ACCESS Florida Application

Do you have a reason that makes it difficult for you to come to the office for an interview?
☐ Illness ☐ Transportation ☐ Work or Training ☐ Live in a Rural Area ☐ Care for a sick or Disabled Household Member ☐ Other (explain):

Date Stamp: _____

Case Number:

I would like to apply for: ☐ **Food Assistance** ☐ **Cash** ☐ **Relative Caregiver** ☐ **OSS/Optional State Supplementation** ☐ **Medical** ☐ **Medicaid Waiver/Home & Community Based Services** ☐ **Hospice** ☐ **Nursing Home Care** – Living address prior to entering Nursing Home:

Welcome to the Florida Department of Children and Families (DCF). If you need help in completing this application or need interpreter services, please contact ACCESS Florida at 1-866-762-2237. We need at least your name, address, and a signature. Processing begins the day we receive your signed application. Household members who are ineligible, or who are not applying for benefits, may be designated as non-applicants. Non-applicants, or persons applying only for Emergency Medicaid, Refugee Cash Assistance, or Refugee Medical Assistance, are NOT required to provide a Social Security Number (SSN) based on the Food Stamp Act. If you are not eligible for an SSN because of your immigration status, you may be eligible for a non-work SSN to receive the benefits that require one. If you need an SSN, we can help you apply for one. Non-applicants are NOT required to provide proof of immigration status. Noncitizens who are applying for benefits will have their immigration status verified with the United States Citizenship and Immigration Services (USCIS). We will not tell USCIS about the immigration status of those living in your household who are not applying for benefits. Under no circumstances will individuals who are not applying for benefits be reported as not lawfully residing in the United States. If you are completing this application for someone else, answer the questions based on their circumstances.

EXPEDITED FOOD ASSISTANCE – Eligible households may receive food assistance benefits within 7 days

Is your household's gross income less than $150? ☐ YES ☐ NO		Do you pay to heat or cool your home? ☐ YES ☐ NO	
Are your total liquid assets (such as cash, bank accounts, etc) less than $100? ☐ YES ☐ NO		What is the monthly amount of your rent or mortgage? $	
Is your household's monthly gross income plus your total liquid assets less than your monthly rent or mortgage plus utilities? ☐ YES ☐ NO		Has all of your household's income recently stopped? If yes, WHEN? ☐ YES ☐ NO	
Check the bills you pay: ☐ Electricity ☐ Gas ☐ Water ☐ Sewage ☐ Phone		Is anyone in your household a migrant or seasonal farm worker? If yes, WHO? ☐ YES ☐ NO	

APPLICANT INFORMATION

Name: First	Middle	Last	Home or Message Phone Number:	E-Mail Address:		
Home Address: Street	Apt. No.		City	State	Zip Code	Work Phone Number:
Address where you get your mail (if different from where you live): Street/P. O. Box			City	State	Zip Code	Cell Phone Number:

INFORMATION FOR ALL PROGRAMS

Is anyone in your home fleeing the law due to a felony or a probation or parole violation? ☐ YES ☐ NO If yes, who?	Has anyone in your home been convicted of a drug trafficking felony? ☐ YES ☐ NO If yes, who?	Has anyone in your home ever been convicted of receiving food assistance, temporary cash assistance, or Medicaid in more than one state at the same time? ☐ YES ☐ NO If yes, who?
Has anyone in your home sold or given away any property or assets in the last 5 years? ☐ YES ☐ NO If yes, who?	Did anyone in your home quit a job in the last 60 days or is anyone on strike? ☐ YES ☐ NO If yes, who?	Has anyone in your home received food, cash, or medical assistance from another state or source in the last 30 days? ☐ YES ☐ NO If yes, who?

STATEMENT OF UNDERSTANDING

I understand that information that I provide with this application, interview, or when requesting other benefits, including computer information matches with other agencies, is subject to verification by DCF and other Federal and State agencies including the Division of Public Assistance Fraud (DPAF). I understand and agree to the following: DCF, DPAF, and authorized Federal Agencies may verify the information I give on this form, interview, or when requesting other benefits. Information may be obtained from my past or present employers. My signature authorizes release of such information to DCF and/or DPAF. As a condition of participation in Medicaid, I consent to review and release of all medical records deemed necessary by Medicaid under its auditing and investigatory powers. If any information is incorrect, benefits may be reduced or denied and I may be subject to criminal prosecution or disqualified from the program for knowingly providing incorrect or false information or hiding information. I have read my Rights and Responsibilities. I certify under penalty of perjury that the information on this form is true to the best of my knowledge, including the citizen or noncitizen status of those who are applying for benefits. I hereby acknowledge receipt of the Florida DCF CFOP 60-17, Chapter 1, Attachment 2, Management and Protection of Personal Health Information Policy.

SIGNATURES

Signature of Adult Household Member Date Signed

Signature of Witness if signed with an "X"

Authorized/Designated Representative – Print Name, Address, and Phone

Signature of Authorized/Designated Representative

Application continues on page 2. Please provide as much information as you can to help us determine your eligibility quickly.

FOR OFFICE USE ONLY	Community Access Site Participant Name/Phone Number:	Date Stamp:

HOUSEHOLD INFORMATION: If you need extra space in the following sections, please use extra pages. Please provide as much information as you can to help us determine your eligibility quickly.

List yourself and all those living in your home even if you are not applying for them. If you are not applying for a member, you do not have to give their SSN or citizenship status. If living in a nursing home or other institutional arrangement, list only self, spouse and dependents.

OPTIONAL INFORMATION – *ETHNICITY:* **A** = Hispanic or Latino; **B** = Not Hispanic or Latino

RACE: You may choose one or more numbers: **1** – American Indian or Alaskan Native, **2** – Asian, **3** – Black or African American, **4** – Native Hawaiian, **5** – White

Section A – List All Adults Living At Your Address

Legal Name First, Middle, Last	Relationship to you	Want to Apply?	Sex	Social Security Number (see instructions above)	Date and Place of Birth	U.S. Citizen	Ethnicity (see above)	Race (see above)	Marital Status	Attends School/ # Hours/Week/ Last Grade Completed	Buys and Eats Food with You
	SELF	☐YES ☐NO	☐F ☐M			☐YES ☐NO USCIS #	☐A ☐B	☐1 ☐2 ☐3 ☐4 ☐5		☐YES ☐NO # hours per week: ________ Last Grade Completed: ________	☐YES ☐NO
		☐YES ☐NO	☐F ☐M			☐YES ☐NO USCIS #	☐A ☐B	☐1 ☐2 ☐3 ☐4 ☐5		☐YES ☐NO # hours per week: ________ Last Grade Completed: ________	☐YES ☐NO
		☐YES ☐NO	☐F ☐M			☐YES ☐NO USCIS #	☐A ☐B	☐1 ☐2 ☐3 ☐4 ☐5		☐YES ☐NO # hours per week: ________ Last Grade Completed: ________	☐YES ☐NO
		☐YES ☐NO	☐F ☐M			☐YES ☐NO USCIS #	☐A ☐B	☐1 ☐2 ☐3 ☐4 ☐5		☐YES ☐NO # hours per week: ________ Last Grade Completed: ________	☐YES ☐NO

Section B – List All Children Living At Your Address. If anyone is pregnant, list "unborn" as the name and the due date as the date of birth.

Legal Name First, Middle, Last	Relationship to you	Want to Apply?	Sex	Social Security Number (see instructions above)	Date and Place of Birth	U.S. Citizen	Ethnicity (see page 2)	Race (see page 2)	Child under Age 5 Immunized	Attends School/ School Name	Date To Graduate	Buys and Eats Food with You
Child 1 Would you like this child to get child health checkup services? ☐YES ☐NO		☐YES ☐NO	☐F ☐M			☐YES ☐NO USCIS #	☐A ☐B	☐1 ☐2 ☐3 ☐4 ☐5	☐YES ☐NO	☐YES ☐NO If yes, school name:		☐YES ☐NO
Child 2 Would you like this child to get child health checkup services? ☐YES ☐NO		☐YES ☐NO	☐F ☐M			☐YES ☐NO USCIS #	☐A ☐B	☐1 ☐2 ☐3 ☐4 ☐5	☐YES ☐NO	☐YES ☐NO If yes, school name:		☐YES ☐NO

Section B – List All Children Living At Your Address. If anyone is pregnant, list "unborn" as the name and the due date as the date of birth.												
Child 3 Would you like this child to get child health checkup services? ☐ YES ☐ NO		☐ YES ☐ NO	☐ F ☐ M			☐ YES ☐ NO USCIS #	☐ A ☐ B	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	☐ YES ☐ NO	☐ YES ☐ NO If yes, school name:		☐ YES ☐ NO
Child 4 Would you like this child to get child health checkup services? ☐ YES ☐ NO		☐ YES ☐ NO	☐ F ☐ M			☐ YES ☐ NO USCIS #	☐ A ☐ B	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	☐ YES ☐ NO	☐ YES ☐ NO If yes, school name:		☐ YES ☐ NO

Medicaid: For children under age 16, if no other proof of identity is available such as school records or photo ID, read and sign below:

I certify under penalty of perjury that all the children listed above are who I claim them to be.

_____
Signature

Section C – Absent Parent Information: Provide the following information for each child in Section B whose mother and/or father is not in the home.

Child 1	Absent Parent's Name and Last Known Address		Date of Birth	Social Security No.	Race	Reason for Absence	
	Mother				(see pg.2)		
	Is this the child's legal parent? ☐ YES ☐ NO	Do you want Child Support Enforcement services if not approved for benefits? ☐ YES ☐ NO	Mother's Place of Birth	Mother's Phone #	Medical Insurance Information: Carrier Name:	Policy Number:	
	Mother's Employer's Name:	Employer's Address:				Employer's Phone #:	
	Absent Parent's Name and Last Known Address		Date of Birth	Social Security No.	Race	Reason for Absence	
	Father				(see pg.2)		
	Is this the child's legal parent? ☐ YES ☐ NO	Do you want Child Support Enforcement services if not approved for benefits? ☐ YES ☐ NO	Father's Place of Birth	Father's Phone #	Medical Insurance Information: Carrier Name:	Policy Number:	
	Father's Employer's Name:	Employer's Address:				Employer's Phone #:	
Child 2	Absent Parent's Name and Last Known Address		Date of Birth	Social Security No.	Race	Reason for Absence	
	Mother				(see pg.2)		
	Is this the child's legal parent? ☐ YES ☐ NO	Do you want Child Support Enforcement services if not approved for benefits? ☐ YES ☐ NO	Mother's Place of Birth	Mother's Phone #	Medical Insurance Information: Carrier Name:	Policy Number:	
	Mother's Employer's Name:	Employer's Address:				Employer's Phone #:	
	Absent Parent's Name and Last Known Address		Date of Birth	Social Security No.	Race	Reason for Absence	
	Father				(see pg.2)		
	Is this the child's legal parent? ☐ YES ☐ NO	Do you want Child Support Enforcement services if not approved for benefits? ☐ YES ☐ NO	Father's Place of Birth	Father's Phone #	Medical Insurance Information: Carrier Name:	Policy Number:	
	Father's Employer's Name:	Employer's Address:				Employer's Phone #:	

Section C – Absent Parent Information: Provide the following information for each child in Section B whose mother and/or father is not in the home.

		Absent Parent's Name and Last Known Address	Date of Birth	Social Security No.	Race	Reason for Absence
Child 3	Mother				(see pg.2)	
		Is this the child's legal parent? ☐YES ☐NO / Do you want Child Support Enforcement services if not approved for benefits? ☐YES ☐NO	Mother's Place of Birth	Mother's Phone #	Medical Insurance Information: Carrier Name: / Policy Number:	
		Mother's Employer's Name: / Employer's Address:				Employer's Phone #:
	Father	Absent Parent's Name and Last Known Address	Date of Birth	Social Security No.	Race (see pg.2)	Reason for Absence
		Is this the child's legal parent? ☐YES ☐NO / Do you want Child Support Enforcement services if not approved for benefits? ☐YES ☐NO	Father's Place of Birth	Father's Phone #	Medical Insurance Information: Carrier Name: / Policy Number:	
		Father's Employer's Name: / Employer's Address:				Employer's Phone #:
Child 4	Mother	Absent Parent's Name and Last Known Address	Date of Birth	Social Security No.	Race (see pg.2)	Reason for Absence
		Is this the child's legal parent? ☐YES ☐NO / Do you want Child Support Enforcement services if not approved for benefits? ☐YES ☐NO	Mother's Place of Birth	Mother's Phone #	Medical Insurance Information: Carrier Name: / Policy Number:	
		Mother's Employer's Name: / Employer's Address:				Employer's Phone #:
	Father	Absent Parent's Name and Last Known Address	Date of Birth	Social Security No.	Race (see pg.2)	Reason for Absence
		Is this the child's legal parent? ☐YES ☐NO / Do you want Child Support Enforcement services if not approved for benefits? ☐YES ☐NO	Father's Place of Birth	Father's Phone #	Medical Insurance Information: Carrier Name: / Policy Number:	
		Father's Employer's Name: / Employer's Address:				Employer's Phone #:

Section D – General Information: Answer the following questions about those listed in Sections A and B who are applying for assistance.

1. Is everyone a resident of the state of Florida?	☐YES	☐NO	If no, who is not?
2. Is anyone in the household pregnant?	☐YES	☐NO	Who? Due Date: # Babies Due:
* 3. Has anyone attended a school conference for any of the children who are ages 6-18?	☐YES	☐NO	Who? When?
4. Has anyone or their parent (if still a child) or deceased spouse (if applicable) served in the U.S. military?	☐YES	☐NO	Who? When?
5. Is anyone in your household a sponsored noncitizen?	☐YES	☐NO	Who?
6. Is anyone living in a special setting such as a homeless shelter, drug treatment center, nursing home, assisted living facility, adult family care home, mental health residential treatment facility, or other institution?	☐YES	☐NO	Who? Facility Name and Type:
7. Is anyone a foster child?	☐YES	☐NO	Who?
* 8. Are any of the children limited or prevented in any way in his or her ability to do the things most children of the same age can do?	☐YES	☐NO	Who?
* 9. Do any of the children need to get special therapy, such as physical, occupational or speech therapy, or treatment or counseling for an emotional, developmental, or behavioral problem?	☐YES	☐NO	Who?
*10. Do any of the children need or use more medical care, mental health, or educational services than is usual for most children of the same age?	☐YES	☐NO	Who?
11. If you are applying for nursing home type services, do you have a child (of any age) living in your home who is blind or disabled?	☐YES	☐NO	Who? What is their relationship to you?
12. Has anyone been determined disabled by Social Security or the State of Florida?	☐YES	☐NO	Who?

Section D – General Information: Answer the following questions about those listed in Sections A and B who are applying for assistance.			
13. Is anyone claiming to be disabled who has not already been determined disabled by Social Security or the State of Florida?	☐ YES	☐ NO	Who?
14. Has anyone been denied Supplemental Security Income (SSI) in the past 90 days?	☐ YES	☐ NO	Who? When?
*15. Does anyone in your household need help with Medicare premiums or medical bills from the past three (3) months?	☐ YES	☐ NO	Who?
*16. Does anyone who was denied for disability have a new medical condition not considered by the Social Security Administration?	☐ YES	☐ NO	Who?
17. Is anyone in your household a victim of human trafficking? (Victims of human trafficking are people taken, kept, or moved by force or fraud for sexual exploitation or forced labor.)	☐ YES	☐ NO	Who?

***** If you need extra space in the following sections, please use extra pages. *****

Section E – Assets & Insurance: Answer the following questions about those listed in Sections A and B who are applying for assistance.

1. Does anyone that you are applying for own all or part of any assets, such as: vehicles, bank accounts, tax sheltered accounts, property, Certificates of Deposit (CDs), cash, mortgage notes, promissory notes, *loans, *IRAs, *401Ks, bonds, annuities, stocks, real estate, life estate, trusts, *Keogh plans, *continuing care retirement community or life care community contracts, burial contracts or plots, prepaid funeral expenses, savings bonds or certificates, business assets, large sums of money received in last 3 months, health/long-term care/life/auto insurance, HMOs, Medicare or Medicare supplements, etc? Include the assets/insurance of parents of minor child applicants if living in the home and assets/insurance of spouses of applicants if living in the home. ☐ YES ☐ NO **If yes, list below:**

IMPORTANT INFORMATION FOR OWNERS OF AN ANNUITY: In accordance with Public Law 109-171, individuals (and their spouses) who are applying for or receiving Medicaid Institutional Care Program (nursing home care), Hospice, Home and Community Based Services waiver programs, or the Program of All-Inclusive Care for the Elderly must list all annuities they own. Certain annuity purchases (or other transactions) made on or after 11/01/2007 will be considered a transfer of an asset for less than fair market value unless the annuity names the State of Florida, Agency for Health Care Administration, as the first remainder beneficiary (or second remainder beneficiary after the community spouse or minor or disabled child) for the total amount of Medicaid funds paid on the Medicaid recipient's behalf.

Individual	Type of Asset or Insurance	Vehicles Year, Make, Model	Amount Owed on Vehicle/Property	Location of Asset/Insurance Bank/Company Name and Address	Account # or Insurance ID #	Amount or Value

2. Are any of the above assets set aside to cover burial expenses?	☐ YES	☐ NO	Which?	What Amount?
3. Has anyone closed bank accounts or other investments, added anyone to the title of an asset, given away assets or property, or liquidated assets greater than $3,000 to buy another asset or service in the last 5 years?	☐ YES	☐ NO	Who? What?	When? Value?

Section F – Income: Answer the following questions about those listed in Sections A and B who are applying for assistance.

1. Does anyone that you are applying for receive any type of income, such as: wages, tips, self-employment, Social Security/Railroad Retirement or Disability, SSI, other disability, VA income, pension, Civil Service, unemployment, child support, alimony, dividends, interest, stipend, money from another person, annuity, rent, workers' compensation, estate/trust, public assistance, grants, scholarships, student loans, reparations payments, training allowances, etc? (Include the income of parents living at home with minor child applicants and income of spouses and dependents of applicants if living in the home.) ☐ YES ☐ NO **If yes, list below:**

Individual	Type of Income	Name of Employer or Source of Income	Phone Number of Employer	Monthly Amount Before Deductions	How Often Received (weekly/biweekly/monthly)	Pay Day on What Day of the Week	Weekly # of Work Hours

2. Has anyone's income in the household ended in the last 60 days?	☐ YES	☐ NO	Who? When?	Source?

Section F – Income: Answer the following questions about those listed in Sections A and B who are applying for assistance.				
3. Will anyone in your household receive additional income from the source that ended?	☐ YES	☐ NO	Who? When?	Gross amount (before deductions) received in this month only? $
4. Does anyone have a pending application for Social Security or Unemployment Compensation benefits?	☐ YES	☐ NO	Who?	Which Benefit?
5. Have deposits been made to Income or Miller Type Trusts in any of the past 3 months?	☐ YES	☐ NO	Whose Trust?	Date(s) and Amount(s) of Deposit(s):

Section G – Expenses: Answer the following questions about those listed in Sections A and B who are applying for assistance.

1. Is anyone that you are applying for required to pay expenses, such as: rent, mortgage, property tax, homeowner's insurance, condo/maintenance fees, gas, electric, fuel, LIHEAP, medical bills such as but not limited to: prescriptions, glasses, transportation, doctor visits, dental, health aides, hospitalization, or insurance or Medicare premiums not covered by insurance or another third party, telephone, day (child) care, or court ordered child support for a child not in your household? Include the expenses of parents of minor child applicants if living in the home and expenses of spouse of applicants if the spouse is living at home. ☐ YES ☐ NO **If yes, list below:**

Type of Expense	Who is Obligated to Pay This Expense	If a Medical Expense, Who Received the Medical Service?	Monthly Amount	Paid to Whom	Date Paid	Still Owed?	For Court Ordered Child Support Only, Name of Child for Whom Support is Paid
						☐ YES ☐ NO	
						☐ YES ☐ NO	
						☐ YES ☐ NO	
						☐ YES ☐ NO	

2. How do you heat or cool your home?

3. Does anyone help you pay expenses? ☐ YES ☐ NO **If yes, explain:**

YOU CAN APPLY TO REGISTER TO VOTE HERE

If you are not registered to vote where you live now, would you like to register to vote here today? Check YES if you would like to apply to register to vote or update your voter registration information. If you check the NO box or do not check a box, you will be considered to have decided not to apply to register to vote or update your voter registration information. Checking YES, NO, or leaving this question blank will not affect your receipt of benefits. ☐ **YES** ☐ **NO**

NOTICE OF RIGHTS

Help: If you would like help in filling out your voter registration application, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration application in private.

Benefits: If you are applying for public assistance from this agency, applying to register, or declining to register to vote will not affect the amount of assistance you will be provided by this agency.

Privacy: Your decision not to register or update your record and the location where you applied to register or update your voter registration record is confidential and may only be used for voter registration purposes.

Formal Complaint: If you believe someone has interfered with either your right to apply to register or to decline to register to vote, your right to privacy in deciding whether to apply to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with: Florida Secretary of State, Division of Elections, NVRA Administrator, R.A. Gray Building, 500 S. Bronough Street, Tallahassee, Florida 32399-0250. Forms for filing a complaint are available at http://election.dos.state.fl.us/nvra/index.shtml or call 1-850-245-6200.

[Authority: National Voter Registration Act (42 U.S.C. 1973 gg); ss. 97.023, 97.058 and 97.0585, F.S.]

YOU MAY BE ELIGIBLE FOR REDUCED TELEPHONE RATES

Check YES if you would like DCF to release your Name, SSN, Phone Number, and the fact that you receive food assistance, Temporary Cash Assistance, or Medicaid to the local telephone company so you may receive a reduced telephone rate through the Lifeline Program. ☐ **YES** ☐ **NO**

NOTICE OF PENALTIES

You may be subject to prosecution for knowingly providing incorrect information to receive public assistance benefits.

REPORTING REQUIREMENTS

You must report any change in your situation according to program requirements to DCF. Food assistance households are required to report changes that increase benefits and food assistance households with a member disqualified for breaking program rules, felony drug trafficking, running away from a felony warrant, or not participating in a work program must report when the household's monthly income exceeds the food assistance gross income limit for the household size. Households receiving Medicaid or Temporary Cash Assistance must continue to report changes that could affect eligibility within 10 days.

IMPORTANT INFORMATION FOR IMMIGRANTS

Applying for or receiving food assistance benefits or Medicaid will not affect you or your family members' immigration status or ability to get permanent resident status (green card). Receiving Temporary Cash Assistance or long–term institutional care such as nursing home benefits might create problems with getting that status, especially if the benefits are your family's only income.

NOTICE OF PENALTIES – Food Stamps:

If you are found guilty (by a state or federal court, or an administrative disqualification hearing, or sign a hearing waiver) of intentionally making a false or misleading statement, concealing or withholding facts in order to receive or in an attempt to receive food assistance or committing any act that violates the Food and Nutrition Act, food assistance regulations, or any state statute for purposes of using, presenting, transferring, acquiring, receiving, or possessing food assistance benefits, you will be disqualified. You will be ineligible for food assistance for 12 months for the first violation, 24 months for the second violation and permanently for the third violation. If you are convicted of trafficking in food assistance benefits of $500 or more, you will be disqualified permanently. If you are convicted of these acts, depending on the severity, you may be fined up to $250,000, imprisoned for up to 20 years, or both.

If you are convicted by a state or federal court of making a fraudulent statement with respect to identity or residency in order to receive food assistance in more than one state at the same time, you will be ineligible to participate in the Food Assistance Program for a period of 10 years.

If you are fleeing to avoid prosecution, custody, or confinement, after conviction for a crime or an attempt to commit a crime, which is a felony, or are in violation of probation or parole imposed under a federal or state law, you are ineligible for food assistance. This information may be disclosed to other federal and state agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law.

If you are found guilty of a drug-trafficking felony, or convicted by a federal, state, or local court of trading firearms, ammunition, or explosives for food assistance benefits, you are ineligible for food assistance.

NOTICE OF PENALTIES – Temporary Cash Assistance:

If you intentionally give false information or hide information to receive or continue to receive Temporary Cash Assistance and are convicted by a state or federal court or by an administrative disqualification hearing, or sign a hearing waiver, you may be disqualified for 12 months for the first violation, 24 months for the second violation and permanently for the third violation.

If you are found guilty of a drug-trafficking felony, or fleeing to avoid prosecution, custody or confinement, after conviction for a crime or an attempt to commit a crime which is a felony, or are in violation of probation or parole imposed under a federal or state law, you are ineligible for Temporary Cash Assistance. If you are convicted by a state or federal court of making a fraudulent statement with respect to identity or residency in order to receive Temporary Cash Assistance in more than one state at the same time, you will be ineligible to participate in the Temporary Cash Assistance program for a period of 10 years.

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES NON-DISCRIMINATION STATEMENT

No person shall, on the basis of race, color, religion, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to unlawful discrimination under any program or activity receiving or benefiting from federal financial assistance and administered by the Department. To file a complaint, alleging violations of this policy, contact the Office of Civil Rights, Florida Department of Children and Families, 1317 Winewood Boulevard, Tallahassee, Florida 32399-0700 or call 1-850-487-1901, or TDD 1-850-922-9220.

USDA-HHS NON-DISCRIMINATION STATEMENT

In accordance with Federal Law and U. S. Department of Agriculture (USDA) and U. S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs. To file a complaint of discrimination, contact USDA or HHS. Write USDA, Director, Office of Adjudication, 1400 Independence Avenue, S. W., Washington, D. C. 20250-9410 or call toll free (866) 632-9992 (voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201or call (202) 619-0403 (voice) or (202) 619-3257 (TTY). USDA and HHS are equal opportunity providers and employers.

SUBMITTING THE APPLICATION FOR ASSISTANCE

An Application for Assistance may be submitted to any Department of Children and Families Economic Self-Sufficiency Services office in the State of Florida by you, or by someone acting for you, in person, by mail, by facsimile (FAX), or electronically through the internet. Applications received during normal business hours are considered received the same day. When an application is received after normal business hours, it will be considered received on the first business day following its receipt.

YOUR RIGHTS AND RESPONSIBILITIES

YOU HAVE THE RIGHT TO:

- Apply for help and to have your eligibility decided without us looking at your race, color, sex, age, disability, religion, national origin (place of birth), or political belief. If you have a disability that limits you in any way, please tell us so we can make accommodations to assist you. The Department of Children and Families (DCF) is an equal opportunity provider.
- In accordance with Federal Law and U. S. Department of Agriculture (USDA) and U. S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs. To file a complaint of discrimination, contact USDA or HHS. Write USDA, Director, Office of Adjudication, 1400 Independence Avenue, S. W., Washington, D. C. 20250-9410 or call toll free (866)632-9992 (voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800)877-8339, or (800)845-6136 (Spanish). Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202)619-0403 (voice) or (202)619-3257 (TTY). USDA and HHS are equal opportunity providers and employers.
- Apply for help on-line through our web application. Or you can turn in a paper application at a local service center or a community partner, or you can mail or fax it. You can turn in an incomplete application (either web or paper), as long as it has your name and address on it, and is signed by you, or another responsible member of your household, or someone acting for you as your authorized or designated representative.
- Be interviewed and notified of your eligibility for food assistance within 30 days from when you turned in a signed application, and for other programs within 45 days (90 days for Medicaid if your disability is considered in deciding your eligibility).
- Have DCF staff, or someone else, help you fill out forms. Let us know if you need help getting information we need.
- Receive, or have someone receive for you, the benefits for which you are eligible and be notified quickly of any action we take on your application or any change we make in your benefits.
- Be told about other programs we have that might help you or your family.
- Ask for a fair hearing within 90 days of when we make a decision on your case.
- Have the information received by us about you or the people in your household protected as required by federal and state laws.
- Name the adult parent of children or someone acting in the role of parent as the payee (the person who will receive your food assistance benefits). If there are no children in your assistance group, then the payee must be the person who earns the most money.

YOU HAVE THE RESPONSIBILITY TO:

(**NOTE:** You have these same responsibilities if you are applying on behalf of someone else.)

- Give us complete and correct proof of requested information, within the time limits given to you, to determine if you are eligible for help.
- Use your temporary cash assistance benefits to the best benefit of the children in the assistance group. Florida law says that anyone who uses the money given for the support of a child or children for some other reason can be fined, sent to jail, or both.
- Declare the U.S. citizenship or noncitizen status of your household members, who are applying for help, by signing the application for assistance. You must provide proof of noncitizen status, from the United States Citizenship and Immigration Services (USCIS), for all persons who are not U. S. citizens for whom you are requesting help. We may ask USCIS to confirm this information. Information received from USCIS may affect your eligibility and amount of benefits. Proof of USCIS status is not required for individuals for whom you are not asking help.
- Apply for benefits from other sources if this application, or information received by us, shows that you might be eligible for those benefits. (This does not apply to the Food Assistance Program.)
- Assign your rights to child support to the state and cooperate with Child Support Enforcement (CSE) in establishing paternity and obtaining support from an absent parent of the children who are in your care, unless you can show CSE good cause for not doing so. (For the Temporary Cash Assistance Program, you must assign your rights to the state. Assigning rights to the state does not apply to the Food Assistance Program.)
- Report any insurance or other health plan which may pay medical costs for you or a member of your household for whom you are asking help. You must also assign the state your rights to any payments from insurance or other health plans, unless you can show us good cause for not doing so. (This applies to anyone asking for or receiving help from the Temporary Cash Assistance, Refugee Assistance or Medicaid Programs.)
- Participate in the work activities of the Food Assistance, Temporary Cash Assistance and Refugee Assistance employment and training programs. This includes registering for employment, unless we have told you that you don't have to do so.
- Report to us, within 5 calendar days, if a child in your family is expected to be out of the home for 30 days or more. (This applies to the Temporary Cash Assistance Program only). It's best to contact us whenever you're not sure if a change should be reported.

(continued on next page)

- Report changes within 10 days if your household receives Medicaid or Temporary Cash Assistance only or receives food assistance and Medicaid or Temporary Cash Assistance. Most food assistance only households have to report changes only at recertification. However, food assistance only households with a member disqualified for breaking program rules, felony drug trafficking, running away from a felony warrant, or not participating in a work program must report when the household's gross monthly income goes higher than the 130% gross income limit for the household size. These food assistance only households must report this change within the first 10 days of the month after the month the change happens. (Example: If the change happens in June, report the change by July 10.)
- Make sure that your school age child (ages 6 through 17) attends school. If your child is identified as truant or a drop out, that child may be removed from your temporary cash assistance and your cash benefit amount lowered, unless you can show that the child has good cause for missing school. (This applies to the Temporary Cash Assistance Program only.)
- Have a conference with a school official for each school age child (ages 6 through 17) during each semester to talk about the child's schoolwork progress or problems at school. If you fail to have this conference, you may be removed from the temporary cash assistance and your cash benefit amount lowered, unless you can show that you have good cause for not having the conference. (This applies to the Temporary Cash Assistance Program only.)
- Have your preschool age children's (ages 0 through 4) immunizations up-to-date. (This applies to the Temporary Cash Assistance Program only.)
- Cooperate with state and federal officials when they review your case and answer their questions if you are able.
- Repay the Department of Children and Families for any benefits received for which you are not eligible. The amount owed can be subtracted from your monthly cash assistance payments or food assistance benefits until the entire amount is paid back. If a Medicaid overpayment occurs, you will have to personally repay the amount.
- Give us the Social Security Number (SSN), or apply for a SSN, for all household members for whom you're asking help. This applies to the Food Assistance, Temporary Cash Assistance, and Medicaid programs. You do not have to apply for or give us a SSN for any household members for whom help is not being requested. However, you may have to give us income and asset information about those individuals for us to determine the eligibility of other household members for whom help is requested.

THE DEPARTMENT OF CHILDREN AND FAMILIES HAS THE RIGHT TO:

- Contact anyone necessary to decide your eligibility for help or any other person for whom you are applying or receiving help.
- Use computer matches with other government agencies to confirm the amount of income and assets available to you and the individuals for whom you're applying or receiving help. Your benefit amount may be changed based on this information.
- Apply a 48 month limit on the number of months families can receive temporary cash assistance benefits. This limit applies to families with at least one eligible adult, unless he or she qualifies for an exemption or is granted a hardship extension by the Regional Workforce Board.

THE AGENCY FOR HEALTH CARE ADMINISTRATION HAS THE RIGHT TO:

- Release medical and Medicaid benefit information to insurance companies or other health plan carriers making medical payments so that they can bill for health care services received by members of the Medicaid assistance group. (This does not apply to the Food Assistance or Temporary Cash Assistance Programs.)
- Get payment for medical expenses from sources other than Medicaid, such as insurance companies or other health plan carriers. (This does not apply to the Food Assistance or Temporary Cash Assistance programs.)
- Collect and review copies of medical and financial information about health care costs paid by Medicaid.
- Be repaid for Medicaid payments made for a person who is receiving money from a judgment, award, settlement, insurance or some other legally responsible source. The person, the person's attorney or the person's insurance company must tell the Agency for Health Care Administration about all possible payments from any of these sources.
- File a claim against a deceased Medicaid recipient's estate for repayment of the Medicaid debt. Receiving Medicaid benefits, by a person age 55 or older, creates a debt to AHCA for the amount of Medicaid payments made before the person's death. The person representing the estate must tell AHCA's Estate Recovery Unit, when the process begins for approval of the will by the court. (This does not apply to Medicare Savings Programs.)

FLORIDA FRAUD LAW INFORMATION

Any person (including the designated or authorized representative) who knowingly does not tell the truth, hides information, pretends to be someone else, does not give all the information needed about themselves, the person(s) they are applying for, or other people in their home, or does anything else unlawful in order to get state or federal public assistance benefits is guilty of a crime and will be punished as state or federal law allows. Further, any person (including the designated or authorized representative) who knowingly does not report a change in circumstances in order to continue to receive such aid or benefits which they should not get, or more benefits than they should get, is guilty of a crime and will be punished as state or federal law allows. Any person who purposely helps another person to do any of the above acts is guilty of a crime, and will be punished as federal and state law allows. This information is located in Section 414.39, Florida Statutes. You can get more information about this law in the local public assistance office or on the Internet.

MANAGEMENT AND PROTECTION OF PERSONAL HEALTH INFORMATION POLICY

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. *Please review it carefully.*

I. Our Duties As They Relate to Your Protected Health Information (PHI). Our records about you contain health information that is very personal. The confidentiality of this personal information is protected by federal and state law. We have a duty to safeguard your Protected Health Information (PHI) which includes individually identifiable information about:

- your past, present, or future health or condition,
- provision of health care to you,
- payment for the health care considered PHI.

We are required to:

- safeguard the privacy of your PHI,
- give you this Notice which describes our privacy practices,
- explain how, when and why we may use or disclose your PHI.

Except in very specific circumstances, we must use or disclose only the minimum PHI that is necessary to accomplish the reason for the use or disclosure.

We must follow the privacy practices described in this Notice; however, **we reserve the right to change the terms of this Notice at any time and to make the new Notice provisions effective for all protected health information that we receive, disclose or maintain.** Should our Notice change, we will post a new Notice in your local service center. You may request a copy of the new notice from your local service center and from our website at www.myflorida.com.

Why We May Need to Use or Disclose Your PHI: We use or disclose PHI for a variety of reasons. For some of these uses or disclosures, we must have your written authorization. For some, the law permits us to make some uses or disclosures without your authorization.

Generally these uses or disclosures are related to treatment, payment, or health care operations. Some examples of these uses or disclosures are:

- For Treatment: We may disclose your PHI to doctors, nurses, and other health care personnel who are involved in providing your health care. For example, your PHI will be shared among members of your treatment team.
- To Obtain Payment: We may use or disclose your PHI in order to bill and collect payment for your health care services. For example, we may release portions of your PHI to Medicaid to get paid for services that we have given or provided for you.
- For Health Care Operations: We may use or disclose your PHI in the course of operating our program. For example, we may use your PHI in evaluating the quality of services provided, or disclose your PHI to our accountant or attorney for audit purposes.
- To Remind You of Appointments: Unless you provide us with alternative instructions, we may send appointment reminders and other similar materials to your home.

Uses and Disclosures For Which We Require Your Authorization (consent):

- When the use or disclosure goes beyond treatment, payment, or health care operations, we are required to have your written authorization. There are some exceptions to this rule, and they are listed below.
- Authorizations can be revoked by you at any time to stop future uses or disclosures, except where we have already used or disclosed your PHI in reliance upon your authorization.

Uses and Disclosures For Which We Do Not Require Your Authorization: The law permits us to use or disclose your PHI *without written authorization* in the following circumstances:

- When a Law Requires Disclosure: We may disclose PHI when a law requires that we report information about suspected abuse, neglect or domestic violence, or in response to a court order, or to a law enforcement official. We must also disclose PHI to authorities who monitor our compliance with these privacy requirements.
- For Public Health Activities: We may disclose PHI when we are required to collect information about diseases or injuries, or to report vital statistics to a public health authority.
- For health oversight activities: We may disclose PHI for health oversight activities such as audits; inspections; civil or criminal investigations or actions.
- Relating to decedents: We may disclose PHI relating to an individual's death to coroners, medical examiners or funeral directors.
- For organ, eye or tissue donations purposes: We may disclose PHI to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- For research purposes: In certain circumstances, and under supervision of a privacy board or institutional review board, we may disclose PHI for research purposes.

- To avert threat to health or safety: In order to avoid a serious threat to health or safety, we may disclose PHI as necessary to law enforcement or others persons who can reasonably prevent or lessen the threat of harm.
- For specialized government functions: We may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons, such as protection of the President.
- For workers' compensation: We may disclose PHI to comply with workers' compensation laws.

Uses or Disclosures For Which You Must Be Given An Opportunity To Object: Sometimes we may disclose your PHI if we have told you that we are going to use or disclose your information and you did not object. Some examples are:

- Patient directories: Your name, location, general condition, and religious affiliation may be put into our patient directory for use by clergy and callers or visitors who ask for you by name.
- To family, friends, or others involved in your care: We may share with these people information directly related to your family's friend's or other person's involvement in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death.

If there is an emergency situation and we do not have time to allow you to object to the disclosure, we may still disclose your PHI if you have previously given your permission and disclosure is determined to be in your best interests. If we do this, you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so.

II. Your Rights As They Relate to Your Protected Health Information (PHI). You have the following rights relating to your PHI:

- To request restrictions on uses or disclosures: You have the right to ask that we limit how we use or disclose your PHI. We will consider your request, but are not legally bound to agree to the restriction. To the extent that we do agree to any restrictions on our use or disclosure of your PHI, we will put the agreement in writing and abide by it except in emergency situations. We cannot agree to limit uses or disclosures that are required by law.
- To choose how we contact you: You have the right to ask that we send you information at an alternative address or by an alternative means. We must agree to your request as long as it is reasonably easy for us to do so.
- To inspect and copy your PHI: Unless your access is restricted for clear and documented reasons, you have a right to see your protected health information if you put your request in writing. We will respond to your request within 30 days for PHI we keep on-site, within 60 days for PHI that is not kept on-site. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed.
- To request amendment of your PHI: If you believe that there is a mistake or missing information in our record of your PHI, you may request, in writing, that we correct or add to the record. We will respond within 60 days of receiving your request. We may deny the request if we determine that the PHI is:

  (i) correct and complete;
  (ii) not created by us or not part of our records; or,
  (iii) not permitted to be disclosed.

A denial will state the reasons for denial. It will also explain your rights to have your request, our denial, and any statement in response that you provide, added to your PHI.

If we approve the request for amendment, we will change the PHI and inform you, as well as tell others who need to know about the change in the PHI.

- To find out what disclosures have been made: You have a right to get a list of when, to whom, for what purpose, and what content of your PHI has been released, except for instances of disclosure that were made for treatment, for payment, for health care operations, to you, per a written authorization, for national security or intelligence purposes, to correctional institutions or law enforcement officials, or for the facility directory. The list also will not include any disclosures made before April 14, 2003.

We will respond to your written request for such a list within 60 days of receiving it. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

- To receive a copy of this notice: You have a right to receive a paper copy of this Notice or an electronic copy by email upon request.

III. How to Complain about our Privacy Practices. If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section IV below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services at the following address: United States Department of Health and Human Services (HHS), Attention: Office for Civil Rights, Sam Nunn Atlanta Federal Center, Suite 3B70, 61 Forsyth Street SW, Atlanta, Georgia 32303-8909. We will take no retaliatory action against you if you make such complaints.

IV. Contact Person for Additional Information, or to Submit a Complaint. If you have questions about this Notice, need additional information, or have any complaints about our privacy practices, please contact: Department of Children and Families, Office of Civil Rights, 1317 Winewood Boulevard, Building 1, Room 101, Tallahassee, Florida 32399-0700, (850) 487-1901.

V. Effective Date. This Notice is effective on February 1, 2003.