Application for Re-evaluation

INSTRUCTIONS FOR COMPLETING THE RE-EVALUATION PROCESS

The information provided on this form will be used only to determine your ongoing eligibility for persons already receiving benefits.

If you want to add someone to your benefits, such as a newborn child or someone who has moved into your home, please complete the Add-A-Person page enclosed with this form.

1. Use blue or black ink to complete all pages.

Carefully review the information on the form. You must provide current information about all people in your household. If you need to provide more information than space allows, attach extra sheets.

2. Sign the Rights and Responsibilities page.

You or your authorized representative must sign the form for it to be complete and valid.

3. Provide documents to prove the information provided on this form.

Gather documents (examples are listed throughout the form) that can be used to prove the information on the form. Send copies of these documents with your completed form. You may take original documents to a local office.

4. Turn in all re-evaluation paperwork within 10 days of receiving this form.

Use the enclosed return envelope to mail your completed application and verifications. You may also fax paperwork to 1-866-434-8278, email it to mybenefits@dhw.idaho.gov, or take it to a Health & Welfare office near you.

After turning in all re-evaluation paperwork, there is no need to contact the Department. If we need additional information, we will notify you.

IMPORTANT NOTICE
lf you need any assistance, please ask. The following services are free: • Help filling out this form • Accommodation for a disability • Language Interpreter. Call 1-800-926-2588 or TDD 208-332-7205
What is your preferred language? Spoken: Written:
Do you want an interpreter if you are interviewed? One will be provided at no cost to you. Yes No
¿Necesita un Interpréte para su entrevista? Uno estará disponible sin costo alguno para usted ? 🔲 Si 👚 No
Please contact your local office if you cannot participate in an interview during normal office hours or if you need interpreter services.



HOUSEHOLD INFORMATION

Tell us if the information listed below is correct. Please make corrections if there are changes, or tell us about any new information.

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•	on	ıLa	CL	m	IU	rm	au	u	п

The contact information we know about is listed below. If any information is incorrect, cross out the incorrect information and use the blank spaces below to provide correct or updated information.

Primary Per	rson:	Р	hone:		Тур	e:	Maili	ng Address:	Phy	sical Address:
Is the information a	bove correct	:? 🔲 Y	es 🗌	No						
If not, please use th	e space belo	w to pro	vide co	rrected	or updated	d inforn	nation.			
Primary Person:						Pho	one		Туре	
									Home	☐ Cell
Street Address						C:a		Country	Work	Other
Street Address						City	′	County	State	Zip
Mailing Address (i	f different)					City	,	County	State	Zip
People Living In T We know about the		oonla livi	na in w	our hom	na Chack t	ha ann	ropriate hov to	a tell us the curre	nt status of e	ach person
We know about the	i Tollowing pe	eopie iivi	ing iir y	our non	ie. Check t	пе арр	opriate box to	J tell us the curren	Tit status of ea	For
Name	ров		Currer	nt Statu	c		How will eac	h person be clai	med on your	Dependents
Ivaille			Currer	it Statu	•		next tax retu	ırn?		who will be the Primary Filer?
			_	l in hom		ved out	Primary Tax I	Filer Won't File	1	
			_	arcerate ceased	ed ∏ In fa ∏ Oth	acility	Claimed as a	Dependent by a hou	seho l d member	
				ceaseu		ici.	Claimed as a	Dependent by a non-	-househo l d mem	nber
Dependents Not L	iving In The	Homo								
List all other depen	_		tax reti	urn that	do not liv	e in you	r home and th	neir current incom	ne.	
Full Name	Ge	ender		DOB		Relatio	nship to you	Social Secu	rity Number	Current income for
		¬м г	∃F				. ,		•	this person
	L	 □ M	<u>」「</u>] F							
Tell us about any re	elationship cl			marriao	ne or adon	tion) in	vour househo	ld Please indicat	e who and w	hat the change is
Name(s)	elationship ci	nanges (:	sucii as	marnag	je or adop		it is the chang		.e who and w	nat the change is.
								9 = -		
List everyone else li answering yes or no						ll us if th	ne people you	list below buy, p	repare, and e	eat with you by
Full Name		Ger	nder		How are	you rel	ated to the h	ousehold?	F	Purchase/ prepare?
]M]F							☐Yes ☐No
					I					

If you want to add another person to your benefits, please use the "Add A Person" form enclosed with this packet.

about any new information about any new informat for household members	ion. Note	: Social Securit	y Numb	ers and citizenship ve	_	
Social Security We do not have Social Security Numbers	s (SSN) for th	ne individuals liste	ed below.	Please provide updated ir	nformation if av	railable.
Name		Have SSN or Al	ien ID#?	If yes, provide SSN or A	lien ID#	
		☐Yes ☐	No			
Citizenship We know the status of the following ind	ividuals who	o are not citizens.	Please to	ell us whether the status h	as changed.	
Name	Citizeı	nship status			ect? If no, stat	us?
					Yes No	
Medical Conditions Tell us about everyone in the home who	is pregnant	t.				
Name				Due	date	
Tell us about everyone in the home who	has a disab	ility.				
Name				Receiving/applied for So	ocial Security	benefits?
			☐ Yes	☐ No		
			☐ Yes	☐ No		
			☐ Yes	☐ No		
School Attendance Tell us about everyone in the home who	is 17 or old	er and attending :	school.			
Student name	:	School name		Expected graduation date	Awarded work study?	Student status
					☐ Yes ☐ No	Full-time Part-time Not attending
Tell us about everyone in the home who	is between	-	•	old and NOT attending sc	hool.	
		Nam	ne(s)			



	ly. Income	is money ear	ned (wages or sala	ary) fro	m a job or	self-employ	ment, or unearn	Attach Proof II as any money received ed from sources such as	
Check this box meet.	if there is	no income co	oming into your ho	ouseho	ld. Please a	attach a writ	ten statement ex	xplaining how you make ends	
Name of person wit	th income		Source of income	e/empl	oyer name		Employer phon	e	
How often paid	Hours pe	er week	Hourly rate of pay	у	Monthly in	ncome (pre-	Start date	Expected to change?	
Name of person wit	th income		Source of income	e/empl	oyer name		Employer phon	e	
How often paid	Hours pe	er week	Hourly rate of pay	у	Monthly in	ncome (pre-	Start date	Expected to change?	
Name of person wit	th income		Source of income	e/empl	oyer name		Employer phone		
How often paid	Hours pe	er week	Hourly rate of pay	у	Monthly in	ncome (pre-	Start date	Expected to change? Yes No	
Name of person wit	th income		Source of income/employer name				Employer phone		
How often paid	Hours pe	er week	Hourly rate of pay	y	Monthly in	ncome (pre-	Start date	Expected to change? Yes No	
• Work	stubs for t verification	he last 30 day	/S •	Te Ta	ermination ax returns (of employm personal and	nent d business for se		
Motor Vehicles Fell us about all vehic owns.	les—cars,	trucks, moto	rcycles, trailers, bo	ats, sno	owmobiles	, and other r	ecreational vehi	icles—your household	
Owner		Year, ma	ke, and model	Curre	ent value	What do	you primarily (use this for (choose one)?	
						Busines Medical Persona			

Resources Attach Proof

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

Name/Owner	Resource type	Name of financial institution	Account number	Current value

Attach proof

Send us proof of all resources you own. Examples of acceptable proof include copies of the following:

- Most recent bank statements
- Printouts from local bank (clearly showing account name, number, and current value)
- Statements showing current value of stocks, bonds, trust funds, life insurance, burial policies, etc.

Property Attach Proof

Tell us about all other property (including your home) owned by anyone living in your home.

Owner	Property type	Property Address	Value	What do you primarily use this property for (choose one)?
				Home Rental income
				Businesss/Self-employment
				Other:
				☐ Home ☐ Rental income
				Businesss/Self-employment
				Other:
				☐ Home ☐ Rental income
				Businesss/Self-employment
				Other:

Attach proof

Send us proof of all property you own. Examples of acceptable proof include copies of the following:

- Property tax assessment notice
- Property deed
- Current mortgage statement



EXPENSES

Please tell us about your expenses, including rent, utilities, child care, and medical insurance.

Note: If you do not tell us about any of the expenses indicated below, we will take that to mean that

you do not want a deduction for those expenses. After this re-evaluation is complete, we will not be able to add or change expenses until your next re-evaluation.

	our recurring expe				ise, include only the DA fees, etc., please		Attach Proof pay. If your out and record them
Rent p	er month	Mortgag	e per month	2nd Mortg	age per month	Space re	ent per month
\$		\$		\$		\$	
Irri	gation	Prop	perty tax	НС	DA fees	Homeow	ners insurance
\$	per	\$ 1	per	\$	per	\$	per
Please check t	he boxes below to	tell us what util	lities you pay that	are not include	d in your rent or m	ortgage.	
Heating	Cooli	ng	Water	Sewer	Trash		Telephone
Landlord's nar	ne:			Landlord's cont	tact number:		
	of all household ex lortgage or rent sta ome Owners Assoc roperty taxes tility bills	ntement		proof include c	opies of the follow	ing:	
•	below to tell us abo ousehold member	•	•	•	s include child sup telling us the amou	•	Attach Proof some medical sense, include only
N	lame	Ехре	nse type	A	Amount	How	often paid?
■ S	of all expenses. Ex tatement of child s ledical expense rec	upport paid	eptable proof inclu	ude copies of the	e following:		

- Medical insurance premiums*
- Prescription receipts*

^{*} For elderly or disabled household members only.

Dependant name	Total amount	Amount you pay	How often paid
Provider name	Provider address		Provider phone
Dependant name	Total amount	Amount you pay	How often paid
Provider name	Provider address		Provider name
Dependant name	Total amount	Amount you pay	How often paid
Provider name	Provider address		Provider name

Attach Proof

Attach proof

Dependant Care Expenses

Send us proof of all dependant care expenses. Examples of acceptable proof include copies of the following:

Use the space below to tell us about any child care, adult disabled care, or elderly care.

- Statement from child care provider
- Dependant Care Charges Form

Health Coverage Attach Proof

Tell us about everyone in your home who is receiving or has received health coverage within the last six months.

Name of person insured	Insurance company name		Insurance company phone		
Policy holder	Policy number	Start date	End date	Monthly premium amount	

Attach proof

Send us proof of your health coverage. Examples of acceptable proof include copies of the following:

- Insurance card (front and back)
- Health insurance policy



Re-evaluation Checklist

Use the checklist below to help make sure you have completed all necessary parts of the re-evaluation process. If the Department needs more information, you will receive a notice in the mail.

lease make sure you:								
Check all information and answer all questions on the form.								
Attach proof of all income, resources, and expenses as listed throughout the form.								
Read, sign, and date the Rights and Responsibilities page at the end of this form.								
Review the instructions at the top of this form to see if an interview is required for this re-evaluation.								
Return or mail this form along with all proofs to the Department.								
Mail: Self Reliance Programs PO Box 83720 Boise, ID 83720-0026								
Fax: 1-866-434-8278								
Email: mybenefits@dhw.idaho.gov								
Failure to complete all of these steps may cause your benefits to be late or close.								

RIGHTS & RESPONSIBILITIES

IUNDERSTAND THAT...

- 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 by the Idaho Department of Health and Welfare. 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 in reliance on this consent. If I revoke this consent, the Department may not provide further benefits or services.
- I understand that I will be notified of the right to appeal Department decisions and I can contact the Department for information on the appeal process.
- I have read and understand the plan choices and that I might be responsible for paying part of the cost of my child's health plan.
- My signature certifies that the citizenship status marked on this form is correct for each child/person applying.
- If I receive a Child Support payment in error, Child Support Services will withhold future payments to recover the amount unless I submit written instructions to the contrary.
- I am required to report changes in my circumstance, including income, assets, and living situation within 10 days of the change.

- By applying for benefits for a minor child, a child support case must be opened, when applicable.
- If a third party is responsible for my child's disease or injury, I give the Idaho health plan any rights I may have, or may acquire in the future, to be compensated by the responsible party for any medical benefits I receive for my children.
- My signature or the signature of my representative authorizes State offices to communicate with insurance companies related to my child's medical assistance.
- 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.
- If I am determined eligible for Medicaid, I choose the plan that is based on my health needs, unless I tell the Self Reliance worker otherwise.
- 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.
- To receive Food Assistance, I may be required to participate in work programs. Failure to do so may result in a loss or decrease in 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.
- My signature indicates I have received a copy of the Department Privacy Practices.

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.

Signature of Applicant	Date
Signature of other adult in the home	Date

Personal / Authorized Representative

You may authorize someone else to apply for benefits for you and use your Food Stamp benefits to buy food for you. Authorized Representatives are also allowed to report or request information about your benefits. To do so, enter their name, phone, and address below. **NOTE:** If your Authorized Representative gives incorrect information that causes us to give you benefits you are not entitled to receive, you will have to repay the extra benefits to us.

Name of Authorized Representative	Phone	
Address / City / State / ZIP		
Signature of Authorized Representative		Date