6/1/2010	a941	9/1/2010

Alias Name/or Social Security Number (SSN) Details Change

Name	Alias name	Alias SSN
Mary Smith	MaryEllen Walton	

Household Information Details Change

Name	Date left U.S.	Date returned to U.S.
Mary Smith	6/1/2011	Not entered

Pregnancy Details Change

Name	Due date	Babies expected
Mary Smith	6/1/2012	1

School Details Change

Name	School type	Graduation date
Allie Smith	Elementary	Not entered

Disability Details Change

Name	Disability established
Mary Smith	Yes

Disability pamphlet reviewed? Yes

Supplemental Security Income Details Change

Name	Received SSI and SSA at the same time	Received SSI in month before receiving SSA benefits
Mary Smith	Yes	Yes

Case Information Change

Register to vote	Interested in Lifeline assistance	Migrant or seasonal farm worker

Yes	Yes	Yes

Case Details

Currently have phone service	SSN	Phone service provider	Phone number	Name on the phone bill
Yes	810051100	T-Mobile South LLC (cell phone)	(850)123-4567	Mary Smith

Migrant Details Change

Income terminated	New income source	Paid date	Amount paid
Yes	No	Not entered	Not entered

Asset Summary

Asset Information Change

Name	Liquid assets	Life insurance	Vehicle	Real estate/property	Business assets
Mary Smith	Yes	Yes	Yes	Yes	Yes
Allie Smith	No	No	No	No	No
Bobby Smith	No	No	No	No	No

Asset Information Change

Name	Asset transfer	Received cash settlement
Mary Smith	Yes	Yes
Allie Smith	No	No
Bobby Smith	No	No

Liquid Asset Details Change

Name	Type of asset	Bank or company name	Amount or value
Mary Smith	Cash		$400.00

Life Insurance Details Change

Name	Type of insurance	Policy number
Mary Smith	Group	1234567

Vehicle Details Change

Name	Year	Make	Model	Value
Mary Smith	2004	ford	taurus	

Real Estate/Property Details Change

Name	Property type	Value
Mary Smith	Homestead property	$10,000.00

Business Asset Details Change

Name	Type of asset	Value

Mary Smith	Bank account	$250.00

Asset Transfer Details Change

Name	Type of asset	Date transferred	Value
Mary Smith	Life insurance	06/01/2010	$15,000.00

Cash Settlement Details Change

Name	Type of asset	Amount
Mary Smith	Inheritance	

Employment Summary

Employment Information Change

Name	Current employment	Past employment	Self employment	Room and board	Strike
Mary Smith	Yes	Yes	Yes	Yes	No
Allie Smith	No	No	No	No	No
Bobby Smith	No	No	No	No	No

Employment Information continued Change

Name	Refuse a job
Mary Smith	No
Allie Smith	No
Bobby Smith	No

Current Employment Income Details Change

Name	Employer	Income	Comments
Mary Smith	Joe's Place	$500.00	

Past Employment Income Details Change

Name	Employer	Income	Comments
Mary Smith	Casey's	$400.00	

Self Employment Income and Expenses Details Change

Name	Description	Income	Expense
Mary Smith	DayCare	$600.00	$0.00

Room and Board Income Details Change

Name	Payer	Room	Room and board
Mary Smith	Mary Smith	$100.00	N/A

Other Income Summary

Other Income Information Change

Name	Social	Supplemental	Worker's	Income	Alimony

	Security Income	Security Income	Compensation or Disability/Sick Benefits	from another agency, assistance from another state or money from another person	or child support
Mary Smith	Yes	No	No	No	No
Allie Smith	No	No	No	No	No
Bobby Smith	No	No	No	No	No

Other Income Information continued Change

Name	Unemployment Compensation	Dividends, Interest Income, Qualified Trust or Estate/Trust Fund	Public Retirement, Railroad Retirement, Civil Service Annuity, Union Funds or Pensions	Reparation Payment or Black Lung Benefits
Mary Smith	No	No	No	No
Allie Smith	No	No	No	No
Bobby Smith	No	No	No	No

Other Income Information continued Change

Name	Training Allowance or Educational Stipends	Veteran's Benefits or Military Allotments	Home Care for the Elderly or Disabled Adults	Other source	Application for Other Benefits
Mary Smith	No	No	No	No	Yes
Allie Smith	No	No	No	No	No
Bobby Smith	No	No	No	No	No

Other Income Details Change

Name	Type	Amount	How often received	Income begin date
Mary Smith	Social Security	$850.00	Monthly	6/1/2010

Application for Other Benefits Details Change

Name	Type	Date applied
Mary Smith	Dividends	6/1/2011

Expense Summary

Expense Information Change

Name	Medicare	Housing	Utility	Child/adult daycare
Mary Smith	Yes	Yes	Yes	Yes
Allie Smith	No	No	No	No

Bobby	Smith	No	No	No	No

Expense Information continued Change

Name	Room and board	Heating and cooling costs	Homeless	Support payments
Mary Smith	Yes	Yes	Yes	Yes
Allie Smith	No	No	No	No
Bobby Smith	No	No	No	No

Expense Information continued Change

Name	Past Medical expense	Medical expense	Blind Work expense
Mary Smith	Yes	Yes	Yes
Allie Smith	No	No	No
Bobby Smith	No	No	No

Health Insurance	Yes
Received low income housing energy assistance (LIHEAP)?	Yes

Health Insurance Details Change

Name	Type	Expense amount	Other payer
joes smith	Basic medical	$150.00	Yes

Medicare Details Change

Name	Medicare number	Part A	Part B
Mary Smith	Not entered	Yes	No

Medicare Premium Details

Name	Part A amount	Part B amount
Mary Smith	$150.00	N/A

Housing Expense Details Change

Name	Expense type	Expense amount	Other payer	Comments
Mary Smith	Condo/Maintenance main	$100.00	Not entered	

Utility Expense Details Change

Name	Expense type	Expense amount	Other payer	Comments
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Child or Adult Daycare Expense Details Change

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Paid by	Type	Provider
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Blind Work Expense Details Change

Name	Type	Amount
Mary Smith	Bus Trans To/From Work	$50.00

Comments

You have **500** characters remaining for your description.

When completed, click the Continue button below.

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Statement of Understanding

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Read the following carefully. It explains what the Department of Children and Families (DCF) can do with the information you provide and what may happen if you give incorrect information. When you finish reading this section click on the "I Understand" button. If you have any questions, contact DCF for help.
The information given on this application and at any interview, and information the Department of Children and Families gets from other agencies using computerized data matches, may be checked by DCF, and federal and state agencies including the office of Public Assistance Fraud (PAF).

I understand and agree to the following:

- DCF, PAF, and authorized federal and state agencies may check the information I give on this application and at any interview.
- My signature on this application authorizes DCF and PAF to contact my current and past employers to check the information I have provided.
- To get Medicaid, I give the state Medicaid office permission to look at and share all medical records necessary under its auditing and investigatory authority.
- If any information I give on this application or during any interview is not correct, my benefits may be reduced or denied.
- If it is found that I gave incorrect information on purpose, I may be subject to criminal prosecution and/or disqualified from getting Food Assistance, Temporary Cash assistance, or Medicaid Programs.
- I was given a chance to read My **Rights and Responsibilities ,** explaining what I can expect from DCF and what DCF expects from me.
- I certify under penalty of perjury, the information on this application is true to the best of my knowledge, including the citizenship or noncitizen status of those applying for benefits.
- I was given information about DCF's operating procedure CFOP 60-17 Chapter 1, Attachment 2, **Management and Protection of Personal Health information,** explaining how DCF can use and protect my medical information.
- **Privacy Act Statement**
  Collecting the information on your application, including the social security number (SSN) of each household member, is authorized under the Food Stamp Act of 1977, as amended, 7 U.S.C. 2011-2036, will be verified through computer matches, and is voluntary. We will use the information to determine initial and ongoing eligibility for public assistance, to check on compliance with program rules, and will deny public assistance under Federal benefit programs for each person who fails to provide an SSN. We will use any SSNs you provide the same way we use SSNs of eligible household members. We may give this information to Federal and State agencies for official investigation and to law enforcement so they can find people running away from the law. If you get benefits for which you are not eligible, we may refer your information to Federal and State agencies or private collection agencies to collect the overpayment.
- **Florida Department of Children and Families Non-Discrimination Statement**
  No person shall, on the basis of race, color, religion, national origin, sex, age, or disability be excluded from participation in, denied the benefits of, or be subjected to unlawful discrimination under any program or activity receiving

or benefiting from federal financial assistance and administered by the Department. To file a complain, alleging violations of this policy, contact the Office of Civil Rights, Florida Department of Children and Families, 1317 Winewood Boulevard, Building 1, Room 101, Tallahassee, Florida 32399-0700 or call 1-850-487-1901 or TDD 1-850-922-9220.

- **USDA-HHS Non-Discrimination Statement**
  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 and Nutrition 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, Room 326-W, Whitten Building, 1400 Independence Avenue, S. W., Washington, D. C. 20250-9410 or call (202) 720-5964 (voice or TDD). Write Regional Manager, DHHS Office of Civil Rights, Region IV, Atlanta Federal Center, 61 Forsyth Street, SW, Suite 3B70, Atlanta, GA 30303-8909 or call 1-800-368-1019 or TDD 1-800-537-7697.

You must check YES to continue

☐ **Yes, I have read and understand the "Statement of Understanding"**

When completed, click the Continue button below.

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Electronic Signature

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You may submit your application using an electronic signature by clicking the "SIGN NOW" button below.

Clicking on the "SIGN NOW" button means that you accept responsibility that all the information given on this application is correct. Clicking on the "SIGN NOW" button allows DCF to accept and finish working on your online application. If you do not click the "SIGN NOW" button The department has not received a completed application

If you do not submit the online application within 30 days, you will have to start the process over. If you have any questions about the online application, you may call or visit a DCF office for additional information. If you chose not to sign and submit your application electronically, you may file a paper application.

I certify under penalty of perjury, the information on this application is true to the best of my knowledge, including the citizenship or noncitizen status of those applying for benefits.

I choose to apply for public assistance benefits for myself, my family or someone else. I choose to apply using the internet and authorize processing my online application with my electronic signature.	If you do not wish to apply for public assistance using the internet, whether for yourself, your family, or someone else, and you do not wish to authorize processing of your application with your electronic signature, then please click "Save & Quit". Complete a paper application if you still wish to apply for public assistance.
Sign Now	Save & Quit

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Electronic Signature

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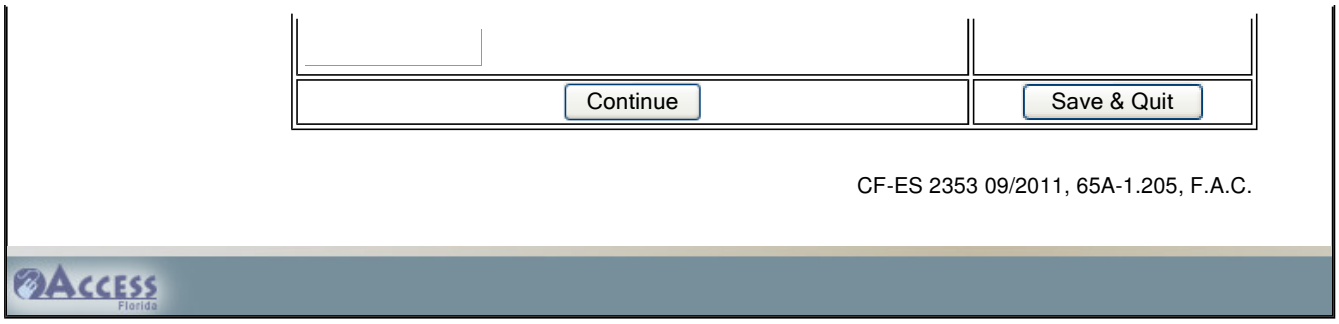
I certify under penalty of perjury, the information on this application is true to the best of my knowledge, including the citizenship or noncitizen status of those applying for benefits.

I choose to apply for public assistance on behalf of someone else. I choose to apply using the internet and authorize processing my application with my electronic signature. I understand by applying for public assistance on behalf of someone else I accept responsibility for the information given on this application. The Department of Children and Families may need to mail you appointment notices and information about actions taken on the case because you are the designated representative. Please provide your First name Middle initial Last name Suffix Address line 1 Address line 2 City State Zip Phone number	If you do not wish to apply for public assistance using the internet, whether for yourself, your family, or someone else, and you do not wish to authorize processing of your application with your electronic signature, then please click "Save & Quit". Complete a paper application if you still wish to apply for public assistance.


Continue
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Department of Children & Families — Acceptance Test — ACCESS Florida

ACCESS Online #: 800026543 Print

CONFIRMATION PAGE

Your electronic application for assistance, dated 10/06/2011 has been received.

Your ACCESS number is 800026543.

You may print this page for your receipt.

Would you like to get an email confirmation? ○ Yes ○ No

We will send an email confirmation to the email address you entered.
By entering your email address you are saying it is okay for the department to send emails to you about your case.

Email Address _____ Retype email address _____

If you are completing this application for assistance between the hours of 8:00 AM and 4:00 PM (Monday thru Friday excluding holidays) and you are available to speak to a Department representative, please include a phone number where we can reach you if necessary. _____

Would you be willing to complete a survey? ○ Yes ○ No

Your application is dated the day you submit it using the electronic signature. The date of application will be the next business day if we get your application after hours or on a weekend or holiday Allow 15 to 30 days to process your application. Some applications for Medicaid may take longer if we need to determine if someone is disabled.

We have determined that you are not eligible for an expedited interview: You do not appear to meet the expedited food assistance criteria because of the answers you gave on this application.

Read the following information about what happens next.

- If you are at a local Customer Service Center, you may have a short interview with Department of Children and Families staff, or
- If you are not at a (DCF) Service Center, we may contact you for more information.
- If we need more information or to interview you, we will contact you within 5 to 10 days after getting your application.

After we process your application you will get a letter with a decision about the benefits you applied for.

If you would like to check the status of your application you may go to **http://www.myflorida.com/accessflorida** and click on the My ACCESS Account link. My ACCESS Account will allow you to view information about your case. This information will include any scheduled appointments, information still needed to determine benefits and any benefits for which you may be eligible.

If you need to add comments to this application before it is processed, go back to the beginning of the application and choose, "Add Comments to an Application that Has been Submitted With an E-signature". If we are already processing your case, you will receive a message when you enter the ACCESS number and will not be able to enter the comments.

Normal business hours are 8:00 A.M until 5:00 P. M. local time, Monday through Friday.

Continue

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Department of Children & Families — Acceptance Test — ACCESS Florida

ACCESS Online #: 800026543

ACCESS Online Survey

Thank you for agreeing to complete our survey. This will only take you a few minutes. Please tell us about your experience using the ACCESS ONLINE Web Application.

Please rate your experience with our screens:	○ Easy	○ Fair	○ Difficult
How long did it take to complete the application ?	○ 1-30 minutes	○ 30-60 minutes	○ more than 1 hour
Did you need help using the Web application?	○ Yes	○ No	
If you needed help, was the help available?	○ Yes	○ No	
If you received help, where did you get the help?	○ Help screens	○ Staff or other person	○ Both

If you had problems completing the application, where was the problem?

○ Adding Persons	○ Completing Relationships	○ Income questions
○ Asset questions	○ Expense questions	○ Other

Where were you when you completed the application	○ In a DCF Office		○ Other Location
How much computer experience do you have?	○ First time user	○ Use occasionally	○ Use frequently
Would you use this web application again?	○ Yes	○ No	

Thank you for completing this survey.

Continue

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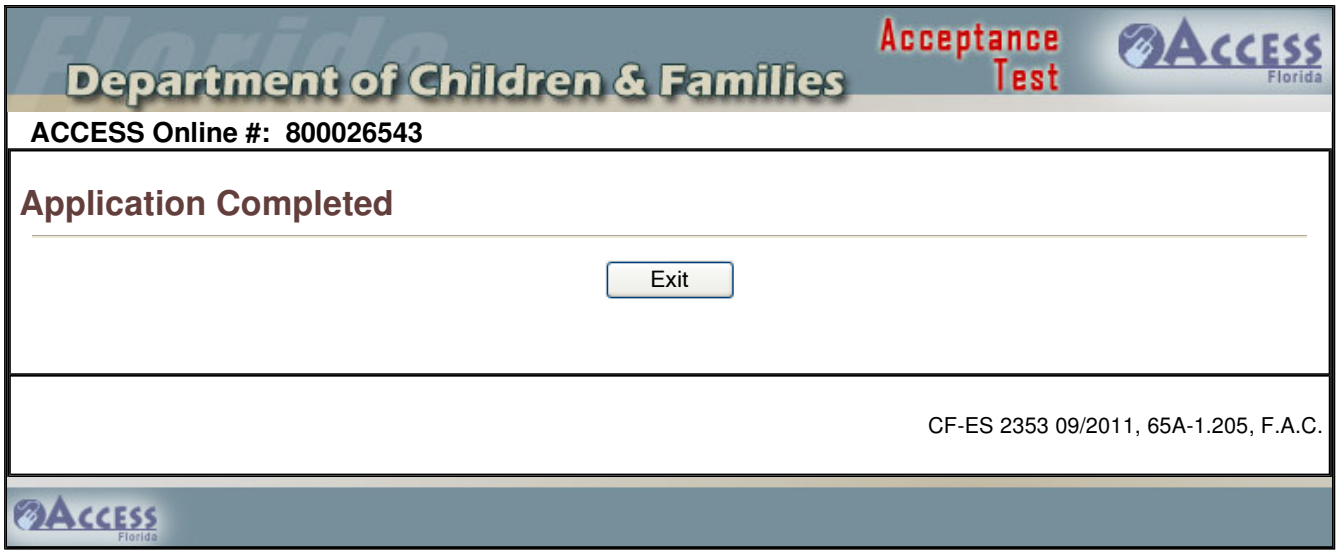
Department of Children & Families
Acceptance Test
ACCESS Florida
ACCESS Online #: 800026543
Application Completed
Exit
CF-ES 2353 09/2011, 65A-1.205, F.A.C.
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