ACCESS FLORIDA APPLICATION

☒ Before You Begin

You are ready to start your application. Here is some important information when applying and what to expect.

Applying for Benefits

You may apply for help by giving us just your name, address, and signing your application. We encourage you to answer as many questions as you can, and sign your application today. This will allow us to help you more quickly. If you need help in completing this application or need interpreter services, there may be Community Partners in your area who can help. Visit our website at www.myflorida.com/accessflorida or contact our Customer Call Center at 1-866-762-2237 for more information. You may apply faster online at www.myflorida.com/accessflorida.

Processing Your Application

Processing begins with the date we receive your signed application. It may take 7 to 30 days to process your food assistance application. Expedited households may get food assistance benefits within seven days. Your answers on the application will decide if your household meets expedited food assistance criteria. Expedited households must have: 1. Monthly gross income less than $150 and liquid assets less than $150; 2. Monthly gross income plus liquid assets less than the household rent or mortgage plus utility costs; or, 3. Be a destitute migrant or seasonal farmworker with liquid assets less than $100. Applications for Medical Assistance and Temporary Cash Assistance may take 30 to 45 days, and Medical Assistance applications may take longer if we need to determine if someone is disabled. You may check the status of your application by visiting the ACCESS Florida website at http://www.myflorida.com/accessflorida and click on the "My ACCESS Account" link.

An Application for Assistance may be submitted to any Department of Children and Families Economic Self-Sufficiency Services office in the State of Florida by you, or by someone acting for you, in person, by mail, by facsimile (FAX), or electronically through the internet. Applications received during normal business hours are considered received the same day. When an application is received after normal business hours, it will be considered received on the first business day following its receipt. Food assistance benefits start from the date of application if the applicant meets all eligibility requirements, completes the interview, and provides all necessary eligibility information by the 30th day after the date of application. The household has the right to file an application form on the same day it contacts DCF, in an office, by phone, fax, in person, or electronically. Applicants do not have to complete the interview prior to filing the application. Receiving food assistance does not affect other program time limits. For an individual applying for food assistance and SSI at the same time, the filing date is the date of release from the institution or the actual date of receipt if filed after release. The collection of information on the application, including the SSN of each household member, is authorized under the Food and Nutrition Act of 2008 as amended, 7 U.S.C. 2011-2036. The information will be used to determine whether your household is eligible, or continues to be eligible to participate in food assistance. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management. The household cannot be denied food assistance benefits solely because of the denial of other program benefits.

Head of Household

The household may select an adult parent of children (of any age) living in the household, or an adult who has parental control over children (under 18 years of age) living in the household, as the head of household provided all adult household members agree to the selection. Households may select the head of household at application, at each review, or when there is a change in household composition. If all adult household members do not agree to the selection, or decline to select an adult parent as the head of household, the state agency may designate the head of household or permit the household to make another selection. If the household does not consist of adult parents and children or adults who have parental control of children living in the household, the state agency shall designate the head of household or permit the household to do so.

Social Security Number

We may treat household members who are ineligible, or who are not applying for benefits, as non-applicants. Non-applicants, or persons applying only for Emergency Medical Assistance for Aliens, Refugee Cash Assistance, or Refugee Medical Assistance, do NOT need to give a Social Security Number (SSN). If you were not eligible for an SSN because of your immigration status, you may be eligible for a non-work SSN. If you need an SSN, we can help you apply for one. Non-applicants do NOT need to give proof of immigration status. Noncitizens who are applying for benefits will have their immigration status verified with the U.S. Citizenship and Immigration Services (USCIS). We will not tell USCIS about the immigration status of those living in your household who are not applying for benefits.

Important Information for Immigrants

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

Public Assistance Fraud / Notice of Penalties
If you are found guilty (by a state or federal court, or an administrative disqualification hearing, or sign a hearing waiver) of intentionally making a false or misleading statement, concealing or withholding facts in order to receive or in an attempt to receive food assistance or Temporary Cash Assistance (TCA) or committing any act that violates the Food and Nutrition Act of 2008, food assistance regulations, or any state statute for purposes of using, presenting, transferring, acquiring, receiving, or possessing food assistance benefits, you will be disqualified. You will be ineligible for food assistance or TCA for 12 months for the first violation, 24 months for the second violation, and permanently for the third violation. If you are convicted of trafficking food assistance benefits of $500 or more, you will be disqualified permanently. Trafficking of food assistance includes:

1. Buying, selling, stealing, or exchanging benefits for cash;
2. Exchanging firearms, ammunition, explosives, or illegal drugs for benefits;
3. Buying sodas, water, or other items in a container to get the cash deposit;
4. Buying an item with food assistance and then purposely selling the item for cash; and
5. Trading cash for items paid for with food assistance benefits.

If you are convicted of these acts, depending on the severity, you may be fined up to $250,000, imprisoned for up to 20 years, or both. You may also be subject to prosecution under other applicable Federal and State Laws. You may be barred from receiving food assistance for an additional 18 months if court ordered. If you are convicted by a state or federal court of making a fraudulent statement with respect to identity or residency in order to receive food assistance or TCA in more than one state at the same time, you will be ineligible to participate in the Food Assistance Program or TCA for a period of 10 years.

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

If you are found guilty of a drug-trafficking felony after 8/22/96, or convicted by a federal, state, or local court of trading firearms, ammunition, or explosives for food assistance benefits, you are ineligible for food assistance. If you are convicted of using or receiving food assistance benefits in a transaction involving the sale of a controlled substance, you will be ineligible 24 months for the first violation and permanently for the second violation. Households must not use food assistance benefits to purchase nonfood items, pay on credit accounts, pay for food purchased on a credit account, use or possess the Electronic Benefits Transfer (EBT) cards of others, allow unauthorized use of the household's EBT card by non-household members, sell or trade EBT cards, or use someone else's EBT card. If a food assistance claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action.

Income and Eligibility Verification System (IEVS)
We will request information through computer matches in IEVS and may verify the information if we find differences based on the answers you gave on your application. We may use the information found in IEVS to affect your eligibility and level of benefits.

Reporting Requirements
For all programs, households are encouraged to report any change in the household living and/or mailing address. For programs except Food Assistance (SNAP), households must report changes in who lives in the household, employment, and income. Food Assistance (SNAP) households must report when the total monthly household gross income exceeds 130% of the federal poverty level for the household size and when the work hours of able-bodied adults fall below 20 hours per week when averaged monthly, by the 10th of the month after the month of the change. Households receiving Medicaid or Temporary Cash Assistance must report changes within 10 days.

Requesting a Fair Hearing
You have the right to ask for a hearing before a state hearings officer. You can bring with you or be represented at the hearing by a lawyer, relative, friend, or anyone you choose. If you want a hearing, you must ask for the hearing by writing, calling the Customer Call Center, or coming into the office within 90 days from the mailing date of your notice of case action. If you ask for a hearing by the end of the last day of the month prior to the effective date of the adverse action, your benefits may continue at the prior level until the hearing decision. You will be responsible to repay any benefits continued if the hearing decision is not in your favor. If you need information about how to receive free legal advice, you can call the Customer Call Center toll free at 1-866-762-2237 for a listing of free legal agencies in your area.

Medical Assistance Applications
Use this application to see what coverage choices you qualify for such as free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP), affordable private health insurance plans that offer comprehensive coverage to help you stay well, and a new tax credit that can immediately help pay your premiums for health coverage. To complete your application, you may need social security numbers, document numbers for legal immigrants, employer and income information for everyone in your family, policy numbers for current health insurance, and job-related health insurance information. Please send copies not originals.

What Happens Next
Submit your signed application at any Department of Children and Families Economic Self-Sufficiency Services office or mail your application to ACCESS Central Mail Center, P.O. Box 1770, Ocala, FL 34478-1770. You may fax your application to a Customer Service Center in your area. Find a local fax number at http://www.myflfamilies.com/service-programs/access-florida-food-medical-assistance-cash/locate-service-center-your-area.

ACCESS FLORIDA APPLICATION

MYFLFAMILIES.COM

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

APPLICANT INFORMATION

Name: (Head of Household – see "Before You Begin" section)

First Middle Last

Home Address: (Leave blank if you do not have one.)

Street Apt. No. City State Zip Code County

Address where you get your mail: (if different from where you live)

Street/P. O. Box City State Zip Code

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

E-Mail Address:

Do you want to get information about this application by email? ☐ **YES** ☐ **NO**

Do you have a reason that makes it difficult for you to come to the office for an interview?

☐ Illness ☐ Transportation ☐ Work or Training ☐ Live in a Rural Area ☐ Care for a sick or Disabled Household Member ☐ Other (explain): _____

What is your preferred spoken or written language (if not English)? _____

STATEMENT OF UNDERSTANDING

I understand that information that I provide with this application, interview, or when requesting other benefits, including computer information matches with other agencies, is subject to verification by DCF and other Federal and State agencies including Division of Public Assistance Fraud (DPAF). I understand and agree to the following: DCF, DPAF, and authorized Federal Agencies may verify the information I give on this form, interview, or when requesting other benefits. Information may be obtained from my past or present employers. My signature authorizes release of such information to DCF and/or DPAF. As a condition of participation in Medicaid, I consent to review and release of all medical records deemed necessary by Medicaid under its auditing and investigatory powers. If any information is incorrect, benefits may be reduced or denied and I may be subject to criminal prosecution or disqualified from the program for knowingly providing incorrect or false information or hiding information. I have read my Rights and Responsibilities. I certify under penalty of perjury that the information on this form is true to the best of my knowledge, including the citizen or noncitizen status of those who are applying for benefits. I hereby acknowledge receipt of the Florida DCF CFOP 60-17, Chapter 1, Attachment 3, Notice of Privacy Practices.

SIGNATURES

Signature of Adult Household Member / Date Signed

Signature of Witness if signed with an "X"

Authorized/Designated Representative – Please print

Name	
Address	Phone Number

Signature of Authorized/Designated Representative

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

EXPEDITED FOOD ASSISTANCE: Eligible households may receive benefits within 7 days.

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

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

In Sections A and B, list yourself and all people living in your home even if you are not applying for them. If you are not applying for a member, you do not have to give their SSN or citizenship status. Include your spouse, your children under 21 who live with you, anyone you include on your tax return, even if they do not live with you, and anyone else under 21 who you take care of and lives with you. If living in a nursing home or other institutional arrangement, list only self, spouse and dependents.

ETHNICITY (Voluntary/Optional Information): **A** = Hispanic or Latino or, **B** = Not Hispanic or Latino

RACE (Voluntary/Optional Information): You may choose one or more numbers: **1** – American Indian or Alaskan Native; **2** – Asian or Pacific Islander; **3** – Black or African American, Not of Hispanic Origin; **4** – White, Not of Hispanic Origin; **5** – Southeast Asian; **6** – Other; or, **7** – Unknown. This will not affect eligibility or the level of benefits. The reason we ask for this information is to assure program benefits are distributed without regard to race, color, or national origin.

SECTION A – List All Adults Living At Your Address

Adult's Legal Name First, Middle, Last	Want to Apply?	Sex	Social Security Number (see instructions above)	Date and Place of Birth*	U.S. Citizen	Ethnicity (see above)	Race (see above)	Marital Status	Attends School/ # Hours / Week/ Last Grade Completed*	Buys and Eats Food with You
1. Relationship to you: **SELF**	☐ **Yes** ☐ **No**	☐ **F** ☐ **M**			☐ **Yes** ☐ **No** **USCIS #**	☐ **A** ☐ **B**	☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7**		☐ **Yes** ☐ **No** **# hours per week:** *** Last Grade Completed:**	☐ **Yes** ☐ **No**
2. Relationship to you:	☐ **Yes** ☐ **No**	☐ **F** ☐ **M**			☐ **Yes** ☐ **No** **USCIS #**	☐ **A** ☐ **B**	☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7**		☐ **Yes** ☐ **No** **# hours per week:** *** Last Grade Completed:**	☐ **Yes** ☐ **No**
3. Relationship to you:	☐ **Yes** ☐ **No**	☐ **F** ☐ **M**			☐ **Yes** ☐ **No** **USCIS #**	☐ **A** ☐ **B**	☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7**		☐ **Yes** ☐ **N** **# hours per week:** *** Last Grade Completed:**	☐ **Yes** ☐ **No**
4. Relationship to you:	☐ **Yes** ☐ **No**	☐ **F** ☐ **M**			☐ **Yes** ☐ **No** **USCIS #**	☐ **A** ☐ **B**	☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7**		☐ **Yes** ☐ **No** **# hours per week:** *** Last Grade Completed:**	☐ **Yes** ☐ **No**

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

Child's Legal Name First, Middle, Last	Want to Apply?	Sex	Social Security Number (see instructions above)	Date and Place of Birth*	U.S. Citizen	Ethnicity (see page 2)	Race (see page 2)	*Child under Age 5 Immunized	Attends School/ School Name/	*Date To Graduate	Buys and Eats Food with You
1. Relationship to you	☐ Yes ☐ No	☐ F ☐ M			☐ Yes ☐ No USCIS #	☐ A ☐ B	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7	☐ Yes ☐ No	☐ Yes ☐ No School Name:		☐ Yes ☐ No
2. Relationship to you	☐ Yes ☐ No	☐ F ☐ M			☐ Yes ☐ No USCIS #	☐ A ☐ B	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7	☐ Yes ☐ No	☐ Yes ☐ No School Name:		☐ Yes ☐ No
3. Relationship to you	☐ Yes ☐ No	☐ F ☐ M			☐ Yes ☐ No USCIS #	☐ A ☐ B	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7	☐ Yes ☐ No	☐ Yes ☐ No School Name:		☐ Yes ☐ No
4. Relationship to you	☐ Yes ☐ No	☐ F ☐ M			☐ Yes ☐ No USCIS #	☐ A ☐ B	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7	☐ Yes ☐ No	☐ Yes ☐ No School Name:		☐ Yes ☐ No

SECTION C – ABSENT PARENT INFORMATION: Provide the following information for each child in Section B whose mother and/or father is not in the home.

		Name, Address, Phone number	Date of Birth	Social Security Number	Race (see page 2)	Reason for Absence	Child's Legal Parent?
Child 1	Mother						☐ YES ☐ NO
	Father						☐ YES ☐ NO
Child 2	Mother						☐ YES ☐ NO
	Father						☐ YES ☐ NO
Child 3	Mother						☐ YES ☐ NO
	Father						☐ YES ☐ NO
Child 4	Mother						☐ YES ☐ NO
	Father						☐ YES ☐ NO

SECTION D – GENERAL INFORMATION: Answer the following questions about the people listed in Sections A and B who are applying for assistance.

Is anyone in your home fleeing the law due to a felony or a probation or parole violation?
☐ **YES** ☐ **NO** **If yes, who?**

Has anyone in your home sold or given away any property or assets in the last 3 months (food assistance purposes) or 5 years (Medicaid)?
☐ **YES** ☐ **NO** **If yes, who?**

Has anyone in your home been convicted of a drug trafficking felony including agreeing, conspiring, combining, or confederating with another person to commit the act committed after 8/22/1996? ☐ **YES** ☐ **NO** **If yes, who?**

Did anyone in your home quit a job in the last 60 days or is anyone on strike?
☐ **YES** ☐ **NO** **If yes, who?**

Has anyone in your home been convicted on or after 8/22/96, of receiving food assistance, temporary cash assistance, or Medicaid in more than one state at the same time? ☐ **YES** ☐ **NO** **If yes, who?**

Has anyone in your home received food, cash, or medical assistance from another state or source in the last 30 days?
☐ **YES** ☐ **NO** **If yes, who?**

Is everyone a resident of the state of Florida? ☐ **YES** ☐ **NO** **If no, who is not?**

Is anyone in the household pregnant? ☐ **YES** ☐ **NO** **If yes, who?**
Due Date: **Number of Babies Due:**

*Has anyone attended a school conference for any of the children who are ages 6-18?
☐ **YES** ☐ **NO** **If yes, who?** **When?**

Is anyone in your household a sponsored noncitizen? ☐ **YES** ☐ **NO** **If yes, who?**

Is anyone living in a special setting such as a homeless shelter, drug treatment center, nursing home, assisted living facility, adult family care home, mental health residential treatment facility, or other institution?
☐ **YES** ☐ **NO** **If yes, who?**
Facility name and Type:

Is anyone a foster child? ☐ **YES** ☐ **NO** **If yes, who?**

Was anyone in Florida foster care at age 18 or older? ☐ **YES** ☐ **NO** **If yes, who?**

*If you are applying for nursing home type services, do you have a child (of any age) living in your home who is blind or disabled?
☐ **YES** ☐ **NO** **If yes, who?** **What is their relationship to you?**

Has anyone been determined disabled by Social Security or the State of Florida? ☐ **YES** ☐ **NO** **If yes, who?**

*Has anyone been denied Supplemental Security Income (SSI) in the past 90 days?
☐ **YES** ☐ **NO** **If yes, who?** **When?**

*Does anyone in your household need help with Medicare premiums or medical bills from the past three (3) months?
☐ **YES** ☐ **NO** **If yes, who?**

*Does anyone who was denied for disability have a new medical condition not considered by the Social Security Administration?
☐ **YES** ☐ **NO** **If yes, who?**

Is anyone in your household a victim of human trafficking? (Victims of human trafficking are people taken, kept, or moved by force or fraud for sexual exploitation or forced labor.) ☐ **YES** ☐ **NO** **If yes, who?**

Have you or any member of your household been convicted of trading food assistance benefits for drugs, convicted of buying or selling food assistance benefits over $500, or convicted of trading food assistance benefits for guns, ammunitions, or explosives?
☐ **YES** ☐ **NO** **If yes, who?**

Does anyone in the household pay for a room (Roomer) or for room and meals (Boarder)?
☐ **YES** ☐ **NO** **If yes, who?**

*Does anyone have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical faciltiy or nursing home? ☐ **YES** ☐ **NO** **If yes, who?**

*Is any child limited or prevented in any way in his or her ability to do the same things most children of the same age do?
☐ **YES** ☐ **NO** **If yes, who?**

*Does anyone need or get special therapy, such as physical, occupational or speech therapy, or treatment or counseling for an emotional, developmental, or behavioral problem? ☐ **YES** ☐ **NO** **If yes, who?**

*Does any child need or use more medical care, mental health, or educational services than is usual for most children of the same age?
☐ **YES** ☐ **NO** **If yes, who?**

SECTION E – ASSETS: Answer the following questions about the people listed in Sections A and B who are applying for assistance. If you need extra space in the following sections, please use extra pages.

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

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

*DCF must determine the value of assets of Medicaid applicants and recipients of aged (65 or older), blind, or disabled individuals. Applicants and recipients must agree to allow DCF to ask for financial records from any bank, savings and loan, credit union, or other financial institution by completing the Financial Information Release, form CF-ES 2613.

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

Are any of the above assets set aside to cover burial expenses? ☐ **YES** ☐ **NO** **If yes, which?** **Amount?**

Has anyone closed bank accounts or other investments, added anyone to the title of an asset, given away assets or property, or liquidated assets greater than $3,000 to buy another asset or service in the last 3 months (food assistance) or 5 years (Medicaid)? ☐ **YES** ☐ **NO**

If yes, who?

What? **When?** **Value?**

Are any assets jointly owned with a person that does not live with you? ☐ **YES** ☐ **NO**

If yes, who?

What? **When?** **Value?**

YOU CAN APPLY TO REGISTER TO VOTE HERE

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

☐ **YES** ☐ **NO**

NOTICE OF RIGHTS

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

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

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

Formal Complaint: If you believe someone has interfered with either your right to apply to register or to decline to register to vote, your right to privacy in deciding whether to apply to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with: Florida Secretary of State, Division of Elections, NVRA Administrator, R.A. Gray Building, 500 S. Bronough Street, Tallahassee, Florida 32399-0250. Forms for filing a complaint are available at http://election.dos.state.fl.us/nvra/index.shtml or call 1-850-245-6200. For complaints not related to voter registration, see "**USDA-HHS NON DISCRIMINATION STATEMENT**" on the last page of this application.
[Authority: National Voter Registration Act (42 U.S.C. 1973 gg); ss. 97.023, 97.058 and 97.0585, F.S.]

SECTION F – INCOME: Answer the following questions about the people listed in Sections A and B who are applying for assistance.

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

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

Has anyone's income in the household ended or had their work hours reduced in the last 60 days or the past year? ☐ **YES** ☐ **NO**
If yes, who? **When?** **Source?**

Will anyone in your household receive additional income from the source that ended? ☐ **YES** ☐ **NO** **Gross amount (before deductions received in this month only?** $
If yes, who? **When?**

Does anyone have a pending application for Social Security or Unemployment Compensation benefits? ☐ **YES** ☐ **NO**
If yes, who? **Which Benefit?**

Have deposits been made to Income or Miller Type Trusts in any of the past 3 months? ☐ **YES** ☐ **NO** **If yes, whose trust?** **Date(s) and amount of deposit(s)?**

If self-employed, what is the type of work? Monthly net income amount (profits after paying business expenses): $

*Do you plan to file a federal income tax return NEXT YEAR? ☐ **YES** ☐ **NO** **If yes, answer the questions below:**
*Will you file jointly with your spouse? ☐ **YES** ☐ **NO** **If yes, what is your spouse's name?**
*Will you claim any dependents on your tax return? ☐ **YES** ☐ **NO** **If yes, list the names of dependents:**
*Will someone else claim you as a dependent on their tax return? ☐ **YES** ☐ **NO** **If yes, what is the name of the tax filer?** **How are you related to this tax filer?**

*Is anyone listed on this application offered health coverage from a job? ☐ **YES** ☐ **NO** **If yes, who?**

*Who can we contact about employee health coverage at this job?

*Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months? ☐ **YES** ☐ **NO**

*Does the employer offer a health plan that meets the minimum value standard? ☐ **YES** ☐ **NO** [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.]

*For the lowest-cost plan that meets the minimum value standard offered to the employee (don't include family plans): If the employer has wellness programs, provide the premium the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive another discount based on wellness programs. How much would the employee have to pay in premiums for this plan? $
How often? ☐ **Weekly** ☐ **Biweekly** ☐ **Monthly** ☐ **Quarterly** ☐ **Yearly**

*What change will the employer make for the new plan year? ☐ **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. How much will the employee have to pay in premiums for that plan?** $
How often? ☐ **Weekly** ☐ **Biweekly** ☐ **Monthly** ☐ **Quarterly** ☐ **Yearly** **Date of change?**

SECTION G – EXPENSES: Answer the following questions about the people listed in Sections A and B who are applying for assistance.

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

Failure to report and/or verify any of the listed expenses will be considered as a statement by the household that they do not want to receive a deduction for the unreported expense.

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

How do you heat or cool your home?

Does anyone help you pay expenses? ☐ **YES** ☐ **NO** **If yes, who?**

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. You should not include a cost you already considered in your answer to net self-employment. Check all that apply, give the amount, and how often you pay it.

☐ **Alimony paid** $ ……**How often?**

☐ **Student loan interest** $ ……**How often?**

☐ **Other deductions, Type:** ……**How often?**

SECTION H – YOUR FAMILY'S HEALTH COVERAGE: Answer the questions for anyone who needs health coverage.

*Is anyone enrolled in health coverage now from any of the following? ☐ **YES** ☐ **NO** **If yes, write their name(s) next to the coverage they have.**

☐ Medicaid: _____

☐ Medicare: _____

☐ VA health programs: _____

☐ Employer insurance: _____

Name of Insurance: _____

Name of person insured: _____

Policy number: _____

Is this COBRA coverage? ☐ **YES** ☐ **NO**

Is this a retiree health plan? ☐ **YES** ☐ **NO**

☐ Florida KidCare: _____

☐ TRICARE: _____
(for TRICARE, do not check if you have direct care or Line of Duty)

☐ Peace Corps: _____

☐ Other: _____

Name of Health Insurance: _____

Name of person insured: _____

Policy number: _____

Is this a limited-benefit plan (like school accident policy)?
☐ **YES** ☐ **NO**

*Has anyone voluntarily canceled health insurance for children in the last two months for any of these reasons?

☐ The cost of an applicant child's health insurance is more than 5% of your family's income.

☐ Domestic violence led to the loss of coverage for an applicant child.

☐ Parent lost a job that provided employer-sponsored coverage for an applicant child.

☐ The coverage does not cover the applicant child's health care needs.

☐ Parent who had the health coverage for an applicant child is deceased.

☐ The employer providing the applicant child's coverage canceled the coverage.

☐ The applicant child's coverage ended because the child reached the maximum lifetime coverage limit or an annual benefit limit.

☐ An applicant child has a medical condition that, without medical care, would cause serious disability, loss of function, or death.

☐ The applicant child's parent canceled COBRA coverage or the COBRA coverage reached its legal limit.

☐ A non-custodial parent dropped the applicant child's coverage.

YOU MAY BE ELIGIBLE FOR REDUCED TELEPHONE RATES

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

SECTION I – AMERICAN INDIAN OR ALASKA NATIVE FAMILY MEMBER: Complete this section if you or a family member are American Indian or Alaska Native.

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

Name First, Middle, Last	Member of a Federally recognized tribe	Has this person ever received 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 yes, tribe name:**	☐ **YES** ☐ **NO**	If no, is this person eligible to get services from one of these programs? ☐ **YES** ☐ **NO**
	☐ **YES** ☐ **NO** **If yes, tribe name:**	☐ **YES** ☐ **NO**	If no, is this person eligible to get services from one of these programs? ☐ **YES** ☐ **NO**
	☐ **YES** ☐ **NO** **If yes, tribe name:**	☐ **YES** ☐ **NO**	If no, is this person eligible to get services from one of these programs? ☐ **YES** ☐ **NO**
	☐ **YES** ☐ **NO** **If yes, tribe name:**	☐ **YES** ☐ **NO**	If no, is this person eligible to get services from one of these programs? ☐ **YES** ☐ **NO**

*Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income 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?** ☐ **YES** ☐ **NO**

If yes, who? **Amount:** $

☐ **Payments from natural resouces, farming, ranching, fishing, leases, or royalties from land by the Department of Interior (including reservations and former reservations?** ☐ **YES** ☐ **NO**

If yes, who? **Amount:** $

☐ **Money from selling things that have cultural significance?** ☐ **YES** ☐ **NO**

If yes, who? **Amount:** $

AUTHORIZED REPRESENTATIVE

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 are a legally appointed representative for someone on this application, submit proof with the application. By entering the information on page 1, 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.

FOR CERTIFIED APPLICATION COUNSELORS, NAVIGATOR, AGENTS, AND BROKERS ONLY: Complete this section if you are a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

Application start date (mm/dd/yyyy): ______________________

Name: First, Middle, Last: ______________________

Organization Name and ID number (if applicable): ______________________

SIGNING THIS APPLICATION: By signing this application you are confirming and attesting that:

- *No one applying for health insurance on this application is incarcerated.
- *The information provided on this application establishes the identity of children under age 16.
- You have read and understand your rights and responsibilities.
- *You are giving the Medicaid agency rights to pursue and get any money from other health insurance, legal settlements, or other third parties. You are also giving the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- *You know this information will be used to check your eligibility for help paying for health coverage if you choose to apply. We will check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, Department of Homeland Security, and/or a consumer reporting agency.

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES NON-DISCRIMINATION STATEMENT

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

USDA-HHS NON-DISCRIMINATION STATEMENT

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 Department of Children and Families, where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at http://www.fns.usda.gov/snap/contact_info/hotlines.htm. To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY). This institution is an equal opportunity provider.

YOUR RIGHTS AND RESPONSIBILITIES

YOU HAVE THE RIGHT TO:

- Apply for help and to have your eligibility decided without us looking at your race, color, sex, age, disability, religion, national origin (place of birth), or political belief. If you have a disability that limits you in any way, please tell us so we can make accommodations to assist you. The Department of Children and Families (DCF) is an equal opportunity provider.
- 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 Department of Children and Families where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm. To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS) write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY). This institution is an equal opportunity provider.
- Apply for help on-line through our web application. Or you can turn in a paper application at a local service center or a community partner, or you can mail or fax it. You can turn in an incomplete application (either web or paper), as long as it has your name and address on it, and is signed by you, or another responsible member of your household, or someone acting for you as your authorized or designated representative.
- Be interviewed and notified of your eligibility within 30 days from when you turned in a signed application (90 days for Medicaid if your disability is considered in deciding your eligibility).
- Have DCF staff, or someone else, help you fill out forms. Let us know if you need help getting information we need.
- Receive, or have someone receive for you, the benefits for which you are eligible and be notified quickly of any action we take on your application or any change we make in your benefits.
- Be told about other programs we have that might help you or your family.
- Ask for a hearing before a state hearings officer. You can bring with you or be represented at the hearing by a lawyer, relative, friend or anyone you choose. If you want a hearing, you must ask for the hearing by writing, calling the Customer Call Center or coming into the office within 90 days from the mailing date of your notice of case action. If you ask for a hearing by the end of the last day of the month prior to the effective date of the adverse action, your benefits may continue at the prior level until the hearing decision. You will be responsible to repay any benefits continued if the hearing decision is not in your favor. If you need information about how to receive free legal advice, you can call the ACCESS Florida Customer Call Center toll free at 1-866-762-2237 for a listing of free legal agencies in your area.
- Have the information received by us about you or the people in your household protected as required by federal and state laws.
- Name the adult parent of children or someone acting in the role of parent as the payee (the person who will receive your food assistance benefits). If there are no children in your assistance group, then the payee must be the person who earns the most money.

YOU HAVE THE RESPONSIBILITY TO:

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

- Give us complete and correct proof of requested information, within the time limits given to you, to determine if you are eligible for help.
- Use your temporary cash assistance benefits to the best benefit of the children in the assistance group. Florida law says that anyone who uses the money given for the support of a child or children for some other reason can be fined, sent to jail, or both.
- Declare the U.S. citizenship or noncitizen status of your household members, who are applying for help, by signing the application for assistance. You must provide proof of noncitizen status, from the United States Citizenship and Immigration Services (USCIS), for all persons who are not U. S. citizens for whom you are requesting help. We may ask USCIS to confirm this information. Information received from USCIS may affect your eligibility and amount of benefits. Proof of USCIS status is not required for individuals for whom you are not asking help.
- Apply for benefits from other sources if this application, or information received by us, shows that you might be eligible for those benefits. (This does not apply to the Food Assistance Program.)
- Assign your rights to child support to the state and cooperate with Child Support Enforcement (CSE) in establishing paternity and obtaining support from an absent parent of the children who are in your care, unless you can show CSE good cause for not doing so. (For the Temporary Cash Assistance Program, you must assign your rights to the state. Assigning rights to the state does not apply to the Food Assistance Program.)

(continued on next page)

- Report any insurance or other health plan which may pay medical costs for you or a member of your household for whom you are asking help. You must also assign the state your rights to any payments from insurance or other health plans, unless you can show us good cause for not doing so. (This applies to anyone asking for or receiving help from the Temporary Cash Assistance, Refugee Assistance or Medicaid Programs.)
- Participate in the work activities of the Food Assistance, Temporary Cash Assistance and Refugee Assistance Employment and Training Programs. This includes registering for employment, unless we have told you that you don't have to do so.
- Report to us, within 5 calendar days, if a child in your family is expected to be out of the home for 30 days or more. (This applies to the Temporary Cash Assistance Program only). Report to us, any change in your situation according to program requirements.
- If your household only receives food assistance, report when your household's gross monthly income goes higher than the 130% gross income limit for your household size by the 10th day of the month after the month of the change. If your household receives Temporary Cash Assistance and/or Medicaid (with or without food assistance), you must report changes within 10 days, including any change in the household living and/or mailing address. Report any change in the household email address for contact purposes.
- For food assistance, an able-bodied adult without dependents is ages 18 through 49; physically or mentally fit for employment; does not live and eat with a child under age 18; is not pregnant; and is not exempt from food assistance general employment program work requirements. Able-Bodied Adults Without Dependents must report when their hours of work fall below 20 hours per week averaged to 80 hours per month.
- Make sure that your school age child (ages 6 through 17) attends school. If your child is identified as truant or a drop out, that child may be removed from your Temporary Cash Assistance and your cash benefit amount lowered, unless you can show that the child has good cause for missing school. (This applies to the Temporary Cash Assistance Program only.)
- Have a conference with a school official for each school age child (ages 6 through 17) during each semester to talk about the child's schoolwork progress or problems at school. If you fail to have this conference, you may be removed from the Temporary Cash Assistance and your cash benefit amount lowered, unless you can show that you have good cause for not having the conference. (This applies to the Temporary Cash Assistance Program only.)
- Have your preschool age children's (ages 0 through 4) immunizations up-to-date. (This applies to the Temporary Cash Assistance Program only.)
- Cooperate with state and federal officials when they review your case and answer their questions if you are able.
- Repay the Department of Children and Families for any benefits received for which you are not eligible. The amount owed can be subtracted from your monthly cash assistance payments or food assistance benefits until the entire amount is paid back. If a Medicaid overpayment occurs, you will have to personally repay the amount.
- Give us the Social Security Number (SSN), or apply for a SSN, for all household members for whom you're asking help. This applies to the Food Assistance, Temporary Cash Assistance, and Medicaid programs. You do not have to apply for or give us a SSN for any household members for whom help is not being requested. However, you may have to give us income and asset information about those individuals for us to determine the eligibility of other household members for whom help is requested.

THE DEPARTMENT OF CHILDREN AND FAMILIES HAS THE RIGHT TO:

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

THE AGENCY FOR HEALTH CARE ADMINISTRATION HAS THE RIGHT TO:

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

FLORIDA FRAUD LAW INFORMATION

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

Florida Department of Children and Families

NOTICE OF PRIVACY PRACTICES

Office of Civil Rights
HIPAA Privacy Officer
1317 Winewood Blvd., Bldg, 1, Room 110
Tallahassee, FL 32399-0700
Phone: (850) 487-1901 FAX: (850) 921-8470
Website: www.myfloridafamilies.com/hipaa

Your Information.

Your Rights.

Our Responsibilities.

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. This Notice applies to the Department of Children and Families, their Business Associates and Subcontractors.

-PLEASE REVIEW IT CAREFULLY-

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Choose someone to act for you
- Receive breach notifications
- Get a list of those with whom we've shared your information
- Get a copy of this Privacy Notice
- File a complaint if you believe your Privacy Rights have been violated

⇨ **See page 2 & 3** for more information on these rights and how to exercise them.

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a directory (if applicable)
- Provide mental health care
- Market our service and sell your information
- Raise Funds

⇨ **See page 3** for more information on these choices and how to exercise them.

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for services
- Work with our contracted Business Associates and subcontractors
- Help with public health and/or public safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Respond to lawsuits and legal actions
- Work with a medical examiner or funeral director
- Address workers' compensation, health oversight agencies, law enforcement, and other government requests
- Government agencies providing benefits or services

⇨ **See page 4 & 5** for more information on these choices and how to exercise them.

WHAT IS PROTECTED HEALTH INFORMATION (PHI)?

Protected Health Information (PHI) is information that would enable a person reading or hearing it to identify you individually, referred to as "individually identifiable health information", that relates to:

- your past, present, or future physical or mental health or condition;
- the provision of health care to you;
- the past, present, or future payment for the provision of health care or services to you; or
- your Genetic information.

Your Rights

When it comes to your health information, you have certain rights.

Get an electronic or paper copy of your medical record	• You, or your designee, can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Your request must be in writing to the program office or service provider that maintains your records. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. • We are not required to allow you to see or copy psychotherapy notes, information prepared for use in legal actions or proceedings, or where access is prohibited by law.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Your request must be in writing to the program office or service provider that maintains your records. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, if you are an outpatient client, you could request we contact you at your workplace or via email) or send mail to a different address. Your request must be in writing to the program office or service provider that maintains your records. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information. We are not required to agree to your request, and we may say "no" if it would affect your care. • You can ask us **not** to share certain health information with family members. We are not required to agree to your request, and we may say "no" if it would affect your care. • These requests must be in writing to the program office or service provider that maintains your records.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is you legal guardian, that person can exercise your rights and make choices about your health information. Your request must be in writing to the program office or service provider that maintains your records. • We will make sure the person has this authority and can act for you before we take any action.
Receive breach notifications	• You will receive notification if there is a breach of your unsecured protected health information (PHI).

Get a list of those with whom we've shared Information	• You can ask for a list (Accounting of Disclosures) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. (Note: the list will not include any uses or disclosures made before April 14, 2003.) Your request must be in writing to the program office or service provider that maintains your records. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one Accounting of Disclosures a year for free but may a reasonable, cost-based fee if you ask for another one within twelve months.
Get a copy of this Privacy Notice	• You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. Please contact the office, facility or program where you receive services and we will provide you with a paper copy promptly. • You may also view and download a copy of this Notice at: **http://www.myfloridafamilies.com/hipaa.**
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by sending a letter to the Department of Children and Families, Office of Civil Rights, HIPAA Privacy Officer, 1317 Winewood Boulevard, Building 1, Room 110, Tallahassee, Florida 32399-0700, calling 850-487-1901, or faxing to 850-921-8470. • You can file a complaint with the U. S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S. W., Washington, D. C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr//privacy/hipaa/complaints/. • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care. • Share information in a disaster relief situation. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases, we never share your information unless you give us written permission:	• Marketing purposes. • Sale of your information. • Most sharing of psychotherapy notes.
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways. Please note that not all types of uses and disclosures can be described or listed in this Notice.

Treat you	• We can use your health information and share it with other professionals who are treating you and coordinate services you may need.	*Example:* A doctor performing a clinical evaluation may talk another doctor about your overall health condition.
Run our organization	• We can use and share your health information to run our organization, improve your care, and contact you when necessary.	*Example:* We use health information about you to manage your treatment and services.
Bill for your services	• We can use and share your health information to bill and get payment from health plans and other entities.	*Example:* We give information about you to your health insurance plan so it will pay for your services.
Work with our contracted Business Associates and Subcontractors	• The Department contracts with individuals, other agencies, and businesses to carry out some of the services for which we are responsible. Examples would include community based care agencies, case management agencies, mental health treatment centers, and technology vendors.	

How else can we use or share your health information? We are allowed or required to share your information in the course of investigations, determining eligibility, providing care, services or other benefits, and in other ways— usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers.index.html**

Help with public health and safety issues	• We can share health information about you for certain situations such as: -Preventing disease -Helping with product recalls -Reporting adverse reactions to medications -Reporting suspected abuse, neglect, or domestic violence -Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Respond to lawsuits and legal actions	We can share health information about you in response to a court or administrative order, or in response to a subpoena.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	We can use or share health information about you: -For workers' compensation claims -For law enforcement purposes, with a law enforcement official, or correctional institutions -With health oversight agencies for activities authorized by law -For special government functions such as military, national security, and presidential protective services
Government agencies providing benefits or services	We can share your health information with other government agencies or programs that provide similar services or benefits to you if the release is necessary to coordinate the delivery of your services or benefits, or improves our ability to administer or manage the program.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information (PHI).
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your PHI.
- We must follow the duties and privacy practices described in this Notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**

Changes to the Terms of this Notice

We can change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice will be available upon request, in our office, and on our website at : **www.myfloridafamilies.com/hipaa**.

Effective: September 22, 2013

This Notice of Privacy Practices applies to the following organizations:

The Florida Department of Children and Families, their Business Associates and Subcontractors.

If you feel your privacy rights have been violated, or you disagree with a decision we made about your protected health information (PHI), you may file a complaint with the Secretary of the U. S. Department of Health and Human Services and/or the Department of Children and Families by contacting either agency at the addresses below. No retaliatory actions will be taken against you for filing a complaint.

The Department of Children and Families
Office of Civil Rights
HIPAA Privacy Officer
1317 Winewood Blvd., Bldg. 1, Room 110
Tallahassee, FL 32399-0700
Phone: (850) 487-1901
FAX: (850) 921-8470
Website: www.myfloridafamilies.com/hipaa

U. S. Department of Health and Human Services
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, S. W.
Atlanta, GA 30303-8909
Voice Phone: (404) 562-7453
FAX: (404) 562-7881
TDD: (404) 562-7884