Application for Assistance

Food Assistance

The Supplemental Nutrition Assistance Program (SNAP) helps families buy food for good health. Eligible families get a debit-like card to buy food items. Participants may be required to participate in work programs and cooperate with Child Support Services. Benefits are prorated from your application date.

Cash Assistance

The Temporary Assistance for Families in Idaho program (TAFI) provides cash assistance for emergency situations to families with children. Eligible families receive a one-time or ongoing payment, depending on the needs of the household. The Aid to the Aged, Blind, and Disabled (AABD) program provides cash assistance to individuals eligible for SSI and who meet other guidelines.

Health Coverage Assistance

Health Coverage Assistance (HCA) is available according to individual needs. Eligible families may qualify for Medicaid or Advance Payment of Premium Tax Credit (APTC) to help pay health coverage premiums or affordable private health insurance plans.

Child Care Assistance

The Idaho Child Care Program (ICCP) helps parents and caretakers pay for a part of their child care costs while working, going to school, or participating in approved training activities. Eligible families receive a portion of child care costs paid to the provider.

WHO
can use this application

Anyone can use this application to:

- Apply for assistance for themselves and/or their household members
- Apply for just one type of assistance or for multiple types of assistance

WHAT
you may need to apply

Attaching proof of the household's **income** to this application may help us determine your eligibility faster. We may need other proof, such as verification of resources or expenses, to process your application, but we will ask for this only if we need it.

RESOURCES
to help with this application

Online: healthandwelfare.idaho.gov

Phone: 1-877-456-1233 (toll free) or 1-800-377-3529 (TTY) or 1-800-377-1363 (Voice)

Email: MyBenefits@dhw.idaho.gov

In person: Visit our website or call using the number above to find a local office.

Language interpretation is available at 1-877-456-1233. See the back of this page for more information on accessibility and interpretation services.

WHY
we ask for this information

We keep all information private and secure, as required by law. We ask for this information for a few reasons:

- To figure out what types of assistance you qualify for
- To figure out how much assistance you qualify for
- To make sure you get the right amount of assistance based on your situation

Equal opportunity for applicants

In accordance with federal law and U.S. Department of Agriculture (USDA) and Health and Human Service (HHS) policy, the Idaho Department of Health and Welfare is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited on the basis of religion or political beliefs. To file a complaint of discrimination, contact USDA or HHS at:

U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

Fax: 202-690-7442
Email: program.intake@usda.gov

U.S. Department of Health & Human Services
Room 506F, 200 Independence Avenue, SW
Washington, D.C. 20201

Email: OCRcomplaint@hhs.gov
Phone: 202-619-0403 (Voice)
202-619-3257 (TTY)

HOW
to submit this application

Send your complete, signed application to:

Self-Reliance Programs - Statewide Application Team
PO Box 83720
Boise, ID 83720-0026

Fax: 1-866-434-8278
Email: MyBenefits@dhw.idaho.gov

Eligibility determinations are based on the rules and requirements which pertain to the program you are applying for. We will tell you if you're eligible or not, or give you further instructions for completing your application. You also can check the status of your application online at idalink.idaho.gov.

Accessibility and interpretation services

The Idaho Department of Health and Welfare (IDHW) offers the following services free to you. Please ask if you need the following assistance to communicate more effectively with us:

- Assistance in understanding this form
- Accommodation for a disability
- Language Interpreter

To access any of these services, please call: 1-877-456-1233 (toll free) or 1-800-377-3529 (TTY) or 1-800-377-1363 (Voice) for those with a hearing impairment.

English	ATTENTION: Language assistance services, free of charge, are available to you. Call 1-877-456-1233.	Tagalog (Tagalog/ Filipino)	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-456-1233.
Español (Spanish)	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-456-1233.	Русский (Russian)	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-456-1233.
繁體中文 (Chinese)	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-456-1233。	Français (French)	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-456-1233.
Srpsko-hrvatski (Serbo-Croatian)	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-877-456-1233.	日本語 (Japanese)	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-456-1233 まで、お電話にてご連絡ください。
한국어 (Korean)	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-456-1233 번으로 전화해 주십시오.	Română (Romanian)	ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-877-456-1233.
नेपाली (Nepali)	ध्यान दिनुहोस्: तपाईंले नेपाली ब?ोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उप?लब्ध छ । फोन गर्नुहोस् 1-877-456-1233 ।	Ikirundi (Bantu-Kirundi)	ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-877-456-1233.
Tiếng Việt (Vietnamese)	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-456-1233.	فارسی (Farsi)	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما، بگیرید تماس 1-877-456-1233.
العربية (Arabic)	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-456-1233	Deutsch (German)	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-456-1233.

Appeal/Hearing rights

You have the right to ask for a hearing if you disagree with the decision made by the Idaho Department of Health and Welfare.

You have 90 days to ask for a hearing for SNAP, and 30 days for Temporary Assistance for Families in Idaho (TAFI), Idaho Child Care Program (ICCP), Aid to the Aged, Blind, and Disabled (AABD) cash, Medicaid, and Advance Payment of Premium Tax Credit (APTC). These timeframes start the day after IDHW gave or mailed you a notice of the action with which you disagree.

Please be advised that a re-evaluation of eligibility will be assessed for all members of the household at the time this appeal is considered.

To request a hearing or a legal aid referral:

- Call 1-877-456-1233 (toll free) or 1-800-377-3529 (TTY) or 1-800-377-1363 (Voice)
- Email us at MyBenefits@dhw.idaho.gov
- Fill out and submit the Fair Hearing Request Form at mybenefitforms.dhw.idaho.gov.

At the hearing, you may represent yourself or use legal counsel, a relative, a friend, or other spokesperson to represent you.

idalink

idalink is Idaho's online self-service website where you can view information about the benefits you receive, report a change, and apply for other programs offered by IDHW. Registering is easy.
Visit idalink.idaho.gov to get started today!

Tell us about yourself

You will be the primary contact person for this application, even if you may not be applying for assistance for yourself.

Information that is optional or not required :

- Social Security number - *optional for people not applying and for people applying for emergency health coverage or child care assistance only. However, failure to provide a SSN may result in the denial of SNAP benefits to everyone failing to provide a SSN.*
- Immunization or federal tax return questions - *optional if applying for SNAP only.*
- Hispanic or Latino
- U.S. citizen or national questions - *optional for household members who are not applying for assistance*
- Race

Are you interested in the Medicaid for Workers with Disabilities program? ☐ No ☐ Yes

1.	Which type of assistance are you requesting for yourself? (*check all that apply*)	☐ SNAP *(Food Assistance)*	☐ HCA *(Health Coverage)*	☐ TAFI/AABD *(Cash Assistance)*	☐ ICCP *(Child Care)*	☐ None
2.	Full name	First	Middle	Last		
3.	Former names *(if any)*	First	Middle	Last		
4.	Social Security number					
5.	Date of birth					
6.	Sex	☐ Male	☐ Female			
7.	Marital status	☐ Married	☐ Divorced	☐ Separated	☐ Widowed	☐ Never been married
8.	Physical address	Street	City	State	Zip	County
9.	Mailing address *(if different)*	Street	City	State	Zip	County
10.	Email					
11.	Primary phone	Phone type: ☐ Home ☐ Cell ☐ Work				
		If none, what number may we use to leave a message?				
12.	Would you like to name someone as your authorized representative?	☐ No ☐ Yes, complete **Appendix A**				
		You may give a trusted friend, partner, or third party representative permission as an "authorized representative" to talk to the Department, see your information, and act on your behalf for all matters relating to your case.				

Applying for Food Assistance

If applying for SNAP, you may start the application process immediately by filling out your name and address in the questions above and signing below. You must complete the rest of the application and submit it as soon as possible to receive a benefit determination. Your filing date is the date we receive an application with your name, address, and signature.

If applying for SNAP, does your household meet one of the following situations? *(check all that apply)*

☐ Your household will have less than $150 income and less than $100 liquid resources (cash, checking, savings) this month

☐ Your household's income and resources are less than your monthly housing and utility costs

☐ Your household includes a migrant or seasonal farm worker

If you qualify, emergency SNAP benefits can begin within 7 days of the date on this application.

Printed name of applicant/authorized representative requesting SNAP	*Signature of applicant/authorized representative requesting SNAP*	*Date*

Continue telling us about yourself

13. Pregnant	☐ No ☐ Yes, complete a and b.
	a. Due date?
	b. How many are you expecting?
14. Immunizations up-to-date	☐ No ☐ Yes
15.. Preferred language *Interpretation services are listed on the cover page of this application.*	Spoken
	Written
16. Interpreter	Do you want an interpreter if you are interviewed? (One will be provided at no cost to you) ¿Quiere usted un interprete si usted sea entrevistado? (Se le proparcionara uno sin costo alguno) ☐ No ☐ Yes
17. Race	☐ White ☐ Asian ☐ Black/African American
	☐ Native Hawaiian/Pacific Island, name of Tribe:
	☐ American Indian/Alaska Native, name of Tribe:
18. Hispanic or Latino?	☐ No ☐ Yes
19. U.S. Citizen or national	☐ No ☐ Yes
20. If not a U.S. citizen, do you have eligible immigration status?	☐ No ☐ Yes, complete a and b. *Alien status will be verified with USCIS. The response from USCIS may affect your household's eligibility and benefit amount.*
	a. Immigration document type:
	b. Document ID number:
21. Do you plan to file a federal tax return for the CURRENT YEAR?	☐ No, skip to c below. ☐ Yes, complete a-c.
	a. Do you plan to file jointly with a spouse? ☐ No ☐ Yes. If yes, complete i and ii.
	i. Name of spouse:
	If your household is approved for Advance Payment of Premium Tax Credit (APTC) and you decide to purchase insurance through Your Health Idaho (YHI), one adult tax filer will be assigned as the primary account holder. Choose which spouse you wish to be assigned as the primary account holder for your household. ii. Name of primary account holder:
	b. Will you claim dependents? ☐ No ☐ Yes, complete i.
	i. Name of dependents
	c. Will you be claimed as a dependent on someone else's tax return? ☐ No ☐ Yes, complete i.
	i. Name of tax filer:

Tell us about everyone in your household

Who you need to include on this application:

- Regardless of the types of assistance you apply for, we need information about everyone in your household.
- If applying for health coverage assistance for anyone under 65 and not disabled, we need information about everyone you plan to include on your federal tax return this year, even if they don't live with you.

Note: You do not need to file taxes to get health coverage.

Read the questions down the center of the page and fill in the answers and information under each Person.

Person 1	Question	Person 2
1. ☐ SNAP ☐ HCA ☐ TAFI/AABD ☐ ICCP ☐ None	1. Types of assistance requested *(check all that apply)*	1. ☐ SNAP ☐ HCA ☐ TAFI/AABD ☐ ICCP ☐ None
2.	2. Relationship to you	2.
3. First / Middle / Last	3. Name	3. First / Middle / Last
4.	4. Former names, if any	4.
5.	5. Social Security number	5.
6.	6. Date of birth	6.
7. ☐ Male ☐ Female	7. Sex	7. ☐ Male ☐ Female
8. ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Never Married	8. Marital status	8. ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Never Married
9. ☐ No ☐ Yes	9. Immunizations up-to-date	9. ☐ No ☐ Yes
10. ☐ No ☐ Yes, complete a and b.	10. Pregnant	10. ☐ No ☐ Yes, complete a and b.
a.	a. Due date	a.
b.	b. How many are you expecting?	b.
11. ☐ No ☐ Yes	11. Hispanic or Latino	11. ☐ No ☐ Yes
12. ☐ No ☐ Yes	12. US citizen or national	12. ☐ No ☐ Yes
13. ☐ No ☐ Yes, complete a and b.	13. If not a citizen, has eligible immigration status	13. ☐ No ☐ Yes, complete a and b.
a.	a. Immigration document type	a.
b.	b. Document ID number	b.
14. ☐ White ☐ Asian ☐ Black/ African American ☐ Native Hawaiian/Pacific Island ☐ American Indian/Alaska Native	14. Race	14. ☐ White ☐ Asian ☐ Black/ African American ☐ Native Hawaiian/Pacific Island ☐ American Indian/Alaska Native
a.	a. Name of Tribe *(if applicable)*	a.
15. ☐ No, skip to c. ☐ Yes, complete a-c.	15. File federal tax return for CURRENT YEAR	15. ☐ No, skip to c. ☐ Yes, complete a-c.
a. ☐ No ☐ Yes. If yes, complete i and ii.	a. File jointly with a spouse	a. ☐ No ☐ Yes. If yes, complete i and ii.
i.	i. Name of spouse	i.
ii.	ii. Name of primary account holder	ii.
b. ☐ No ☐ Yes. If yes, complete i.	b. Claiming dependents	b. ☐ No ☐ Yes. If yes, complete i.
i.	i. Name of dependents	i.
c. ☐ No ☐ Yes. If yes, complete i.	c. Claimed as a dependent	c. ☐ No ☐ Yes. If yes, complete i.
i.	i. Name of tax filer	i.

Continue telling us about everyone in your household

Read the questions down the center of the page and fill in the answers and information under each Person.

Person 3	Question	Person 4
1. ☐ SNAP ☐ HCA ☐ TAFI/AABD ☐ ICCP ☐ None	1. Types of assistance requested *(check all that apply)*	1. ☐ SNAP ☐ HCA ☐ TAFI/AABD ☐ ICCP ☐ None
2.	2. Relationship to you	2.
3. First Middle Last	3. Name	3. First Middle Last
4.	4. Former names, if any	4.
5.	5. Social Security number	5.
6.	6. Date of birth	6.
7. ☐ Male ☐ Female	7. Sex	7. ☐ Male ☐ Female
8. ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Never Married	8. Marital status	8. ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Never Married
9. ☐ No ☐ Yes	9. Immunizations up-to-date	9. ☐ No ☐ Yes
10. ☐ No ☐ Yes, complete a and b.	10. Pregnant	10. ☐ No ☐ Yes, complete a and b.
a.	a. Due date	a.
b.	b. How many are you expecting?	b.
11. ☐ No ☐ Yes	11. Hispanic or Latino	11. ☐ No ☐ Yes
12. ☐ No ☐ Yes	12. US citizen or national	12. ☐ No ☐ Yes
13. ☐ No ☐ Yes, complete a and b.	13. If not a citizen, has eligible immigration status	13. ☐ No ☐ Yes, complete a and b.
a.	a. Immigration document type	a.
b.	b. Document ID number	b.
14. ☐ White ☐ Asian ☐ Black/ African American ☐ Native Hawaiian/Pacific Island ☐ American Indian/Alaska Native	14. Race	14. ☐ White ☐ Asian ☐ Black/ African American ☐ Native Hawaiian/Pacific Island ☐ American Indian/Alaska Native
a.	a. Name of Tribe *(if applicable)*	a.
15. ☐ No, skip to c. ☐ Yes, complete a-c.	15. File federal tax return for CURRENT YEAR	15. ☐ No, skip to c. ☐ Yes, complete a-c.
a. ☐ No ☐ Yes. If yes, complete i and ii.	a. File jointly with a spouse	a. ☐ No ☐ Yes. If yes, complete i and ii.
i.	i. Name of spouse	i.
ii.	ii. Name of primary account holder	ii.
b. ☐ No ☐ Yes. If yes, complete i.	b. Claiming dependents	b. ☐ No ☐ Yes. If yes, complete i.
i.	i. Name of dependents	i.
c. ☐ No ☐ Yes. If yes, complete i.	c. Claimed as a dependent	c. ☐ No ☐ Yes. If yes, complete i.
i.	i. Name of tax filer	i.

Tell us about your household situation

1. Is anyone in your household applying for or already receiving tribal commodities?	☐ No ☐ Yes, who?
2. Is anyone in your household applying for or already receiving foster care or adoption assistance?	☐ No ☐ Yes, who?
3. Was anyone in your household in Idaho foster care when they turned 18? (**If applying for SNAP only, skip this question**)	☐ No ☐ Yes, who?
4. Is anyone in your household currently receiving assistance from another state?	☐ No ☐ Yes, complete a-c.
a. Dates of assistance	From *(month/year):* To *(month/year):*
b. Where assistance is received from	City County State
c. Type of assistance received	☐ SNAP ☐ TANF/Cash ☐ AABD ☐ Medicaid ☐ Child care ☐ Other:
5. Is anyone in your household 65 or older?	☐ No ☐ Yes, who?
6. Is anyone in your household disabled?	☐ No ☐ Yes, who?
7. Does anyone who is applying have a pending application for Social Security Disability?	☐ No ☐ Yes, who?
8. Is anyone in your household working and believe that they would meet disability status as determined by the Social Security Administration?	☐ No ☐ Yes, who?
9. If applying for HCA, does anyone who is applying need medical services in the home? (**If applying for SNAP only, skip this question**)	☐ No ☐ Yes, who?
10. Does anyone who is applying live in a medical care facility or receive in-home care? (**If applying for SNAP only, skip this question**)	☐ No ☐ Yes, complete a-d. a. Who?
b. Facility/provider type	☐ Nursing home ☐ Assisted Living Facility ☐ Certified Family Home ☐ In-home care
c. Facility/provider name	
d. Facility/provider phone	

Tell us about your qualifying life event

Complete this section if anyone in the household is applying for Health Coverage Assistance. This information may be necessary as part of your eligibility determination for Advance Payment of Premium Tax Credit (APTC). If applying for SNAP only, **skip to page 6.**

Complete the questions below based on any life events within the last 60 days, unless otherwise noted.

1. Did any member of your household recently lose or expect to lose health insurance coverage within the next 60 days?	☐ No ☐ Yes, who?
2. Did any member of your household recently become a citizen or lawful immigrant in the US?	☐ No ☐ Yes, who?
3. Did any person move into or leave your household?	☐ No ☐ Yes, who? Why? ☐ Had a baby ☐ Got married ☐ Divorced ☐ Adopted or is fostering a child ☐ Other
4. Did any existing tax filer in your household recently gain a new tax dependent?	☐ No ☐ Yes, who?
5. Did your household recently move to Idaho?	☐ No ☐ Yes, when?
6. Did your household recently move within Idaho?	☐ No ☐ Yes, when?
7. Did your household income recently change?	☐ No ☐ Yes, when? How? ☐ Increase ☐ Decrease

Continue telling us about your household situation

If applying for health coverage only, and all household members are under 65 and not disabled, **skip to question 10.**

1. Has anyone in your household been disqualified from public assistance due to an intentional program violation?	☐ No ☐ Yes, who? When? State:
2. Has anyone in your household been convicted of a felony?	☐ No ☐ Yes, who? Are they in compliance with their sentencing requirements? ☐ No ☐ Yes
3. Is anyone in your household fleeing to avoid felony prosecution or jail time?	☐ No ☐ Yes, who?
4. Has anyone in your household been convicted of trading Food Stamp benefits for guns, ammunitions, or explosives?	☐ No ☐ Yes, who?
5. Has anyone in your household been convicted of buying or selling SNAP benefits over $500?	☐ No ☐ Yes, who?
6. Has anyone in your household been convicted of receiving duplicate SNAP benefits in any state?	☐ No ☐ Yes, who?
7. Is anyone in your household currently violating conditions of probation or parole?	☐ No ☐ Yes, who?
8. If applying for ICCP, is anyone in your household participating in a work/training program provided by a homeless shelter?	☐ No ☐ Yes, have the agency complete the **Child Care Activity Form**. *This form can be found at mybenefitforms.dhw.idaho.gov.*
9. Has anyone in your household received $3,500.00 or more in lottery or gaming winnings (at one time) within the last 12 months?	☐ No ☐ Yes, date of winning: *(dd/mm/yyyy)*
10. Is anyone listed on this application currently incarcerated?	☐ No ☐ Yes, who?

Tell us about students

Tell us about any applicant between the ages of 16 and 49 who is attending school (high school or higher education).

Read the questions down the center of the page and fill in the answers and information under each Person.

Person 1	Question	Person 2
	Student name	
	School name	
	How many hours per week does the student attend school?	
	Anticipated graduation date	
☐ High School ☐ College, complete a-d.	School type (check one)	☐ High School ☐ College, complete a-d.
☐ Undergraduate ☐ Graduate	a. Degree type	☐ Undergraduate ☐ Graduate
☐ Full time ☐ Half time ☐ Less than half time	b. Status	☐ Full time ☐ Half time ☐ Less than half time
☐ No ☐ Yes	c. Was the student awarded work study?	☐ No ☐ Yes
☐ No ☐ Yes	d. Are all classes online?	☐ No ☐ Yes

Tell us about parents not in the home

Complete the following for each child who has a parent (or parents) **NOT** living with them. Any information will be provided to Child Support Services in order to pursue a child support case if eligible. You must cooperate with Child Support Services. If you do not wish to open a child support case, you must contact us by dialing 1-877-456-1233 (toll free) or 1-800-377-3529 (TTY) or 1-800-377-1363 (Voice).

Read the questions down the center of the page and fill in the answers and information under each Parent.

Other Parent 1	Question	Other Parent 2
1.	1. Child's name	1.
2. First MI Last	2. Name of parent not in the home	2. First MI Last
3.	3. Former names of parent not in home, if any	3.
4. SSN ☐ M ☐ F	4. Social Security number and sex	4. SSN ☐ M ☐ F
5. DOB Age	5. Date of birth and/or approximate age	5. DOB Age
6. Street City State Zip County	6. Physical address	6. Street City State Zip County
7. Street City State Zip	7. Mailing address (if different)	7. Street City State Zip
8.	8. Email address	8.
9.	9. Phone number	9.
10.	10. Last known employer	10.
11.	11. Last known employer city	11.

Other Parent 3	Question	Other Parent 4
1.	1. Child's name	1.
2. First MI Last	2. Name of parent not in the home	2. First MI Last
3.	3. Former names of parent on in home, if any	3.
4. SSN ☐ M ☐ F	4. Social Security number and sex	4. SSN ☐ M ☐ F
5. DOB Age	5. Date of birth and/or approximate age	5. DOB Age
6. Street City State Zip County	6. Physical address	6. Street City State Zip County
7. Street City State Zip	7. Mailing address (if different)	7. Street City State Zip
8.	8. Email address	8.
9.	9. Phone number	9.
10.	10. Last known employer	10.
11.	11. Last known employer city	11.

Tell us about your household income

Note: *If applying for health coverage only, and all household members* ***are under 65 and not disabled****, report your* **taxable income**.

For all other programs, tell us about **all income** your household receives. This includes any money received by an adult, or by children, aged 16 or older, and not attending high school. We want to know about the last 30 days, as well as any money received quarterly or annually. We also want to know about income from any job you have just started or will start within the next 30 days. Types of income include:

Unearned

Income from sources such as:

- Unemployment benefits
- Gaming/lottery winnings
- Rental income
- Social Security/Veterans
- Disability income
- Retirement/Pension income
- Cash gifts
- Child Support

Earned

Wages or salary from:

- Job
- Self-employment *(including owning your own business, odd jobs, baby-sitting, collecting cans, donating plasma, etc.).*

Income 1

Name of person with income:

Income from a job - Tell us about any income this person gets from working a job.

Employer's name		Employer's phone number	
Average hours worked each week		Wages/tips (*before taxes*)	
How often paid? *(check one)*	☐ Weekly ☐ Monthly ☐ Yearly ☐ Every 2 weeks ☐ Semi-monthly, which days *(i.e.: 5th & 20th)?*		
Is income expected to change?	☐ No ☐ Yes, why? *(raise, hours changes, etc.)*		

Income from own business - Tell us about any income this person gets from a business they own. If self-employed and estimated income is zero, indicate this by writing "0" or "none" for the estimated gross income question.

Name of business				Type of work	
Estimated gross income this month		Average hours worked each week		Number of years in business	

Income from other sources - Tell us about any other income for this person, such as Social Security, retirement, unemployment benefits, cash gifts, and gaming/lottery winnings.

Source of income		Amount	
How often paid? *(check one)*	☐ Weekly ☐ Monthly ☐ Yearly ☐ Every 2 weeks ☐ Semi-monthly, which days *(i.e.: 5th & 20th)?*		
Source of income		Amount	
How often paid? *(check one)*	☐ Weekly ☐ Monthly ☐ Yearly ☐ Every 2 weeks ☐ Semi-monthly, which days *(i.e.: 5th & 20th)?*		

Income from alimony - Tell us about any alimony this person receives.

Alimony source			
Date ordered by judge *(month/year)*		Alimony amount	
How often paid? *(check one)*	☐ Weekly ☐ Monthly ☐ Yearly ☐ Every 2 weeks ☐ Semi-monthly, which days *(i.e.: 5th & 20th)?*		

Income 2

Name of person with income:

Income from a job - Tell us about any income this person gets from working a job.

Employer's name		Employer's phone number	
Average hours worked each week		Wages/tips (*before taxes*)	
How often paid? *(check one)*	☐ Weekly ☐ Monthly ☐ Yearly ☐ Every 2 weeks ☐ Semi-monthly, which days *(i.e.: 5th & 20th)?*		
Is income expected to change?	☐ No ☐ Yes, why? *(raise, hours changes, etc.)*		

Income from own business - Tell us about any income this person gets from a business they own. If self-employed and estimated income is zero, indicate this by writing "0" or "none" for the estimated gross income question.

Name of business				Type of work	
Estimated gross income this month		Average hours worked each week		Number of years in business	

Income from other sources - Tell us about any other income for this person, such as Social Security, retirement, unemployment benefits, cash gifts, and gaming/lottery winnings.

Source of income		Amount	
How often paid? *(check one)*	☐ Weekly ☐ Monthly ☐ Yearly ☐ Every 2 weeks ☐ Semi-monthly, which days *(i.e.: 5th & 20th)?*		
Source of income		Amount	
How often paid? *(check one)*	☐ Weekly ☐ Monthly ☐ Yearly ☐ Every 2 weeks ☐ Semi-monthly, which days *(i.e.: 5th & 20th)?*		

Income from alimony - Tell us about any alimony this person receives.

Alimony source			
Date ordered by judge *(month/year)*		Alimony amount	
How often paid? *(check one)*	☐ Weekly ☐ Monthly ☐ Yearly ☐ Every 2 weeks ☐ Semi-monthly, which days *(i.e.: 5th & 20th)?*		

Continue telling us about your household income

Income 3

Name of person with income:

Income from a job - Tell us about any income this person gets from working a job.

Employer's name		Employer's phone number	
Average hours worked each week		Wages/tips (*before taxes*)	
How often paid? *(check one)*	☐ Weekly ☐ Monthly ☐ Yearly ☐ Every 2 weeks ☐ Semi-monthly, which days *(i.e.: 5th & 20th)?*		
Is income expected to change?	☐ No ☐ Yes, why? *(raise, hours changes, etc.)*		

Income from own business - Tell us about any income this person gets from a business they own. If self-employed and estimated income is zero, indicate this by writing "0" or "none" for the estimated gross income question.

Name of business				Type of work	
Estimated gross income this month		Average hours worked each week		Number of years in business	

Income from other sources - Tell us about any other income for this person, such as Social Security, retirement, unemployment benefits, cash gifts, and gaming/lottery winnings.

Source of income		Amount	
How often paid? *(check one)*	☐ Weekly ☐ Monthly ☐ Yearly ☐ Every 2 weeks ☐ Semi-monthly, which days *(i.e.: 5th & 20th)?*		
Source of income		Amount	
How often paid? *(check one)*	☐ Weekly ☐ Monthly ☐ Yearly ☐ Every 2 weeks ☐ Semi-monthly, which days *(i.e.: 5th & 20th)?*		

Income from alimony - Tell us about any alimony this person receives.

Alimony source			
Date ordered by judge *(month/year)*		Alimony amount	
How often paid? *(check one)*	☐ Weekly ☐ Monthly ☐ Yearly ☐ Every 2 weeks ☐ Semi-monthly, which days *(i.e.: 5th & 20th)?*		

Income 4

Name of person with income:

Income from a job - Tell us about any income this person gets from working a job.

Employer's name		Employer's phone number	
Average hours worked each week		Wages/tips (*before taxes*)	
How often paid? *(check one)*	☐ Weekly ☐ Monthly ☐ Yearly ☐ Every 2 weeks ☐ Semi-monthly, which days *(i.e.: 5th & 20th)?*		
Is income expected to change?	☐ No ☐ Yes, why? *(raise, hours changes, etc.)*		

Income from own business - Tell us about any income this person gets from a business they own. If self-employed and estimated income is zero, indicate this by writing "0" or "none" for the estimated gross income question.

Name of business				Type of work	
Estimated gross income this month		Average hours worked each week		Number of years in business	

Income from other sources - Tell us about any other income for this person, such as Social Security, retirement, unemployment benefits, cash gifts, and gaming/lottery winnings.

Source of income		Amount	
How often paid? *(check one)*	☐ Weekly ☐ Monthly ☐ Yearly ☐ Every 2 weeks ☐ Semi-monthly, which days *(i.e.: 5th & 20th)?*		
Source of income		Amount	
How often paid? *(check one)*	☐ Weekly ☐ Monthly ☐ Yearly ☐ Every 2 weeks ☐ Semi-monthly, which days *(i.e.: 5th & 20th)?*		

Income from alimony - Tell us about any alimony this person receives.

Alimony source			
Date ordered by judge *(month/year)*		Alimony amount	
How often paid? *(check one)*	☐ Weekly ☐ Monthly ☐ Yearly ☐ Every 2 weeks ☐ Semi-monthly, which days *(i.e.: 5th & 20th)?*		

Applying for Health Coverage Assistance

Tell us about your Anticipated Annual Income.

Your Anticipated Annual Income (AAI) is the gross (before deductions or taxes), taxable income *(earned and unearned)* you expect to receive for your entire household for the current year *(Jan.-Dec.)*. If you know your AAI please enter it here: $

If you do not know your AAI for this year, you can calculate it using the worksheet in **Appendix C.**

Tell us about your vehicles and bank accounts

If applying for health coverage only, and all household members are under 65 and not disabled, **skip to page 13.** Otherwise, complete this section.

Motor Vehicles

Tell us about all vehicles, including cars, trucks, motorcycles, trailers, boats, snowmobiles, and other recreational vehicles that your household owns.

Owner		Current value	
Year, make, model			
Primary use *(choose one)*	☐ Used for self-employment business	☐ Recreational	☐ Personal/Everyday use
	☐ Medical reasons/transport disabled person(s)	☐ Residence	☐ Seeking employment
	☐ Travel to and from work	☐ Income producing *(taxi, ride-sharing, deliveries, etc.)*	☐ Other
Owner		Current value	
Year, make, model			
Primary use *(choose one)*	☐ Used for self-employment business	☐ Recreational	☐ Personal/Everyday use
	☐ Medical reasons/transport disabled person(s)	☐ Residence	☐ Seeking employment
	☐ Travel to and from work	☐ Income producing *(taxi, ride-sharing, deliveries, etc.)*	☐ Other
Owner		Current value	
Year, make, model			
Primary use *(choose one)*	☐ Used for self-employment business	☐ Recreational	☐ Personal/Everyday use
	☐ Medical reasons/transport disabled person(s)	☐ Residence	☐ Seeking employment
	☐ Travel to and from work	☐ Income producing *(taxi, ride-sharing, deliveries, etc.)*	☐ Other
Owner		Current value	
Year, make, model			
Primary use *(choose one)*	☐ Used for self-employment business	☐ Recreational	☐ Personal/Everyday use
	☐ Medical reasons/transport disabled person(s)	☐ Residence	☐ Seeking employment
	☐ Travel to and from work	☐ Income producing *(taxi, ride-sharing, deliveries, etc.)*	☐ Other

Checking/Savings

Tell us about all bank accounts your household has.

Primary Account Holder		Account Type	
Name of Financial Institution			
Account Number		Current Balance	
Primary Account Holder		Account Type	
Name of Financial Institution			
Account Number		Current Balance	
Primary Account Holder		Account Type	
Name of Financial Institution			
Account Number		Current Balance	
Primary Account Holder		Account Type	
Name of Financial Institution			
Account Number		Current Balance	

 Copy this page or attach another sheet if you need to provide more information than space allows.

Tell us about your resources and property

If applying for health coverage only, and all household members are under 65 and not disabled, **skip to page 13.** Otherwise, complete this section.

Resources

Tell us about all resources your household owns, including cash on-hand, stocks, bonds, mutual funds, 401Ks, IRAs, trusts, CDs, life insurance policies, burial funds, etc.

Owner		Resource Type	
Name of Financial Institution			
Account Number		Current Value	
Owner		Resource Type	
Name of Financial Institution			
Account Number		Current Value	
Owner		Resource Type	
Name of Financial Institution			
Account Number		Current Value	
Owner		Resource Type	
Name of Financial Institution			
Account Number		Current Value	

Property

Tell us about all other property *(including your home)* owned by anyone in your household. This includes land, buildings, rental properties, etc.

Owner		Property type	
Property address		Value	
Primary use	☐ Home ☐ Rental income ☐ Business/Self-employment ☐ Other:		
Owner		Property type	
Property address		Value	
Primary use	☐ Home ☐ Rental income ☐ Business/Self-employment ☐ Other:		
Owner		Property type	
Property address		Value	
Primary use	☐ Home ☐ Rental income ☐ Business/Self-employment ☐ Other:		
Owner		Property type	
Property address		Value	
Primary use	☐ Home ☐ Rental income ☐ Business/Self-employment ☐ Other:		

Sale or transfer of resources and property

Tell us about everyone in your home who has sold, transferred, or given away cash, property, vehicles, or other assets within the last five years.

Owner			What asset		
Date of Transaction		Amount received		Fair market value	
Owner			What asset		
Date of Transaction		Amount received		Fair market value	
Owner			What asset		
Date of Transaction		Amount received		Fair market value	
Owner			What asset		
Date of Transaction		Amount received		Fair market value	
Owner			What asset		
Date of Transaction		Amount received		Fair market value	

Tell us about your household expenses

If applying for health coverage only, and all household members are under 65 and not disabled, **skip to page 13.** Otherwise, complete this section.

Your Food Stamps may increase if you have expenses such as child or adult care costs, child support paid for children not living with you, housing costs, medical costs (including prescriptions) for people with disabilities or who are over 65, and utility costs. However, if you do not report or verify any of these expenses, it will mean that you do not want a deduction for the unreported or unverified expenses.

Shelter expenses

Tell us about your shelter expenses. When telling us the amount of each expense, include only the amount **YOU** pay.

Rent *(for residence)*	☐ No	☐ Yes, monthly amount:		
Landlord's Name			Phone number	
Space rent	☐ No	☐ Yes, monthly amount:		
Mortgage	☐ No	☐ Yes, monthly amount:		
Does your mortgage amount include any of the following expenses: *If you do not pay a mortgage expense, indicate this by writing "0" or "none" in the expense field.*	Irrigation	☐ Yes	☐ No, monthly amount:	
	Property tax	☐ Yes	☐ No, monthly amount:	
	HOA fees	☐ Yes	☐ No, monthly amount:	
	Homeowners insurance	☐ Yes	☐ No, monthly amount:	
2nd Mortgage	☐ No	☐ Yes, monthly amount:		
Check the boxes for each utility you pay that is **NOT** included in your rent or mortgage	☐ Heating	☐ Cooling	☐ Water	☐ Sewer ☐ Trash ☐ Telephone

Dependent care expenses

Tell us about any child care, adult disabled care, or elderly care you pay. If applying for ICCP, your provider must also complete a **Child Care Provider** form, *found at mybenefitforms.dhw.idaho.gov.*

Dependent's name				
Total charge for care		Amount you pay		How often you pay
Provider's name			Provider's phone number	
Provider's address				
Dependent's name				
Total charge for care		Amount you pay		How often you pay
Provider's name			Provider's phone number	
Provider's address				
Dependent's name				
Total charge for care		Amount you pay		How often you pay
Provider's name			Provider's phone number	
Provider's address				

Child Support Expense

Tell us about any **court ordered** child support expense or arrears you pay to someone who is not in your household.

Name of person with expense		Amount you pay	
Who receives payment?		How often you pay	
Name of person with expense		Amount you pay	
Who receives payment?		How often you pay	
Name of person with expense		Amount you pay	
Who receives payment?		How often you pay	

Individual Expenses

Tell us about any individual expenses **ONLY** for the individuals in your household who are 65 or older (60 if applying for SNAP) or disabled. *Allowable expenses include some medical expenses and health insurance premiums you pay.*

Name of person with expense		Amount paid	
Expense type		How often paid	
Name of person with expense		Amount paid	
Expense type		How often paid	
Name of person with expense		Amount paid	
Expense type		How often paid	
Name of person with expense		Amount paid	
Expense type		How often paid	

Tell us about your health coverage situation

If applying for SNAP or ICCP only, **skip to page 14**.

1. Does anyone who is applying for HCA want help paying for medical costs from the **last three (3) months**?

☐ No ☐ Yes, complete a and b.

a. Name of person with costs:

b. For which of the last 3 months do you need assistance? Include the gross household income *(before taxes)* received by your family in each of those months.

☐ Month name:

Gross income for month:

☐ Month name:

Gross income for month:

☐ Month name:

Gross income for month:

2. Is anyone who is applying for HCA currently receiving coverage from any of the following:

CHIP	☐ No	☐ Yes, who?
Medicare	☐ No	☐ Yes, who?
TRICARE	☐ No	☐ Yes, who?
VA Health Care	☐ No	☐ Yes, who?
Employer Insurance	☐ No	☐ Yes, who?
Peace Corps	☐ No	☐ Yes, who?
Other	☐ No	☐ Yes, who?

Insurance carrier:

Was this coverage purchased from the insurance marketplace? ☐ No ☐ Yes

3. Does anyone have access to health insurance from a job?

☐ No ☐ Yes, complete **Appendix B.**

(Check "yes" even if the coverage is from someone else's job, such as a parent or spouse).

4. Are any children *(under the age of 19)* who are applying, currently receiving health coverage?

☐ No ☐ Yes, complete a and b for each child receiving coverage.

a. **Name of child:**

b. Which of the following services are covered by this child's health insurance? *(check all that apply)*

☐ Inpatient/outpatient hospital services ☐ Physicians medical/ surgical services ☐ Lab services ☐ X-ray services

a. **Name of child:**

b. Which of the following services are covered by this child's health insurance? *(check all that apply)*

☐ Inpatient/outpatient hospital services ☐ Physicians medical/ surgical services ☐ Lab services ☐ X-ray services

a. **Name of child:**

b. Which of the following services are covered by this child's health insurance? *(check all that apply)*

☐ Inpatient/outpatient hospital services ☐ Physicians medical/ surgical services ☐ Lab services ☐ X-ray services

Rights and Responsibilities

Read and initial each statement below **for all types of assistance.**

- **My signature certifies that the information on this application is true and accurate. I could be sanctioned and required to return any benefit I receive if my information is not true. Sanctions may include administrative, civil, or criminal actions against me, including prosecution.**
- **I consent to the gathering, use, and disclosure of my information, including my SSN, by the Idaho Department of Health and Welfare or its designees. I understand the information is needed for the purpose of providing benefits or services, obtaining payment for my benefits or services, and for normal business operations of the Department.**
- I have the right to revoke this consent, in writing, at any time, except to the extent the Department has already used and disclosed my information. If I revoke this consent, the Department will not provide further benefits or services.
- My signature indicates I have received a copy of the Department Privacy Practices.
- I am required to report when my household's monthly income exceeds the gross limit for my household size.
- I will be notified of the right to appeal Department decisions and I can contact the Department for information on the appeal process.
- I understand that all adult household members may be responsible for repaying benefits if the household received benefits it was not entitled to receive. This applies to an over-issuance of benefits as a result of an agency error, an inadvertent household error, and intentional program violations. If a there is an overpayment of benefits to your household, the information on this application, including all adult SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies for collection action.
- This information may be disclosed to other federal and state agencies for official examination, and to law enforcement officials, for apprehending persons fleeing to avoid the law.
- Information available through the Income Eligibility Verification System (IEVS), and other online sources, is used and may be verified through a third-party contact when differences are discovered between the system and what you report. This information may affect your eligibility and level of benefits.
- I may be required to cooperate with state or federal reviewers who are making sure my benefits are correct. I may not be eligible to receive benefits if I do not cooperate.
- As part of my application, I understand that IDHW will open a Child Support case and I must cooperate with Child Support Services.

Read and initial each statement below if anyone is applying for **SNAP**, formerly Food Stamps.

- To receive SNAP, I may be required to participate in work programs. Failure to do so may result in a loss or decrease in benefits.
- It is illegal to give my EBT card away or to trade the benefits on my card for cash, firearms, drugs, or other goods and services. Penalties include fines, imprisonment, and disqualification from future benefits. The benefits I receive are for me and members of my household only. I may not use my SNAP benefits on individuals outside of my household.

Read and initial each statement below if anyone is applying for **HCA**

- I consent to the gathering and use of income data, including information from the Internal Revenue Service (IRS), for determining eligibility for help paying for health coverage in future years (up to 5 years). I will receive notice when this occurs, be able to make changes, and may opt out at any time. I have the right to revoke this consent, in writing, at any time except to the extent the Department has already used and disclosed my information in reliance on this consent. If I revoke this consent, I will not be eligible for APTC.
- If I am determined eligible to receive a tax credit (also known as APTC) and use these funds towards the purchase of a Qualified Health Plan (QHP), any discrepancies between my reported income, which was used to determine eligibility, and the amount of the tax credit, will be reconciled with the final income reported on my taxes at the end of the calendar year. The IRS will be responsible for conducting this reconciliation, and any discrepancies may result in an adjustment of the tax credit, including entitlement to additional credits or re-payment of credits received by me.
- If I am determined eligible for Medicaid, the plan I will be enrolled in depends on my individual needs.
- My signature or the signature of my representative authorizes state offices to communicate with insurance companies related to my/my child's medical assistance.
- If I receive Medicaid after age 55, my estate may be subject to recovery of medical expenses paid on my behalf, and that any transfer of assets may be set aside by a court if I do not receive adequate value.
- I have the right to choose a Healthy Connections primary care doctor to request referrals for services, and to change the doctor/clinic if my circumstances change.

Read and initial the statement below if anyone is applying for **TAFI** or **AABD**

- If I receive cash assistance (TAFI or AABD), I may not withdraw cash benefits or use cash benefit funds to purchase products and services in gambling establishments, liquor and tobacco stores, adult entertainment venues, other establishments prohibiting persons under the age of 18, or tattoo, body piercing, or other branding parlors.

Read and initial the statement below if anyone is applying for **ICCP**

- If I am determined eligible for the Idaho Child Care Program (ICCP), I may be responsible for paying part of my child care costs.

Signature (must be completed)

Under penalty of perjury, I swear or affirm the information I have provided is true and complete. My signature confirms that I have read and understand the Rights and Responsibilities listed on this page and my reporting requirements.

Printed name of applicant/authorized representative	Signature of applicant/authorized representative	Date
Printed name of applicant/authorized representative	Signature of applicant/authorized representative	Date

Appendix A

Authorized Representative Form

You may give a trusted person, such as a friend, partner, third party caseworker or an organization permission to talk about this application with us, see your information, and act for you on all matters related to this application, including getting information about your application and signing your application and/or renewal information on your behalf. This person is called an "authorized representative."

If you ever need to change your authorized representative or revoke the access to your information, contact the Department to complete a new Authorized Representative Form or to update your information about who can access your account.

If you are a legally appointed representative for someone on this application, you must submit proof, such as Power of Attorney, with the application.

Tell us about yourself

1. Full name	First	Middle	Last
2. Social Security number			
3. Date of birth			

Tell us who you want to name as your authorized representative

1. Full name	First	Middle	Last		
2. Relationship to applicant					
3. Mailing address	Street	City	State	Zip	County
4. Phone			Phone type	☐ Home	☐ Work ☐ Cell
5. Email					

Complete this section for an organization to be your authorized representative

1. Organization name					
2. Organization ID *(if applicable)*					
3. Mailing address	Street	City	State	Zip	County
4. Phone					
5. Email *(if applicable)*					

Signature

As an authorized representative, I understand that I agree to maintain the confidentiality of any information regarding the applicant or beneficiary provided by the Department of Health and Welfare. For Healthcare programs, I understand that any person who knowingly and willfully uses or discloses information in violation of section 1411(g) of the Affordable Care Act will be subject to a Civil Monetary Penalty (CMP) of not more than $25,000 as adjusted annually under 45 CFR part 102 per person or entity, per use or disclosure, consistent with the bases and process for imposing civil penalties specified at §155.285, in addition to other penalties that may be prescribed by law.

Printed name of authorized representative	Signature of authorized representative	Date
(In the case of an Organization, please provide a name of someone attesting to the terms and conditions of this form)		
Printed name of applicant	Signature of applicant	Date

Appendix B

Health Coverage from Employers

Complete this appendix if someone in the household has access to or is currently receiving health coverage from a job. Attach a copy of this page for each job that offers coverage. **You do not need to complete this appendix if applying for SNAP or ICCP only.**

Employee Information

Full name	First	Middle	Last	
Social Security number				
Address	Street	City	State	Zip
Phone				
Email				
List everyone who is eligible for coverage from this plan				
Did you miss your employer's open enrollment period and do you have to wait until the next open enrollment period?	☐ Yes ☐ No, complete a.			
	a. If you're in a waiting or probationary period, when can you enroll in coverage? *(MM/DD/YYYY):*			

Health Plan Information *(must be completed by employer)*

Does the plan meet Minimum Essential Coverage (MEC)?* ☐ No ☐ Yes

Does the plan meet Minimum Value Standard?** ☐ No ☐ Yes, complete a.

a. If the employer has wellness programs, provide the premium amount that the employee would pay if he/she received the maximum discount for any tobacco-cessation programs, and did not receive any other discounts based on wellness programs. *Please complete this section for the lowest-cost plan that meets the minimum value standard** offered only to the employee (do not include family plans).*

How much would the employee have to pay in premiums for this plan? $ _____

How often is the premium paid? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

Employer Information

Company name	
Phone number	
Email	
Name of person completing form	
Who may we contact about employee health coverage at this job *(if different)*?	

Employer Signature *(must be completed)*

Under penalty of perjury, I swear or affirm the information I have provided is true and complete.

_____ _____

Signature of employer Date

* An employer-sponsored health plan meets the "Minimum Essential Coverage" if it meets the essential health benefits as defined in 1302(a) of the Affordable Care Act.

** An employer-sponsored health plan meets the "Minimum Value Standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (section 36B9c09209C0(ii) of the Internal Revenue code of 1986.

Appendix C

Anticipated Annual Income Worksheet

Complete this worksheet if anyone in your household is applying for health coverage assistance (HCA). We will use the information you provide to determine eligibility for the Advance Payment of Premium Tax Credit (APTC).
You do not need to complete this appendix if you are only applying for SNAP.

Your Anticipated Annual Income (AAI) is the gross, taxable income you expect to receive for the current (January-December) year. Use the tables below to enter gross income (before taxes) for all members of your household for each month of the current year. If you need help determining who to count in your household, see page one of this application. *Ask for or make a copy of this worksheet if you have more than two household members with income.*

Earned income

Income is money earned *(wages or salary)* from a job or self-employment *(including owning your own business, doing odd jobs, babysitting, collecting cans, donating plasma, etc.).* Enter any self-employment income as net *(instead of gross)* income.

Name of person with income:

Income source 1:	Jan:	Feb:	Mar:	Apr:	May:	Jun:
	Jul:	Aug:	Sep:	Oct:	Nov:	Dec:
Income source 2:	Jan:	Feb:	Mar:	Apr:	May:	Jun:
	Jul:	Aug:	Sep:	Oct:	Nov:	Dec:

Name of person with income:

Income source 1:	Jan:	Feb:	Mar:	Apr:	May:	Jun:
	Jul:	Aug:	Sep:	Oct:	Nov:	Dec:
Income source 2:	Jan:	Feb:	Mar:	Apr:	May:	Jun:
	Jul:	Aug:	Sep:	Oct:	Nov:	Dec:

Social Security income

Include Social Security Disability and Social Security retirement benefits. DO NOT subtract any payments you make out of your entitlement amount. DO NOT include Social Security Survivors or Supplemental Social Security Income *(also known as Title XVI)*.

Recipient 1 name:	Jan:	Feb:	Mar:	Apr:	May:	Jun:
	Jul:	Aug:	Sep:	Oct:	Nov:	Dec:
Recipient 2 name:	Jan:	Feb:	Mar:	Apr:	May:	Jun:
	Jul:	Aug:	Sep:	Oct:	Nov:	Dec:

Unearned income

Include taxable income such as rental, retirement, unemployment, and gaming/lottery winnings.

Name of person with income:

Income source 1:	Jan:	Feb:	Mar:	Apr:	May:	Jun:
	Jul:	Aug:	Sep:	Oct:	Nov:	Dec:
Income source 2:	Jan:	Feb:	Mar:	Apr:	May:	Jun:
	Jul:	Aug:	Sep:	Oct:	Nov:	Dec:

Name of person with income:

Income source 1:	Jan:	Feb:	Mar:	Apr:	May:	Jun:
	Jul:	Aug:	Sep:	Oct:	Nov:	Dec:
Income source 2:	Jan:	Feb:	Mar:	Apr:	May:	Jun:
	Jul:	Aug:	Sep:	Oct:	Nov:	Dec:

Add all figures together that you entered into the tables above. Enter the total here: $
This is your Anticipated Annual Income.
*Please enter this figure in the question box on the bottom of **page 9** of this application.*