

# Presumptive Eligibility Medicaid

Presumptive Eligibility Medicaid allows approved healthcare providers to give access to temporary Medicaid coverage to individuals who appear eligible. This form should be used when applying for Health Coverage Assistance through the Idaho Department of Health and Welfare is not possible.

<b>WHO can use this application</b>	Hospital representatives and customers can use this form to apply for Presumptive Eligibility Medicaid.		
<b>WHAT you may need to apply</b>	<ul style="list-style-type: none"> <li>• Employer and income information for everyone in the customer's family (for example: pay stubs, tax returns, or other wage and tax statements)</li> <li>• Social Security numbers (or document numbers for legal immigrants)</li> <li>• Proofs of identity (for example: drivers license or passport)</li> </ul>		
<b>WHEN to use this application</b>	Use this application if a customer is in need of medical services, does not have current health coverage, and meets the criteria below: <ul style="list-style-type: none"> <li>• Customer is an Idaho citizen/legal permanent resident</li> <li>• Customer income is at or below the monthly income limit for Medicaid</li> <li>• Customer has not received Presumptive Eligibility Medicaid coverage in the past 12 months</li> <li>• Customer has not received Presumptive Eligibility Medicaid for this term of pregnancy</li> <li>• Customer meets one of the following criteria:                         <ul style="list-style-type: none"> <li>• Customer is a child under the age of 19</li> <li>• Customer is a parent or caretaker relative of a minor child</li> <li>• Customer is a pregnant woman</li> <li>• Customer is an adult 19-64 years old, not receiving Medicare</li> <li>• Customer is 18-24 years old and received Idaho Medicaid through the foster care program on their 18th birthday</li> </ul> </li> </ul>		
	<p><b>Equal opportunity for applicants</b>                      In accordance with federal law and U.S. Department of Health and Human Services (HHS) policy, the Idaho Department of Health and Welfare (IDHW) is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. Idaho Department of Health and Welfare does not exclude people or treat them differently because of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, contact HHS or IDHW at:</p> <table border="0"> <tr> <td data-bbox="496 1304 933 1480"> <p><b>Idaho Department of Health and Welfare</b>                              Civil Rights Manager                              P.O Box 83720                              Boise, ID 83720-0036  <b>Fax:</b> 202-690-7442  <b>Email:</b> program.intake@usda.gov</p> </td> <td data-bbox="1013 1304 1494 1507"> <p><b>U.S. Department of Health &amp; Human Services</b>                              Room 506F, 200 Independence Avenue, SW                              200 Independence Avenue, SW                              Washington, D.C. 20201  <b>Email:</b> OCRcomplaint@hhs.gov  <b>Phone:</b> 202-619-0403 (voice)                              202-619-3257 (TTY)</p> </td> </tr> </table>	<p><b>Idaho Department of Health and Welfare</b>                              Civil Rights Manager                              P.O Box 83720                              Boise, ID 83720-0036  <b>Fax:</b> 202-690-7442  <b>Email:</b> program.intake@usda.gov</p>	<p><b>U.S. Department of Health &amp; Human Services</b>                              Room 506F, 200 Independence Avenue, SW                              200 Independence Avenue, SW                              Washington, D.C. 20201  <b>Email:</b> OCRcomplaint@hhs.gov  <b>Phone:</b> 202-619-0403 (voice)                              202-619-3257 (TTY)</p>
<p><b>Idaho Department of Health and Welfare</b>                              Civil Rights Manager                              P.O Box 83720                              Boise, ID 83720-0036  <b>Fax:</b> 202-690-7442  <b>Email:</b> program.intake@usda.gov</p>	<p><b>U.S. Department of Health &amp; Human Services</b>                              Room 506F, 200 Independence Avenue, SW                              200 Independence Avenue, SW                              Washington, D.C. 20201  <b>Email:</b> OCRcomplaint@hhs.gov  <b>Phone:</b> 202-619-0403 (voice)                              202-619-3257 (TTY)</p>		
<b>HOW to submit this application</b>	Call the Idaho Department of Health and Welfare (IDHW) to submit this application: <p style="text-align: right;"><b>1-877-456-1233</b>   Monday - Friday, 8:00 am - 5:00 pm.</p>		

## Eligibility Criteria

### - Hospital Use Only -

Select all eligibility criteria that apply to the applicant. All statements must be true for the applicant to be determine eligible.

- |   |  |
|---|--|
| <input type="checkbox"/> Applicant is an Idaho resident   | <input type="checkbox"/> If pregnant, applicant has not received Presumptive Eligibility Medicaid for this term of pregnancy |
| <input type="checkbox"/> Applicant meets residency/citizen requirements                                   | <input type="checkbox"/> Applicant meets one or more of the following requirements (select all that apply)                   |
| <input type="checkbox"/> Applicant's household income is within the income limit                          | <input type="checkbox"/> Is a child under age 19 <input type="checkbox"/> Is a former foster care child                      |
| <input type="checkbox"/> Applicant has not receive Presumptive Eligibility Medicaid in the last 12 months | <input type="checkbox"/> Is pregnant <input type="checkbox"/> Is a parent/caretaker relative                                 |
|   | <input type="checkbox"/> Is an adult age 19-64 without Medicare  |

# 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. 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: तपाइंले नेपाली बोलुनुहुन्छ भने तपाइंको निम्ति भाषा सहायता सेवाहरू नि:शुल्क रूपमा उपलब्ध 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 بکیرید تماس 1-877-456-1233
العربية (Arabic)	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالجان. 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 the Supplemental Nutrition Assistance Program (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
- 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](http://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:**

- U.S. citizenship status - optional for people not applying for assistance
- Social Security number - optional for people not applying for assistance
- Race - optional
- Hispanic or Latino - optional

1. Are you applying for Health Coverage Assistance (HCA) for yourself?						<input type="checkbox"/> No	<input type="checkbox"/> Yes
2. Full name	First	Middle	Last				
3. Former names (if any)	First	Middle	Last				
4. Physical address	Street	City	State	Zip	County		
5. Mailing address (if different)	Street	City	State	Zip	County		
6. Email							
7. Primary phone				Phone type:	<input type="checkbox"/> Home	<input type="checkbox"/> Cell	<input type="checkbox"/> Work
	If none, what number may we use to leave a message?						
8. Social Security number							
9. Date of birth							
10. Sex	<input type="checkbox"/> Male	<input type="checkbox"/> Female					
11. Marital status	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated	<input type="checkbox"/> Widowed	<input type="checkbox"/> Never been married		
12. Pregnant	<input type="checkbox"/> No		<input type="checkbox"/> Yes, complete a and b.				
	a. Due date?		b. How many are you expecting?				
13. Preferred language	Spoken		Written				
14. 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 proporcionara uno sin costo alguno)						
	<input type="checkbox"/> No		<input type="checkbox"/> Yes				
15. Race	<input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Island <input type="checkbox"/> American Indian/Alaska Native Name of Tribe (if any):						
16. Hispanic or Latino?	<input type="checkbox"/> No		<input type="checkbox"/> Yes				
17. U.S. citizen or national	<input type="checkbox"/> No		<input type="checkbox"/> Yes				
18. If not a U.S. citizen, do you have eligible immigration status?	<input type="checkbox"/> No		<input type="checkbox"/> Yes, complete a and b.		<i>Alien status will be verified with USCIS. The response from USCIS may affect your household's eligibility and benefit amount.</i>		
	a. Document type:		b. Document ID number:				
19. Do you plan to file a federal tax return for the CURRENT YEAR?	<input type="checkbox"/> No, skip to c below.		<input type="checkbox"/> Yes, complete a-c.				
	a. Do you plan to file jointly with a spouse?		<input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, complete i and ii.				
	i. Name of spouse:						
	<i>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.</i>						
	ii. Name of primary account holder:						
	b. Will you claim dependents?		<input type="checkbox"/> No <input type="checkbox"/> Yes, complete i.				
	i. Name of dependents						
	c. Will you be claimed as a dependent on someone else's tax return?				<input type="checkbox"/> No <input type="checkbox"/> 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. <input type="checkbox"/> No <input type="checkbox"/> Yes	1. Is this person applying for HCA?	1. <input type="checkbox"/> No <input type="checkbox"/> Yes
2. <input type="checkbox"/> No <input type="checkbox"/> Yes	2. Lives at the same address as you?	2. <input type="checkbox"/> No <input type="checkbox"/> Yes
3.	3. Relationship to you	3.
4. First	4. Name	4. First
Middle		Middle
Last		Last
5.	5. Former names, if any	5.
6.	6. Social Security number	6.
7.	7. Date of birth	7.
8. <input type="checkbox"/> Male <input type="checkbox"/> Female	8. Sex	8. <input type="checkbox"/> Male <input type="checkbox"/> Female
9. <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Never Married	9. Marital status	9. <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Never Married
10. <input type="checkbox"/> No <input type="checkbox"/> Yes, complete a and b.	10. Pregnant	10. <input type="checkbox"/> No <input type="checkbox"/> Yes, complete a and b.
a.	a. Due date	a.
b.	b. How many are you expecting?	b.
11. <input type="checkbox"/> No <input type="checkbox"/> Yes	11. Hispanic or Latino	11. <input type="checkbox"/> No <input type="checkbox"/> Yes
12. <input type="checkbox"/> No <input type="checkbox"/> Yes	12. US citizen or national	12. <input type="checkbox"/> No <input type="checkbox"/> Yes
13. <input type="checkbox"/> No <input type="checkbox"/> Yes, complete a and b.	13. If not a citizen, has eligible immigration status	13. <input type="checkbox"/> No <input type="checkbox"/> Yes, complete a and b.
a.	a. Immigration document type	a.
b.	b. Document ID number	b.
14. <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black/ African American <input type="checkbox"/> Native Hawaiian/Pacific Island <input type="checkbox"/> American Indian/Alaska Native	14. Race	14. <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black/ African American <input type="checkbox"/> Native Hawaiian/Pacific Island <input type="checkbox"/> American Indian/Alaska Native
a.	a. Name of Tribe (if applicable)	a.
15. <input type="checkbox"/> No, skip to c. <input type="checkbox"/> Yes, complete a-c.	15. File federal tax return for CURRENT YEAR	15. <input type="checkbox"/> No, skip to c. <input type="checkbox"/> Yes, complete a-c.
a. <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, complete i and ii.	a. File jointly with a spouse	a. <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, complete i and ii.
i.	i. Name of spouse	i.
ii.	ii. Name of primary account holder	ii.
b. <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, complete i.	b. Claiming dependents	b. <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, complete i.
i.	i. Name of dependents	i.
c. <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, complete i.	c. Claimed as a dependent	c. <input type="checkbox"/> No <input type="checkbox"/> 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 foster care or adoption assistance?  No  Yes, who?

2. Was anyone in your household in Idaho foster care when they turned 18?  No  Yes, who?

3. Is anyone in your household currently receiving Medicaid from another state?  No  Yes, complete a and b.

a. Dates of assistance From (month/year): To (month/year):

b. Where assistance is received from City County State

# Tell us about your health coverage situation

Does any child (under the age of 19) who is applying for HCA currently receive health coverage?

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

a. Name of insured child

b. Covered services (check all that apply)  Inpatient/Outpatient hospital services  Lab services  
 Physicians medical/surgical service  X-ray Services

a. Name of insured child

b. Covered services (check all that apply)  Inpatient/Outpatient hospital services  Lab services  
 Physicians medical/surgical service  X-ray Services

a. Name of insured child

b. Covered services (check all that apply)  Inpatient/Outpatient hospital services  Lab services  
 Physicians medical/surgical service  X-ray Services

a. Name of insured child

b. Covered services (check all that apply)  Inpatient/Outpatient hospital services  Lab services  
 Physicians medical/surgical service  X-ray Services

# Tell us about your household income

Tell us about all **taxable income** your household receives. 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. Income types include:

## Earned

### Wages or salary from:

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

## Unearned

### Income from sources such as:

- Unemployment benefits
- Gaming/lottery payments
- Rental income
- Social Security
- Cash gifts
- Retirement income

**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)	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Yearly	<input type="checkbox"/> Every 2 weeks	<input type="checkbox"/> Semi-monthly, which days (i.e.: 5th & 20th)?
Is income expected to change?	<input type="checkbox"/> No	<input type="checkbox"/> 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)	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Yearly	<input type="checkbox"/> Every 2 weeks	<input type="checkbox"/> Semi-monthly, which days (i.e.: 5th & 20th)?
Source of income		Amount			
How often paid? (check one)	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Yearly	<input type="checkbox"/> Every 2 weeks	<input type="checkbox"/> 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)	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Yearly	<input type="checkbox"/> Every 2 weeks	<input type="checkbox"/> 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)	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Yearly	<input type="checkbox"/> Every 2 weeks	<input type="checkbox"/> Semi-monthly, which days (i.e.: 5th & 20th)?
Is income expected to change?	<input type="checkbox"/> No	<input type="checkbox"/> 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)	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Yearly	<input type="checkbox"/> Every 2 weeks	<input type="checkbox"/> Semi-monthly, which days (i.e.: 5th & 20th)?
Source of income		Amount			
How often paid? (check one)	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Yearly	<input type="checkbox"/> Every 2 weeks	<input type="checkbox"/> 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)	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Yearly	<input type="checkbox"/> Every 2 weeks	<input type="checkbox"/> Semi-monthly, which days (i.e.: 5th & 20th)?

# Rights and Responsibilities

Read and initial each statement below.

<input type="checkbox"/> <b>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.</b>	<input type="checkbox"/> 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.
<input type="checkbox"/> <b>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.</b>	<input type="checkbox"/> As part of my application, I understand that IDHW will open a Child Support case and I must cooperate with Child Support Services.
<input type="checkbox"/> 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.	<input type="checkbox"/> 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.
<input type="checkbox"/> My signature indicates I have received a copy of the Department Privacy Practices.	<input type="checkbox"/> If I am determined eligible for Medicaid, the plan I will be enrolled in depends on my individual needs.
<input type="checkbox"/> I am required to report when my household's monthly income exceeds the gross limit for my household size.	<input type="checkbox"/> My signature or the signature of my representative authorizes state offices to communicate with insurance companies related to my/my child's medical assistance.
<input type="checkbox"/> I will be notified of the right to appeal Department decisions and I can contact the Department for information on the appeal process.	<input type="checkbox"/> 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.
<input type="checkbox"/> 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 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.	<input type="checkbox"/> 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.
	<input type="checkbox"/> 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.

## Applicant 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

## Hospital Representative Signature (must be completed)

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

\_\_\_\_\_  
Printed name of hospital representative

\_\_\_\_\_  
Signature of of hospital representative

\_\_\_\_\_  
Date