


For agency use only:	CBMS case number	
Tech number	Date of Face to Face Interview	
Technician name	County household number	

	<b>State of Colorado</b> <b>Department of Human Services</b> <b>Department of Health Care Policy and Financing</b>
	<hr/> Name of Applicant
	<hr/> Date Application Received by County or MA site
	<hr/> Signature of Person Who Received the Application

Please mark each program you are applying for.

	Cash Assistance Programs		Medical Assistance Programs
<input type="checkbox"/>	Aid to the Blind (State AB)	<input type="checkbox"/>	Child Health Plan Plus (CHP+)/Family Medical Assistance
<input type="checkbox"/>	Aid to the Needy Disabled (State AND)	<input type="checkbox"/>	Emergency Medical Services (non-qualifying citizen)
<input type="checkbox"/>	Colorado Supplement to SSI	<input type="checkbox"/>	Medicaid Long Term Care (Nursing Home)
<input type="checkbox"/>	Colorado Works (TANF)	<input type="checkbox"/>	Medicaid Long Term Care (Home and Community Based Services)
<input type="checkbox"/>	Food Assistance	<input type="checkbox"/>	Medicare Part D – Low Income Subsidy
<input type="checkbox"/>	Home Care Allowance (HCA)	<input type="checkbox"/>	Medicare Savings Program - Medicaid
<input type="checkbox"/>	Old Age Pension (OAP) Financial		

## Language Information

**English:** If you need help completing this application, please contact your local county department of social services.

**Spanish:** Si usted necesita ayuda a completar esta aplicación, contacta por favor su departamento local de condado de servicios sociales.

**Russian:** Если Вы нуждаетесь в помощи, заканчивая это заявление, пожалуйста свяжитесь с вашим местным отделом социального обеспечения графства.

**Arabic:** ةي عامتجا تامدخ نم مسبق مي لقا ةي لحم كء اجر ، قيبطت اذه متي ةدع اسم جاتحت تنأ نإ ب لصتا .

**Farsi:** ، تس او خرد نی ا ندرک لم ا کافطلدی نک کم کدی رادب جای ت ح امش رگا  
دری گب سامت ی عامتجا تامدخ ار ناتیلحم ناتسا ت مسبق

**Vietnamese:** Chương trình chưa dịch được câu này. Câu của bạn sẽ được chuyển đến những người sử dụng khác dưới dạng bài tập. Nếu bạn dịch được ngay câu này, hãy nhấn nút.



State of Colorado  
 Department of Human Services  
 Department of Health Care Policy and Financing

## Application for Assistance

**Important Information for Food Assistance (formerly called Food Stamps) applicants:** Please complete and sign page 1 of this application to begin the process to apply for benefits. The information requested on the additional pages is needed to determine your eligibility.

**Important Information for Nursing Home applicants:** If you are applying for Medicaid Long-Term Care Nursing Home and need to secure your application date for Medicaid billing, copy pages 1 through 5, sign page 21, and submit them to your local Human Services office. You must submit the entire application within 10 business days from the date you submitted the pages. Please identify your nursing home here: \_\_\_\_\_

### Household Information

#### Tell us about you

Last Name				First Name				Middle Initial		Maiden or other name you have used			
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> (Answer to this question is not required by Food Assistance.)													
Date of Birth (mm-dd-yyyy)						Place of Birth (City, State, Country)							
Social Security Number (SSN)						<input type="checkbox"/> Check if you do not have a SSN							
-     -		Phone number				Message Number (or another number to contact you or where message can be left)							
Home Address (Street, PO Box, etc.)						Mailing Address (if different than home address)							
City		State		ZIP Code		City		State		ZIP Code			
Signature						Date							

#### Available Services/accommodations



Handicap Accessible



Vision Impaired



ASL



TDDY



Language Interpreters

## Household Information

### Tell us more about you

Race/National Origin/Ethnicity (Optional, check all that apply):

- Asian       American Indian or Alaska Native       Black or African American  
 Hispanic or Latino       Native Hawaiian/Other Pacific Islander       White       Other

Student?    Yes   No

*If yes, please complete*

\_\_\_\_\_  
Last Grade  
Completed

\_\_\_\_\_  
Name of school

Answers to the following questions are not required by Food Assistance:

Pregnant?    Yes   No    *If yes, please complete:*

➤ \_\_\_\_\_  
Due Date (mm-dd-yyyy)

\_\_\_\_\_  
Number of Babies Expected

Marital Status:    Married    Never Married    Divorced    Widowed    Separated

1. **What is your primary language?** Spoken: \_\_\_\_\_ Written: \_\_\_\_\_
2. **Are you a Colorado resident?**    Yes   No
3. **Are you receiving benefits from another State, or have you received benefits from another state?**    Yes   No    *If yes, please complete:*

\_\_\_\_\_  
What benefits are you receiving?

\_\_\_\_\_  
Date last received

\_\_\_\_\_  
What state/county?

4. **Are you receiving any benefits from another Colorado county?**    Yes   No
5. **Are you homeless?**    Yes   No

### Nondiscrimination Statement

In accordance with Federal law and U.S. Department of Health and Human Services (HHS) and U.S. Department of Agriculture (USDA) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Assistance Act and USDA policy, discrimination is also prohibited on the basis of marital status, familial status, parental status, religion, sexual orientation, genetic information, political beliefs, reprisal, or because all or part of an individual's income is derived from any public program. (Not all prohibited bases apply to all programs.) If you think you have been discriminated against for any of these reasons, you can file a complaint with the County Client Civil Rights Contact Person. At any time, you may also file a complaint of discrimination with one of the following Federal agencies, without fear of retaliation:

For Financial Assistance issues, contact:

US Department of Health and Human Services (HHS)  
Director, Office for Civil Rights (OCR)  
Room 506-F, 200 Independence Ave. S.W.  
Washington, D.C. 20201  
(202) 619-0403 (voice) or (202) 619- 3257 (TDD)

For Food Assistance issues, contact:

US Department of Agriculture (USDA)  
Director, Office for Civil Rights  
1400 Independence Ave., SW  
Washington DC, 20250-9410  
(800) 795-3272 (voice)

\* Persons with disabilities who require alternative means for communication of program information (Braille, large print, audiotape) should contact USDA's TARGET Center at 202-720-2600 (voice or TDD). We will make reasonable efforts to meet your special needs if you have a qualifying disability under the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act. Contact your county worker if you have special needs and want to request a reasonable accommodation under the ADA.

**Expedited Services for Food Assistance.** Your household may qualify for Expedited Service and receive food Assistance within 7 days. If you would like to apply for expedited Food Assistance, complete this box. You must meet one of the following criteria:

- Your gross monthly income is less than \$150 and liquid resources are \$100 or less; or
- Your monthly shelter bills are higher than your household's gross monthly income plus your liquid resources; or
- Your household is a migrant or seasonal farm worker household with little or no income and resources

Give us the information below, so your eligibility for expedited service can be determined:

How many people live with you? \_\_\_\_\_

Total money expected this month before deductions \_\_\_\_\_

Total cash, money in checking/savings accounts, CDs \_\_\_\_\_

Total utilities for this month \_\_\_\_\_

Total rent or mortgage for this month \_\_\_\_\_

If you qualify for Expedited Food Assistance: You are to receive benefits within seven days of your application. If you are denied Expedited Food Assistance and you do not agree with the denial, you may request an informal conference at your Food Assistance office. This conference is to be held within two days of your request unless you ask for a later date.

**6. Have you, or any member of your household, been convicted of fraudulently receiving duplicate Food Assistance benefits in any State after September 22, 1996?** Yes No

**7. Are you or any member of your household hiding or running from the law to avoid prosecution, being taken into custody, going to jail, or violating a condition of parole or probation?** Yes No *If yes, who?* \_\_\_\_\_

**8. Have you or any member of your household been convicted of a felony under Federal or State law for possession, use or distribution of a controlled drug substance (felony drug conviction) or for a crime committed while under the influence of a controlled drug substance after August 22, 1996?** Yes No *If yes, who?* \_\_\_\_\_

**9. Have you or any member of your household been convicted of buying or selling Food Assistance benefits over \$500 after September 22, 1996?** Yes No

**10. Have you or any member of your household been convicted of trading Food Assistance benefits for guns, ammunitions, or explosives after September 22, 1996?** Yes No

**11. Have you or any member of your household been convicted of trading Food Assistance benefits for drugs after September 22, 1996?** Yes No

**12. Have you, or any member of your household, applying for assistance been convicted of Welfare Fraud?** Yes No *If yes, who?* \_\_\_\_\_

## Household Information

Tell us about everyone in your household who is applying for assistance

		<table border="1"> <tr> <td></td><td></td><td></td><td>-</td><td></td><td></td><td>-</td><td></td><td></td><td></td> </tr> </table>												-			-			
			-			-														
Name (last, first, middle initial)		Relationship to You			SSN <input type="checkbox"/> Check if you do not have a SSN															
Date of Birth (mm-dd-yyyy)		Place of Birth (City, State, Country)																		
Student? <input type="checkbox"/> Yes No <input type="checkbox"/> If yes, please complete:																				
					Last Grade Completed			Name of school												
Race/National Origin/Ethnicity (Optional, check all that apply):																				
<input type="checkbox"/> American Indian or Alaska Native		<input type="checkbox"/> Asian		<input type="checkbox"/> Black or African American			<input type="checkbox"/> Hispanic or Latino													
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander		<input type="checkbox"/> White			<input type="checkbox"/> Other															
Answers to the following questions are not required by Food Assistance:																				
Pregnant? <input type="checkbox"/> Yes No <input type="checkbox"/>																				
If yes, please complete ➤ Due Date (mm-dd-yyyy)					Number of Babies Expected															
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated					Sex: <input type="checkbox"/> Male Female <input type="checkbox"/>															

		<table border="1"> <tr> <td></td><td></td><td></td><td>-</td><td></td><td></td><td>-</td><td></td><td></td><td></td> </tr> </table>												-			-			
			-			-														
Name (last, first, middle initial)		Relationship to You			SSN <input type="checkbox"/> Check if you do not have a SSN															
Date of Birth (mm-dd-yyyy)		Place of Birth (City, State, Country)																		
Student? <input type="checkbox"/> Yes No <input type="checkbox"/> If yes, please complete:																				
					Last Grade Completed			Name of school												
Race/National Origin/Ethnicity (Optional, check all that apply):																				
<input type="checkbox"/> American Indian or Alaska Native		<input type="checkbox"/> Asian		<input type="checkbox"/> Black or African American			<input type="checkbox"/> Hispanic or Latino													
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander		<input type="checkbox"/> White			<input type="checkbox"/> Other															
Answers to the following questions are not required by Food Assistance:																				
Pregnant? <input type="checkbox"/> Yes No <input type="checkbox"/>																				
If yes, please complete ➤ Due Date (mm-dd-yyyy)					Number of Babies Expected															
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated					Sex: <input type="checkbox"/> Male Female <input type="checkbox"/>															



**Household Information** Tell us about anyone else who lives with you (even if they are not applying for assistance). You must list everyone who lives with you even if they are not applying. If you have already listed them in the previous section you do not need to list them here.

Name	Relationship to You	Date of Birth	Sex (Answer to this question is not required for Food Assistance.)	Do they usually buy food, prepare food, and eat with everyone in the house?
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Expenses** Tell us about the expenses of your household. This section will collect information about your shelter expenses. Some programs will consider these costs when determining how much your benefits should be.

- 13. What is your current living arrangement?** Check all boxes that apply to your situation.
- Own/Buying a home   
 Renting   
 Living with relatives   
 Living on an Indian reservation  
 Living with friends   
 Living in subsidized housing   
 Migrant/seasonal farm worker  
 No permanent home   
 Living in a group home   
 Staying at a shelter

- 14. Are you applying for benefits for anyone in a Medical Facility?** (For Example: Hospital, Nursing Home, Mental Health Institution)  Yes  No  If yes, please complete:

Name	Name of Facility	Medical Facility Address	Date Entered
1.			
2.			
3.			

- 15. Does anyone outside of the household help pay any shelter costs?**  Yes  No  If yes, please complete:

Who helps pay: \_\_\_\_\_

How much do they pay per month? \_\_\_\_\_

\$ \_\_\_\_\_

## Expenses Tell us about the expenses of your household.

16. Do you provide support to an individual not living in your household? Yes No  
 If yes, do you also claim them on your Federal Income Tax? Yes No

17. Are you asked to pay, or are you billed, for rent or a mortgage? Yes No *If yes, please complete:*

	Amount Paid	Amount Billed	How Often	Landlord/Mortgage Name/Address/Phone
Rent	\$	\$		
Mortgage	\$	\$		
2 <sup>nd</sup> Mortgage	\$	\$		
3 <sup>rd</sup> Mortgage	\$	\$		

18. Are your homeowner taxes, insurance, and homeowners' association (HOA) fees billed separately from the above house payment? Yes No *If yes, please complete:*

	Amount Billed	Amount Paid	How Often	Name/Address Where Payment Is Sent
HOA	\$	\$		
Insurance	\$	\$		
Taxes	\$	\$		

19. Do you, or anyone in your household, pay legally obligated support to someone outside of your household? Yes No *If yes, please complete:*

Child Support or Spousal Maintenance Paid							
Name(s) of persons receiving support	Person paying support	Legally obligated amount	Amount Actually Paid	Date of Last Payment	How Often Paid	County/State of Court Order	Amount of Arrearages
1.							
2.							

## Expenses Tell us about the expenses of your household.

20. Are you billed for any of the following: heating, cooling, water, trash, sewage or phone expenses?  Yes  No *If yes, please complete:*

	Amount Billed	Amount Paid	How Often	Name and Address where Payment is Sent
Heating	\$	\$		
Air Conditioning	\$	\$		
Electricity	\$	\$		
Water	\$	\$		
Trash	\$	\$		
Sewer	\$	\$		
Phone/Cell phone	\$	\$		

21. Is anyone in your household billed for child care?  Yes  No *If yes, please complete:*

Name of child Receiving Care	Care Facility/Provider Name and Address	Amount Billed	Amount Paid	How Often Paid	Are you receiving help with these costs?
1.					<input type="checkbox"/> Yes <input type="checkbox"/> No
2.					<input type="checkbox"/> Yes <input type="checkbox"/> No

22. Are you, or anyone in your household, disabled?  Yes  No *If yes, please complete:*

Name of the Person with the Disability	Currently receiving treatment?
1.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	<input type="checkbox"/> Yes <input type="checkbox"/> No

23. Has a medical provider told you, or anyone in your household, to cut back or limit activities?  Yes  No *If yes, please complete:*

Name of Person with Limitations

Limitations

## Expenses Tell us about the expenses of your household.

**24 Are you, or is anyone in your household, billed for care of an adult or disabled person?**

Yes  No *If yes, please complete:*

Name of Person Receiving Care	Care Facility/Provider Name and Address	Amount Billed	Amount Paid	How Often Paid	Receiving help with these costs? <input type="checkbox"/> Yes <input type="checkbox"/> No
1.					<input type="checkbox"/> Yes <input type="checkbox"/> No
2.					<input type="checkbox"/> Yes <input type="checkbox"/> No
3.					<input type="checkbox"/> Yes <input type="checkbox"/> No

**25. Do you, or anyone in your household, have an injury?**  Yes  No *If yes, please complete:*

\_\_\_\_\_  
Name of Injured Person

\_\_\_\_\_  
Date of Injury

**25a. Was this injury work related?**  Yes  No

**25b. Have you filed a Workers' Compensation claim for this injury?**  Yes  No

**25c. Do you, or does anyone in your household, have a lawsuit or claim for any injuries?**  Yes  No *If yes, which household member and filing date of claim (if known)?*

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

**26. Do you have an attorney?**  Yes  No *If yes, please complete:*

\_\_\_\_\_  
Attorney Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone/ FAX

\_\_\_\_\_  
City

\_\_\_\_\_  
State ZIP Code

**27. Does anyone outside the household help pay medical costs?**  Yes  No

**28. Do you, or anyone in your household, have Medicare?**  Yes  No *If yes, please complete:*

Name of Person Receiving Medicare	Which Part of Medicare?	Effective Date	Claim Number
1.	Part A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/>		
2.	Part A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/>		
3.	Part A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/>		
4.	Part A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/>		

## Expenses Tell us about the expenses of your household.

**CHP+ provides health insurance for low-income children up to age 19 and pregnant women (19 and older).** If you are interested in applying for CHP+, please complete this box.

**29. Does anyone who is applying (up to age 19, or pregnant and over 19) have health insurance now?**  Yes  No  If yes, please complete: (Include a copy of the front/back of the insurance card). Name(s) of person(s) covered: \_\_\_\_\_

Policyholder's name: \_\_\_\_\_  
 Last name First Name Middle Initial

Policy /Group number Name and address of insurance company

**29a. Has anyone in the household who is applying for CHP+ had health insurance through an employer's group in the last three (3) months?**  Yes  No  If yes, please complete:

Why did the person lose this insurance? When did this insurance end? (m/dd/yy)

Policyholder's name Phone number of insurance company Name of employer's insurance company

Name(s) of person(s) covered Amount paid monthly Amount employer paid each month

**29b. Do you, or any member of your household, have access to group health insurance and would like help paying the monthly premiums?**  Yes  No

**29c. Does either parent or legal guardian of this child work for a Colorado state government agency and have access to State health benefits?**  Yes  No  (Some children of Colorado State agency employees may not be eligible for CHP+ due to federal law.)

To receive health insurance by CHP+, you must choose an Health Maintenance Organization (HMO) for the child applying. You can find information about HMOs at [colorado.gov/hcpf](http://colorado.gov/hcpf). Please list your HMO here:

**30. Are you, or anyone in your household, paying medical expenses?** (For Example: prescriptions, co-pays, health insurance premiums, insurance deductibles)  Yes  No  If yes, please complete:

Name of Person with Expense	Name of Provider of the Service	Type of Medical Expense	Amount Paid	Date of Service	How Often
1.			\$		
2.			\$		
3.			\$		
4.			\$		
5.			\$		

**31. If you are under 21, do you or your children, need medical services?**  Yes  No  If yes, please check the medical services you need?

- Baby Shots                       Dental Check-Ups                       Eye Exams  
 Hearing Tests                       Medical Check-Ups                       Pregnancy Care  
 Sick Care/Medicine               Supplemental Nutritional Program for Women, Infants and Children (WIC)

**Expenses** Tell us about the expenses of your household.

**RETROACTIVE MEDICAID** You can request Medicaid coverage for three months prior to this application date. If you wish to apply for Retroactive Medicaid, complete this box.

**32. Did you, or anyone in your household, have medical expenses in the past three months?**  
 Yes  No  If yes, please complete:

Name of person with Medical Expenses in the Past 3 Months	Dates of Service

*You will be required to provide verification of income and resources for these 3 months.*

**33. Do you, or anyone in your household, have health insurance/medical coverage other than Medicaid?**  Yes  No  If yes, please complete:

Name of Person Covered	Name of Policy Holder	Policy Number	Monthly Payment	Date of Coverage	Insurance Company Name, Address, and Phone Number

**Not a U.S. Citizen?** If you are not a U.S. citizen please complete this box.

**34. Do you, your spouse, or parents, have Work Quarters in the United States?** (A work quarter is equal to three months of work income recognized by Social Security).  Yes  No

First Person's Name	Relationship to Applicant	SSN (optional)
Date of Entry (mm-dd-yyyy)	Alien Registration Number	<input type="checkbox"/> Check if you do not have a SSN
Second Person's Name	Relationship to Applicant	SSN (optional)
Date of Entry (mm-dd-yyyy)	Alien Registration Number	<input type="checkbox"/> Check if you do not have a SSN

**34a. Do you, or anyone in your household, have a sponsor?**  Yes  No  If yes, please complete:

First Sponsor's Name	First Sponsor's Complete Address \$	Relationship to Applicant
Sponsor's Phone Number	Gross Monthly Income	Resources/ Assets
Second Sponsor's Name	Second Sponsor's Complete Address \$	Relationship to Applicant
Sponsor's Phone Number	Gross Monthly Income	Resources/ Assets
		Number in Sponsor's Family

**Income** This section will collect all income including wages or any other money received by you or anyone in your household.

35. Do you, or anyone in your household, have a job?  Yes  No  If yes, please complete:

Name of Employed Person in your Household	Employer's Name, Address, and Phone Number	Date Started	Hourly Wage/ Tips	Gross Monthly Income	How Often Paid	What day is payday?
1.			\$	\$		
2.			\$	\$		
3.			\$	\$		
4.			\$	\$		

36. Did you, or anyone in your household, leave or lose a job in the past 60 days?  Yes  No  If yes, please complete:

First person	Name of person who lost job			Reason for Leaving		Last Date Worked	
	\$		Employer Name, Address, Phone:				
	Gross Amount of Last Paycheck		Date of Last Paycheck				
	Check if this was your final paycheck. <input type="checkbox"/>						

Second person	Name of person who lost job			Reason for Leaving		Last Date Worked	
	\$		Employer Name, Address, Phone:				
	Gross Amount of Last Paycheck		Date of Last Paycheck				
	Check if this was your final paycheck. <input type="checkbox"/>						

36a. Did you, or anyone in your household, reduce the number of hours per week worked, in the past 60 days?  Yes  No

Name of person whose hours were reduced	Reason for reduced hours	Number of hours worked before reduction	Number of current hours worked

## Income Tell us about the income in your household.

**37. Are you, or anyone in your household, self-employed?**  Yes  No *If yes, please complete:*

Are there other owners or partners?  Yes  No

\_\_\_\_\_  
Name of Self-Employed Person

\$ \_\_\_\_\_

Average  
Monthly  
Income

Number of  
Hours Worked  
Per Week

Business Name, Address, and  
Phone Number

**You will be asked to  
provide proof of your  
business earnings and  
expenses.**

**38. Are you, or anyone in the household, on strike?**  Yes  No *If yes, please complete:*

\_\_\_\_\_  
Name

\_\_\_\_\_  
Employer Name, Address, and Phone Number

\$ \_\_\_\_\_

Gross Income Before Strike

\_\_\_\_\_  
Date Person  
Began Strike

\_\_\_\_\_  
Union Name, Address, and Phone Number

**39. Have you, or anyone in the household, applied for Unemployment benefits?**  Yes  No *If yes, please complete:*

Name of Person Who Applied for Unemployment	Date Applied for Unemployment
1.	
2.	
3.	

**40. Does anyone pay you or any member of your household for meals, a room or both?**

Yes  No *If yes, please complete:*

\_\_\_\_\_  
Name of Person Receiving Payment

Room Only  Room and Meals

\$ \_\_\_\_\_  
Amount Received

\_\_\_\_\_  
How Often?

\_\_\_\_\_  
Name of Person Receiving Payment

Room Only  Room and Meals

\$ \_\_\_\_\_  
Amount Received

\_\_\_\_\_  
How Often?

**40a. Do you, or anyone in your household, have expenses for providing meals, a room or both?**  Yes  No *If yes, you will be asked to provide proof of your business earnings/expenses.*

Person Who Is Paying the Expense	Type of Expense	Amount of Expense	Hours Spent Providing Meals, a Room, or Both
1.		\$ _____	
2.		\$ _____	

## Income Tell us about the income in your household.

**41. Do you, or anyone in your household, attend college, technical school or trade school?**

Yes  No *If yes, please complete:*

Name of Person Attending School	Enrollment Status	Expected Graduation Date	Name of School
1.	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time		
2.	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time		

**42. Do you, or anyone in your household, receive student financial aid?**  Yes  No

Name of Student Receiving Financial Aid	Type of Expense (books, transportation, lab fees):	Type of Grants/Loans Received (Pell Grants, Stafford Loan, Perkins Loan, Work Study)
1.		
2.		

**43. Have you, or anyone in your household, applied for Social Security Benefits or Supplemental Security Income (SSI)?**  Yes  No *If yes, please complete:*

Name of Person(s) Who Applied	Date of Application	Status of Application (pending, approved, denied)
1.		
2.		
3.		
4.		

**44. Have you, or anyone in your household received a lump sum payment?** (For Example: a lawsuit settlement, insurance settlement, inheritance, proceeds from surrender of life insurance or annuity, or SSI or Social Security settlement)  Yes  No *If yes, please complete:*

Name of Person Who Received the Lump Sum	Type of Lump Sum	Amount Received	Date Received
1.		\$	
2.		\$	
3.		\$	
4.		\$	

# Income Tell us about the income in your household.

45. Do you, or anyone in your household, receive any type of money other than income from work?  Yes  No *If yes, please complete*

Type of Income	Name of Person Receiving Income	Gross Amount Received	How Often Received?	Claim or Account Number
Alimony, Maintenance, Income from Ex-Spouse		\$		
Annuity		\$		
Cash Contributions/Gifts		\$		
Child Support		\$		
		\$		
Dividends/Interest		\$		
Income from Trust		\$		
Insurance/Lawsuit Payments		\$		
Loans		\$		
Public Assistance (OAP, AND, AB, Colorado Works, TANF)		\$		
Railroad Retirement Benefits		\$		
Rental Income		\$		
Retirement/Pension		\$		
Social Security Benefits		\$		
Unemployment Benefits		\$		
Veterans Benefits		\$		
Workers' Compensation		\$		
Other Income: (Please describe)		\$		
		\$		

**Resources** Tell us about what you own, or are buying (For Example: vehicles, bank accounts, personal property or insurance for anyone in your household.)

46. Do you or anyone in your household have the following? Yes No  If yes, please complete:

Type	Owner	Account Number	Amount/balance	Name/Address of institution	Jointly owned
Annuity			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
Cash			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
Certificate of Deposit (CD)			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
Checking Account			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
Savings Account			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
College Fund/Educational Accounts			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
Inheritance			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
Investments, Mutual Funds			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
PASS Account or Individual Development Account			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
Proceeds from Sale of a Home or Other Assets			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
Promissory Note(s) owed to you			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
Retirement Account: IRA, Keogh, 401(k)			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
Reverse Mortgage			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
Safe Deposit Box			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
Stocks/Bonds			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
Trusts			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
Other (Please describe)					<input type="checkbox"/> Yes <input type="checkbox"/> No

## Resources Tell us about the resources in your household.

**47. Do you, or anyone in your household, have a vehicle that you are buying, have registered, or own?** (For Example: car, van, motorcycle, truck, RV, boat, trailer )  Yes  No *If yes, please complete:*

	First Vehicle	Second Vehicle	Third Vehicle	Fourth Vehicle	Fifth Vehicle
Name of Person on Title and Registration					
Name of Person with Vehicle					
Jointly Owned?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vehicle Make					
Vehicle Model					
Vehicle Year					
What Is Vehicle Used for (work, medical, school)					
Value	\$	\$	\$	\$	\$
Amount Owed	\$	\$	\$	\$	\$

**48. Do you, or anyone in your household, have any life insurance?**  Yes  No *If yes, please complete:*

	First Policy	Second Policy	Third Policy	Fourth Policy
Name of Insured Person				
Name of Insurance Company				
Insurance Company Address/phone				
Name of Policy Owner				
Policy Number				
Date Purchased				
Loan Against Policy	\$	\$	\$	\$
Type of Life Insurance (whole, term)				
Face Value	\$	\$	\$	\$
Cash Surrender Value	\$	\$	\$	\$

**49. Do you, or anyone in your household, have a burial policy or any money set aside to be used for burial, cremation or other funeral expenses?**  Yes  No *If yes, please complete:*

Name of Person the Money Is Being Held for	Amount Being held	Is it irrevocable?	Name, address, and phone number of Mortuary, Bank, Insurance Company or Person holding money
	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**50. There may be help with funeral expenses for some recipients. If your family should need such help, what would you prefer?**  Cremation  Burial  No Preference

## Resources Tell us about the resources in your household.

**51. Did you, or anyone in your household, give away anything of value within the last 5 years or 3 months for Food Assistance?** (For Example: land, home, money, buildings, cars, boats, cash) Yes No *If yes, please complete:*

Name of Person Who Gave Item Away	Item Given Away	Date Given Away	Value of Item	Amount Owed
1.			\$	\$
2.			\$	\$
3.			\$	\$

**52. Are you, or anyone in your household, buying or the owner of any real estate other than the property where you live?** (For Example: rental property, Timeshare, warehouse, empty lot) Yes No *If yes, please complete for each piece of real estate:*

	Jointly Owned? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of First Owner(s) or Buyer(s)	\$	Type of Real Estate
Address of Where Property is Located (Street, city, state, and country)	Value	Amount Owed
	Jointly Owned? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Second Owner(s) or Buyer(s)	\$	Type of Real Estate
Address of Where Property is Located (Street, city, state, and country)	Value	Amount Owed

## Veteran, or entitled to Veteran Benefits? Tell us about your veteran information in this box.

**53. Have you, or anyone in your household, ever been in the military?** Yes No

**53a. Are you the widow(er) or a survivor of anyone that has been in the military?**

Yes No *If Yes to either of the above questions, please complete:*

Veteran's name, address & phone number

Veteran's date of birth and place

If deceased, Veteran's date and place of death

Your Relationship to Veteran

Dates of Service

Branch of Service

Date of last VA benefit application or receipt of VA benefits

Serial Number

**53b. If spouse of Veteran, what was the maiden name, date & place of marriage:**

**54. If we are in need of additional information regarding your application and are unable to contact you, whom may we contact?**

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Name of person, address and phone

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Relationship to You

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## Rights, Responsibilities, and Penalties

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**For your protection, it is important to read the following carefully before you sign.**

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**NOTICE TO MEDICAL ASSISTANCE CLIENTS – The Medical Assistance Estate Recovery Program:**

Under Federal law (Social Security Act, Title 19, Sec. 1917 [42 U.S.C 1396P]) and State law (25.5-4-302, C.R.S.), the Medical Assistance Estate Recovery Program authorizes the Department of Health Care Policy and Financing to recover all medical assistance benefits paid on behalf of Medicaid clients, including capitation payments, from the estates of deceased Medicaid clients who were permanently institutionalized or were over the age of 55 when benefits were provided. The Federal and State laws provide for certain exemptions to the Medical Assistance Estate Recovery Program. For further information or questions about the Medical Assistance Estate Recovery you should contact your county worker and request “The Medical Assistance Estate Recovery Program” brochure.

**I UNDERSTAND AND AGREE THAT:**

It is a crime to lie on this application. Benefits will be denied if any information on this application is found not true or if requested information is left off the application. If any information that I provide is incorrect, my application may be denied and I may be subject to criminal prosecution for knowingly providing incorrect information. I must tell the agency if there are changes in the information I give on this application within the time frames explained to me at the interview with the county worker. For Colorado Works (TANF), medical assistance programs and adult financial cases, I must inform the agency within 10 days of any changes to my case. I am allowing the agency to get records from financial institutions to show assets held for the person(s) named in this application. This includes banks, saving and loan companies, credit unions, insurance companies and other financial institutions. I am also allowing the agency to receive information from other persons or agencies to provide documentation or verify information in my application. I release these persons, agencies or institutions from all liability for supplying such information pertaining to myself or members of my household.

I will present proof of lawful presence in the United States (not required for Food Assistance), or alien registration documentation received from the United States Citizen and Immigration Service (USCIS), for every alien member in my household.

The agency will verify information with USCIS and that information received from USCIS may affect my eligibility and benefits. Federal law (Public Law 97-98) requires me to give the agency the SSN(s) and alien registration number(s) of persons who apply for public assistance. The agency will confirm and share information with other state, local and federal agencies.

The agency will match information with the Social Security Administration, the Internal Revenue Service and the Colorado Department of Labor and Employment through the use of SSNs. The agency will verify information that may affect eligibility and payment. The agency will contact employers and they may release information to this agency. The agency will verify information regarding child support payments with child support enforcement agencies or the courts. The agency may provide information to law enforcement agencies.

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## Rights, Responsibilities, and Penalties (continued)

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### I UNDERSTAND AND AGREE THAT:

On approval of this application, I assign to the State all rights to payment for medical expenses and treatment. If I get Medicaid and receive money for the same medical bills that the State has paid, I will give the money to the State. The State may collect from any insurance company or court settlement for medical bills that the State has paid. I will immediately notify the State of any claim or lawsuit that I have; and will cooperate with the State in collecting the medical bills that the State has paid.

If I get cash assistance under Colorado Works (TANF), I will give the agency all rights to current support and past due support owed on an existing court order. I know that I must give the agency rights to medical support to reimburse medical costs paid by Medicaid. I know I must give the agency all child support, medical support, and spousal maintenance paid directly to me while my children and I receive cash assistance under Colorado Works (TANF) and Medicaid. While my children and I receive cash assistance under Colorado Works (TANF) and Medicaid, the agency will try to collect current and overdue support. When we no longer receive cash assistance under Colorado Works (TANF) or Medicaid, the agency will continue to collect past due support and medical support amounts that accrued while I received benefits. The current child support, spousal maintenance and medical support will be sent to me.

I must identify health insurance that is available to any person who is included in this application for Medicaid or medical assistance. I know that I may be required to enroll in an employer-based group health insurance if it is less expensive than Medicaid. In that case, Medicaid will pay the insurance cost.

My household will not be eligible for Food Assistance if I refuse to cooperate with any review of my case, including a quality control review. If my household gets benefits for which we are not eligible, we may be required to repay those benefits. Any past due claims may be collected by taking an income tax refund that my household may be entitled to.

A person found to have intentionally given false information cannot get Colorado Works (TANF) or Food Assistance for 12 months for the first offense, 24 months for the second offense, and permanently for the third offense. A court can also stop a person from getting Food Assistance for another eighteen months. This crime is subject to prosecution under other federal laws. Receiving duplicate benefits of Food Assistance or Colorado Works (TANF) by misrepresenting identity or residence will be a 10-year disqualification.

It is a crime to knowingly receive money or benefits for which I am not eligible. This crime is punishable by a fine of up to \$250,000 or a jail term of up to 20 years, or both.

A person found guilty of using Food Assistance to illegally purchase controlled substances shall be disqualified for 2 years for a first offense and permanently for a second offense.

Individuals found by a Federal, State or local court to have used or received benefits in a transaction involving the sale of firearms, ammunition or explosives shall be permanently ineligible to participate in the Program upon the first occasion of such violation.

An individual convicted by a Federal, State or local court of having trafficked benefits for an aggregate amount of \$500 or more shall be permanently ineligible to participate in the Program upon the first occasion of such violation.

To receive Food Assistance, certain members of the household need to register for work. This means that certain members of the household must: 1) Report to the Employment First (work program) when the Food Assistance office schedules you for an appointment. 2) Comply with the instructions the Employment First (work program) gives you, including reporting for all scheduled appointments and following through on the written agreements you sign. 3) Provide information to the Food Assistance office or the Employment First (work program) about any jobs you get while you are on food Assistance. 4) Tell the Food Assistance office or Employment First (work program) if you are not able to work – you will be asked to provide verification; work any *Workfare Hours* you are assigned; go to job interviews arranged for you.

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# Rights, Responsibilities, and Penalties (continued)

## I UNDERSTAND AND AGREE THAT:

If you do not do what you are assigned to do, you may be disqualified from receiving Food Assistance benefits. If you are an adult between the ages of 18 and 49, with no children under the age of 18 in your Food Assistance household, you will only be able to get Food Assistance benefits for three months during the next three years unless: You work in a job 80 hours each month and report that information to Employment First (work program); or you work your assigned hours in your county's Employment First (work program), including *Workfare*; or The Employment First (work program), or you are determined to be physically or mentally unable to work, or the Food Assistance office tells you that you are exempt. As long as you do one of these activities each month, you will be able to receive Food Assistance benefits if you are otherwise eligible.

## Your Signature

By signing this form, I certify that I have reviewed this application; I understand and agree to the Rights, Responsibilities and Penalties and under penalty of perjury, I certify the information I have given is true including the information concerning citizenship and alien status. I have received information on how to apply, what information is available, and what I may need to give the county to help me with getting benefits.

Signature of Applicant	Date (mm-dd-yyyy)
Applicant's Printed Name	Signature of person who helped complete application
Authorized Representative, Conservator, POA, or Guardian Signature	Date (mm-dd-yyyy)
Authorized Representative, Conservator, POA, or Guardian Printed Name	Guardian or person who helped complete application address/phone

**If you are applying for Medicaid** You need to send proof of U.S. Citizenship and Identity. You can send ONE of these to prove **both** Citizenship and Identity:

- U.S. passport **OR**
- Certificate of Naturalization (DHS Forms N-550 or N-570) **OR**
- Certificate of US Citizenship (DHS Forms N-560 or N-561)

If you don't have any of those, send one paper proving Citizenship AND one paper proving identity for any person applying for Medicaid from the list below.

Citizenship	Identity
<ul style="list-style-type: none"> <li>▪ U.S. Birth Certificate</li> <li>▪ Certificate of birth abroad (Form FS 545)</li> <li>▪ U.S. National ID card (Form I-197 or I-179)</li> <li>▪ Native American Tribal Document</li> <li>▪ Final adoption decree</li> <li>▪ Official military record of service showing a U.S. place of birth</li> <li>▪ Religious/School records</li> </ul>	<ul style="list-style-type: none"> <li>▪ Driver's license or state ID card with photo</li> <li>▪ ID card issued by a federal, state, or local government agency</li> <li>▪ U.S. military card or draft record or U.S. Coast Guard Merchant Mariner Card</li> <li>▪ School ID card with a photo</li> <li>▪ Verified School, Nursery or Daycare records (for children under 16)</li> <li>▪ Clinic, Doctor or Hospital records (for children under 16)</li> </ul>

Copies of the original documents may be accepted **ONLY** after documentation has been viewed and certified by a site approved by the State of Colorado. A list of approved sites is available at:

<http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1217412405165> under "List of Locations that can Verify Documents" If you need help or more information regarding additional documentation, ask your county technician or visit [colorado.gov/hcpf](http://colorado.gov/hcpf)

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**This form is required for Family Medicaid, CHP+ and Adult Medicaid**

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By signing this form, I certify that I have reviewed this application; I understand and agree to the Rights, Responsibilities and Penalties and under penalty of perjury I certify the information I have given is true including the information concerning citizenship and alien status. I have received information on how to apply, what information is available and what I may need to give the county to help me with getting benefits. **For medical assistance applications, anyone 18 or older must sign the application in addition to the person completing the application.**

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date (mm-dd-yyyy)

\_\_\_\_\_  
Applicant's Printed Name

\_\_\_\_\_  
Signature of person who helped complete this form

\_\_\_\_\_  
Authorized Representative, Conservator, or Guardian's  
Signature

\_\_\_\_\_  
Date (mm-dd-yyyy)

By signing this form, I certify that I have reviewed this application; I understand and agree to the Rights, Responsibilities and Penalties and under penalty of perjury I certify the information I have given is true including the information concerning citizenship and alien status. I have received information on how to apply, what information is available and what I may need to give the county to help me with getting benefits. **For medical assistance applications, anyone 18 or older must sign the application in addition to the person completing the application.**

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date (mm-dd-yyyy)

\_\_\_\_\_  
Applicant's Printed Name

\_\_\_\_\_  
Signature of person who helped complete this form

\_\_\_\_\_  
Authorized Representative, Conservator, or Guardian's  
Signature

\_\_\_\_\_  
Date (mm-dd-yyyy)

By signing this form, I certify that I have reviewed this application; I understand and agree to the Rights, Responsibilities and Penalties and under penalty of perjury I certify the information I have given is true including the information concerning citizenship and alien status. I have received information on how to apply, what information is available and what I may need to give the county to help me with getting benefits. **For medical assistance applications, anyone 18 or older must sign the application in addition to the person completing the application.**

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date (mm-dd-yyyy)

\_\_\_\_\_  
Applicant's Printed Name

\_\_\_\_\_  
Signature of person who helped complete this form

\_\_\_\_\_  
Authorized Representative, Conservator, or Guardian's  
Signature

\_\_\_\_\_  
Date (mm-dd-yyyy)

This form is required for **cash assistance**. An Affidavit of Proof of Lawful Presence is required for each individual (age 18 or older) that is applying for benefits or for adults applying for their children.

## Affidavit of Proof of Lawful Presence in the United States

Please note, this affidavit is not required to apply for or receive Food Assistance and Medicaid programs that are subject to the Deficit Reduction Act of 2005. Every applicant in your household 18 years of age and older must sign an Affidavit of Proof of Lawful Presence in the United States.

I swear or affirm under penalty of perjury under the laws of the state of Colorado (Check one):

- I am a United States citizen; or
- I am a Legal Permanent Resident of the United States; or
- I am lawfully present in the United States pursuant to federal law

I understand this sworn statement is required by law because I have applied for a public benefit. I understand that state law requires me to provide proof that I am lawfully present in the United States prior to receipt of this public benefit. I further acknowledge that making a false, fictitious, or fraudulent statement or representation in this sworn affidavit is punishable under the criminal laws of Colorado as perjury in the second degree under Colorado Revised Statute 18-8-503 and it shall constitute a separate criminal offense each time a public benefit is fraudulently received.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Affidavit of Proof of Lawful Presence in the United States

Please note, this affidavit is not required to apply for or receive Food Assistance and Medicaid programs that are subject to the Deficit Reduction Act of 2005. Every applicant in your household 18 years of age and older must sign an Affidavit of Proof of Lawful Presence in the United States.

I swear or affirm under penalty of perjury under the laws of the state of Colorado (Check one):

- I am a United States citizen; or
- I am a Legal Permanent Resident of the United States; or
- I am lawfully present in the United States pursuant to federal law

I understand this sworn statement is required by law because I have applied for a public benefit. I understand that state law requires me to provide proof that I am lawfully present in the United States prior to receipt of this public benefit. I further acknowledge that making a false, fictitious, or fraudulent statement or representation in this sworn affidavit is punishable under the criminal laws of Colorado as perjury in the second degree under Colorado Revised Statute 18-8-503 and it shall constitute a separate criminal offense each time a public benefit is fraudulently received.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Child Support Information.** This section must be completed if you have a parent absent from your home and you are applying for Colorado Works (TANF) or Adult Medicaid with SSI Children. You may complete this section if you would like assistance with child support.

**Are there any children in your household who have a parent(s) not living in the home?**  Yes  
 No *If yes, please complete the following pages:*

**Applicant's Full Name** (last, first, middle initial; include maiden or any other names used)

**SSN**

**Phone Number**

**Message Number**

**Home Address** (street, PO Box, etc.)

**Mailing Address** (if different than home address)

**City**                      **State**                      **ZIP Code**

**City**                      **State**                      **ZIP Code**

**IMPORTANT** If cooperation could result in serious physical or emotional harm to you or the child(ren) due to the absent parent becoming angry about paying child support or providing health insurance, you may apply for good cause. For good cause to be approved you must provide the county department with evidence within 20 days of your good cause claim. If you need more time you may request it.

Examples of such evidence includes:

Court, criminal, child protective services, social services, psychological or law enforcement records that indicate that the alleged non-custodial parent might inflict physical or emotional harm on you or the children,

The child was born after forcible rape or incest. Evidence include medical or law enforcement records indicating incest or forcible rape occurred, or sworn statement from persons who have knowledge of the basis of claim,

The child is in the process of being adopted. Evidence includes court documents or a written statement from the public or private agency handling the adoption.

If it is decided, with your evidence that good cause is granted, your benefits will not be affected. If you do not have good cause you will receive notice from the county department to cooperate with the CSE unit, unless you appeal the decision.

**Do you wish to request good cause?**  Yes  No

The Colorado Child Support Enforcement (CSE) Program assists you in getting child support for your children from the absent parent (parent not living in your home). Also, the CSE unit can assist in obtaining spousal maintenance. Such assistance includes locating the absent parent, establishing paternity if needed and a child support order. The CSE unit also modifies child support orders when appropriate. As a condition of your Colorado Works (TANF) and/or Medicaid eligibility, *you must cooperate with the CSE unit.* Cooperating means giving information about the absent parent to the CSE unit needed to proceed.

Failure to cooperate with the CSE unit could cause you to lose all or part of your Colorado Works (TANF) benefits or Medicaid for yourself. By cooperating, the absent parent is held to their responsibility for your child or children.

You will receive a periodic notice of support payments collected by the CSE unit. When you are no longer receiving Colorado Works (TANF) or Medicaid, the CSE Office will continue to provide child support services unless you tell them in writing to stop. At that time, the money collected for current child support will go directly to you. Should the money collected be unfunded (a bad check for example), it is possible you would be responsible for returning the money.

**Child Support Information.** This section must be completed if you have a parent absent from your home and you are applying for Colorado Works (TANF) or Adult Medicaid with SSI Children. You may complete this section if you voluntarily would like assistance with child support.

This section collects needed information about your child(ren) and the parent(s) who are not included in your household but who may have a responsibility to children in your household. Please complete this section **only if you are applying for Colorado Works (TANF) and/or Adult Medicaid with SSI children** (recipients of other Medicaid types may apply for child support services).

	First Child	Second Child	Third Child
Full Legal Name			
Gender (M or F)			
Date of Birth			
SSN*			
State or County of Conception			
Who is listed as the father on the birth certificate?			

	Fourth Child	Fifth Child	Sixth Child
Full Legal Name			
Gender (M or F)			
Date of Birth			
SSN*			
State or County of Conception			
Who is listed as the father on the birth certificate?			

\*SSNs are used by the CSE Program to locate individuals or to establish paternity and support obligations. Also, the SSN assists to modify and enforce support obligations and to distribute child support payments. However, if your child(ren) or the absent parent's SSN is unknown, the CSE unit will not deny your request for assistance. The CSE unit may request more information at a later date, as needed, in their effort to get child and medical support for your family.

Legal Name of Absent Parent	1 <sup>st</sup> Absent Parent	2 <sup>nd</sup> Absent Parent	3 <sup>rd</sup> Absent Parent
Is there a court order for this Absent Parent to pay Child Support?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for which child? <b>1 2 3 4 5 6</b> PLEASE CIRCLE	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for which child? <b>1 2 3 4 5 6</b> PLEASE CIRCLE	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for which child? <b>1 2 3 4 5 6</b> PLEASE CIRCLE
If yes, enter the Court case number.			
If yes, enter the date of the order.			
If yes, enter court's city and state.			
If yes, enter the amount of child support order and how often to be paid (example: \$200 a month).			
If yes, was medical support a part of the order?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Last known address of Absent Parent:			
Last known phone number:			
*SSN of Absent Parent, date and place of birth (if neither is known, approximate age of absent parent).	SSN DOB Or approximate age  Place of birth	SSN DOB Or approximate age  Place of birth	SSN DOB Or approximate age  Place of birth
Is there any other information about the absent parent? i.e. (absent parent's physical description, name, address and phone of Absent Parent's parents, siblings or friends)			
Name of Absent Parent's most recent employer and address or phone number of this employer			
Last known date Absent Parent was employed:			
If this absent parent has died, enter the date and city and state of death:			
If the absent parent is disabled or incarcerated, describe the disability or where they are incarcerated:			