ITEMS NEEDED FOR PROCESSING DCTP APPLICATION

- DCTP and MEDICAID APPLICATIONS COMPLETED, SIGNED, AND DATED

- PROOF OF INCOME
  - 3 consecutive pay stubs
  - Social security income document
  - Department of Labor unemployment income document
  - Workers compensation income

- LEGIBLE COPY OF DRIVERS LICENSE OR STATE ID

- MARKETPLACE APPLICATION APPROVAL OR DENIAL
  - Call 1-800-318-2596 to apply

- DCTP CERTIFICATE OF DIAGNOSIS
  - Your treating physician must fill this out

- LEGIBLE COPY OF BIRTH CERTIFICATE
  *required for Medicaid application processing only

If you need assistance in completing the application process,
Please call: 1-844-245-9580

Delaware Cancer Treatment Program
Division of Public Health
C/O Gainwell Technologies
P.O. Box 950 Manor Branch
New Castle, DE 19720-0950
1-844-245-9580
Fax 302-454-0223

Dear Delaware Resident:

Enclosed you will find an application form for the Delaware Cancer Treatment Program (DCTP), a program of the Delaware Health and Social Services (DHSS), Division of Public Health. The DCTP pays for cancer treatment services for eligible clients for a period of up to 24 months after the date that cancer treatment is initiated, **when services are provided by a Delaware Medical Assistance Provider.**

You will also find an application for the Delaware Medical Assistance Program. After reviewing your DCTP application, you may be eligible for more complete health benefits through this program including cancer treatment. In order to determine how we can best meet your needs, please be sure to complete and return **BOTH** applications.

This program is available to Delaware residents who:

- Were diagnosed with cancer on or after July 1, 2004
- Have no comprehensive health insurance OR maximum out-of-pocket expenses are more than 15 percent of income (does not include premiums)
- Do not receive benefits through the Medicaid breast and cervical cancer treatment program
- Meet income guidelines (up to 650 percent of the Federal Poverty Level)
- Are not eligible for health insurance

To apply, you must complete the following 8 steps:

1. Complete, sign and date the enclosed applications for DCTP and Medicaid.
2. Provide a clear copy of your photo ID
   *Please note: Photocopies of all immigration documents including those that are expired MUST be submitted in order to determine eligibility
3. Provide proof of Delaware Residence at time of diagnosis
4. Attach certificate of diagnosis document completed by your treating physician
5. Provide documentation of benefits covered by health insurance to include out of pocket costs before insurance will pay 100% of cancer treatment (if applicable)
6. Attach eligibility status for Health Insurance Marketplace, if uninsured
7. Attach proof of income, such as copies of your federal income tax form, check stubs, award letters, etc. as referenced below. You must indicate the source of income, how often you receive the income and the amount of income of gross income before taxes/deductions. Proof of income must be supplied for all household members.
8. Provide a legible copy of your birth certificate – required for Medicaid application processing only

Current Income to Report

Earnings from Work	Pensions/Retirement/Social Security	Other Income
❖ Wages/Salaries/Tips ❖ Unemployment Compensation ❖ Workers' Compensation ❖ Net Income from self-owned business or farm	❖ Pensions ❖ Retirement Income ❖ Veteran's Payments ❖ Social Security	❖ Disability Benefits ❖ Interest/Dividends ❖ Income from Estates/Trusts/Investments ❖ Net Rental Income ❖ Alimony ❖ Any Other Income

If you need assistance in completing your application or have questions: Please call the DCTP customer service line Monday through Friday from 8:00 a.m. to 4:30 p.m. at **1-844-245-9580.**

PLEASE SEND THE COMPLETED, SIGNED, & DATED APPLICATIONS IN THE RETURN ENVELOPE.
You will receive written notification of eligibility and the right to appeal.

Revised July 2023

Please complete and sign this form and return it using the self-addressed envelope.
Your eligibility for this program cannot be determined unless your application is signed and all documents requested are attached.

Delaware Cancer Treatment Program
Division of Public Health
C/O Gainwell Technologies
P.O. Box 950 Manor Branch
New Castle, DE 19720-0950
1-844-245-9580
Fax 302-454-0223

1. Applicant Information

Application type - Check one:

New_____Waiver ____

First Name	MI	Last Name	Social Security Number*	Marital Status	Household Size
			- - *Social Security Number is optional, however, providing it will help facilitate processing your application	☐ Married/Civil Union ☐ Divorced ☐ Widowed ☐ Never Married/Civil Union ☐ Separated	

Residence Street Address (cannot be a P.O. Box)	Apt. No.	City	Zip	County	Phone Number
Mailing Address (if different from above)	Apt. No.	City	Zip	County	Phone Number

Ethnicity	Race	Gender	Date of Birth	Do you have Health Insurance?
☐ Hispanic ☐ Non- Hispanic	☐ Alaskan ☐ Hawaiian ☐ White ☐ Pacific Islander ☐ Asian ☐ Other ☐ Black ☐ American Indian ☐ More than one race	☐ Female ☐ Male	/ / MM / DD / YYYY	☐ Yes ☐No If yes: Plan Name: Plan Phone Number:

If you are not a U.S. citizen or a U.S. national, do you have eligible immigration status? ☐ **Yes** ☐ **No**

If yes, please fill in your document type and ID number. _____

*Photocopies of all immigration documents including those that are expired MUST be submitted in order to determine eligibility.

Were you a Delaware resident at the time of your cancer diagnosis? ☐ **Yes** ☐ **No**

What was the date of your cancer diagnosis? _____/_____/ _____
MM DD YYYY

Do you currently live in Delaware and intend to remain in Delaware? ☐ **Yes** ☐ **No**

Name of Treating Physician:_____**Phone number:** _____

2. Income Information

Documentation (or Proof) should be provided with this application. Please send photocopies only, not original documents.
You, your spouse's/legal partner's, and other household members' income must be reported. Earnings, interest on savings and/or investments, Social Security, Veteran Benefit, cash given to you and any other income must be reported. If you have no income, please provide written explanation of how you are supported.

Rights and Responsibilities

I have read or have had read to me all of the statements on this form and the information I give is true and complete to the best of my knowledge. I understand that I could be penalized if I knowingly give false information.
I understand that all the information I give is confidential and federal and state laws limit disclosure of information about me.
I understand and agree to give proof of my statements. I understand that the Department of Health and Social Services may contact other persons or organizations to obtain the necessary proof of my eligibility.

Signature of Applicant or Representative Date

If representative, please print name, relationship and phone number

Name: Relationship: Phone:

Delaware Cancer Treatment Program
Certificate of Cancer Diagnosis
Medical Referral

Facility/Clinic: _____

Client Name: _____ DOB: _____

Cancer Diagnosis Code: _____

- Please enter the cancer diagnosis code and include the fourth/fifth digit of specificity. A three digit diagnosis code will not be accepted when a more specific code is available.

- Please enter the cancer treatment start date. Eligibility in the DCTP will begin on the cancer treatment start date. The Delaware Cancer Treatment Program does not cover the cost of services used to diagnose cancer unless those services are considered cancer treatment and are part of the cancer treatment plan. Coverage will not begin until cancer treatment services have been performed.

- The client must need treatment for cancer in the opinion of the applicant's licensed physician of record. Cancer treatment does not include routine monitoring for pre-cancerous conditions or monitoring for recurrence during or after remission.

Diagnosis Date:_____/_____/_____ **Treatment Start Date:**_____/_____/_____

MM DD YYYY MM DD YYYY

_____ _____

Physician Signature Date Physician Printed Name

_____ _____

Physician Phone Number Physician Fax Number

Please send the original certificate with the physician's signature and a completed DCTP Application.
Prescriptions for the treatment of cancer may require a Cancer Diagnosis written on them.

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

Delaware Cancer Treatment Program
Division of Public Health
C/O Gainwell Technologies
P.O. Box 950 Manor Branch
New Castle, DE 19720-0950
1-844-245-9580
Fax 302-454-0223

Revised/effective July 2023

DELAWARE HEALTH AND SOCIAL SERVICES (DHSS)
APPLICATION FOR FOOD BENEFITS, CASH, MEDICAL, AND CHILD CARE ASSISTANCE

Welcome to the State of Delaware Health and Social Services (DHSS)

Apply faster online

Apply faster online at www.assist.dhss.delaware.gov
This includes anyone wishing to apply for Medical Assistance only.

Who can use this application?

- Use this application to apply for anyone in your home including any tax dependents who are out of the home.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.
- If applying for Medical Assistance only, you may be able to use a short form.

What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants)
- Employer and income information for everyone in your household (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family. You may need to complete Appendix A.

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.**

What happens next?

Please use the stamped self-addressed envelope to mail your signed application. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow-up with you. You'll get instructions on the next steps. If you don't hear from us, call 1-800-372-2022.

Get help with this application

- **Phone:** Call our Customer Relations Unit at **1-800-372-2022.**
- **In person:** There may be social workers/case managers in your area who can help.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-866-843-7212.**
- **In a language other than English:** Call **1-866-843-7212.**
- **TTY users:** Call **711** or **1-800-232-5460.**

DELAWARE HEALTH AND SOCIAL SERVICES (DHSS)
APPLICATION FOR FOOD BENEFITS, CASH, MEDICAL, AND CHILD CARE ASSISTANCE

Welcome to the State of Delaware Health and Social Services (DHSS)

We help Delawareans in need by providing food benefits, medical, child care, and cash assistance. We can provide information about other helpful services in your community. You can answer only the questions related to the program(s) you are applying for. If you answer ALL the questions on the Assistance Application, we can see if you are eligible for all programs. A friend or relative, or anyone that you wish, may help you complete this application.

Your application is not complete until you sign the last page. Return the application to us.

At your interview, you will need to show us:

- Proof of who you are
- Proof of your address
- Proof of child care costs (only for cash assistance)
- Proof of money you have received in the last 30 days

STEP 1 Tell us about yourself.

(We need one adult in the household to be the contact person for your application.)

For which program(s) are you applying?

❑ Cash Assistance ❑ Food Benefits
❑ Medical Assistance ❑ Child Care

First Name, Middle Name, Last Name, & Suffix		
Home Address		
City	**State**	**Zip Code**
Mailing Address (if different from Home Address)		
City	**State**	**Zip Code**
Primary Telephone	**Secondary Telephone**	

Preferred Methods of Contact

I want to receive information about this application and future communication by: ☐ **Email Address** ☐ **U.S. Mail**

E-Mail Address: _____

Preferred spoken or written language (if not English)

If you wish to have someone else manage your case and act as your representative, please complete Appendix C.

For Food Benefits, the day we get this first page of the application with your name, address, and signature sets the date benefits may start if you sign and return the completed application to DHSS within 30 days.

_____ _____
Applicant's Signature (Required) **Date**

_____ _____
Authorized Representative's Signature **Date**

Delaware's Emergency Food Benefit

If your household has little or no income right now, you may be able to receive emergency food benefits within 7 days from the day we receive your completed application**.**

You may be able to get emergency food benefits in seven days if:

- Your household expects to receive less than $150 in income this month
- Your household does not have more than $100 in cash or bank accounts
- Your household is a migrant or seasonal farm worker household
- Your household's rent, mortgage, and utilities are more than your household's gross monthly income and liquid resources combined

Delaware's Food First Electronic Benefits Transfer (EBT) Card

We issue food benefits on an EBT card. To use your food benefits, you must have an EBT card and a Personal Identification Number (PIN). When we approve your benefits, our EBT vendor will mail your card to you if you never had one before. You can also go to a card issuance site to get your card.

In each of the headings in this application, you will see program symbols. These symbols will help you to identify the questions you must answer for the program(s) you are requesting.

Symbols	Programs
	**Medical Assistance Programs** (doctors, hospitals, prescriptions, labs, and x-rays) - free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP) - affordable, private health insurance plans through the Marketplace - a new tax credit that can immediately help pay your premiums for health coverage
	**Child Care Assistance** (help with the cost of child care)
	**Cash Assistance - Temporary Assistance for Needy Families (TANF) - General Assistance (GA) – Refugee Cash Assistance (RCA)**
	**Food Supplement Program** (help with monthly food expenses)
	**Signature Required**

Terms	Definition
Alien:	A person who is not a U.S. citizen
EBT card:	**E**lectronic **B**enefit **T**ransfer—a plastic card that you use at a store to buy food.
Eligible:	Meeting all of the guidelines to get benefits.
Household:	A person or a group of people who live together and buy food and fix meals together.
ABAWD:	Able Bodied Adult Without Dependents—An adult aged 18 through 50 years old, without dependents, and physically able to work.

STEP 2 Tell us about yourself and the people in your household.

Are you? ❑ Single ❑ Married ❑ Divorced ❑ Civil Union ❑ Separated ❑ Widowed ❑ Unmarried Partnership

Instructions

Fill in the blocks for all of the people who live with you. If you are applying for medical assistance and file taxes, we need to know about everyone on your tax return.

Race: B = Black/African American; W=White; PI = Native Hawaiian/Pacific Islander; A=Asian; I = American Indian/Alaskan Native (If anyone in your household is American Indian/Alaskan Native, also complete Appendix B.)

Ethnic Group: H=Hispanic/Latino; N=Non-Hispanic/Latino

Last Name	First Name, Middle Name	Relation to you	Are you applying for this person?	Sex M/F	Birth Date mm/dd/yyyy	Social Security Number*	Race/ Ethnic Group (optional)		U.S. Citizen? Answer for applicants only. **
		Self	❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No
			❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No
			❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No
			❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No
			❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No
			❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No
			❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No

***We need this if you want health coverage and have an SSN.** Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit **socialsecurity.gov.**
TTY users should call 1-800-325-0778.

****Applies to applicants for health coverage only.**

Complete this section for legal alien applicants only.

1. Do applicants have eligible immigration status? ❑ Yes. Complete the section below.

Name	Immigration Document Type	Document ID number	Have you lived in the U.S. since 1996?	Are you or your spouse or parent a veteran or an active-duty member of the U.S. military?

2. Has anyone ever received cash, food, or child care assistance in another state? ❑ Yes ❑ No

What benefits?_____ Name of state?_____Month/Year _____

3. Has anyone ever been disqualified for cash or food assistance in another state? ❑ Yes ❑ No

What benefits?_____Name of state?_____Month/Year _____

4. Is anyone in your household in violation of probation or parole or fleeing prosecution? ❑ Yes ❑ No
(Applies to TANF, food benefits, and general assistance.)

5. Has anyone been convicted of a drug felony after August 22, 1996? ❑ Yes ❑ No
(Applies to TANF and general assistance.)

6. Have you or any member of your household been convicted of trading food benefits for drugs after September 22, 1996?
(Applies to food benefits.) ❑ Yes ❑ No

7. Have you or any member of your household been convicted of buying or selling food benefits over $500 after September 22, 1996? (Applies to food benefits.) ❑ Yes ❑ No

8. Have you or any member of your household been convicted of fraudulently receiving duplicate food benefits in any state after September 22, 1996? (Applies to food benefits.) ❑ Yes ❑ No

9. Have you or any member of your household been convicted of trading food benefits for guns, ammunitions, or explosives after September 22, 1996? (Applies to food benefits.) ❑ Yes ❑ No

10. Answer the questions below if a parent(s) of any child under 18 does not live in your household.

Child's Name	Absent Parent's Name	Absent Parent's Date of Birth	Absent Parent's Social Security Number	Absent Parent's Address	Absent Parent's Employer

11. Are there any children under the age 19 living in the household? ❑ Yes ❑ No If yes, fill in below.

Parent or Caregiver's Name	Child's Name

STEP 3 Tell us about your health care.

Is anyone in your household offered health coverage from a job (even if the coverage is from someone else's job, such as a parent or spouse)? If yes, you'll need to complete Appendix A. ❑ Yes ❑ No

Is this a state employee benefit plan? ❑ Yes ❑ No

Other than Medicaid does anyone in your household have health insurance or Medicare? ❑ Yes ❑ No

If yes, provide the following information:

Name of Policy Holder	Name of Insurance	Who is Covered	Circle what is Covered	Policy Number
			Doctor · Hospital · Lab Tests · X-rays	
			Doctor · Hospital · Lab Tests · X-rays	
			Doctor · Hospital · Lab Tests · X-rays	

12. Name anyone in your household who is pregnant _____ due date _____
How many babies are expected during this pregnancy? _____

13. Name anyone who has a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, working, etc.) or live in a medical facility or nursing home _____.

14. Name anyone who was injured in the last 2 years (car accident, work related injury, medical malpractice, etc.). _____

15. Does anyone plan to file a tax return for current year? ❑ Yes ❑ No

(You can still apply for medical assistance even if you don't file a tax return.)

If yes, please fill in below and answer question A. If no, skip to question B.

Name of Tax Filer	Who will be claimed as a Tax Dependent

A. Will anyone file jointly with a spouse? ❑ Yes ❑ No

If yes, name of spouse: _____

B. Will you be claimed as a dependent on someone's tax return? ❑ Yes ❑ No

If yes, please list the name of the tax filer and how you are related to the tax filer: _____

_____

16. Do you want help paying for medical bills from the last 3 months? ❑ Yes ❑ No

17. Name anyone in your household who was in Delaware Foster Care at age 18 or older and received Delaware Medicaid Benefits: _____

STEP 4 Tell us about the money people in your household get.

❑ **Employed**
If anyone is currently employed, tell us about his or her income. Start with question 18.

❑ **Not employed**
Skip to question 30.

❑ **Self-employed**
Skip to question 28.

❑ CURRENT JOB 1

18. Please list the person's name:

19. Employer name and address

20. Employer phone number ( ) –

21. Wages/tips/commission (before taxes) ❑ Hourly ❑ Weekly ❑ Every 2 weeks ❑ Twice a month ❑ Monthly ❑ Yearly

$ _____

22. Average hours worked each WEEK

❑ CURRENT JOB 2

23. Please list the person's name:

(If your household has more jobs, attach another sheet of paper.)

24. Employer name and address

25. Employer phone number ( ) –

26. Wages/tips/commission (before taxes) ❑ Hourly ❑ Weekly ❑ Every 2 weeks ❑ Twice a month ❑ Monthly ❑ Yearly

$ _____

27. Average hours worked each WEEK

❑ SELF-EMPLOYMENT

28. Please list the person's name:

29. If self-employed, answer the following questions:

a. Type of Work

b. How much gross income will you get from this self-employment this month?

$

c. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$

30. ❑ **OTHER INCOME**

Where does the money come from?	Who gets the money?	How much do they get?	How often are they paid?
Social Security		$	
Supplemental Security Income (SSI)		$	
VA Benefits		$	
Pensions		$	
Retirement Accounts		$	
Unemployment Compensation		$	
Workers Compensation		$	
Child Support		$	
Alimony Received		$	
Work Study		$	
Money Earned from Interest or Dividends		$	
Net Farming/Fishing		$	
Net Rental/Royalty		$	
Other Income		$	

31. In the past year, did anyone: ❑Change jobs ❑Stop working ❑Start working fewer hours ❑None of these

Complete questions 32 - 34 for Food Benefits Only

32. Has anyone in your household quit a job in the last 30 days? ❑ Yes ❑ No

If yes, employer name _____

33. Is anyone in your household a migrant or seasonal worker? ❑ Yes ❑ No

If yes, who? _____

34. Is anyone in your household on strike? ❑ Yes ❑ No

If yes, who? _____

STEP 5 Which of the following do you have?

Complete this section for Cash Assistance Only

35. Does anyone in your household have any vehicles (don't include your car)?

❑ Yes ❑ No If yes, provide the following information:

Make	Model	Year	Amount Still Owed
			$
			$

36. Does anyone have or own any land, buildings, or houses other than the one you live in? ❑ Yes ❑ No

If yes, who owns it? _____

37. Does anyone receive income from these properties? ❑ Yes ❑ No

If yes, how much? $ _____

38. Does anyone in your household have any of the following?

Type of Account	Yes or No	Name on the account	Account Number	Balance
Bank or Credit Union	❑ Yes ❑ No			$
Stocks or Bonds	❑ Yes ❑ No			$
Savings Certificates	❑ Yes ❑ No			$
IRAs or Keogh	❑ Yes ❑ No			$
Trust Funds	❑ Yes ❑ No			$
Cash On Hand	❑ Yes ❑ No			$
Other	❑ Yes ❑ No			$

STEP 6 Tell us about your tax deductions.

Check all that apply, and give the amount and how often you pay it.
If you pay for certain things that can be deducted on a tax return, telling us about them could make the cost of health coverage a little lower.
NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 29c).

❑ Alimony paid $ _____ How often? _____

❑Student loan interest $ _____ How often?_____Type:_____

❑ Other tax deductions* $ _____ How often?_____

*For other potential deductions, refer to your current tax return form 1040 under the Adjusted Gross Income section.

STEP 7 Tell us about your medical expenses.

If you or anyone in your household has medical expenses and are age 60 or older, or blind, and/or receiving Federal disability benefits (SSA, SSI, VA), please list the name of the person and the amount of the medical expenses paid monthly.

Name		Name	
Hospitalization	$	Hospitalization	$
Prescription drugs	$	Prescription drugs	$
Doctor	$	Doctor	$
Eye Care	$	Eye Care	$
Dental	$	Dental	$
Insurance Premiums	$	Insurance Premiums	$
Transportation for medical care	$	Transportation for medical care	$
Other	$	Other	$

STEP 8 Tell us about your household expenses.

Please tell us about your bills. (Copies of bills may be needed.)

Shelter:

What are your shelter expenses (enter what you are required to pay)?

39. Rent: $_____ per month

Is this Section 8, HUD or other rental assistance? ❑ Yes ❑ No

Does your rent include meals (room and board)? ❑ Yes $_____ ❑ No

Or are you paying for meals only? ❑ Yes $_____ ❑ No

40. Mobile Home Lot Rent $_____ per month

41. Mortgage/ Mobile Home $_____ per month

42. Second Mortgage or Home Equity Loan $_____ per month

43. Homeowner's Insurance $_____ per month

44. Property Taxes $_____ per month

45. Special Assessment $_____ per month

46. Condominium/Association Fees $_____ per month

Utilities:

Check the boxes that apply and fill in the amount.

❑ Electric $ _____

❑ Air Conditioning (central or window unit) $ _____

❑ Heat (gas, electric, oil, propane, wood, kerosene) $ _____

❑ Gas (cooking) $ _____

❑ Water/Sewer $ _____

❑ Trash $ _____

❑ Telephone $ _____

❑ HUD/WHA/DSHA (utility allowance check) $ _____

❑ Excess Utilities Only $ _____

Other:

47. Dependent Care Expenses? ❑ Yes $_____ ❑ No

48. Legally-obligated Child Support Payments? ❑ Yes $_____ ❑ No

Reporting and Verifying Expenses:

Please be sure to enter all of your expenses so that you can qualify for the full amount of food benefits that you need. If you do not put an expense down, we will not be able to count it as we decide the amount of aid to give you.

- Shelter (rent/mortgage/lot) expenses;
- Real estate taxes;
- Water and sewage expenses;
- Phone expenses;
- Dependent care expenses;
- Homeowner's Insurance;
- Utility expenses (gas/electric/oil);
- Garbage expenses;
- Medical expenses;
- Child support expenses paid to children who do not live in your household.

Do You Need Child Care?

Please tell us why you need child care?

❑ Working ❑ High School or GED completion

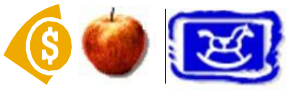
❑ Education/training (as part of DSS Employment & Training Program (E&T))

❑ Health (explain): _____

❑ Other (explain): _____

Child(ren)'s Name(s) Needing Child Care	How many hours needed?	Provider name, address and phone number	Provider ID number	DHSS Provider Or Self-arranged	Date Care Began

Is Anyone in Your Household in School?



Complete this section for Cash Assistance, Food Supplement, and Child Care Only

Complete the table for anyone in your household attending school, including trade school.

Person(s) In School	Name of School	Full/Part Time	Grade	Expected Graduation Date if 16 or Older

Authorizations

Authorization for Receipt of Pregnancy Prevention Information

If you wish to receive information, you can call Planned Parenthood at 1–800–230–PLAN (7526).

To get teen pregnancy information, call the Alliance for Adolescent Pregnancy Prevention at 1–800–499–WAIT (9248). You can also call the Delaware Helpline at 211 or 1–800–464–4357 for the Public Health Family Planning clinic in your area.

Penalties

For the Food Supplement, Cash and Medical Assistance Programs

Although providing Social Security Numbers is voluntary, you understand that if you fail to give Social Security Numbers you or a member of your household may be denied services. Your Social Security Number will be used to determine initial and ongoing eligibility. Non-lawful aliens are not required to give a Social Security Number.

We will use your Social Security Number to check information in our records with other Federal, State, and Local agency computer matching systems. If you give us false information on purpose, we will take legal action against you.

If you receive benefits that you should not get, you will be responsible to repay those benefits during your period of eligibility and after you are no longer receiving benefits.

An individual will not be able to get Food Benefits or Cash Assistance if:

- he/she is fleeing to avoid prosecution, custody or confinement after a conviction that is a felony, or
- violating a condition of probation or parole imposed under a Federal or State law

Penalties in the Cash Assistance Program

Do Not give false information or hide information to get or continue to get Cash Assistance.

If…	You will …
▪ Any member of your household breaks a Temporary Assistance for Needy Families (TANF) rule on purpose	▪ lose cash assistance for 12 months for the first violation ▪ lose cash assistance for 24 months for the second violation ▪ lose cash assistance permanently for the third violation
▪ Any applicant or recipient gives false information in order to obtain benefits	▪ be subject to penalties that include a fine of up to $500 and imprisonment up to 6 months
▪ Any member of your household is found guilty of misrepresenting his or her place of residence in order to get multiple benefits in two or more states for the same month from programs funded under TANF	▪ lose cash assistance for 10 years
▪ Any member of your household is convicted of a felony for having, using, or selling controlled substances	▪ lose cash assistance permanently

TANF Job Quit Penalties
If an individual quits a job without good cause the entire TANF case will close for one month or until the individual meets work and training requirements for four weeks in a row, whichever is later.

TANF Work and Training Penalties
When an individual does not comply with work and training the entire TANF case will close for one month or until the individual meets work and training requirements for four weeks in a row, whichever is later.

Penalties in the Food Supplement Program

If you…	You will lose food benefits…
▪ Hide information or make false statements ▪ Use EBT cards that belong to someone else ▪ Use food benefits to buy alcohol or tobacco ▪ Trade or sell benefits or EBT cards	▪ 12 months for the first offense ▪ 24 months for the second offense and ▪ permanently for the third offense
▪ Trade food benefits for controlled substances, such as drugs	▪ for 24 months for the first offense and ▪ permanently for the second offense
▪ Trade food benefits for firearms, ammunition or explosives	▪ Permanently
▪ Trade, buy or sell food benefits of $500 or more	▪ Permanently
▪ Give false information about who you are and where you live so you can get extra food benefits	▪ 10 years for each offense

You can also be fined up to $250,000 or put in prison for up to 20 years or both, for doing these things. You may also be charged under Federal laws.

The information you give us will be checked to make sure your household is eligible for food benefits and Cash Assistance. Federal, State, and Local officials will check the information you give us. The information you give us may also be checked by other Federal Aid programs and Federally-Aided State programs, such as School Lunch and Medicaid. If any information given is found to be incorrect, you may be denied Food Benefits/Cash Assistance. If you give false information on purpose, legal action may be taken against you. You may also have to pay back the amount of benefits you should not have received.

For Food Benefits
Nondiscrimination Statement

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

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.
USDA is an equal opportunity provider and employer.

For Cash Assistance, Medical Assistance, and Child Care

Nondiscrimination Statement

I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.

What You Need To Know About the Medical Assistance Program

For the Food Supplement, Cash and Medical Assistance Programs

I understand and agree:

- I will apply for and accept other benefits that I may be eligible to get such as Unemployment Compensation, Social Security, or Medicare.
- By law, as a condition of eligibility, I assign all rights to medical support and to payment for medical care from any third party to DHSS.
- To allow DHSS, directly or through its agents or the Diamond State Health Plan or the Delaware Healthy Children Program, to have access to all medical and school-based health and related services records of every member of my household who is eligible for Medical Assistance. This will allow DHSS to administer the medical assistance program, coordinate care, determine medical necessity, and evaluate or pay for pending or incurred medical services.
- I confirm that no one applying for medical assistance on this application is incarcerated (detained or jailed). If not,_____is incarcerated. I understand that I cannot receive Medical Assistance or CHIP benefits while incarcerated.

  We need this information to check your eligibility for help paying for medical assistance if you choose to apply. Your answers will be checked using information from electronic databases. If the information does not match, you may be asked to send proof.

Renewal of coverage in future years

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

Yes, renew my eligibility automatically for the next ❑ 5 years (the maximum number of years allowed), or for a shorter number of years:

❑ 4 years ❑ 3 years ❑ 2 years ❑ 1 year ❑ Don't use information from tax returns to renew my coverage.

I understand and agree:

- I will automatically receive child support services from the Division of Child Support Enforcement (DCSE).
- I must cooperate with DCSE in establishing paternity and obtaining medical support for any child receiving medical assistance.
- DCSE is authorized to deduct directly from my support payments, any and all monies owed to the Division of Social Services.
- I will not be eligible for benefits if I fail to cooperate with DCSE unless a good cause is established. My child(ren) may still be eligible.
- Pregnant women are not required to cooperate in establishing paternity and obtaining medical support.

Some Medicaid programs require you to enroll in a managed care organization.

To enroll in a managed care organization (MCO), call the Health Benefits Manager at 1-800-996-9969.

Disclosure of Information

For All Programs
All information and documentation gathered for determining your Cash Assistance, Food Supplement, Child Care and Medical Assistance eligibility or other program related use is confidential. Each program provides safeguards, restricting the use and disclosure of information about you to purposes directly connected with the administration of the program.

Releasing information concerning your eligibility to anyone not authorized to receive the information is a violation of State and Federal law and may result in legal action.

We will keep your eligibility information confidential, unless you give us permission to release information to others.

Certifications and Signatures

Certification of Citizenship and Alien Status
I certify, under penalty of perjury, that I, and any other members of my household, are U.S. citizens or aliens in lawful immigration status. Non-lawful aliens may be eligible for emergency services and labor and delivery only.

Certification of Head of Household Selection
I have read and have had explained to me the provisions about selecting a head of household. I have selected the following person to be the head of household and I certify that all adult members in my household agree to this selection.

_____
(Head of Household Designee)

Certification of Understanding and Accuracy of Application Answers
I understand the questions on this application and the penalty for hiding or giving false information or breaking any of the rules listed in the penalty warning. I certify, under penalty of perjury, that all my answers are correct and complete including information about the citizenship or alien status of each household member applying for benefits. I understand and agree to provide documents to prove what I have said. I understand and agree that DHSS may contact other persons or organizations to obtain the necessary proof of my eligibility and level of benefits.

I have read, or have had read to me, all statements on this form and the information I give is true and complete to the best of my knowledge. I understand that I could be penalized if I knowingly give false information. I

understand that all information I give is confidential and federal and state laws limit disclosure of information about me.

I agree to allow Delaware Health and Social Services, or its representatives, to act as my agent in recovering money spent by its medical assistance programs when other money from insurance, estates, etc. is available to pay my medical bills.

I have a right to request a Fair Hearing if I am not satisfied with any decision made about my eligibility or benefits. An attorney or any other person I choose may represent me.

I have read, or had read to me, and understand the current Rights and Responsibilities. I have received a copy of the Rights and Responsibilities from the DHSS worker.

The person who filled out step 1 should sign this application. If you are an authorized representative, you may sign here as long as you have provided the information required in Appendix C.

Applicant's Signature	**Date**	**Witness**
Authorized Representative's Signature	**Date**	**Witness**
Spouse/Partner's Signature **(Not required for medical assistance)**	**Date**	**Witness**

For Persons Who Cannot Speak English

Translation services were offered or a family member or other person was present to translate.

Translator's Signature	**Date**	**Phone Number & Agency/Relationship**

DELAWARE HEALTH AND SOCIAL SERVICES **APPENDIX A**

Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the **job** that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

EMPLOYEE Information

1. Employee name (First, Middle, Last)	2. Employee Social Security number _____-_____-_____

EMPLOYER Information

3. Employer name		4. Employer Identification Number (EIN) _____- _____
5. Employer address		6. Employer phone number ( ) –
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above) ( ) –	12. Email address	

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

☐ **Yes** (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name:_____ Name:_____ Name: _____

☐ **No (** Stop here and go to Step 5 in the application)

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15)
☐ No (Stop and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? **$** _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $_____
b. How often? ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Once a month ☐Quarterly ☐Yearly

Date of change (mm/dd/yyyy): _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below matches the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

EMPLOYEE Information

1. Employee name (First, Middle, Last)	2. Employee Social Security number _____-_____-_____

EMPLOYER Information

3. Employer name		4. Employer Identification Number (EIN) _____- _____
5. Employer address		6. Employer phone number ( ) –
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above) ( ) –	12. Email address	

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

☐ **Yes** (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name:_____ Name:_____ Name: _____

☐ **No (** Stop here and go to Step 5 in the application)

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15)
☐ No (Stop and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? **$** _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $_____
b. How often? ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Once a month ☐Quarterly ☐Yearly

Date of change (mm/dd/yyyy): _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Delaware Health and Social Services (DHSS) **APPENDIX B**

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First Name, Middle Name, Last Name)	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes **If yes**, tribe name No	☐ Yes **If yes**, tribe name No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	Yes No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? Yes No	Yes No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? Yes No
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	**$** _____ How often?_____	**$** _____ How often?_____

DELAWARE HEALTH AND SOCIAL SERVICES **APPENDIX C**

Assistance with Completing this Application

You can choose an authorized representative for

- ❑ Medical Assistance
- ❑ Cash Assistance
- ❑ Child Care
- ❑ Food Benefits
- ❑ EBT Card

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact the Delaware Health and Social Services (DHSS). If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First Name, Middle Name, Last Name, & Suffix)

2. Address		3. Apartment or Suite Number
4. City	5. State	6. Zip Code

7. Phone Number ( ) –

Authorized Representative For My EBT Card

I,_____want _____

Your Name **Your Representative's Name**

to be my representative to be issued an Electronic Benefit Transfer (EBT) card for my food benefit account and will be able to use it to purchase food. I understand that this gives the representative access to my food benefits and that any benefits spent by the representative will not be replaced.

8. Organization name	9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

10. Your signature	11. Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)

2. First Name, Middle Name, Last Name, & Suffix

3. Organization name	4. ID number (if applicable)