Help in your Language

Food Assistance: (303) 441-1000

Español	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Tiếng Việt	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
繁體中文	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。
한국어	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
Русский	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
አማርኛ	ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡
العربيـــة	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان.
Deutsch	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Français	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.
नेपाली	ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू नि:शुल्क रूपमा उपलब्ध छ ।
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
日本語	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
Oroomiffa	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama.
فارســـی	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
Polski	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej.

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VERIFICATION OF INFORMATION

Please provide as much of the following information as you can. All bills and proof of information must be current. We will tell you if we need any other information at the time your application is processed or at the time of interview. *If you have a Sponsor, you may need to provide proof of your Sponsor's income and resources.*

1. PROOF OF ALL INCOME RECEIVED BY YOU OR OTHER MEMBERS OF YOUR HOUSEHOLD.
Income is any money your household receives. Proof of income may include but is not limited to:

Wages/Tips	Retirement Pension	Gifts/Allowances/Contributions
Self Employment	Veterans Benefits	Interest from savings, cd, etc.
Child Support	Military Allotment	Educational Loan/Grant
Unemployment	Rental Income	
Social Security	Roomer/Boarder	
Alimony/Maintenance	Colorado Works Cash	

2. SOCIAL SECURITY NUMBERS (SSN).
The SSN or proof of applying for an SSN should be provided for each member unless the member does not wish to apply for benefits or does not have one.

3. PROOF OF AGE AND IDENTITY.
You *may* be required to provide identification for yourself and all household members applying for benefits such as a:

Birth Certificate	ID for Health Benefits
Baptismal Record	Work ID
US Passport	Other Documents
Drivers License	

Identification Cards for US Citizens (CIS-I-179 or CIS-I-197)
Certificate of US Citizenship (CIS form N-560 or NH-561)
Certificate of Naturalization (CIS form N-550 or N-570)
Certificate of birth abroad of a citizen in the US (Department of State forms FS-545 or DS-1350)

4. PROOF OF CITIZENSHIP AND RESIDENCE.
You *may* be required to provide proof of citizenship and residence.

<u>If you are a US citizen, you may be required to provide proof, such as a:</u>

Birth Certificate	ID for Health Benefits
Client Statement	Work ID
US Passport	Baptismal Record
Drivers License	Other Documents

Forms from Citizenship and Immigration Services (CIS) such as:

Identification Cards for US Citizens (CIS-I-179 or CIS-I-197)
Certificate of US Citizenship (CIS form N-560 or NH-561)
Certificate of Naturalization (CIS form N-550 or N-570)
Certificate of birth abroad of a citizen in the US (Department of State forms FS-545 or DS-1350)

If you are a legal non-citizen, you may be required to provide proof of your status, such as:

CIS Documents
I-551 Resident Alien Card
I-94 Arrival/Departure Record
I-688B or I-766 Employment Authorization Document
A letter from CIS indicating a person's status

5. PROOF OF RESOURCES. (Not required for Colorado Works programs)
You *may* be required to provide proof of resources. Proof of resources may include, but are not limited to:

Vehicles	Trust Funds	Checking/Savings
Real Estate	Life Insurance	Accounts Other
Stock and Bonds	Burial Insurance	
Retirement Funds	Home you do not live in	

6. PROOF OF EXPENSES.
You *may* be required to provide proof of expenses. Proof of expenses may include, but are not limited to:

Utilities	Child support payments
Medical expenses	Child dependent care costs
Rent or mortgage costs	Expenses for care of disabled household members

7. LIVING ARRANGEMENTS. (For Food Assistance Only)
If you are living with other people in the same house, an explanation of your living arrangements will be helpful. It should include how you buy and prepare food and how rent/ mortgage and utilities are paid.

8. CHILD SUPPORT INFORMATION. (For Food Assistance and Colorado Works Only)
If a parent to your child(ren) is out of the home, you must bring copies of any court orders. These court orders include orders involving a divorce, child support or paternity establishment. In addition to social security numbers for you and your children, please provide social security number(s) for the absent parent(s), if available.

What I Should Know

By completing and signing the State of Colorado Application for Public Assistance and other documents required to determine whether I'm eligible for public assistance benefits **AND** by accepting benefits that I am eligible to receive, I understand the following information and agree to the following requirements:

- I must tell the truth; it is a crime to lie on this application.
- I may have to give papers that show what I've told you is true.
- I may have to tell you of any changes to the information I gave you on my application. If I think you made a mistake, I can ask for an appeal or fair hearing.
- The department will not discriminate.
- The department will confirm citizenship and immigration status for everyone applying for benefits.
- The department will tell you if your benefits change.
- The department or relevant federal agency will take back any benefits you should not have received.

1. The Department of Health Care Policy and Financing (HCPF) is the state agency responsible for Medical Assistance Programs in Colorado. The Department of Human Services is the state agency responsible for the other public assistance programs. The County Departments of Human/Social Services and Medical Assistance Sites are the agencies that receive and process applications for all public assistance programs. In this statement, the term "department" is used to refer to all agencies.

2. I must give the department all needed proof and documents before qualifying for benefits.

3. The information I give on the application and in the application interview is confidential. However, the department can use or share the information with other program(s) that any of my family and/or household members are getting or are applying for. The information can only be used for purposes of treatment, payment, determining eligibility, and other program and administrative operations, or other purposes permitted by law for my family and/or household members or me. Additionally, 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. It will also be determined if the information is factual. If any information is incorrect, Food Assistance may be denied and the applicant may be subject to criminal prosecution for knowingly providing incorrect information.

4. It is a crime to lie on the application or to take benefits that I know that my family and I are not eligible to receive and I may be subject to criminal prosecution for knowingly providing false information. Giving false information may be punished by a fine of up to $250,000 or a jail term of up to 20 years, or both.

5. A person found to have intentionally given false information cannot get Food Assistance and/or Cash Programs 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 state and federal laws. Receiving duplicate benefits of Food Assistance by lying about identity or residence will result in a ten (10) year disqualification for the first offense, a ten (10) year disqualification for the second offense and a permanent disqualification for the third offense. If I omit or provide any information (other than lying about identity or residence) that leads to duplicate benefits being issued, I can be disqualified for 12 months for the 1st offense, 24 months for the 2nd offense and permanently for the 3rd offense. A person convicted by a court or whose disqualification was obtained through an *Intentional Program Violation* (IPV) waiver for misrepresenting their residence in order to obtain assistance in two states at the same time will have their Colorado Works assistance denied for ten (10) years.

6. If I am receiving Food Assistance, I must report if anyone in the household age 18 years or older has been convicted on or after 2/7/2014 and is not in compliance with the terms of their sentence of the following: aggravated sexual abuse, murder, sexual exploitation and or abuse of a child (ren) or sexual assault.

7. The department will notify me in writing of how and when to tell the department of any changes. If I am receiving Cash Programs, I know that I must tell the organization providing the assistance if information I listed on this application changes by the 10th of the month following the change. I am aware I have 10 calendar days to report any changes if I am enrolled in Health First Colorado or Child Health Plan Plus (CHP+). Changes are to be reported to my local county office for Health First Colorado or to CHP+. I am responsible for paying fees, premiums and co-payments for myself and my family if they are required for Medical Assistance benefits. I know I have 30 calendar days to report any change to Connect for Health Colorado if I am receiving Advance Premium Tax Credits, Reduced Co-Pays or Deductibles, or I am enrolled in a Qualified Health Plan. If my family is enrolled in multiple insurance affordability programs, I must report changes to each organization in the appropriate time frame. I understand that a change in information could affect my eligibility and eligibility of member(s) of my household.

8. If I do not tell the truth on my application or if information is left off of the application, or if I do not report changes to the department, as required, I may lose my assistance, and I may have to pay back the department for the assistance received when I was not eligible. If I have to pay back money to the department, I understand that state or federal salaries, rebates, or tax refunds that would be received by me or another person on this application may be taken.

9. The law says the department must check the immigration status and citizenship for anyone who is applying. They will not

check immigration status of family members who are not applying for benefits. I may be requested to give proof of non-citizen registration documentation received from the United States Citizen and Immigration Service (USCIS) for every non-citizen member in my house who is applying for benefits. The department will confirm information with USCIS and any information received from USCIS may affect my eligibility and benefits. Federal law (Public Law 97-98) requires me to give the department the Social Security number and/or alien registration number of all persons who are applying for public assistance. I must also provide the Social Security number and/or alien registration number for all sponsors. **For Adult Financial and Colorado Works programs, sponsor information will be confirmed with USCIS and the information received from USCIS may affect sponsor repayment for my eligibility and benefits. My sponsor and I may be responsible for reimbursing the state for benefits that I receive.**

10. The following applies to all qualified non-citizens applying for Cash Programs: As a condition of my eligibility for financial assistance programs I agree that, during the time I am receiving such assistance, I will not sign an Affidavit of Support to sponsor a non-citizen who is seeking permission to enter or remain in the United States. I understand that any Affidavit of Support signed prior to July 1, 1997 does not affect **my eligibility** for assistance. If I do not agree, I will no longer be eligible for financial assistance from the State of Colorado.

11. I do not have to be a U.S. citizen to apply for assistance. **Please do not let the fear about immigration status stop you from seeking benefits for your family.**

12. If I am a resident of an institution and jointly applying for SSI and Food Assistance prior to leaving the institution, the filing date of the application is my date of release from the institution. Processing time will begin from the date the application is received in the Food Assistance office.

13. Privacy Act Information: The department is authorized to collect information on the application, including Social Security numbers and will confirm information that may affect initial or ongoing eligibility and payments for all persons listed on my application. **I am allowing the department to use Social Security numbers (SSN) and other information from my application to request and receive information or records to confirm the information in my application.** Food Assistance will be denied to individuals that do not provide a Social Security number, and Social Security numbers will be used and disclosed in the same manner for both eligible and ineligible members. **I release the department from all liability for sharing this information with other agencies for this purpose.** For example, the department may get and share information with any of the following agencies: Social Security Administration; Internal Revenue Service; United States Customs and Immigration Services; Colorado Department of Labor and Employment; financial institutions (banks, savings and loans, credit unions, insurance companies, landlords, leasing agents, etc.); child support services; employers; courts; and other federal or state agencies; and for Food Assistance, law enforcement officials for the purposes of apprehending persons fleeing to avoid the law.

14. If a Food Assistance, Colorado Works, and/or Adult Financial over-payment occurs against my household, the information on this application, including all Social Security numbers, may be referred to Federal and State agencies, as well as private claims collection agencies for claims collection action.

15. The EBT (or Quest) card is used to pay me most of my public assistance benefits. I cannot trade or sell EBT cards. The only people allowed to use my household's EBT card are members of my household, my authorized representative(s), and individuals outside my household that have my permission to use my EBT card to access benefits for the people in my household. I cannot use my EBT card to access my cash benefits at locations identified as prohibited locations including licensed gaming establishments, in-state simulcast facilities, tracks for racing, commercial bingo facilities, stores or establishments in which the principal business is the sale of firearms, retail establishment licensed to sell malt, vinous, or spirituous liquors, establishments licensed to sell medical marijuana or medical marijuana-infused products, or retail marijuana or retail marijuana products, establishments that provide adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment. **Continued misuse of my EBT card at prohibited locations will cause my cash benefits to be suspended on my EBT card and/or my cash benefits to be terminated for a period of 30 days requiring a new application.**

16. I can name someone or an organization to be my representative. I must do this in writing. The person and/or organization I designate to be my authorized representative may help me apply for assistance, get my benefits, and use my benefits to buy food for me. I may name one person to help me with each separate task or I may name one person to help me with all of these tasks.

17. If I think the department made a mistake, I can ask for a Fair Hearing. The department will tell me in writing how to make an appeal. I can ask for a Fair Hearing either verbally or in writing. My case may be presented by a member of my household or my representative, such as legal counsel, friend, or relative. I may request an appeal for any action on any program except for the CHP+ program.

18. If I think the CHP+ program made a mistake, I can ask for an appeal. CHP+ tells me about how to make an appeal in writing.

19. Colorado Works is not an entitlement program and benefits are not guaranteed. To remain eligible, I may be required to complete an assessment and develop a plan. Unless exempted, I will be required to participate in work readiness activities.

20. As an applicant for Colorado Works, if I refuse to cooperate with Child Support Services at the time I apply or while receiving cash assistance through Colorado Works, without good cause, I will not receive assistance or a basic cash assistance grant for my family. Good cause for not working with Child Support can be, but is not limited to; potential physical or emotional harm to a child(ren), parent or caretaker relative; pregnancy or birth of a child related to incest or forcible rape; legal adoption before court or a parent receiving pre-adoption services; or other reasons determined to be in the best interest of the child. In order to cooperate with Child Support Services, I will be required to complete additional documentation

concerning the child(ren), parentage of the child(ren) and provide all court documents that concern the child(ren).

21. If I am an adult between the ages of 18 and 49, with no children under the age of 18 in my Food Assistance house, I will only be eligible to receive Food Assistance benefits for three months, unless one of the following applies: I work in a job 80 hours each month and report my hours worked to my local Employment First office, or I meet the Workfare program requirements or work program requirements set by the Employment First office. Additionally, I may continue to receive my Food Assistance benefits if I am determined to be physically or mentally unable to work or if the Food Assistance office identifies other applicable exemptions. If I meet any of these criteria, I will be able to continue receiving Food Assistance as long as I remain eligible.

22. I understand and agree that to receive Food Assistance, certain members of the household need to register for work. This means that certain members of the household must: A) Report to the Employment First (work program) when the Food Assistance office schedules an appointment. B) Comply with the instructions the Employment First (work program) gives including reporting for all scheduled appointments and following through on the written agreements signed. C) Provide information to the Food Assistance office or the Employment First (work program) about any jobs me or my household member(s) get while on Food Assistance. D) Tell the Food Assistance office or the Employment First (work program) if me or my household member(s) are not able to work - I will be asked to provide verification; work any workfare hours assigned; go to job interviews arranged for me or my household member(s). Anyone who does not follow the work requirements may be disqualified from receiving Food Assistance.

23. I must cooperate fully with state and federal staff if my case is reviewed. My information on this application may be reviewed and confirmed by the department, or its representatives. 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.

24. I cannot use Food Assistance benefits to buy nonfood items, such as alcohol or cigarettes. I can be disqualified for using Food Assistance to pay for items purchased on credit. **If a court of law finds a person guilty of using Food Assistance benefits to illegally purchase or receive controlled substances that individual shall be disqualified for two 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 receive Food Assistance upon the first occasion of such violation. If a court of law finds a person guilty of having trafficked benefits for an aggregate amount of $500 or more, that individual will be permanently ineligible to receive Food Assistance upon the first occasion of such violation.**

25. The trafficking of benefits means:

a. The buying, selling, stealing, or otherwise effecting an exchange of Food Assistance benefits issued and accessed via Electronic Benefit Transfer (EBT) cards, card numbers and personal identification numbers (PINs), or by manual voucher and signature, for cash or consideration other than eligible food, either directly, indirectly, in complicity or collusion with others, or acting alone ; or,

b. The exchange of Food Assistance benefits or EBT cards for firearms, ammunition, explosives, or controlled substances; or,

c. A Food Assistance participant, including the participant's designated authorized representative, who knowingly transfers Food Assistance benefit to another who does not, or does not intend to, use the Food Assistance benefits for the Food Assistance household for whom the Food Assistance benefits were intended; or

d. The reselling of food that was purchased with Food Assistance benefits for cash; or

e. Obtaining a cash deposit when returning water or other containers that were purchased with Food Assistance benefits. Purchasing water containers is an eligible food item that can be paid for with Food Assistance benefits; however, when the container is returned, the deposit should be returned to the client's EBT card and not given to the client in cash.

f. Attempting to buy, sell, steal, or otherwise affect an exchange of SNAP benefits issued and accessed via Electronic Benefit Transfer (EBT) cards, card numbers and personal identification numbers (PINs), or by manual voucher and signatures, for cash or consideration other than eligible food, either directly, indirectly, in complicity or collusion with others, or acting alone.

26. If I do not report and provide proof of mortgage, housing fees, property insurance, property taxes, court ordered child support payments, child or adult care, and medical expenses paid by people in my household who are elderly or who have a disability, I am stating that I do not want that specific deduction used to determine my Food Assistance benefit amount.

27. I can ask for Food Assistance apart from asking for benefits from other programs. My eligibility for Food Assistance will be determined apart from any other programs. The Food Assistance office shall process all Food Assistance applications in accordance with Food Assistance timeliness, noticing, and fair hearing requirements, even if I am applying for other programs.

28. Colorado residents who have a qualifying disability, such as persons receiving SSI or SSDI benefits, or residents who are at least 65 years of age (or a surviving spouse age 58 or older) might also qualify for a Property Tax/Rent/Heat Rebate from the Department of Revenue. Visit www.TaxColorado.com and click on the PTC button at the top of the page or call 303-238-7378 for details.

29. IEVS refers to the Income Eligibility Verification System. IEVS reports discrepancies between the information you provide and information in the Department of Labor's system as well as Social Security Administration's various systems. Information available through IEVS will be requested, used, and may be verified through collateral contacts when discrepancies are found. This information may affect your eligibility and benefit level.

30. I will immediately notify the State of any medical claim or lawsuit I have. I will cooperate with the State in collecting the medical bills the State has paid. The state may collect from any insurance company or court settlement for medical bills that

the State has paid. If I am on Medical Assistance and receive money for the same medical bills that the State has paid, I will give the money to the State. I assign to the State all rights to payment for medical expenses and treatment. I also assign my right to appeal a denial of benefits by another party responsible for payment for the benefits to the State.

31. Federal and Colorado state law require the Department of Health Care Policy and Financing to recover all medical assistance benefits, including capitation payments, paid on behalf of Health First Colorado clients from the estates of deceased Health First Colorado clients who were permanently institutionalized. For Health First Colorado clients who were over the age of 55 when benefits were provided, the Department recovers payments for nursing facility services, home and community-based services, and related hospital and prescription drug services. There are certain exemptions to estate recovery. For further information, please contact your county and request the “Medical Assistance Estate Recovery Program” brochure.

- I must report single game cash lottery or gambling winnings by any adult household member equal to or greater than $3500 before taxes or other amounts are withheld. I understand that these winnings will disqualify the entire household.

CDHS Nondiscrimination Policy

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex, and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact the USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Compliant Form, (AD-3027), found online at: http://www.ascr.usda.gov/compliant_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

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

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

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

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

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

This institution is an equal opportunity provider.

Medical Assistance Nondiscrimination Policy

The Department of Health Care Policy and Financing and Connect for Health Colorado do not discriminate on the basis of race, color, ethnic or national origin and expression, marital status, religion, creed, political beliefs, or disability in any of its programs, services and activities. For further information about the Department's policy, to request free disability and/or language aids and services, or to file a discriminating complain, contact: 504/ADA Coordinator, 1570 Grant St., Denver, CO 80203, Phone: 303-866-6010, Fax: 303-866-2828, State Relay: 711, Email: hcpf504ada@state.co.us. For information about Connect for Health Colorado's policy, aids and services or to file a discrimination complaint, contact: General Counsel, 3773 Cherry Creek N. Dr., Suite 1005, Phone: 303-590-9640, Fax: 303-322-4217. Complaints can also be filed with the U.S Department of Health and Human Services Office for Civil Rights at http://www.hhs.gov/ocr/filing-with-ocr/index.html.

For Other Programs: For information about the Colorado Department of Human Services policies, to request free disability and/or language aids and services, or to file a discrimination complaint, contact: 504/ADA Coordinator, 1575 Sherman St Denver, CO 80203, Phone: 303-866-7129, Fax: 303-866-6080, State Relay: 711, Email: CDHSCR@state.co.us. For additional information please visit www.colorado.gov/cdhs.

Civil rights complaints can also be filed with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf or by mail, phone, or fax at: 1961 Stout Street Room 08-148 Denver, CO 80294, Telephone: 800-368-1019, Fax: 202-619-3818, TDD: 800-537-7697. Complaint forms are available at http://www.hhs.gov/civil-rights/filing-a-complaint/index.html.

Domestic violence information and services are available to me. If I ever feel I am in immediate danger I should call 911. If I would like to receive information regarding safety and services in Colorado, I will call the Colorado Coalition Against Domestic Violence at 303-831-9632 or toll free at 1-888-778-7091. I may also find the location of services near me by going to www.colorado.gov/cdhs/dvp. The National Domestic Violence Hotline at 1−800−799−SAFE (7233) or TTY 1−800−787−3224 or www.thehotline.org can also provide information. If I am a survivor of domestic violence, sexual assault, or stalking, the Address Confidentiality Program (ACP) can provide me with a legal substitute address to use instead of my physical address for use with state and local government agencies. I can find out more about the ACP at acp.colorado.gov. If I need or receive either of these services, I should tell my department worker.

STATE OF COLORADO

Notice to Reapply
You Need to Act Now

Name: _____

Address:

_____

_____

_____

Case ID: 1B

Please return your information to us at:

Via email: imaging@bouldercounty.org

Drop off: HHS Community Support 515 COFFMAN ST, SUITE 100 LONGMONT CO 80501-5409

Via fax: 303-441-1523

Call: (303) 441-1000/TTY: 1-800-659-3656

To see if you can still get benefits, please review and update all information provided on the pages and answer any applicable questions. Sign and return this to us.

Any changes reported can result in a reduction or termination of benefits. Turning this form in incomplete and/or after due date can result in a delay of benefits being issued. I have read this form to renew my benefits and to the best of my knowledge and belief, my answers are true. This information includes the people who live in my house and, citizenship and non-citizenship information. I have listed all amounts and sources of income, money and property I receive or own. I understand and agree to the information provided in the section titled 'What I Should Know'.

I have the right to apply again for Food Assistance benefits by submitting an application for assistance as long as it has my name, address and signature. I can send this application in by mail, drop it off at the office, or through an authorized representative. If everyone in my household receives SSI, I can apply again for benefits at the local Social Security office.

SIGN HERE:_____ **Date:**_____

Best phone number to call you: _____
Have you moved? ☐ Yes ☐ No
If yes, what is your new address? _____

Please complete this section:

Is anyone who lives in your house a migrant or a seasonal farm worker?	☐ Yes ☐ No
Is the money (before deductions) you think you will get this month less than $150?	☐ Yes ☐ No
Is all the cash, and money in the checking and savings accounts for the house less than $100?	☐ Yes ☐ No
Are your monthly housing and utility costs more than the total monthly money, including cash, money from employment gifts, and money in the checking and savings accounts?	☐ Yes ☐ No

People who Live with You
Attach additional pages if you cannot write your answer in the space provided.

Full Name	Relation to You	Birth Date	Male/ Female	People who do not want benefits do not have to answer these questions.			Current Benefits
				Social Security Number	US Citizen	Race/ Ethnicity (see codes below)	

* Male/Female is optional

* Household members who are seeking Food Assistance benefits must supply information about SSNs and citizenship or immigration status. You don't have to give this information if you are not applying for Food Assistance. We use SSNs to check income and other information to see who's eligible for Food Assistance. Household members who are not seeking benefits will still be required to provide their financial information if it is needed to determine eligibility and benefit amount for persons who are applying. The collection of SSNs is authorized under the Food and Nutrition Act and any household member who does not provide a SSN or immigration status will be denied benefits. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov TTY users should call 1-800-325-0778.

* Race/Ethnicity is optional. Race options include: Asian-A; Hispanic/Latino-H; American Indian/ Alaskan Native-AI; White-W; Native Hawaiian/Pacific Islander-NH; Black/African American-B; Other- O

* Current Benefits: AF= Adult financial, CW= Colorado Works FA=Food Assistance (SNAP)

I have no changes ☐ Checking the box, "I have no changes", means that you agree with the information that's been provided in this section. Please review and update the information below. If anyone in the home has a new job, please add that information.

Is anyone in the home pregnant? ☐ Yes ☐ No Who? _____

When is the baby due? _____ How many babies does she expect? _____

List the name of the father: _____

For a quick decision, please send in a doctor's statement with a due date.

Is anyone in the home 18 years or older and in school? ☐ Yes ☐ No

Who? _____

Are there any school aged children who do not go to school right now (excluding breaks)?

☐ Yes ☐ No Who? _____

Are you or any member of your household: ☐ In Jail/Prison ☐ In a Nursing Home

☐ In a Group Home ☐ In Rehab ☐ A convicted felon
☐ A fleeing felon, probation violator or parolee violator

If yes, please provide the household member' s name and date this happened: _____

Have any adults in the household been convicted of aggravated sexual abuse, murder, sexual exploitation, and/or abuse of a child(ren) or sexual assault for conduct that occurred after February 7, 2014? ☐ Yes ☐ No

Are all adults with these convictions in compliance with the terms of their sentence? ☐ Yes ☐ No

Have you or any member of your home applying for assistance ever been disqualified for an Intentional Program Violation or been convicted of welfare fraud in a criminal case? ☐ Yes ☐ No

Money in Your Home
Attach additional pages if you cannot write your answer in the space provided.

Please review and update the information below. If anyone in the home has a new job, please add that information.

Person Working	Employer Name	How Often Are You Paid?	Tell Us How Much You Get for Each Paycheck? (Before Deductions)
			$
			$
			$
			$
			$
			$
			$

I have no changes ☐ Checking the box, "I have no changes", means that you agree with the information that's been provided in this section. Please review and update the information below. If anyone in the home has a new job, please add that information.

You must send in proof of all money in the house. Help us make a quicker decision by sending in the proof with this packet.

Did you or anyone in the home leave or lose a job in the past 60 days? ☐ Yes ☐ No

Who? _____ When? _____
Employer Name: _____ Employer phone number: _____
Date of last pay check: _____ Amount of last pay check: $ _____

Are you or anyone in the home on strike? ☐ Yes ☐ No
Who? _____ When? _____

Does anyone get any OTHER type of money? ☐Yes ☐ No

Examples: Unemployment benefits; Child Support; Retirement/Pension; Social Security Benefits; Veterans Benefits; Dividends/Interest; Trust; Loans/Gifts; In-kind money (i.e. work around the house in exchange for rent), Worker' s Compensation; Alimony, Disability.

Person Getting Money	Money From	How Often is it Received?	Amount
			$
			$
			$
			$

I have no changes ☐ Checking the box, "I have no changes", means that you agree with the information that's been provided in this section. Please review and update the information below. If anyone in the home has a new job, please add that information.

You must send in proof of all money in the house. Help us make a quicker decision by sending in the proof with this packet.

Things You Pay For
Attach additional pages if you cannot write your answer in the space provided.

Please tell us if you have any changes in what you pay for rent/mortgage, home insurance, property taxes, HOA fees, utilities, child/adult day care, medical expenses and court-ordered child support, OR if you have any new things that you pay for.

Type	How Often Do You Pay?	Amount You Told Us You Pay	Amount you now pay
			$
			$
			$
			$
			$
			$
			$

I have no changes ☐ Checking the box, "I have no changes", means that you agree with the information that's been provided in this section. Please review and update the information below. If anyone in the home has a new job, please add that information.

You must send in proof of all money in the house. Help us make a quicker decision by sending in the proof with this packet.

Did you get LEAP within the past 12 calendar months? ☐Yes ☐ No

If I do not report and provide requested proof of rent, mortgage, housing fees, property insurance, property taxes, court ordered child support payments, child or adult care, and medical expenses paid by elderly or disabled members, I am stating that I do not want that specific expense used as a

deduction to determine my food assistance benefit amount.

Things You Own

Attach additional pages if you cannot write your answer in the space provided.

Please tell us if you have any cash, checking and savings accounts, annuities, trusts, mutual funds, promissory notes, property (land and/or homes), vehicles and retirement accounts, OR if you have new things that you own.

Name of Person(s) Who Owns the Item/ Account	Type	Current Value
		$
		$
		$

I have no changes ☐ Checking the box, "I have no changes", means that you agree with the information that's been provided in this section. Please review and update the information below. If anyone in the home has a new job, please add that information.

You must send in proof of all money in the house. Help us make a quicker decision by sending in the proof with this packet.

Have you given away anything of value since the last time you applied or re-applied?

☐Yes ☐No

Person who Gave it Away:_____

What was Given Away and When?_____ Value: $ _____

This page is intentionally left blank.

Stop Here if you are only receiving Food Assistance, Adult Financial (OAP, AND, etc.) or Colorado Works. If you are receiving Medical Assistance, please complete these additional questions.

Starting October 1, 2013, changes in Federal law require Colorado to ask additional questions about you and your family. We have identified that you have not provided the information required as of October 1, 2013.

Instructions: Please complete the questions below for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. If you don't file a tax return, remember to still add family members who live with you. Use More Paper if Necessary.

Send this letter back to the person and address listed above or you can enter the information on PEAK Redetermination at Colorado.gov/PEAK.

If you receive Medical benefits:

Has anyone in the home had changes in their medical health insurance? ☐Yes ☐No

Who? _____ What changed? _____

Do You Plan to File a Federal Income Tax Return NEXT YEAR?	☐ Yes If yes, answer questions 1-3 ☐ No If no, answer question 3	*You can still apply for Health First Colorado (Colorado's Medicaid Program), CHP+, or health insurance even if you do not file a federal income tax return.*
1. Will you file jointly with a spouse?	☐ Yes If yes, please list full legal name of spouse ☐ No	
2. Will you claim any dependents on your tax return?	☐ Yes If yes, list full legal name of dependents ☐ No	
3. Will you be claimed as a dependent on someone's tax return?	☐ Yes If yes, list full legal name of the tax filer ☐ No How are you related to the tax filer?	

Does Anyone Else in the Home Plan to File a Federal Income Tax Return NEXT YEAR?	☐ Yes If yes, answer questions 1-3 ☐ No If no, answer question 3	*You can still apply for Health First Colorado (Colorado's Medicaid Program), CHP+, or health insurance even if you do not file a federal income tax return.*
Name		
1. Will they file jointly with a spouse?	☐ Yes If yes, please list full legal name of spouse ☐ No	
2. Will they claim any dependents on their tax return?	☐ Yes If yes, list full legal name of dependents ☐ No	

3. Will they be claimed as a dependent on someone's tax return?	☐ Yes If yes, list full legal name of the tax filer ☐ No How are they related to the tax filer?	