APPLICATION FOR ASSISTANCE
NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
SFN 405 (12-2019)

Instructions For Application For Assistance

This application may be used to apply for Child Care Assistance Program (CCAP), Supplemental Nutrition Assistance Program (SNAP), Health Care Coverage (HCC), Basic Care Assistance Program (BCAP), and Temporary Assistance for Needy Families (TANF). See the Guidebook for more information. You may also view the guidebook and apply online at: http://apply.dhs.nd.gov

What Do I Need to Do to Get Assistance?

Follow these steps to apply for assistance:

Step 1: Fill out this application.

All applicants must fill out Section 1 and Section 7.

Depending on the program you are applying for, you will also need to complete:

- Child Care Assistance Program (CCAP) - You need to complete Section 6.
- Supplemental Nutrition Assistance Program (SNAP) - You need to complete Sections 3 and 4.
- Health Care Coverage (HCC) - You need to complete Sections 2, 3, and 5. (Aid to Blind, Medicaid, Medicare Savings Program) Information of individuals applying for HCC will be sent to the Health Insurance Marketplace for eligibility determination for help paying for private health insurance.
- Basic Care Assistance Program (BCAP) - You need to complete Sections 3 and 5.
- Temporary Assistance for Needy Families (TANF) - You need to complete Sections 3, 4, and 5.

Answer as many questions as you can. If you need help applying for assistance, you may have a friend, relative or someone else help you apply. Your local county social service office can also help you apply for assistance. If you need additional space, attach a separate sheet of paper.

Step 2: Return the application to your local county social service office.

If you cannot fill out the whole application today, turn in Section 1. **If you do not fill out all of Section 1, you have the right to file an incomplete application as long as it contains the applicant's name, address and signature of either the applicant or the authorized representative. If you are eligible, your assistance will start from the date we receive Section 1 or an incomplete application.**

Fill out and turn in the rest of the application as soon as you can. You can mail or drop off your application.

Step 3: Talk with us.

When we receive your application for SNAP or TANF, we will set up an interview with you. For SNAP, a face-to-face interview may be waived in favor of a telephone interview on a case-by-case basis determined by household hardship reasons. HCC, BCAP, and CCAP do not require an interview.

Appointment Date:	Appointment Time:

If you miss your appointment and still wish to apply, please contact the county social service office to schedule a second appointment.

To speed up the processing of your application, turn in proof of the following items with your application. You may also bring proof with you to your interview. Your workers will help you obtain these things if needed.

☐ **Proof of Alien or Citizenship Status such as** (original documents required if applying for Health Care Coverage):

- Resident Alien Card (Form I-551)
- Employment Authorization Card (Form I-688A)
- American Indian/Alaskan Native Tribal Document
- Birth Certificate (if born in the United States)
- Temporary Resident Card (Form I-688)
- Arrival-Departure Record (Form I-94)
- Passport

You will be asked to provide information about the citizenship or immigration status for all persons for whom you want to receive assistance. This information may be subject to verification by the United States Citizenship and Immigration Service (USCIS), and that the submitted information received from USCIS may affect the household's eligibility and level of benefits. **For HCC, verification will be required if not available through electronic notifications.**
For CCAP, HCC, and SNAP: if any of these persons do not want to give information about their citizenship or immigration status, they will not be eligible for benefits. These persons must provide their financial information to determine eligibility for other household members. Other household members may still get benefits if they are otherwise eligible. We will not share alien or citizenship information about non-applicants with the United States Citizenship and Immigration Service (USCIS).
For TANF: if an individual who is required to be included in the TANF household does not want to give information about their citizenship or immigration status, the entire household will be ineligible to receive benefits.

☐ **Proof of the value of current assets such as:**

- Annuities
- Business Accounts
- Certificates of Deposit
- Checking/Savings/Credit Union Accounts
- IRA/401K/KEOGH plans
- Life Insurance
- Real Property (Land, Rental Property, etc.)
- Savings Bonds
- Stocks/Bonds/Mutual Funds
- Trusts

If only applying for Child Care Assistance or Health Care Coverage for families with children and non-disabled adults between the ages of 19 and 65, you do not need to report or bring records of your assets.

☐ **Proof of most current expenses such as:**

- Child/Dependent Care
- Court Ordered Payments (Child Support, Spousal Support, Health Insurance Premiums, Other Support)
- Medical or Health Insurance Premiums (if applying for SNAP only, you do not need to provide information for household members under age 60 unless they are disabled.)
- Utility/Shelter Expenses (if applying for SNAP)
  - Heating and Cooling Costs
  - Home Owner's Insurance
  - House Payment (Mortgage)
  - Other Utility Bills
  - Property Taxes
  - Rent (Receipt, Lease Agreement, Housing Assistance Contract)
  - Telephone Bill

If only applying for HCC for families with children and non-disabled adults between the ages of 19 and 64, you do not need to provide expense information.

☐ **Proof of most current income (last month and this month) such as:**

- Bonuses
- Child Support
- Commissions
- Lease Income
- Money from Friends, Relatives, or Others
- Pay (Pay Stubs or Employer Statement)
- Pension/Retirement Benefits
- Rental Income
- Self-employment Income (most recent copy of Federal Income Tax Form)
- Social Security Benefits
- Spousal Support
- SSI (Supplemental Security Income)
- Unemployment Benefits
- Veteran's/Military Benefits
- Workers Compensation

For HCC, proof will be requested if the information cannot be verified through our electronic verification sources.

☐ **Proof of other information such as:**

- Identity (Birth Certificate, Driver's License, Work or School ID, American Indian/Alaskan Native Tribal Document, Passport - original documents required if applying for Health Care Coverage)
- Age (Birth Certificate, Driver's License)
- Residence (Rent Receipts, Utility Bills, Lease)
- Social Security Numbers (card or proof of applicant for SSN)
- Verification of Pregnancy (Doctor's statement or due date)

For HCC, proof will be requested if the information cannot be verified through our electronic verification sources.

To learn when you may get assistance, go to the General Information section of the Guidebook. If you have questions, contact your local county social service office.

APPLICATION FOR ASSISTANCE

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES

SFN 405 (12-2019)

Clear Fields

Agency Use Only

Case Number	Date Requested
Date Received	Interview Date
Individual Interviewed	

Application for Assistance - Section 1

Check the assistance you are applying for. Sign and date below. If you would like more information on these programs and privacy information, see the Guidebook. If you did not receive the Guidebook, contact your local county social service office.

☐ **TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) (a program for families with children)** - Apply for this program **IF** you are a family with limited income who has a child deprived of the support of a parent (one parent is absent, disabled or no longer living) **AND** the child is under age 18. This program provides temporary cash assistance to assist families while they pursue training and employment opportunities to become self-reliant.

☐ **CHILD CARE ASSISTANCE PROGRAM (CCAP)** - Assist individuals with child care costs while the individual is employed, attending high school, obtaining their GED, pursuing postsecondary education, training, or job searching.

☐ **SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)** - Formerly known as Food Stamps, helps people buy food. You may get SNAP within 7 days of your application date if any of the following are true:

- Your household's monthly income before taxes is $150 or less; or
- You are a migrant or seasonal farm worker who is destitute provided your liquid resources do not exceed $100; or
- Your household's monthly rent/mortgage and utilities are more than your household's income before taxes.

☐ **HEALTH CARE COVERAGE (HCC)** - **Check the Health Care Coverage(s) you are applying for:**

- ☐ **Aid to the Blind** - Assists with treatment for people who are not eligible for Medicaid and are in danger of losing their vision or require restorative eye services.
- ☐ **Medicaid** - Pays for health services or insurance premiums for eligible individuals. Information of individuals applying for HCC will be sent to the Health Insurance Marketplace for an eligibility determination for help paying for private health insurance.
- ☐ **Medicare Savings Program** - Assists with Medicare Part B premium, coinsurance and deductibles.

☐ **BASIC CARE ASSISTANCE PROGRAM (BCAP) (a program for residents of Basic Care Facilities Only)** - Apply for this program **IF** you live in a licensed Basic Care Facility to meet your health and living needs **AND** you are age 18 or older, blind, disabled or aged. This program helps pay for room and board costs.

Tell Us About You

First Name:	Middle Initial:	Last Name:	Suffix:

Address Where You Live: **	Apartment or Unit Number:

City:	State:	ZIP Code:	Direction to Home (if rural): ***

Mailing Address (if different):

Home Telephone Number:	Work or Message Number:	Cell Phone Number:

If you do not speak English, what is your preferred spoken or written language?

** If you are applying for Health Care Coverage (Medicaid) and you have entered your residential and mailing address as General Delivery, or Homeless, or have left it blank, your mail will be sent to the local county social service office. You will need to arrange to pick up your mail at the local county social service office on a weekly basis. If you do not pick up your mail for three (3) weeks, your case may be closed due to loss of contact.

*** Not required for Medicaid.

Sign and Date Application Here

Signature of Applicant	Date

Other Signature (Spouse, Guardian, or Other Adult)	Date

Tell Us About The People In Your Home

Check the boxes below for all the people who live in your home, including members temporarily out of your home (working away from home, attending school or boarding school, in the military, etc.)

☐ Yourself ☐ Your husband or wife ☐ Your children ☐ Other adults or children living in your home

For each person checked, fill in the boxes below. These people make up your household.

If you need additional space, continue on a separate sheet of paper.

You are asked to provide information about the race and the ethnic background for all persons for whom you want assistance. This information is voluntary and is used to make sure that benefits are provided without regard to race, color, or national origin. Providing this information will not affect your eligibility or benefit amount.

You are also asked to provide information about the sex, last grade completed and marital status of all persons for whom you want assistance. This information is voluntary.

You will be asked to provide Social Security Numbers (SSNs) for all persons for whom you want assistance, except for the Child Care Assistance Program. However, providing your SSN will assist in speeding up the application process even though you are not interested in receiving Health Care Coverage. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778. If you are applying only for emergency Medicaid because of your citizenship or immigration status, you do not need to give us information about your SSN. **(See the 'General Information Section' of the Application for Assistance Guidebook for additional information regarding use of Social Security Numbers.)**

NOTE: If you are applying for Health Care Coverage, include individuals who are in your home and also those individuals who you claim on your federal income tax return

Household Members (Enter Legal Name) First / Middle Initial / Last	Relationship to You	Social Security Number	Date of Birth	Age	Sex	Last Grade Completed *	U. S. Citizen (Yes or No)	Hispanic or Latino (Yes or No)	Race (Use Codes Below)	Marital Status (Use Codes Below)
	Self									

Race Codes: **AI** - American Indian/Alaska Native **AP** - Asian **BL** - Black/African American **HP** - Native Hawaiian/Pacific Islander **WH** - White
Marital Status Codes: **DI** - Divorced **MA** - Married **NM** - Never Married **SE** - Separated **WI** - Widowed

* Last Grade Completed is not required for Health Care Coverage or SNAP.

If any household members are enrolled members in a federally-recognized Indian tribe, list enrolled members, the name of the tribe and their tribal enrollment numbers:

If you are applying for Health Care Coverage you may be eligible for no enrollment fees or premium payments under certain Health Care Coverage.

List other names that have been used by household members (maiden name, prior married name, or nicknames):

List household members temporarily out of the home:

Why are they out of the home? | Date Expected to Return:

List household members who are disabled:

Have household members received, or are they currently receiving assistance in another state (cash, food, medical assistance)? ☐ Yes ☐ No

If Yes, When? | Which City, County, and State?

List household members who are boarders (paying someone to provide meals):

Have household members received commodities through the Tribal Food Distribution Program on Indian Reservations last month or this month? ☐ Yes ☐ No

If Yes, Who?

Have you or any member of your household had a disqualification from the Tribal Food Distribution Program? ☐ Yes ☐ No

If Yes, Who?

Tell Us About Students In Your Home

List each household member age 14 or older who is a student or planning to attend school.

Student Name	Name of School	Student Status
		☐ Full Time ☐ Part Time
		☐ Full Time ☐ Part Time
		☐ Full Time ☐ Part Time

Would You Like to Receive Text and E-mail Notification

By opting to receive text message or e-mail notifications, you agree to the following:

A text message or e-mail notification will be sent to the cell phone number or e-mail address you entered when a review or full application is needed to determine eligibility or continued eligibility for the program(s) you are enrolled in.

Cell phone carrier text message rates may apply and DHS will not be liable for any text message charges.

You are responsible for notifying your case worker of any changes to your e-mail address, cell phone carrier or cell phone number, or if your cell phone is lost or stolen.

It is the policy of DHS not to transmit confidential information by text or e-mail as unencrypted e-mail and text messaging is NOT a secure form of communication. There is some risk that any Protected Health Information (PHI) and other confidential information that may be contained in such e-mail or text messages may be misdirected, disclosed to, or intercepted by, unauthorized third parties. I consent and accept the risk in transmitting PHI and other confidential information via unencrypted e-mail or text messaging.

Would you like to receive text message notifications? ☐ Yes ☐ No	If yes, list name of cell phone provider:
Would you like to receive e-mail notifications? ☐ Yes ☐ No	If yes, list e-mail address:

Signature (text and/or e-mail notifications will not be sent without your signature)	Date

Help with SNAP and HCC?

Did the Great Plains Food Bank offer you SNAP information or application assistance? ☐ Yes ☐ No

Supplemental Nutrition Assistance Program Education (SNAP-Ed) is available to SNAP recipients through NDSU Extension Services Family Nutrition Program. This program provides resources and learning opportunities to help participants make healthy food choices within a limited budget and sustain a healthy weight. Please see www.ag.ndsu.edu/foodwise for more information.

If you are applying for SNAP or HCC, you can give a trusted person permission to talk about this application with us and see your information. This individual can act on your behalf on matters related to this application, including giving and getting information, signing your application and acting for you on all future matters. This person is called an "authorized representative." If you ever need to change your authorized representative, contact your county social service office.

For SNAP, this person can also give information at your interview and can also receive the Electronic Benefit Transfer (EBT) card for you. This gives the representative access to your food benefits. Any benefits spent by the representative will not be replaced. You also have the choice to name a different authorized representative who will not receive notifications about your SNAP case, including the application, but can access your food benefits for you by using your EBT card. Any benefits spent by the representative will not be replaced.

For HCC, if the person you give this permission is a **legally** appointed representative for someone on this application, submit proof with the application.

If you choose to have someone help you, fill in the boxes below with their information:

First Name:	Middle Initial:	Last Name:	Suffix:

Address:	Apartment or Suite Number:

City:	State:	ZIP Code:	Telephone Number

By signing, you authorize this person to serve as your "authorized representative."

Signature	Date

If you choose to have someone help you only to use your EBT card and not receive notifications, fill in the boxes below with their information:

First Name:	Middle Initial:	Last Name:	Suffix:

Address:	Apartment or Suite Number:

City:	State:	ZIP Code:	Telephone Number

By signing, you authorize this person to serve as your "authorized representative" to use your EBT card.

Signature	Date

Help Us Decide if You Can Receive SNAP Within Seven Days

If you are applying for SNAP, completing this section may help you receive benefits within seven days:

Are you a migrant or seasonal farm worker with less than $100 liquid resources? ☐ Yes ☐ No

About how much total earned income will your household receive this month before taxes (gross)?

About how much total unearned income or other money will your household receive this month?

How much is your household's monthly rent, lot rent, and/or house payment?

Check all the utilities your household is responsible for:

☐ Heating ☐ Cooling ☐ Electricity ☐ Telephone ☐ Water ☐ Sewer ☐ Garbage

Has anyone in your household received LIHEAP (fuel assistance) in the past 12 months? ☐ Yes ☐ No

If Yes, List Household Member:

Do you have a North Dakota Electronic Benefit Transfer (EBT) card for SNAP? ☐ Yes ☐ No

Do household members purchase and prepare meals separately? ☐ Yes ☐ No

If yes, who?

Agency Use Only - Expedited Formula

Eligible for expedited service if:
Countable Income is below $150/ Month
Examples: Wages, Child Support, SSI, Disability, Retirement, Veterans Benefits, Unemployment, Workers Compensation

If not eligible:

Monthly

Gross Countable Income	

Would be less than:

Rent/Mortgage	
Appropriate Utility Standard	+
Total Shelter Cost	=

HLSU - Any of the following:
- Heating
- Cooling
- LIHEAP

LUSA - Two of the following:
- Water
- Electric
- Sewer
- Telephone
- Garbage

MU - One of the following:
- Water
- Garbage
- Sewer
- Electric

TL - Telephone Only

Was the screening for expedited service completed? ☐ Yes ☐ No

Is the household eligible for expedited service? ☐ Yes ☐ No

Was the identity of the applicant verified? ☐ Yes ☐ No

Worker's Initials:

Agency Use Only

Case Number
Date Requested

Tell Us About the Income/Money Your Household Receives

Self-Employment

Are any household members self-employed? ☐ Yes ☐ No

If yes, answer below:

Name of Household Member(s):	Name of Business:	
Type of Business:		Date Business Started:

Employment

Are any household members employed? ☐ Yes ☐ No

If Yes, list information about pay from employment such as wages, commissions, bonuses, and incentives for all household members, including children. If employment stopped last month or this month, also list income received this month here.

Household Member	Employer	Hours Worked Per Week	Hourly Pay	This Month's Pay Before Taxes (Gross)	Next Month's Pay Before Taxes (Gross)	Amount of Tips	Date of Next Check	How Often Paid (Use Codes Below)	Day or Dates Paid (Use Codes Below)

How Often Paid Codes:
M - Monthly **2X** - Twice a Month **W** - Weekly **EX** - Every Two Weeks Other, specify: _____

Day Paid Codes:
M - Monday **T** - Tuesday **W** - Wednesday **TH** - Thursday **F** - Friday **S** - Saturday **SU** - Sunday

Has any household member received commissions, bonuses or incentives other than those included above within the last year?
☐ Yes ☐ No

If yes, complete the following:

Name of Household Member:	Date Received:	Amount Received:

Unearned Income or Other Money Received

The following is a list of different kinds of unearned income. Check yes for each unearned income or other money received by household members. Check no, if not received.

- ☐ Yes ☐ No Benefit while on Strike
- ☐ Yes ☐ No BIA/Tribal General Assistance**
- ☐ Yes ☐ No Bingo/Gambling Winnings
- ☐ Yes ☐ No Child Support** or Spousal Support
- ☐ Yes ☐ No Contract Sale or Rental Income
- ☐ Yes ☐ No Foster Care/Subsidized Adoption Payments
- ☐ Yes ☐ No Income from CRP
- ☐ Yes ☐ No Income from Tribes
- ☐ Yes ☐ No Income from Roomer/Boarder
- ☐ Yes ☐ No Individual Indian Monies (IIM)*
- ☐ Yes ☐ No Insurance/Lawsuit Settlement**
- ☐ Yes ☐ No Interest/Dividend Income
- ☐ Yes ☐ No Money Deposited into a Bank Account from an Individual Outside of Your Household **
- ☐ Yes ☐ No Money from Friends, Relatives or Others**
- ☐ Yes ☐ No Money from Inheritance**
- ☐ Yes ☐ No Oil/Mineral Rights/Royalties
- ☐ Yes ☐ No Pension/Retirement Benefits
- ☐ Yes ☐ No Railroad Benefits
- ☐ Yes ☐ No Refugee Assistance**
- ☐ Yes ☐ No Social Security Benefits
- ☐ Yes ☐ No Supplemental Security Income (SSI)**
- ☐ Yes ☐ No TANF-Temporary Assistance for Needy Families**
- ☐ Yes ☐ No Unemployment Benefits
- ☐ Yes ☐ No Veteran's/Military Benefits**
- ☐ Yes ☐ No Workers' Compensation**

Other, specify: _____

** IIM information is not required for Health Care Coverage.* *** Not required for Health Care Coverage unless over 65 or disabled.*

For all items checked yes, fill in the boxes below:

Type of Unearned Income or Other Money Received	Household Member	How Often Received	Amount This Month	Amount Next Month

Does anyone outside of your household deposit money into a household member's bank account? ** ☐ Yes ☐ No If yes, explain:

** Not required for Health Care Coverage unless over age 65 or disabled.

Have household members applied for benefits not yet received (such as Social Security, SSI, Worker's Compensation, Unemployment Compensation, Veterans/Military Benefits, etc.?) ☐ Yes ☐ No If yes, explain:

Tell Us About Court Ordered Expenses *

Is any household member court ordered to pay child support, spousal support, other support or health insurance? ☐ Yes ☐ No

If yes, who?	Who are the payments for?
Amount Court Ordered:	Amount Paid:

* Court Order Expenses are not required for Health Care Coverage.

Tell Us If You Have Child Care Expenses **

Will your household have child care costs this month? ☐ Yes ☐ No If yes, check the reason:

☐ Employment ☐ High School/GED ☐ Education or Training ☐ Job Search ☐ Other _____

Amount:

Does anyone help you pay your child care costs? ☐ Yes ☐ No If yes, complete the line below:

Name of Person Paying the Child Care Costs:	Amount they are Paying:	Name of Person Paid To:

Do you expect your child care costs for this month to be the same as last month? ☐ Yes ☐ No If no, explain:

** Not required for Health Care Coverage.

Application For Assistance - Section 2

Complete Section 2 if you are applying for:

- **Health Care Coverage (HCC)**

Your Name:

Tell Us About Your Household

If you do not want Health Care Coverage for all members of the household listed on Page 2, please list members you **DO NOT** want Health Coverage for:

Were any applicants who are requesting health care coverage in foster care at age 18 or older? ☐ Yes ☐ No		
If yes, who?	When:	What State:
For any applicants listed on Page 2 who are not a U.S. Citizen or U.S. National, do they have eligible immigration status? ☐ Yes ☐ No		
If Yes, List Document Type	Document ID Number	
For any applicants listed on Page 2 who are not a U.S. Citizen or U.S. National, have they lived in the U.S. since 1996? ☐ Yes ☐ No	If No, Date Entered the U.S.:	
Does any household member pay for guardianship or conservator services? ☐ Yes ☐ No		
Does any household member age 19 or older claim primary responsibility for a child under age 19? ☐ Yes ☐ No		
If Yes, Name of Responsible Person:	Name of Child:	

Tell Us About Your Household's Federal Tax Filing Information

Did you file federal income taxes? ☐ Yes ☐ No		
Do you plan to file a federal income tax return next year? ☐ Yes ☐ No		
If you plan to file a federal income tax return next year, will you file jointly with a spouse? ☐ Yes ☐ No	If Yes, Name of Spouse:	
If you plan to file a federal income tax return next year, will you claim any dependent on your tax return? ☐ Yes ☐ No		
If Yes, Name of Dependents You Will Claim:		
If you plan to file a federal income tax return next year, will any dependents file a tax return? ☐ Yes ☐ No	If Yes, Who:	
If you do NOT plan to file a federal income tax return next year, will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No		
If Yes, List Name of Tax Filer:	Relationship to Tax Filer:	

Tell Us About Deductions Claimed on Your Federal Income Tax

Telling us about certain things that can be deducted on a Federal Income Tax return could make the cost of health insurance a little lower. Check the following income deductions you claimed on your Federal Income Tax:

- ☐ Alimony
- ☐ Student Loan Interest
- ☐ Tax Deductible Tuition and Fees
- ☐ Other Deductions not already considered in your answer to 'Amount of net self-employment income (profits once business expenses are paid)' on Page 9. If checked, please explain:

Ability to Use Tax Data During Renewal

Renewal of Coverage: To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the County Social Services or State Office to use income data, including information from tax returns. The County Social Services or State Office will send me a notice, let me make any changes, and I can opt out at any time.

Tell Us About Your Medical Bills

Medicaid can help pay medical bills, including prescription costs, for up to three months prior to the month of your application. Would you like help paying any of these bills?	☐ Yes	☐ No
Medicaid can allow unpaid medical bills older than three months to reduce your out-of-pocket costs. Do household members have unpaid medical bills older than three months?	☐ Yes	☐ No

If yes, explain:

Tell Us About Your Primary Care Provider (PCP)

Your primary care provider (PCP) is the doctor or nurse practitioner you see for medical care. List the primary care provider for each household member except for those age 65 or older, or disabled. If you do not have a primary care provider, list the clinic (rural health clinic, federally qualified health clinic or Indian Health Services Clinic) in which you receive your medical care.

Household Member	Name of PCP

Tell Us About Your Health Coverage

Is any household member enrolled in health coverage from one or more of the following?*

☐ Medicaid - Who:	☐ Healthy Steps (CHIP) - Who:
☐ Medicare - Who:	☐ Peace Corps - Who:
☐ TRICARE (do not check if you have direct care or Line of Duty) - Who:	
☐ VA Health Care Program - Who:	
Does any household member's employer offer health insurance? ☐ Yes ☐ No If yes, complete the 'Health Coverage from Jobs' form (SFN 1618) included in the Application Packet.	

* Provide a copy, front and back, of insurance card.

Tell Us if You Receive Help With Your Medical Costs

Does anyone help pay your medical costs? ☐ Yes ☐ No If yes, explain:			
Do household members have medical problems due to an accident? ☐ Yes ☐ No			
Does anyone in your household require nursing care services? ☐ Yes ☐ No	If yes, when/will they start receiving nursing care services?		

If receiving nursing care services in a facility, provide name and address of facility:

Name of Facility			
Address	City	State	ZIP Code
Do household members have a pending legal action from which they may receive money or medical benefits (including inheritance?) ** ☐ Yes ☐ No			

** Not required unless over age 65 or disabled.

Power of Attorney or Family Contact

First Name	Relationship		
Mailing Address Where You Want Notices Sent	City	State	ZIP Code
Home Telephone Number	Work or Message Number	Cell Phone Number	
☐ Power of Attorney ☐ Family Contact Person			

Application Counselor, Navigator, Agent or Broker Only

Complete this section if you are a certified application counselor, navigator, agent or broker filling out this application for someone else.

First Name:	Middle Initial:	Last Name:	Suffix:
Name of Organization:	ID Number (if applicable):	Application Start Date:	

Intentionally Left Blank

Application For Assistance - Section 3

Complete Section 3 if you are applying for:

- **Basic Care Assistance Program (BCAP)**
- **Health Care Coverage (HCC)**
- **Supplemental Nutrition Assistance Program (SNAP)**
- **Temporary Assistance for Needy Families (TANF)**

Tell Us About Your Household's Assets

If you are applying for HCC for someone who is disabled or age 65 or older, or if you are applying for BCAP, SNAP, or TANF, you must complete the Vehicles and Other Assets sections.

Vehicles
List vehicles (car, truck, motor home, snowmobile, motorcycle, 3 wheeler/4 wheeler, boat or other watercraft, camper, trailer, etc.) owned, jointly owned or being purchased for all household members, even if the vehicle is not running or not in your possession. Include vehicles licensed through North Dakota, tribal motor vehicle or another state.

Make/Model	Year	Value	Amount Owed	Licensed	Owners
		$	$	☐ Yes ☐ No	
		$	$	☐ Yes ☐ No	
		$	$	☐ Yes ☐ No	
		$	$	☐ Yes ☐ No	
		$	$	☐ Yes ☐ No	
		$	$	☐ Yes ☐ No	

Tell Us About Your Household Assets (continued)

Other Assets

Check yes by the assets owned, jointly owned, or being purchased by household members. Check no, if none.

- ☐ Yes ☐ No Annuities
- ☐ Yes ☐ No Assets Owned with Another Person
- ☐ Yes ☐ No Burial Plots
- ☐ Yes ☐ No Burial Space Items (Casket, Vault, Marker, etc.)
- ☐ Yes ☐ No Business Accounts
- ☐ Yes ☐ No Cash on Hand
- ☐ Yes ☐ No Certificates of Deposit
- ☐ Yes ☐ No Checking/Credit Union Accounts
- ☐ Yes ☐ No Debit Card Account (Not Checking/Savings)
- ☐ Yes ☐ No Farm Equipment, Livestock, Stored Grain
- ☐ Yes ☐ No Home/Mobile Home (Not Owner Occupied)
- ☐ Yes ☐ No Home/Mobile Home (Owner Occupied)
- ☐ Yes ☐ No Income Producing Tools/Equipment
- ☐ Yes ☐ No Individual Indian Monies (IIM) Accounts*
- ☐ Yes ☐ No Inheritance
- ☐ Yes ☐ No Life Estate/Life Lease
- ☐ Yes ☐ No Mineral Rights (Oil, Gas, Gravel, Coal, etc.)
- ☐ Yes ☐ No Money Market Account
- ☐ Yes ☐ No Notes or Contract for Deed
- ☐ Yes ☐ No Prepaid Funeral Plans
- ☐ Yes ☐ No Real Property (Land, Rental Property, Buildings, etc.)
- ☐ Yes ☐ No Retirement Funds (IRA/KEOGH/401K)
- ☐ Yes ☐ No Savings Bonds
- ☐ Yes ☐ No Savings/Credit Union Accounts
- ☐ Yes ☐ No Trusts

Other, specify: _____

** IIM information is not required for Health Care Coverage.*

For all items checked yes, fill in the boxes below:

Type of Asset	Location/Description	Total Value	Amount Owed	Owners

List household members who have made arrangements for funeral expenses or gave money, property, or insurance to someone else to pay for funeral expenses:

Explain:

Do you expect changes in assets next month? ☐ Yes ☐ No If yes, explain:

Transfer of Assets

Have household members sold, given away or transferred anything of value within the past:

3 months? ☐ Yes ☐ No	If yes, list items:	Date:	
5 years? (does not apply to SNAP) ☐ Yes ☐ No	If yes, list items:	Date:	

Are <u>any</u> assets subject to a "Transfer of Death"? (Does not apply to SNAP). ☐ Yes ☐ No

If Yes, Describe Property and Approximate Value:

Application For Assistance - Section 4

Complete Section 4 if you are applying for:

- **Supplemental Nutrition Assistance Program (SNAP)**
- **Temporary Assistance for Needy Families (TANF)**

Tell Us the Value of Your Housing Expenses

Check yes by each expense household members have during any time of the year. Check no, if none.

☐ Yes	☐ No	Air Conditioning or Central Air	☐ Yes	☐ No	Lot Rent
☐ Yes	☐ No	Condo Fees	☐ Yes	☐ No	Property Taxes (not in house payment)
☐ Yes	☐ No	Electricity	☐ Yes	☐ No	Rent
☐ Yes	☐ No	Garbage	☐ Yes	☐ No	Sewer/Septic Tank Installation or Maintenance
☐ Yes	☐ No	Heating (gas, propane, electric, etc.)	☐ Yes	☐ No	Telephone/Cell Phone
☐ Yes	☐ No	Homeowners Insurance (not in house payment)	☐ Yes	☐ No	Use of a Garage
☐ Yes	☐ No	House Payment (mortgage)	☐ Yes	☐ No	Water/Well Installation or Maintenance)

For all items checked yes, fill in the boxes below:

Type of Expense	Who Pays the Expense	Total Amount	Amount Household Member Pays

Do household members work off part of an expense (rent, lot rent, utilities, etc.)?	☐ Yes	☐ No	If yes, complete the line below:
List the Expense:		Amount Worked Off:	
Do household members receive heating assistance (LIHEAP)?	☐ Yes	☐ No	
Do household members plan to apply for heating assistance (LIHEAP)?	☐ Yes	☐ No	
Do you expect changes in expenses (rent, lot rent, utilities, etc.) next month?	☐ Yes	☐ No	If yes, explain:
Does anyone help you pay these expenses (government agency, family member, etc.)?	☐ Yes	☐ No	If yes, complete the line below:

List the Expense:	Name of Person that Pays the Expense:	Amount Paid:

Agency Use Only

Household is entitled to one of the following mandatory utility standards:

- ☐ HL SU (heating/cooling/LIHEAP)
- ☐ LU SA (water, sewer, garbage, electricity, telephone)
- ☐ MU (water, sewer, garbage, electricity)
- ☐ TL (telephone only)

Tell Us About Expenses for Elderly or Disabled Household Members

Do household members, who are disabled or age 60 or older, pay health insurance or medical expenses? (include doctor, dental and eye care visits, hospital bills, in-house-care, nursing home care, prescriptions, medical supplies, hearing aids, eyeglasses and contacts, and cost of transportation and lodging to obtain medical treatment.)	☐ Yes	☐ No	
If yes, who?	Health Insurance Amount:		Medical Expense Amount:
Does anyone help you pay these expenses?	☐ Yes	☐ No	If yes, explain:
Do household members pay adult dependent care?	☐ Yes	☐ No	
Do household members pay representative payee fees?	☐ Yes	☐ No	
Do you expect changes in expenses next month?	☐ Yes	☐ No	If yes, explain:

Tell Us About Your Household's Work Information

Household Members who are Unable to Work:		
Reason They are Unable to Work:		
Household Members who Stopped Their Employment Within the Last 30 Days:		
Date Employment Stopped:	Name of Employer:	
Reason for Leaving: ☐ Laid Off ☐ Quit ☐ Fired ☐ Strike ☐ Injury ☐ Illness ☐ Leave of Absence ☐ Other, specify: _____		Date of Final Paycheck Received by Household Member:
Household Members who Reduced Their Work Hours Within the Last 30 Days:		
Date Reduced:	Reason Reduced:	
Household Members who Refused Work Within the Last 30 Days:		
Date Refused:	Reason Refused:	

Tell Us About Illegal Activities and Disqualifications

Have you or any member of your household been convicted of fraudulently receiving duplicate SNAP or TANF benefits in any state after September 22, 1996?	☐ Yes	☐ No
Are you or any member of your household hiding or running from the law to avoid prosecution, being taken into custody, going to jail, for a felony crime or attempted felony crime?	☐ Yes	☐ No
Have you or any member of your household been convicted of Federal or State aggravated sexual abuse, murder, sexual exploitation and abuse of children, or sexual assault?	☐ Yes	☐ No
Are you or any member of your household violating a condition of parole or probation?	☐ Yes	☐ No
Have you or any member of your household been convicted of buying or selling SNAP benefits over $500 after September 22, 1996?	☐ Yes	☐ No
Have you or any member of your household been convicted of trading SNAP benefits for guns, ammunitions, or explosives after September 22, 1996?	☐ Yes	☐ No
Have you or any member of your household been convicted of trading SNAP benefits for drugs after September 22, 1996?	☐ Yes	☐ No
Are you or is any household member disqualified or have you or any household member ever been disqualified from SNAP or TANF for providing incorrect information or failing to provide information that affected SNAP or TANF eligibility or benefits?	☐ Yes	☐ No

Application For Assistance - Section 5

Complete Section 5 if you are applying for:

- **Basic Care Assistance Program (BCAP)**
- **Health Care Coverage (HCC)**
- **Temporary Assistance for Needy Families (TANF)**

Tell Us About Your Household

I/We have lived in North Dakota since (month, day, and year):		
Do you intend to remain in North Dakota? ☐ Yes ☐ No		
List household members who are a veteran, a spouse, parent, or dependent of a veteran, or are an active-duty member in the US Military:		
Name of Any Children Whose Father's Name Is Not Listed on the Birth Certificate: ***		
Name of Each Household Member Who is Pregnant:		
How many babies are due?	Due Date:	Name of Father of the Unborn Baby: ***
How was pregnancy determined? *** ☐ Physician ☐ Public Health Agency ☐ Home Pregnancy Test ☐ Other, specify: _____		
Do you pay for guardianship or conservator services? ☐ Yes ☐ No		

*** This information is not needed to determine eligibility for Health Care Coverage

Tell Us About Parents Not Living in the Home ***

List each child under age 21 whose parents do not live in the home:

Name of Child Whose Parent is Not Living in the Home	Name of Parent Who is Not Living in the Home	Parent's *** Date of Birth	Parent's *** Social Security Number	Reason Parent Is Not Living in the Home *** Use Codes Below
	Mother:			
	Father:			
	Mother:			
	Father:			
	Mother:			
	Father:			
	Mother:			
	Father:			

Reason Codes:

AB - Abandoned
AN - Legally Annulled
AS - Attending School
DE - Deceased
DI - Divorced
JP - Jail/Prison
LW - Looking for Work
MC - Medical Care
MS - Military Service
NM - Never Married
TR - Parental Rights Terminated
SE - Separated
WO - Working Out of Town or State

*** This information is not needed to determine eligibility for Health Care Coverage

Tell Us About Your Life Insurance

Does any household member have life insurance? ☐ Yes ☐ No

Designated irrevocable itemized burial fund? ☐ Yes ☐ No If yes, fill in the boxes below:

Name of Insured Person	Name and Address of Company	Policy Number	Face Value	Cash Surrender Value	Owners

Tell Us About Your Health Insurance Coverage

List household members who have health insurance: Provide copy, front and back, of insurance card.

Persons Covered	Policy Holder Name and Address	Health Insurance Name, Address, and Telephone Number	Effective Date	Policy Number	Group Number	Monthly Premium	Type of Coverage Use Codes Below

List all that apply

A - Hospital
B - Doctor
C - Major Medical/Lab/X-Ray
D - Dental
E - Vision
F - Nursing Home
G - Cancer
H - Champus/Tricare
I - HMO Insurance
J - Court Ordered
K - Medicare Part A
L - Medicare Part B
M - Medicare Supplement/Advantage
N -Prescription Drug Insurance
P - Workers Compensation or Accident
V - Veterans Administration
W - Medicare Part D

Are any of the policies listed above COBRA coverage? ☐ Yes ☐ No	If Yes, Name of Health Insurance
Date COBRA Coverage Began	Date or Expected Date COBRA Coverage Will End
Are any of the policies listed above a retiree health plan? ☐ Yes ☐ No	If Yes, Name of Health Insurance
Are any of the policies listed above a limited-benefit plan (like a school accident policy) ☐ Yes ☐ No	If Yes, Name of Health Insurance

Are any of the policies a state employee benefit plan? ☐ Yes ☐ No

Does anyone outside the household pay the premium? ☐ Yes ☐ No If yes, who?

Do household members expect changes in health insurance coverage? ☐ Yes ☐ No If yes, explain:

Did anyone in your household have health insurance canceled or stopped within the last 3 months? ☐ Yes ☐ No If yes, complete below:

Name of Person Who Had Insurance Canceled or Stopped:	Date Coverage Ended:

Reason the Insurance was Canceled or Stopped:

Does the household member have a long term care insurance policy that has paid out benefits for long term care services (nursing care, basic care, or assisted living)? ☐ Yes ☐ No This information may allow you to protect additional assets.

If yes, who:	How much has the policy paid in benefits:

Tell Us Where You Got This Application

Where did you get this Health Care Coverage application (check only one)?

- ☐ 1-877-KIDS-NOW
- ☐ Capitol in Bismarck
- ☐ Community Resource Coordinator
- ☐ Daycare
- ☐ Faith-Based Organization
- ☐ Food Pantry
- ☐ Friend/Relative
- ☐ Head Start
- ☐ Insurance Agent
- ☐ Internet
- ☐ Medical Provider
- ☐ Pharmacy
- ☐ Public Health Agency
- ☐ School
- ☐ Social Service Agency
- ☐ WIC
- ☐ Other

Tell Us How Or Where You Found Out About Health Care Coverage

How did you find out about Health Care Coverage in North Dakota (check only one)?

- ☐ Business/Service Club
- ☐ Capitol in Bismarck
- ☐ Daycare
- ☐ Faith-Based Organization
- ☐ Food Pantry
- ☐ Friend/Relative
- ☐ Head Start
- ☐ Insurance Agent
- ☐ Internet
- ☐ Medical Provider
- ☐ Newspaper/Magazine/Newsletter
- ☐ Pharmacy
- ☐ Public Health Agency
- ☐ Radio
- ☐ Social Service Agency
- ☐ Television
- ☐ WIC
- ☐ Other

Information About Other Services for Children and Families

Child Support

Child Support (CS) may help children get financial and medical coverage from parents who do not live in the home and who are or can be court ordered to provide financial or medical coverage.

Medicaid Coverage
If a child is eligible for Medicaid and a parent does not live in the home, we may make a referral to CS. We will not make a referral for children when there is no adult requesting Medicaid coverage, unless the child is in foster care; when the only eligible adult is pregnant; or for children who are eligible for Healthy Steps (Children's Health Insurance Program (CHIP). If a referral is not made, but you would like assistance with CS, please contact them at 1-800-231-4255.

Temporary Assistance for Needy Families (TANF)
If you receive TANF and one parent is not living in the home, your family will automatically be referred to CS. You must cooperate with CS in establishing paternity and in establishing and enforcing child support.

If you are interested in receiving Medicaid or TANF coverage for yourself and/or your children and you do not want assistance from CS because your cooperation might not be in the best interest of your child (example: domestic violence situation), you may claim “good cause”. If you do, a form SFN 446, will be sent to you to provide additional information so we can decide if there is “good cause”.

Are you interested in claiming “good cause” for not cooperating with CS? ☐ Yes ☐ No

Claiming “good cause” does not affect you or your child's eligibility for Medicaid and TANF.

Failure to cooperate with CS does not affect your child's eligibility for Medicaid. However, if you choose not to cooperate with CS efforts and you have not claimed “good cause” or your claim of “good cause” has been denied, you will not be eligible for Medicaid coverage and TANF benefits. However, your children will continue to be eligible for Medicaid or Healthy Steps coverage, provided they meet all other program requirements.

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Application For Assistance - Section 6

Complete Section 6 if you are applying for:

Child Care Assistance Program (CCAP)

Tell Us About Your Household

Total Estimated Value of Your Household Assets

Is your household currently experiencing homelessness? ☐ Yes ☐ No

*If your current address is a temporary living arrangement, you may meet the definition of homeless. Refer to the Child Care Assistance Program (CCAP) section of the Application for Assistance Guidebook.

Is a parent or caretaker currently active duty in the U.S. Military? ☐ Yes ☐ No

Is a parent or caretaker currently a member of the National Guard or a military unit? ☐ Yes ☐ No

Tell Us About Your Child Care Needs

Does your household need assistance with child care costs for last month? ☐ Yes ☐ No

If you are requesting child care for last month, provide verification of all income received last month and a schedule of when you were participating in the activity you are requesting assistance for.

Activity Schedule

Name of Parent or Caretaker Participating in Activity:

Allowable Activity:

☐ Employment ☐ High School/GED ☐ Postsecondary Education ☐ Training

☐ Other - Specify: _____

Provide a schedule of when you participate in each activity

Name of Child Needing Care (If child goes to more than one provider during this activity, complete a separate line for each provider.) **Complete a line for each child needing care for this activity.**	Time Child is: Dropped off at Provider	Time Child is: Picked up from Provider	Does this child attend preschool, Head Start, elementary, school, etc.?	Grade & School Child is in Time School Day Starts and Ends **Provide a copy of the child's school year schedule.**	Name, Address, City, State, ZIP Code, and Telephone Number of Child Care Provider License Number and Expiration Date of Provider	Type of Provider Use Codes Below
			☐ Yes ☐ No			
			☐ Yes ☐ No			
			☐ Yes ☐ No			
			☐ Yes ☐ No			

AR - Approved Relative **IN** - In-Home **NF** - Non- Relative Family **NG** - Group
RF - Relative Family **SD** - Self-Declaration **TR** - Tribal Registration **CT** - Center

If additional space is needed, please attach a separate sheet.

Activity Schedule

(Complete this section if participating in more than one activity or for a second parent (if both parents are in the home)

Name of Parent or Caretaker Participating in Activity:

Allowable Activity:

☐ Employment ☐ High School/GED ☐ Postsecondary Education ☐ Training

☐ Other - Specify: _____

Provide a schedule of when you participate in each activity

Name of Child Needing Care (If child goes to more than one provider during this activity, complete a separate line for each provider.) **Complete a line for each child needing care for this activity.**	Time Child is: Dropped off at Provider	Time Child is: Picked up from Provider	Does this child attend preschool, Head Start, elementary, school, etc.?	Grade & School Child is in Time School Day Starts and Ends **Provide a copy of the child's school year schedule.**	Name, Address, City, State, ZIP Code, and Telephone Number of Child Care Provider License Number and Expiration Date of Provider	Type of Provider Use Codes Below
			☐ Yes ☐ No			
			☐ Yes ☐ No			
			☐ Yes ☐ No			
			☐ Yes ☐ No			

AR - Approved Relative **IN** - In-Home **NF** - Non- Relative Family **NG** - Group
RF - Relative Family **SD** - Self-Declaration **TR** - Tribal Registration **CT** - Center

If additional space is needed, please attach a separate sheet.

Tell Us About Your Postsecondary Education/Training

List all household members that are currently attending postsecondary education/training:

Name of School:

Course of Study:	Anticipated Degree:
Length of Course:	Anticipated Completion Date:

What is your highest education completed? ☐ None ☐ High School ☐ Certificate ☐ Associate Degree ☐ Bachelor's Degree ☐ Master's Degree — Date Completed:

If there is a second parent or caretaker in your household, what is their highest education completed? ☐ None ☐ High School ☐ Certificate ☐ Associate Degree ☐ Bachelor's Degree ☐ Master's Degree — Date Completed:

Application For Assistance - Section7

Read and sign Section 7, if you are applying for any one of the following:

- **Basic Care Assistance Program (BCAP)**
- **Child Care Assistance Program (CCAP)**
- **Health Care Coverage (HCC)**
- **Supplemental Nutrition Assistance Program (SNAP)**
- **Temporary Assistance for Needy Families (TANF)**

Read The Following Information

I have received, reviewed and understand my rights and responsibilities as explained in the Guidebook.

I declare under penalty of law, the information on this application is correct. This includes information about identity, citizenship and alien status of the household members applying for assistance.

I understand that alien status information and other information will be verified when discrepancies are found. The alien status of applicant household members may be subject to verification by USCIS through the submission of information from the application to USCIS. Verification received may affect eligibility and level of benefits.

I understand the information I provide on or with this application is subject to verification by federal, state and local officials to determine if the information is correct, which may include electronic verification. If any of the information is incorrect, a household's eligibility determination and level of benefits may be affected. I may be subject to criminal prosecution for knowingly providing incorrect information.

I agree to report to the county social service office any changes in income, assets, or living arrangements as required.

I understand I will not receive a deduction for any allowable expenses I do not report and provide proof of.

I have been informed my household is authorized to receive TANF Information and Referral services. I have been given the Guidebook that has information about these services.

An individual who breaks any of the rules on purpose can be barred from SNAP for one year to permanently, fined up to $250,000, imprisoned up to 20 years or both. An individual may also be subject to prosecution under other applicable federal and state laws and may also be barred from SNAP for additional 18 months if court ordered.

Any member of the household who intentionally breaks the rules may not get SNAP benefits for one year for the first offense, two years for the second offense and permanently for the third offense.

If a court of law finds you guilty of using or receiving benefits in a transaction involving the sale of a controlled substance, you will not be eligible for benefits for two years for the first offense, and permanently for the second offense.

If a court of law finds you guilty of having used or received benefits in a transaction involving the sale of firearms, ammunition or explosives you will be permanently ineligible to participate in SNAP upon the first offense.

If a court of law finds you guilty of having trafficked benefits for an aggregate amount of $500 or more, you will be permanently ineligible to participate in SNAP upon the first offense.

If you are found to have made a fraudulent statement or representation with respect to the identity or place of residence in order to receive multiple SNAP benefits simultaneously, you will be ineligible to participate in SNAP for a period of 10 years.

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs. The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.
To file a program complaint of discrimination, complete the USDA Program Discrimination Form, (AD-3027), found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

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

(2) fax: (202) 690-7442; or

(3) email: Program.intake@usda.gov

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider

Estate Recovery

State and Federal law requires the Department of Human Services to make claims against the estate of some Medicaid recipients. A claim will be made against the estate of: (1) any recipient who was age 55 or older when the Medicaid benefits were provided: (2) any recipient who has been permanently institutionalized and received services regardless of age: or (3) against the estate of a spouse of any Medicaid recipient who was age 55 or older or permanently institutionalized when the Medicaid benefits were paid. The claim is for the amount of Medicaid benefits issued to a person age 55 or older or if permanently institutionalized. Effective August 1, 2015, the department CANNOT file a claim against the estate to recover payments made on behalf of recipients who received coverage through a private carrier. Individuals eligible under the Medicaid Expansion coverage receive their coverage through a private carrier.

Authorization to Release Information

I/We authorize any person having custody or knowledge of the information relating to me or other household members to disclose any requested information, including confidential information other than protected health information, to any authorized agent of the North Dakota Department of Human Services. I authorize the North Dakota Department of Human Services and the carrier providing Healthy Steps insurance to release to each other information regarding any services or benefits I received under Healthy Steps. This authorization will remain valid until 90 days past case closure or until revoked in writing. I/we authorize Child Support to release any records of child support payments that I/we have made or received. A copy of this authorization is as valid as the original.

Sign And Date The Application Here

By signing my name, I attest that I have read and agree to information contained in Section 7 of this application.

Signature of Applicant:	Date:
Other Signature (Spouse, Guardian or Other Adult):	Date: