# ACCESS Florida Web Application

CF-ES 2353, (insert date) [65A-1.205, F.A.C.]

# ACCESS Florida ACCEPTANCE TEST

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Welcome to ACCESS Florida

## Get Started Now

- Am I Eligible?
- Apply for Benefits
- Create My Access Account

## Learn More

Welcome to Florida Department of Children and Families Automated Community Connection to Economic Self Sufficiency (ACCESS).

Learn More

## Returning Users

*User ID

*Password

Sign In

Forgot your User ID?

Forgot your Password?

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# Apply For Assistance

Before you get started, please read this information.

## Apply For Assistance

You may need the following information for all individuals for whom you are applying.

- Social Security number and date of birth.
- Income information such as job, child support or any other sources.
- Resource or asset information such as checking, savings accounts, vehicles, homes, land or life insurance.
- Housing expenses such as rent or utilities.
- Health insurance information.
- All U.S. citizens applying for, or receiving Medical Assistance, including children, are required to provide proof of U.S. citizenship and identity.

○ **Start a new application for Food Assistance (SNAP), Medical Assistance and/or Cash Assistance**

Choose this option if you have not recently applied for benefits in Florida. Do not choose this if you have recently applied and are waiting for a decision. If you are waiting for a decision on an application, please login to your My ACCESS Florida account.

○ **Finish an unfinished application.**

Choose this option to continue an application that you started earlier but have not completed the Electronic Signature.

When complete, click NEXT.

Next

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# Your My ACCESS Florida Account

Before you start your application, you will need to create an account. This should take a few minutes.

**Do you already have an account?**

If so, select the option below.

○ Log in using your existing account

**Do you need to create an account?**

With your My ACCESS Florida account, you will be able to:

- Start your application
- Save your application
- Come back to your application later
- Check on the status of your application after you submit your application
- View your account status and benefit information
- Request additional assistance
- Report changes
- Submit a review to continue to receive benefits .

Your information will be saved as you move from page to page.

The Florida Department of Children and Families(DCF) runs this website. We will keep your information private and safe.

○ Create an account

Click the NEXT button at the bottom of the page.

If you have problems that prevent you from continuing, you may call the Customer Call Center at 866-762-2237 during business hours for assistance.

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# Setting Up An Account

To apply online, you will need to create a User ID and password. If you already have an account, click here to login.

This account will help to keep your information private and secure. It also lets you save your application and come back to work on it later. You can also log back in to check the status of your application after you submit it.

If you have problems that prevent you from continuing you may call the Customer Call Center at 866-762-2237 during business hours for assistance.

## Step 1: Your Name and Email Address

Fill in your name below.

* First Name
* Last Name
Email (optional)

## Step 2: User ID & Password

If you are a returning User enter your User ID and Password. If you do not have an account click on the link Create a new User Id and Password.

* User ID
* Password
* Retype Password

## Step 3: Security Questions

Next, please select three security questions that you can use if you ever need to recover your password. Click on each box to choose a question that only you know the answer to. Then, fill in your answers. Keep in mind that you will need to type the answer exactly the same way as when you set up your account.

* Security Question 1 <Click here to choose>
* Answer
* Security Question 2 <Click here to choose>
* Answer
* Security Question 3 <Click here to choose>
* Answer

## Step 4: User Acceptance Agreement

☐ As the last step in creating your account, please check the box to let us know that you have read and agreed to Florida's User Acceptance Agreement. Click here to read the Agreement, which tells you more about how we will keep your personal information private and secure.

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## Step 1: Your Name and Email Address

Fill in your name below.

| | |
|---|---|
| * First Name | Jane |
| * Last Name | Doe |
| Email (optional) | |

## Step 2: User ID & Password

If you are a returning User enter your User ID and Password. If you do not have an account click on the link Create a new User Id and Password.

| | |
|---|---|
| * User ID | Jane05 |
| * Password | •••••• |
| * Retype Password | •••••• |

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| | |
|---|---|
| * Security Question 1 | What is your Maternal grandfather's First Name? |
| * Answer | Joe |
| * Security Question 2 | In what city was your father born? |
| * Answer | Tallahassee |
| * Security Question 3 | What is your favorite color? |
| * Answer | Pink |

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## Thank You

**Thank You**

Thank you **Jane Doe** for creating an account with Department of Children and Families. Your User ID is **JANE05**. Please remember your User ID and password and keep it in a safe place. You will need these to log in when you access your My ACCESS Account.

Next

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## Login

If you are a returning User enter your User ID and Password. If you do not have an account click on the link Create a new User Id and Password.

Create a new User Id and Password

* User ID

* Password

Sign In

Forgot your User ID? Forgot your Password?

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If you are a returning User enter your User ID and Password. If you do not have an account click on the link Create a new User Id and Password.

Create a new User Id and Password

* User ID Jane05

* Password ••••••

Sign In

Forgot your User ID? Forgot your Password?

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Get Started | Assets | Income | Expenses | Finish&Submit

Before You Begin | People

## Apply For Assistance

You are ready to start your application. Here are some helpful hints.

### 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. You may click on the "Apply" button after you confirm your address. 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.

**Pre-screening Tool**

Before completing your application, you may answer a few questions to see if you or your household might be eligible for benefits. Complete the questions based on your current circumstances. Estimates are allowed when answering the questions. Please remember the tool is not an application for benefits. If the tool says your household may not be eligible; you may still complete an application. We will make a determination of eligibility based on your application. If you want to use the Pre-screening Tool, click here.

**Processing Your Application**

Your application is date stamped the day we get a signed application. The date stamp will be the next business day if we get your application after hours on a weekend or holiday. Processing begins with the date we receive your signed application. It may take 7 to 30 days to process your food assistance application. Expedited household 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. Applicants may file an incomplete application form as long as it contains their name, address, and signature. 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 that 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.

**Online Application Process**

If you chose to complete the online application, you will be able to back up and check your answers at any point during the application process. At the end of the application process you will be shown a "Final Summary" page which will allow you to check the information you gave on the online application. If you want a copy of the Final Summary for your records, you must have a working printer attached to your computer.

**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 committing any act that violates the Food Stamp 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 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 in more than one state at the same time, you will be ineligible to participate in the Food Assistance Program for a period of 10 years.

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

If you are found guilty of a drug-trafficking felony 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)**

**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), the household 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.

**If you choose to complete the online application, you will be able to backup and check your answers at any point during the application process.**

When complete, click NEXT.

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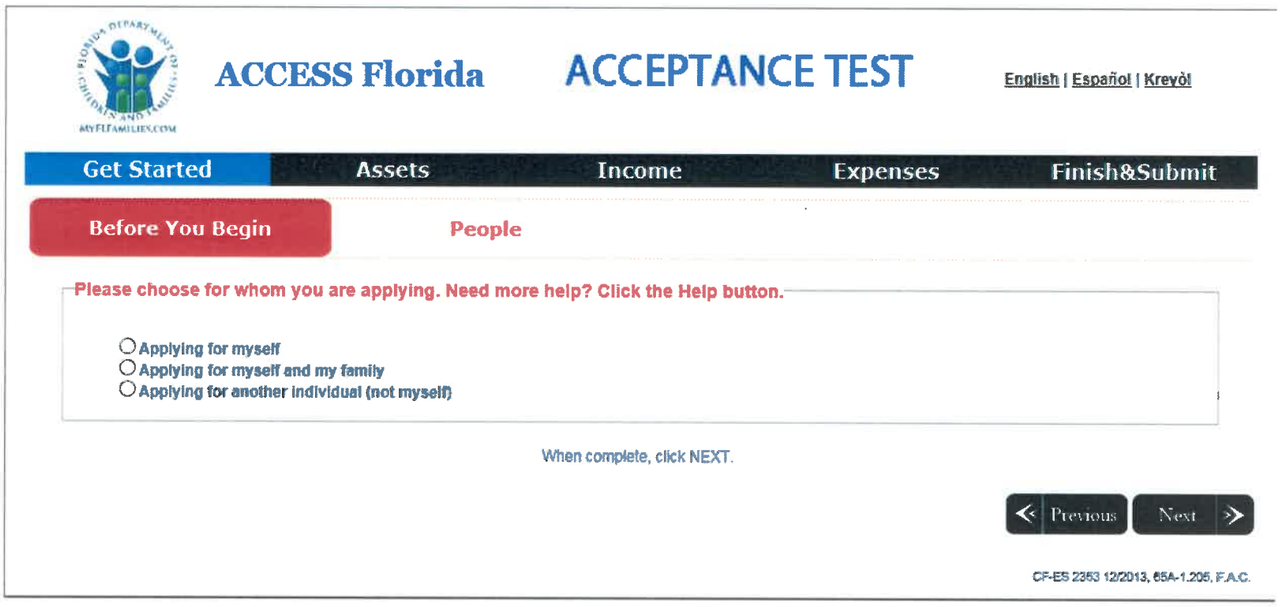
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Please choose for whom you are applying. Need more help? Click the Help button.
Applying for myself
Applying for myself and my family
Applying for another individual (not myself)
When complete, click NEXT.
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Get Started | Assets | Income | Expenses | Finish&Submit

Before You Begin | People

Please choose for whom you are applying. Need more help? Click the Help button.

- (•) Applying for myself
- ( ) Applying for myself and my family
- ( ) Applying for another individual (not myself)

When complete, click NEXT.

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Before You Begin | People

**Choose The Programs For Which You Would Like To Apply**

☐ **All Programs**
All Programs includes Food Assistance (SNAP), Cash and Medical Assistance.

☐ **Food Assistance (SNAP)**
The Food Assistance (SNAP) Program helps low-income households to buy nutritious food. A Food Assistance (SNAP) household is normally a group of people who live together and buy food and prepare meals together.

**Cash Assistance**
The Temporary Cash Assistance (TCA) program gives cash assistance to low income families with children, women in the 9th month of pregnancy, or women in the 6th month of pregnancy who are not able to work.
☐ Cash assistance for myself or myself and my family
☐ Cash assistance for a child the court placed with me
☐ Cash assistance for a child that is not mine but is related to me
☐ Cash assistance for refugees or some legal noncitizens who just came to the United States

☐ **Medical Assistance for Children, their Parents or Caretakers, Pregnant Women and Individuals who aged out of Florida Foster Care who are under age 26.**
An application for medical assistance includes Medicaid (for children, their parents or caretakers, pregnant women), Florida KidCare Program (for children under 19 with too much income for Medicaid) and The Insurance Affordability Program (for adults aged 18 through 64 and children that cannot be covered by either Medicaid or KidCare). The Medicaid and KidCare Programs are administered by the State of Florida and the Insurance Affordability is administered by the Federally Facilitated Marketplace.

☐ **Medical Assistance For the Aged, Blind or Disabled**
Medical Assistance for individuals 65 years of age or older, blind or has been determined disabled or is claiming a disabling condition that will prevent work for twelve months or lead to death.

☐ **Medical Assistance for Individuals in Nursing Home**
Medical Assistance for Individuals in Nursing Home gives medical assistance including the cost of care for individuals placed in nursing homes. Long term care programs provide eligible low income individuals in a nursing home or in danger of being placed in a nursing home with medical coverage.

☐ **Medical Assistance for Individuals Seeking Medicaid Waiver Services**
Medicaid waiver programs provide medical services to individuals at risk of placement in a nursing home and individuals at risk of hospitalization. These programs provide additional services not covered by community based Medicaid programs, and include individuals in need of additional services through the Familial Dysautonomia, iBudget, Model, Statewide Medicaid Managed Care Long-Term Care Waiver programs, and those diagnosed with AIDS with an AIDS-related opportunistic infection(s).

☐ **Medical Assistance for Individuals in Hospice**
The Hospice Medical Assistance program gives health care services to terminally ill individuals when they no longer choose to get medical treatment to cure an illness or disease. Hospice Medical Assistance Services can be given in an individual's home or in a nursing facility.

☐ **Medicare Savings Program**
Medical Assistance savings Programs are Medical Assistance programs that help Medicare beneficiaries of modest means pay all or some of Medicare cost sharing amounts (i.e., premiums, deductibles and co-payments). Programs considered Medicare Savings Programs include Qualified Medicare Beneficiary, Special Low-income Medicare Beneficiary, Qualifying Individuals 1, and Qualified Working and Disabled Individuals.

When complete, click NEXT.

Previous | Save & Exit | Next

Before You Begin | People

**Choose The Programs For Which You Would Like To Apply**

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When complete, click NEXT.

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**Before you can go to the next page, you must:**
***Select at least one Cash Assistance check box.***
***Select at least one Medical Assistance check box***

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☐ Cash assistance for refugees or some legal noncitizens who just came to the United States

☐ **Medical Assistance for Children, their Parents or Caretakers, Pregnant Women and individuals who aged out of Florida Foster Care who are under age 26.**
An application for medical assistance includes Medicaid (for children, their parents or caretakers, pregnant women), Florida KidCare Program (for children under 19 with too much income for Medicaid) and The Insurance Affordability Program (for adults aged 18 through 64 and children that cannot be covered by either Medicaid or KidCare). The Medicaid and KidCare Programs are administered by the State of Florida and the Insurance Affordability is administered by the Federally Facilitated Marketplace.

☐ **Medical Assistance For the Aged, Blind or Disabled**
Medical Assistance for individuals 65 years of age or older, blind or has been determined disabled or is claiming a disabling condition that will prevent work for twelve months or lead to death.

☐ **Medical Assistance for Individuals in Nursing Home**
Medical Assistance for Individuals in Nursing Home gives medical assistance including the cost of care for individuals placed in nursing homes. Long term care programs provide eligible low income individuals in a nursing home or in danger of being placed in a nursing home with medical coverage.

☐ **Medical Assistance for Individuals Seeking Medicaid Waiver Services**
Medicaid waiver programs provide medical services to individuals at risk of placement in a nursing home and individuals at risk of hospitalization. These programs provide additional services not covered by community based Medicaid programs, and include individuals in need of additional services through the Familial Dysautonomia, iBudget, Model, Statewide Medicaid Managed Care Long-Term Care Waiver programs, and those diagnosed with AIDS with an AIDS-related opportunistic infection(s).

☐ **Medical Assistance for Individuals in Hospice**
The Hospice Medical Assistance program gives health care services to terminally ill individuals when they no longer choose to get medical treatment to cure an illness or disease. Hospice Medical Assistance Services can be given in an individual's home or in a nursing facility.

☑ **Medicare Savings Program**
Medical Assistance savings Programs are Medical Assistance programs that help Medicare beneficiaries of modest means pay all or some of Medicare cost sharing amounts (i.e., premiums, deductibles and co-payments). Programs considered Medicare Savings Programs include Qualified Medicare Beneficiary, Special Low-income Medicare Beneficiary, Qualifying individuals 1, and Qualified Working and Disabled Individuals.

When complete, click NEXT.

« Previous | Save & Exit | Next »

Before you can go to the next page, you must:
*Select at least one Medical Assistance check box*

**Choose The Programs For Which You Would Like To Apply**

☑ **All Programs**
All Programs includes Food Assistance (SNAP), Cash and Medical Assistance.

☑ **Food Assistance (SNAP)**
The Food Assistance (SNAP) Program helps low-income households to buy nutritious food. A Food Assistance (SNAP) household is normally a group of people who live together and buy food and prepare meals together.

**Cash Assistance**
The Temporary Cash Assistance (TCA) program gives cash assistance to low income families with children, women in the 9th month of pregnancy, or women in the 6th month of pregnancy who are not able to work.
- ☑ Cash assistance for myself or myself and my family
- ☐ Cash assistance for a child the court placed with me
- ☐ Cash assistance for a child that is not mine but is related to me
- ☐ Cash assistance for refugees or some legal noncitizens who just came to the United States

☑ **Medical Assistance for Children, their Parents or Caretakers, Pregnant Women and individuals who aged out of Florida Foster Care who are under age 26.**
An application for medical assistance includes Medicaid (for children, their parents or caretakers, pregnant women), Florida KidCare Program (for children under 19 with too much income for Medicaid) and The Insurance Affordability Program (for adults aged 18 through 64 and children that cannot be covered by either Medicaid or KidCare). The Medicaid and KidCare Programs are administered by the State of Florida and the Insurance Affordability is administered by the Federally Facilitated Marketplace.

☐ **Medical Assistance For the Aged, Blind or Disabled**
Medical Assistance for individuals 65 years of age or older, blind or has been determined disabled or is claiming a disabling condition that will prevent work for twelve months or lead to death.

☐ **Medical Assistance for Individuals in Nursing Home**
Medical Assistance for Individuals in Nursing Home gives medical assistance including the cost of care for individuals placed in nursing homes. Long term care programs provide eligible low income individuals in a nursing home or in danger of being placed in a nursing home with medical coverage.

☐ **Medical Assistance for Individuals Seeking Medicaid Waiver Services**
Medicaid waiver programs provide medical services to individuals at risk of placement in a nursing home and individuals at risk of hospitalization. These programs provide additional services not covered by community based Medicaid programs, and include individuals in need of additional services through the Familial Dysautonomia, iBudget, Model, Statewide Medicaid Managed Care Long-Term Care Waiver programs, and those diagnosed with AIDS with an AIDS-related opportunistic infection(s).

☐ **Medical Assistance for Individuals in Hospice**
The Hospice Medical Assistance program gives health care services to terminally ill individuals when they no longer choose to get medical treatment to cure an illness or disease. Hospice Medical Assistance Services can be given in an individual's home or in a nursing facility.

☑ **Medicare Savings Program**
Medical Assistance savings Programs are Medical Assistance programs that help Medicare beneficiaries of modest means pay all or some of Medicare cost sharing amounts (i.e., premiums, deductibles and co-payments). Programs considered Medicare Savings Programs include Qualified Medicare Beneficiary, Special Low-income Medicare Beneficiary, Qualifying individuals 1, and Qualified Working and Disabled Individuals.

When complete, click NEXT.

# More About Assistance

Here is more information about the programs you are applying for.

## Temporary Cash Assistance Welfare Transition Program

Parents or relatives getting Temporary Cash Assistance (TCA) for their self may need to take part in a work program. This program is the Welfare Transition (WT) Program. The Welfare Transition Program helps adults

- Set career goals
- Develop a plan
- Takes steps to reach the goals.

Applicants may need to register for the Welfare Transition Program before getting TCA benefits. You will need to go to the career center to register for work. We will mail a letter with instructions.

If we approve you for TCA, you may have to keep working with the Welfare Transition staff. While in the Welfare Transition Program, you will be need to:

- Develop a plan;
- Take the steps in the plan; and
- Take part in work activities.

If you have to take part in the Welfare Transition Program, but do not, we will close your TCA benefits. If you get Food Assistance(SNAP) benefits, and do not meet a Food Assistance employment and training exemption, we will close your Food Assistance(SNAP).

The Welfare Transition Program helps with transportation, child care or other needs to help you meet your goals.

Federal law requires certain people who receive Food Assistance (SNAP) to participate in work activities. The Food Assistance Employment and Training Program helps individuals who get Food Assistance (SNAP) to register and participate in a work activity.

If you start to receive Food Assistance (SNAP), you must participate in Food Assistance (SNAP) Employment and Training activities. You will get a letter in the mail from the Food Assistance (SNAP) Employment and Training program. This letter will explain work activity requirements such as employment and participation in educational activities. Please make sure to follow the instructions in the letter.

If you are required to participate in the Food Assistance (SNAP) Employment and Training Program, and do not complete the work activities, then your Food Assistance (SNAP) will end for one, three, or six months depending on how many times you have failed to participate.

You are an able-bodied adult if:

- you are age 18 through 49, and
- you do not have children under age 18 living with you, and
- you do not meet an exemption, exception, or have good cause.

Able-bodied adults must work or participate in the Food Assistance (SNAP) Employment and Training program 20 hours per week or an average of 80 hours per month. Able-bodied adults who fail to participate in Food Assistance (SNAP) Employment and Training can only receive Food Assistance (SNAP) for three months in a 36-month period. Able-bodied adults who have already received Food Assistance (SNAP) for three time-limited months may get them again by meeting an exception to the rules, working, or taking part in a work program for 80 or more hours separately or in combination in the month before applying for Food Assistance (SNAP).

If you get a letter from the Food Assistance (SNAP) Employment and Training Program, call the phone number in the letter if you have any questions

Adults, age 18 through 49 must participate in Food Assistance (SNAP) Employment and Training if they do not meet an exemption or have good cause.
You may not have to participate in Employment and Training if you are:

- Responsible for the care of a dependent child under age 6
- Responsible for the care of an incapacitated individual, whether or not you live with the individual
- Determined physically or mentally unfit for employment (receiving, or has applied for Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), veteran's disability, or private disability (either temporary or permanent))
- Unfit for employment due to physical or mental limitation (may-but is not required to--have pending application for Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), veteran's disability, or private disability (temporary or permanent))?
- Receiving or applied for Unemployment Compensation
- Employed or self-employed, working a minimum of 30 hours weekly or earning the federal minimum wage multiplied by 30 hours per week
- Working or volunteering 20 to 29 hours per week (averaged to 80 hours per month)
- A regular participant in a drug or alcoholic treatment and rehabilitation program (Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) do not qualify)
- A student enrolled at least half-time in any recognized school, training program or an institution of higher education
- Complying with Temporary Cash Assistance Work Requirements
- Living with a member of your food assistance household who is under the age of 18
- Pregnant
- Homeless

If you believe any of these exemptions apply to you, be sure to discuss them with the caseworker during your interview.

You may not have to participate in Employment and Training immediately if you can show good cause. Good cause includes temporary circumstances beyond a person's control. Some examples are:

- Illness
- Illness of another household member
- A household emergency
- The unavailability of transportation

Other reasons may be considered good cause. If you are not sure, be sure to ask the caseworker during your interview.

**Regaining Eligibility**

Once an Able Bodied Adult Without Dependents (ABAWD) receives food assistance for three time-limited months, they may lose eligibility. In order to regain eligibility, the ABAWD must comply by completing one of the following in a 30-day time period before applying for benefits: work 80 or more hours, take part in and meet all rules of a work program for 80 or more hours, meet an exception to the ABAWD time limits or an E&T exemption, or work and attend a work program for a combined total of 80 hours.

When complete, click NEXT.

# About You

Let's get started. First, please give us some basic information about the Head of the Household. By Head of the Household we mean the responsible adult that lives in the household; do not enter basic information about a child here.If you are completing this application for someone that does not live with you, enter their name (do not use nicknames).If you are completing this application for someone else and you do not live in their household, we will ask you for your name and address when you complete the Electronic Signature.

## Information About You

| | | | |
|---|---|---|---|
| * First Name | Middle Name | * Last Name | Suffix |
| | | | <Click here to choose> |

Gender ○ Male ○ Female

Date of Birth  Ex. mm/dd/yyyy

## Where You Live

Please tell us where you live. If you are homeless right now, please select the "Homeless" option for living arrangement. If you are homeless but you have a mailing address, please type your mailing address in next section.

* Address Line 1

Address Line 2

| | | |
|---|---|---|
| * City: | * State: | * Zip Code: |
| | Florida | |

## Mailing Address

If the person you are applying for does not want us to send any letters about their benefits to the address you've given above, or if they get mail at a different address than listed above, please enter the mailing address below.

* Do the people you are applying for get mail at a different address from the one listed above? If 'Yes', enter the mailing address below.
○ Yes ○ No

Street Address or P.O. Box Number:
Address Line 1

Address Line 2

| | | |
|---|---|---|
| City: | State: | Zip Code: |
| | <Click here to choose> | |

## Contact Information

## Contact Information

Please tell us how we can get in touch with you. For the phone numbers, please be sure to include area code.

Home Phone

Work Phone

Cell/Message Phone

Email Address

Confirm Email Address

When complete, click NEXT.

Previous | Save & Exit | Next

# About You

Let's get started. First, please give us some basic information about the Head of the Household. By Head of the Household we mean the responsible adult that lives in the household; do not enter basic information about a child here.If you are completing this application for someone that does not live with you, enter their name (do not use nicknames).If you are completing this application for someone else and you do not live in their household, we will ask you for your name and address when you complete the Electronic Signature.

## Information About You

| * First Name | Middle Name | * Last Name | Suffix |
|---|---|---|---|
| Jane | | Doe | <Click here to choose> |

Gender: ○ Male ◉ Female

Date of Birth: 01/01/1967 Ex. mm/dd/yyyy

## Where You Live

Please tell us where you live. If you are homeless right now, please select the "Homeless" option for living arrangement. If you are homeless but you have a mailing address, please type your mailing address in next section.

* Address Line 1: 1317 Winewood Blvd

Address Line 2:

| * City: | * State: | * Zip Code: |
|---|---|---|
| Tallahassee | Florida | 32399 |

## Mailing Address

If the person you are applying for does not want us to send any letters about their benefits to the address you've given above, or if they get mail at a different address than listed above, please enter the mailing address below.

* Do the people you are applying for get mail at a different address from the one listed above? If 'Yes', enter the mailing address below.
◉ Yes ○ No

Street Address or P.O. Box Number:
Address Line 1: 1313 Winewood Blvd

Address Line 2:

| City: | State: | Zip Code: |
|---|---|---|
| Tallahassee | Florida | 32399 |

## Contact Information

## Contact Information

Please tell us how we can get in touch with you. For the phone numbers, please be sure to include area code.

| | |
|---|---|
| Home Phone | (850) 727-1111 |
| Work Phone | |
| Cell/Message Phone | (850) 111-1727 |
| Email Address | |
| Confirm Email Address | |

When complete, click NEXT.

« Previous | Save & Exit | Next »

Hello, JANE. Your ACCESS Online number is: 800150685

2% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Before You Begin | People

# Head of Household Summary

Here is the summary of what you've told us. If a section below has a checkmark, you have given us all the information we have asked for. You are not required to give all information before you submit the application.

- If you would like to change your answers , click on the "Pencil" icon under "Options".
- Once you've reviewed this summary and all the information is correct, click the "Next" button at the bottom of the page.

## Review Your Answers: Head of Household Summary

| Applicant | Address | Contact | Section Complete? | Options |
|---|---|---|---|---|
| Jane (31 yrs) | Living Address : 1317 Winewood Blvd, Tallahassee, FL, 32399-6570<br>Mailing Address : 1313 Winewood Blvd, Tallahassee, FL, 32399-0001 | Home : (850)727-1111<br>Cell : (850)111-1727 | ✔ | |

## Review Your Answers: Program selection

Here are your answers to the other questions in this section. Please take a look and make sure your answers are correct. If they are not correct, click on the edit icon to change your answers.

You have selected to apply for the following benefits:

- [x] **Food Assistance (SNAP)**
- [x] **Medical Assistance for Children, their Parents or Caretakers, Pregnant Women and individuals who aged out of Florida Foster Care who are under age 26.**

**Cash Assistance**

- [x] Cash assistance for myself or myself and my family
- [ ] Cash assistance for a child the court placed with me
- [ ] Cash assistance for a child that is not mine but is related to me
- [ ] Cash assistance for refugees or some legal noncitizens who just came to the United States
- [x] **Medicare Savings Program**

When complete, click NEXT.

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## People In Your Home

You have already given us some information about Jane. Please provide more information about Jane.

### Personal Information

| * First Name | Middle Initial | * Last Name | Suffix |
|---|---|---|---|
| Jane | | Doe | <Click here to choose> |

* Gender: ○ Male ◉ Female

* Date of birth (mm/dd/yyyy): 1/1/1987

* What is the primary language spoken in this person's home? English

Does this person need an interpreter? ◉ Yes ○ No

* In what language does this person prefer notices? ◉ English ○ Spanish ○ Creole

What county does this person live in? Leon

* What is this person's marital status? Married

* What is this person's living arrangement? Home/Apartment/Trailer

* Does this person intend to file taxes as either an individual or joint filer? Choose 'no' if this person is a tax dependent. ◉ Yes ○ No

### Citizenship Information

You do not need to provide a Social Security Number if this person is not applying for assistance.

Social Security Number: 123-45-6789

* Has this person ever used a different Social Security number or a different name, such as a maiden or married name? ◉ Yes ○ No

### Ethnicity

Please select this person's ethnicity. You don't have to answer this question if you don't want to. (This answer will not be used to make a decision about your assistance. This will not affect eligibility or the level of benefits. The reason we ask this information is to assure program benefits are distributed without regard to race, color, or national origin.)

○ Hispanic or Latino ◉ Not Hispanic or Latino

### Race

Please select the race of this person. You don't have to answer this question. In most cases, your answer won't be used to make a decision. But, if this person is American Indian or Alaska Native, telling us here may help this person get the most help possible. Black, Not of Hispanic Origin

### Race

Please select the race of this person. You don't have to answer this question. In most cases, your answer won't be used to make a decision. But, if this person is American Indian or Alaska Native, telling us here may help this person get the most help possible. Black, Not of Hispanic Origin

If this person is American Indian / Alaskan Native, are they a member of a federally recognized tribe? ◉ Yes ○ No

If yes, please select tribe name. Seminole Tribe of Florida (Dania, Big

### Benefits Information

* Is this person applying for assistance? ◉ Yes ○ No

### Other people in home

* Does this person want to add another person to this application? ◉ Yes ○ No

When complete, click NEXT.

« Previous | Save & Exit | Next »

Hello, **JANE**. Your ACCESS Online number is: **800150685**

3% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Before You Begin | People

## People In Your Home

You have already given us some information about **Jane**. Please provide more information about **Jane**.

### Personal Information

* What is this person's country of birth? <Click here to choose>

* Is this person a resident of Florida? ○ Yes ○ No

* Is this person disabled or blind? ○ Yes ○ No

### Citizenship Information

* Is this person a U.S. citizen? ○ Yes ○ No

### Outside of US

* Has this person been out of the U.S. in the last 30 days? ○ Yes ○ No

When complete, click NEXT.

Previous | Save & Exit | Next

Hello, JANE. Your ACCESS Online number is: 800150685

3% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Before You Begin | People

## People In Your Home

You have already given us some information about Jane. Please provide more information about Jane.

### Personal Information

* What is this person's country of birth? United States

* Is this person a resident of Florida? (•) Yes ( ) No

* Is this person disabled or blind? (•) Yes ( ) No

### Citizenship Information

* Is this person a U.S. citizen? (•) Yes ( ) No

### Outside of US

* Has this person been out of the U.S. in the last 30 days? (•) Yes ( ) No

When complete, click NEXT.

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## People In Your Home

### Personal Information

| * First Name | Middle Initial | * Last Name | Suffix |
|---|---|---|---|
| | | | <Click here to choose> |

* Gender: ◉ Male ○ Female

* Date of birth (mm/dd/yyyy)

* What is this person's marital status? <Click here to choose>

* What is this person's living arrangement? <Click here to choose>

* Does this person intend to file taxes as either an individual or joint filer? Choose 'no' if this person is a tax dependent. ○ Yes ○ No

### Citizenship Information

You do not need to provide a Social Security Number if this person is not applying for assistance.

Social Security Number

* Has this person ever used a different Social Security number or a different name, such as a maiden or married name? ○ Yes ○ No

### Ethnicity

Please select this person's ethnicity. You don't have to answer this question if you don't want to. (This answer will not be used to make a decision about your assistance. This will not affect eligibility or the level of benefits. The reason we ask this information is to assure program benefits are distributed without regard to race, color, or national origin.)

○ Hispanic or Latino ○ Not Hispanic or Latino

### Race

Please select the race of this person. You don't have to answer this question. In most cases, your answer won't be used to make a decision. But, if this person is American Indian or Alaska Native, telling us here may help this person get the most help possible. <Click here to choose>

If this person is American Indian / Alaskan Native, are they a member of a federally recognized ○ Yes ○ No

### Race

Please select the race of this person. You don't have to answer this question. In most cases, your answer won't be used to make a decision. But, if this person is American Indian or Alaska Native, telling us here may help this person get the most help possible. <Click here to choose>

If this person is American Indian / Alaskan Native, are they a member of a federally recognized tribe? ○ Yes ○ No

If yes, please select tribe name. <Click here to choose>

### Benefits Information

* Is this person applying for assistance? ○ Yes ○ No

### Other people in home

* Does this person want to add another person to this application? ○ Yes ○ No

When complete, click NEXT.

Previous | Save & Exit | Next

# People In Your Home

## Personal Information

| *First Name | Middle Initial | *Last Name | Suffix |
|---|---|---|---|
| Josh | | Doe | <Click here to choose> |

*Gender: (•) Male ( ) Female

*Date of birth (mm/dd/yyyy): 01/01/2015

*What is this person's marital status? Single - Never Married

*What is this person's living arrangement? Home/Apartment/Trailer

*Does this person intend to file taxes as either an individual or joint filer? Choose 'no' if this person is a tax dependent. ( ) Yes (•) No

## Citizenship Information

You do not need to provide a Social Security Number if this person is not applying for assistance.

Social Security Number: 087-65-4321

*Has this person ever used a different Social Security number or a different name, such as a maiden or married name? ( ) Yes (•) No

## Ethnicity

Please select this person's ethnicity. You don't have to answer this question if you don't want to. (This answer will not be used to make a decision about your assistance. This will not affect eligibility or the level of benefits. The reason we ask this information is to assure program benefits are distributed without regard to race, color, or national origin.)

( ) Hispanic or Latino (•) Not Hispanic or Latino

## Race

Please select the race of this person. You don't have to answer this question. In most cases, your answer won't be used to make a decision. But, if this person is American Indian or Alaska Native, telling us here may help this person get the most help possible. Black, Not of Hispanic Origin

If this person is American Indian / Alaskan Native, are they a member of a federally recognized tribe? (•) Yes ( ) No

If yes, please select tribe name. Seminole Tribe of Florida (Dania, Big

## Benefits Information

* Is this person applying for assistance? (•) Yes ( ) No

## Other people in home

* Does this person want to add another person to this application? ( ) Yes (•) No

When complete, click NEXT.

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Before you can go to the next page, you must:
*Add all members in the household even if you are not applying for them.*

## People In Your Home

You have already given us some information about Josh. Please provide more information about Josh.

### Personal Information

| * First Name | Middle Initial | * Last Name | Suffix |
|---|---|---|---|
| Josh | | Doe | <Click here to choose> |

* Gender: (•) Male ( ) Female
* Date of birth (mm/dd/yyyy): 1/1/2015
* What is this person's marital status? Single - Never Married
* What is this person's living arrangement? Home/Apartment/Trailer
* Does this person intend to file taxes as either an individual or joint filer? Choose 'no' if this person is a tax dependent. ( ) Yes (•) No

### Citizenship Information

You do not need to provide a Social Security Number if this person is not applying for assistance.

Social Security Number: 067-55-4321

* Has this person ever used a different Social Security number or a different name, such as a maiden or married name? ( ) Yes (•) No

### Ethnicity

Please select this person's ethnicity. You don't have to answer this question if you don't want to. (The answer will not be used to make a decision about your assistance. This will not affect eligibility or the level of benefits. The reason we ask this information is to assure program benefits are distributed without regard to race, color, or national origin.)

( ) Hispanic or Latino (•) Not Hispanic or Latino

### Race

Please select the race of this person. You don't have to answer this question. In most cases, your answer won't be used to make a decision. But, if this person is American Indian or Alaska Native, telling us here may help this person get the most help possible. Black, Not of Hispanic Origin

If this person is American Indian / Alaskan Native, are they a member of a federally recognized tribe? (•) Yes ( ) No

If yes, please select tribe name. Seminole Tribe of Florida (Dania, Big

### Benefits Information

* Is this person applying for assistance? (•) Yes ( ) No

### Other people in home

* Does this person want to add another person to this application? ( ) Yes (•) No

When complete, click NEXT.

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ACCESS Florida ACCEPTANCE TEST

English | Español | Kreyòl

Click here for Help

Hello, JANE. Your ACCESS Online number is: 800150685

3% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Before You Begin | People

## People In Your Home

You have already given us some information about Josh. Please provide more information about Josh.

### Personal Information

* What is this person's country of birth? <Click here to choose>

* Is this person a resident of Florida? ○ Yes ○ No

* Is this person disabled or blind? ○ Yes ○ No

### Citizenship Information

* Is this person a U.S. citizen? ○ Yes ○ No

### Outside of US

* Has this person been out of the U.S. in the last 30 days? ○ Yes ○ No

When complete, click NEXT.

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CF-ES 2353 12/2013, 65A-1.205, F.A.C.

Hello, JANE. Your ACCESS Online number is: 800150685

3% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Before You Begin | People

## People In Your Home

You have already given us some information about Josh. Please provide more information about Josh.

### Personal Information

* What is this person's country of birth? United States

* Is this person a resident of Florida? (•) Yes ( ) No

* Is this person disabled or blind? (•) Yes ( ) No

### Citizenship Information

* Is this person a U.S. citizen? (•) Yes ( ) No

### Outside of US

* Has this person been out of the U.S. in the last 30 days? (•) Yes ( ) No

When complete, click NEXT.

Previous | Save & Exit | Next

## People In Your Home

### Personal Information

| * First Name | Middle Initial | * Last Name | Suffix |
|---|---|---|---|
| John | | Doe | <Click here to choose> |

* Gender: (•) Male ( ) Female

* Date of birth (mm/dd/yyyy): 01/01/1985

* What is this person's marital status?: Married

* What is this person's living arrangement?: Home/Apartment/Trailer

* Does this person intend to file taxes as either an individual or joint filer? Choose 'no' if this person is a tax dependent.: (•) Yes ( ) No

### Citizenship Information

You do **not need** to provide a Social Security Number if this person is not applying for assistance.

Social Security Number: 456-78-9123

* Has this person ever used a different Social Security number or a different name, such as a maiden or married name?: ( ) Yes (•) No

### Ethnicity

Please select this person's ethnicity. You don't have to answer this question if you don't want to. (This answer will not be used to make a decision about your assistance. This will not affect eligibility or the level of benefits. The reason we ask this information is to assure program benefits are distributed without regard to race, color, or national origin.)

( ) Hispanic or Latino (•) Not Hispanic or Latino

### Race

Please select the race of this person. You don't have to answer this question. In most cases, your answer won't be used to make a decision. But, if this person is American Indian or Alaska Native, telling us here may help this person get the most help possible.: Black, Not of Hispanic Origin

If this person is American Indian / Alaskan Native, are they a member of a federally recognized tribe?: (•) Yes ( ) No

If yes, please select tribe name.: Seminole Tribe of Florida (Dania, Big

### Benefits Information

### Benefits Information

* Is this person applying for assistance?: (•) Yes ( ) No

### Other people in home

* Does this person want to add another person to this application?: ( ) Yes (•) No

When complete, click NEXT.

Previous | Save & Exit | Next

Before you can go to the next page, you must:
*Add all members in the household even if you are not applying for them.*

## People In Your Home

You have already given us some information about John. Please provide more information about John.

### Personal Information

| * First Name | Middle Initial | * Last Name | Suffix |
|---|---|---|---|
| John | | Doe | <Click here to choose> |

* Gender: (•) Male ( ) Female

* Date of birth (mm/dd/yyyy): 1/1/1985

* What is this person's marital status? Married

* What is this person's living arrangement? Home/Apartment/Trailer

* Does this person intend to file taxes as either an individual or joint filer? Choose 'no' if this person is a tax dependent. (•) Yes ( ) No

### Citizenship Information

You do not need to provide a Social Security Number if this person is not applying for assistance.

Social Security Number: 456-78-9123

* Has this person ever used a different Social Security number or a different name, such as a maiden or married name? ( ) Yes (•) No

### Ethnicity

Please select this person's ethnicity. You don't have to answer this question if you don't want to. (This answer will not be used to make a decision about

### Ethnicity

Please select this person's ethnicity. You don't have to answer this question if you don't want to. (This answer will not be used to make a decision about your assistance. This will not affect eligibility or the level of benefits. The reason we ask this information is to assure program benefits are distributed without regard to race, color, or national origin.)

( ) Hispanic or Latino (•) Not Hispanic or Latino

### Race

Please select the race of this person. You don't have to answer this question. In most cases, your answer won't be used to make a decision. But, if this person is American Indian or Alaska Native, telling us here may help this person get the most help possible. Black, Not of Hispanic Origin

If this person is American Indian / Alaskan Native, are they a member of a federally recognized tribe? (•) Yes ( ) No

If yes, please select tribe name. Seminole Tribe of Florida (Dania, Big

### Benefits Information

* Is this person applying for assistance? (•) Yes ( ) No

### Other people in home

* Does this person want to add another person to this application? ( ) Yes (•) No

When complete, click NEXT

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Before You Begin | People

## Rights and Responsibilities

### Rights and Responsibilities

**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:

☐ Yes, I have read and understand the Rights and Responsibilities.

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## Rights and Responsibilities

### Rights and Responsibilities

- 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.

CF-ES 2064, PDF 07-2016 [65A-1.204, F.A.C.]

☑ Yes, I have read and understand the Rights and Responsibilities.

When complete, click NEXT.

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## HIPAA Statement

### HIPAA Statement

CFOP 60-17

Chapter 1, Attachment 2

June 2, 2008

MANAGEMENT AND PROTECTION OF PERSONAL HEALTH INFORMATION POLICY

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

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

☐ Yes, I have read and understand the HIPAA statement.

When complete, click NEXT.

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## HIPAA Statement

**HIPAA Statement**

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

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

IV. Contact Person for Additional Information, or to Submit a Complaint. If you have questions about this Notice, need additional information, or have any complaints about our privacy practices, please contact: Department of Children and Families, Office of Civil Rights, 1317 Winewood Boulevard, Building 6, Room 124, Tallahassee, Florida 32399-0700, (850) 487-1901.

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

☑ **Yes, I have read and understand the HIPAA statement.**

When complete, click NEXT.

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## How you are Related?

Please tell us your changes

**Jane's Relationship To John**

Jane (31 yrs) is the Select Relation of John (33 yrs)

*Does Jane buy food or eat meals with John? ○ Yes ○ No

**Jane's Relationship To Josh**

Jane (31 yrs) is the Select Relation of Josh (3 yrs)

*Does Jane buy food or eat meals with Josh? ○ Yes ○ No

When complete, click NEXT.

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## How you are Related?

Please tell us your changes

**Jane's Relationship To John**

Jane (31 yrs)

is the Wife of

John (33 yrs)

* Does Jane buy food or eat meals with John? (•) Yes ( ) No

**Jane's Relationship To Josh**

Jane (31 yrs)

is the Mother of

Josh (3 yrs)

* Does Jane buy food or eat meals with Josh? (•) Yes ( ) No

When complete, click NEXT.

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## How you are Related?

Please tell us your changes

**John's Relationship To Josh**

John (33 yrs)

is the Select Relation of

Josh (3 yrs)

* Does **John** buy food or eat meals with **Josh**? ○ Yes ○ No

When complete, click NEXT.

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## How you are Related?

Please tell us your changes

**John's Relationship To Josh**

John (33 yrs)

is the Father of

Josh (3 yrs)

* Does **John** buy food or eat meals with **Josh**? ◉ Yes ○ No

When complete, click NEXT.

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## Tax Information

You have told us that Jane is intending to file taxes. Please give us more information about Jane's taxes.

### Jane's Tax Information

* Does Jane intend to file taxes jointly with spouse? ◉ Yes ○ No

Please select Jane's tax dependents.

☐ Josh(3 yrs)

* Select "Yes" if Jane intends to claim any tax dependents who do not live in the household or if Jane is filing jointly with a spouse not living in the household. ○ Yes ○ No

When complete, click NEXT.

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## Tax Information

You have told us that Jane is intending to file taxes. Please give us more information about Jane's taxes.

### Jane's Tax Information

*Does Jane intend to file taxes jointly with spouse? ◉ Yes ○ No

Please select Jane's tax dependents.

☑ Josh(3 yrs)

*Select "Yes" if Jane intends to claim any tax dependents who do not live in the household or if Jane is filing jointly with a spouse not living in the household. ○ Yes ◉ No

When complete, click NEXT.

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## Tax Information

You have told us that John is intending to file taxes. Please give us more information about John's taxes.

**John's Tax Information**

* Select "Yes" if John intends to claim any tax dependents who do not live in the household or if John is filing jointly with a spouse not living in the household. ○ Yes ○ No

When complete, click NEXT.

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## Tax Information

You have told us that John is intending to file taxes. Please give us more information about John's taxes.

### John's Tax Information

* Select "Yes" if John intends to claim any tax dependents who do not live in the household or if John is filing jointly with a spouse not living in the household. ○ Yes ◉ No

When complete, click NEXT.

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## Disability Details

A disability is a condition that may prevent a person from working and be expected to last for a continuous period of at least 12 months.

Click here to read or print the Authorization to Disclose Information form.

Click here to read or print the Statement of the Need for Care form.

You have told us that **Josh** is disabled or blind. Please complete the following disability information.

### Disability Status

| | |
|---|---|
| *Has **Josh**'s disability been decided ? | ○ Yes ○ No |
| Did **Josh** ever get and then stop getting disability for any reason? | ○ Yes ○ No |
| *Will this person 's incapacity or disability last for more than 30 days? | ○ Yes ○ No |
| *Will this person 's incapacity or disability last for more than 12 months? | ○ Yes ○ No |

### Denial Details

| | |
|---|---|
| Has **Josh** ever applied for and been denied disability (SSI or SSDI) by the Social Security Administration (SSA) because medical conditions were not met? | ○ Yes ○ No |
| If yes, please enter the denial date. Note: If you cannot remember the date, give us your best guess.(mm/dd/yyyy) | |
| Is the denial currently under appeal with Social Security Administration(SSA)? | ○ Yes ○ No |
| Does **Josh** have a new condition since the denial or a condition that SSA did not know about when they denied the disability? | ○ Yes ○ No |

When complete, click NEXT.

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# This page can't be displayed

- Make sure the web address http://dnp1.dcf.state.fl.us is correct.
- Look for the page with your search engine.
- Refresh the page in a few minutes.

Fix connection problems

# This page can't be displayed

- Make sure the web address http://dnp1.dcf.state.fl.us is correct.
- Look for the page with your search engine.
- Refresh the page in a few minutes.

Fix connection problems

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Click here to read or print the Authorization to Disclose Information form.

Click here to read or print the Statement of the Need for Care form.

You have told us that Josh is disabled or blind. Please complete the following disability information.

### Disability Status

| | |
|---|---|
| * Has Josh's disability been decided ? | (•) Yes ( ) No |
| Did Josh ever get and then stop getting disability for any reason? | (•) Yes ( ) No |
| * Will this person 's incapacity or disability last for more than 30 days? | (•) Yes ( ) No |
| * Will this person 's incapacity or disability last for more than 12 months? | (•) Yes ( ) No |

### Denial Details

| | |
|---|---|
| Has Josh ever applied for and been denied disability (SSI or SSDI) by the Social Security Administration (SSA) because medical conditions were not met? | (•) Yes ( ) No |
| If yes, please enter the denial date. Note: If you cannot remember the date, give us your best guess.(mm/dd/yyyy) | 02/24/2018 |
| Is the denial currently under appeal with Social Security Administration(SSA)? | (•) Yes ( ) No |
| Does Josh have a new condition since the denial or a condition that SSA did not know about when they denied the disability? | (•) Yes ( ) No |

When complete, click NEXT.

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## Disability Details

A disability is a condition that may prevent a person from working and be expected to last for a continuous period of at least 12 months.

Click here to read or print the Authorization to Disclose Information form.

Click here to read or print the Statement of the Need for Care form.

You have told us that Jane is disabled or blind. Please complete the following disability information.

### Disability Status

| | |
|---|---|
| * Has Jane's disability been decided ? | ○ Yes ○ No |
| Did Jane ever get and then stop getting disability for any reason? | ○ Yes ○ No |
| * Will this person 's incapacity or disability last for more than 30 days? | ○ Yes ○ No |
| * Will this person 's incapacity or disability last for more than 12 months? | ○ Yes ○ No |

### Denial Details

| | |
|---|---|
| Has Jane ever applied for and been denied disability (SSI or SSDI) by the Social Security Administration (SSA) because medical conditions were not met? | ○ Yes ○ No |
| If yes, please enter the denial date. Note: If you cannot remember the date, give us your best guess.(mm/dd/yyyy) | |
| Is the denial currently under appeal with Social Security Administration(SSA)? | ○ Yes ○ No |
| Does Jane have a new condition since the denial or a condition that SSA did not know about when they denied the disability? | ○ Yes ○ No |

When complete, click NEXT.

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Click here to read or print the Statement of the Need for Care form.

You have told us that Jane is disabled or blind. Please complete the following disability information.

### Disability Status

| | |
|---|---|
| * Has Jane's disability been decided ? | (•) Yes ( ) No |
| Did Jane ever get and then stop getting disability for any reason? | (•) Yes ( ) No |
| * Will this person 's incapacity or disability last for more than 30 days? | (•) Yes ( ) No |
| * Will this person 's incapacity or disability last for more than 12 months? | (•) Yes ( ) No |

### Denial Details

| | |
|---|---|
| Has Jane ever applied for and been denied disability (SSI or SSDI) by the Social Security Administration (SSA) because medical conditions were not met? | (•) Yes ( ) No |
| If yes, please enter the denial date. Note: If you cannot remember the date, give us your best guess.(mm/dd/yyyy) | 02/24/2018 |
| Is the denial currently under appeal with Social Security Administration(SSA)? | (•) Yes ( ) No |
| Does Jane have a new condition since the denial or a condition that SSA did not know about when they denied the disability? | (•) Yes ( ) No |

When complete, click NEXT.

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Click here to read or print the Authorization to Disclose Information form.

Click here to read or print the Statement of the Need for Care form.

You have told us that John is disabled or blind. Please complete the following disability information.

### Disability Status

| | |
|---|---|
| * Has John's disability been decided ? | ○ Yes ○ No |
| Did John ever get and then stop getting disability for any reason? | ○ Yes ○ No |
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| | |
|---|---|
| Has John ever applied for and been denied disability (SSI or SSDI) by the Social Security Administration (SSA) because medical conditions were not met? | (•) Yes ( ) No |
| If yes, please enter the denial date. Note: If you cannot remember the date, give us your best guess.(mm/dd/yyyy) | 12/24/2018 |
| Is the denial currently under appeal with Social Security Administration(SSA)? | (•) Yes ( ) No |
| Does John have a new condition since the denial or a condition that SSA did not know about when they denied the disability? | (•) Yes ( ) No |

When complete, click NEXT.

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# Disability Pamphlet

## Disability Pamphlet

Please carefully read the Disability information below.

**ARE YOU DISABLED AND APPLYING FOR MEDICAID?**

Notification of Disability Information and Request Form.

**What to provide with your application for Medicaid.**

**What is Medicaid?** Medicaid is a state run medical assistance program for needy individuals and families with limited income. If you are under age 65 and have no children, you must be disabled to qualify for Florida Medicaid.

**What is Disability?** You may be disabled if you have a condition that has affected (or is expected to affect) your ability to work for at least 12 months, or result in death. Children may be considered disabled if they have a medical condition severe enough to be considered a disability for an adult. If you are applying for Medicaid based on your disability, You must apply for all other disability income you may be able to receive, including Social Security Disability Insurance payments. You are not required to apply for Supplemental Security Income (SSI). For more information about Social Security, call 1-800-772-1213 or visit them online at http://ssa.gov.

**Who decides if I am disabled?** We use the same rules as Social Security to determine disability. If Social Security determines you as disabled, We accept their decision and will automatically consider you as disabled. If you do not have a disability determination from Social Security, we will work with the Division of Disability Determinations (DDD) to have them evaluate your condition based on medical information you provide.

**What do I need to provide?** If you have determination of disability from Social Security, give us a copy of the letter from them to show the decision and the date your disability began. We need no other medical information. If you do not have a determination of disability from Social Security, You need to provide us information about your condition. We will send the information to DDD for them to evaluate and make a Disability decision.

**What information do I need for my interview?**

- Dates of treatment.
- Names of all medications from your doctors, therapists, hospitals and clinics.
- Laboratory and test results.
- Information about normal daily activities, interests and hobbies, and how your condition affects them.
- Unpaid medical bills.
- Signed CF-ES 2514 form (Authorization to Disclose Information).

**What other information should I provide?** In addition to being determined disabled, you must have income and resources within certain limits to qualify for Medicaid. You must also be a Florida resident and a U.S. citizen or qualified non citizen.

**Additional information we need:**

- ✔ Social Security number.*
- ✔ Alien registration card, if not a U.S. citizen.*
- ✔ Proof of gross monthly income from all sources.
- ✔ Any letters you received from Social Security about your disability.
- ✔ Proof you have applied for Social Security Disability Insurance payments.*
- ✔ Information about things you own such as bank accounts, stocks, annuities, real property, cars,etc.

The list above covers the most common types of documentation we need from you to show you are eligible for Medicaid. We may ask you for additional information during the interview or as we proceed your case.

The list above covers the most common types of documentation we need from you to show you are eligible for Medicaid. We may ask you for additional information during the interview or as we proceed your case.

* Not required if you are not a citizen and only applying for Emergency Medical Services to cover periods of emergency services only.

**Don't Delay!** Don't delay your interview if you don't have all this information. You can provide it later or we can help you get it. Giving us medical records with your application may help us make faster decision, but it is not available, we will still send your availability to the Division of Disability Determinations. You may copy your medical records at a customer service center or fax them to your case processor from one of our gold community partner sites. Lists of service centers and partners are online at http://www.dcf.state.fl/less/docs/partner_listing.pdf.

**Very Important!** We handle most interviews by telephone. If you need to reschedule your interview , please call the number on your appointment letter to schedule another interview time. Please understand that rescheduling an interview may cause delay in processing your Medicaid case.

We will make every effort to complete your application within 90 days of the date we receive your application for Medicaid not counting any delays caused by you in getting necessary information to us.

If your case is still pending after 100 days, we will review your case and to determine why there is no decision, instruct eligibility staff on what information is missing, and advise them how to obtain the missing information.

If we complete a 100-day review of your case we will send you a special notice telling you the results of our review. We will continue to monitor your case until a final decision is made.

You can file an application online at http://www.dcf.state.fl/less/ or call 1-866-762-2237 for an application to be mailed by you.

The Department of Children and Families will act on your application without regard to age, race, color, sex, disability, religious creeds, nation origin, marital status, or political beliefs.

☐ **I have read and understand the disability information.**

When complete, click NEXT.

Previous | Save & Exit | Next

# Disability Pamphlet

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- ✔ Proof of gross monthly income from all sources.
- ✔ Any letters you received from Social Security about your disability.
- ✔ Proof you have applied for Social Security Disability Insurance payments.*
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* Not required if you are not a citizen and only applying for Emergency Medical Services to cover periods of emergency services only.

**Don't Delay!** Don't delay your interview if you don't have all this information. You can provide it later or we can help you get it. Giving us medical records with your application may help us make faster decision, but it is not available, we will still send your availability to the Division of Disability Determinations. You may copy your medical records at a customer service center or fax them to your case processor from one of our gold community partner sites. Lists of service centers and partners are online at http://www.dcf.state.fl/ess/docs/partner_listing.pdf.

**Very Important!** We handle most interviews by telephone. If you need to reschedule your interview , please call the number on your appointment letter to schedule another interview time. Please understand that rescheduling an interview may cause delay in processing your Medicaid case.

We will make every effort to complete your application within 90 days of the date we receive your application for Medicaid not counting any delays caused by you in getting necessary information to us.

If your case is still pending after 100 days, we will review your case and to determine why there is no decision, instruct eligibility staff on what information is missing, and advise them how to obtain the missing information.

If we complete a 100-day review of your case we will send you a special notice telling you the results of our review. We will continue to monitor your case until a final decision is made.

You can file an application online at http://www.dcf.state.fl/ess/ or call 1-866-762-2237 for an application to be mailed by you.

The Department of Children and Families will act on your application without regard to age, race, color, sex, disability, religious creeds, nation origin, marital status, or political beliefs.

☑ **I have read and understand the disability information.**

When complete, click NEXT.

Previous | Save & Exit | Next

Hello, JANE. Your ACCESS Online number is: 800150685

8% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Before You Begin | People

## Alias Information

You've told us that Jane has aliases. Please tell us bit more about this.

### Alias Name or Social Security Number(SSN) Details

An alias is any name or Social Security number that a person has used in the past. For example, a maiden or married name or a different Social Security number. Please tell us about the other names or SSNs used by Jane.

Enter names used by Jane in the past. (such as a maiden or married name)

| First name | Middle initial | Last name | Suffix |
|---|---|---|---|
| | | | <Click here to choose> |

Name type <Click here to choose>

Enter the Social Security number used in the past:

Social Security Number | SSN type <Click here to choose>

* Has Jane used any other names or Social Security numbers? ○ Yes ○ No

When complete, click NEXT.

Previous | Save & Exit | Next

Hello, **JANE**. Your ACCESS Online number is: **800150685**

8% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Before You Begin | People

## Alias Information

You've told us that Jane has aliases. Please tell us bit more about this.

### Alias Name or Social Security Number(SSN) Details

An alias is any name or Social Security number that a person has used in the past. For example, a maiden or married name or a different Social Security number. Please tell us about the other names or SSNs used by Jane.

Enter names used by Jane in the past. (such as a maiden or married name)

| First name | Middle initial | Last name | Suffix |
|---|---|---|---|
| Jane | | Doe | <Click here to choose> |

Name type: Maiden/former married

Enter the Social Security number used in the past:

Social Security Number: 123-45-6789 SSN type: Prior SSN

*Has Jane used any other names or Social Security numbers? ○ Yes ◉ No

When complete, click NEXT.

Previous | Save & Exit | Next

Hello, **JANE**. Your ACCESS Online number is: **800150685**

11% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Before You Begin | People

## Outside the US

You have told us that **Josh** was outside of country. Please tell us little bit more about this.

**Outside the U.S. in Past 30 Days**

* Date that this person left the U.S.(mm/dd/yyyy)

Date that this person returned to the U.S.(mm/dd/yyyy)

When complete, click NEXT.

Previous | Save & Exit | Next

Hello, JANE. Your ACCESS Online number is: 800150685

11% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Before You Begin | People

## Outside the US

You have told us that Josh was outside of country. Please tell us little bit more about this.

**Outside the U.S. in Past 30 Days**

| | |
|---|---|
| * Date that this person left the U.S.(mm/dd/yyyy) | 04/24/2018 |
| Date that this person returned to the U.S.(mm/dd/yyyy) | 05/01/2018 |

When complete, click NEXT.

Previous | Save & Exit | Next

Hello, **JANE**. Your ACCESS Online number is: **800150685**

11% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Before You Begin | People

## Outside the US

You have told us that Jane was outside of country. Please tell us little bit more about this.

**Outside the U.S. in Past 30 Days**

* Date that this person left the U.S.(mm/dd/yyyy)

Date that this person returned to the U.S.(mm/dd/yyyy)

When complete, click NEXT.

Previous | Save & Exit | Next

Hello, JANE. Your ACCESS Online number is: 800150685

11% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Before You Begin | People

## Outside the US

You have told us that Jane was outside of country. Please tell us little bit more about this.

**Outside the U.S. in Past 30 Days**

| | |
|---|---|
| * Date that this person left the U.S.(mm/dd/yyyy) | 04/24/2018 |
| Date that this person returned to the U.S.(mm/dd/yyyy) | 05/01/2018 |

When complete, click NEXT.

<< Previous | Save & Exit | Next >>

Hello, JANE. Your ACCESS Online number is: 800150685

11% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Before You Begin | People

## Outside the US

You have told us that John was outside of country. Please tell us little bit more about this.

**Outside the U.S. in Past 30 Days**

* Date that this person left the U.S.(mm/dd/yyyy)

Date that this person returned to the U.S.(mm/dd/yyyy)

When complete, click NEXT.

Previous | Save & Exit | Next

Hello, **JANE**. Your ACCESS Online number is: **800150685**

11% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Before You Begin | People

## Outside the US

You have told us that John was outside of country. Please tell us little bit more about this.

**Outside the U.S. in Past 30 Days**

| | |
|---|---|
| * Date that this person left the U.S.(mm/dd/yyyy) | 04/24/2018 |
| Date that this person returned to the U.S.(mm/dd/yyyy) | 05/01/2018 |

When complete, click NEXT.

Previous | Save & Exit | Next

Hello, **JANE**. Your ACCESS Online number is: **800150685**

12% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Before You Begin | People

## Pregnancy Information

We need to know if anyone in your home is pregnant.

**Pregnancy**

Please check the box for any one in your home who is pregnant. Otherwise, check "No One".

☐ No One

☐ Jane (31 yrs)

When complete, click NEXT.

« Previous | Save & Exit | Next »

Hello, JANE. Your ACCESS Online number is: 800150685

12% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Before You Begin | People

## Pregnancy Information

We need to know if anyone in your home is pregnant.

**Pregnancy**

Please check the box for any one in your home who is pregnant. Otherwise, check "No One".

- [x] No One
- [ ] 

Jane (31 yrs)

When complete, click NEXT.

Previous | Save & Exit | Next

## Other Household Information

Please provide us the following information about your household.

### *Renal Dialysis

Please check the box for anyone who is in renal dialysis. Otherwise, check "No One".

☐ No One


### *School Enrollment

Please check the box for anyone who is attending school, including college and technical school. Otherwise, check "No One".

☐ No One


### *Fleeing Felon/Probation/Parole violation

Please check the box for anyone who is fleeing the law due to a felony or probation or parole violation on or after 8/22/1996. Otherwise, check "No One".

☐ No One


### *Drug Trafficking or Trading Food Assistance

Please check the box for anyone who has 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, or who has 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. Otherwise, Check "No One".

☐ No One

### *Food/Cash/Medical Assistance Conviction

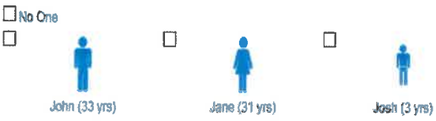
Please check the box for anyone who has been convicted of receiving Food, Cash or Medical Assistance in more than one state at the same time on or after 8/22/1996. Otherwise, check "No one".

☐ No One


### *Benefits Received

Please check the box for anyone who has received Food, Cash or Medical Assistance from another state or source. Otherwise, check "No one".

☐ No One




### *SSI Benefits

Please check the box for anyone who got SSI Benefits in the past but is not receiving them now. Otherwise, check "No One".

☐ No One


### *Daily Living Assistance

Please check the box for anyone that needs help with activities of daily living through personal assistance services, a nursing home, or other medical facility. Otherwise, check "No One".

☐ No One

## About Children in Your Home

To help you get access to specialized care, please answer the next three questions for children 20 or younger. Answer "yes" if they have a chronic and serious medical, behavioral, or other medical condition that has lasted or is expected to last at least 12 months and they meet the conditions described in the question.
Please check the box for any child who is limited in any way in ability to do things most children of the same age can do. Otherwise, check "No One".

☐ No One

☐

Josh (3 yrs)

Please check the box for any child who needs special therapy for emotional, developmental or behavioural problems. Otherwise check "No One".

☐ No One

☐

Josh (3 yrs)

Please check the box for any child who needs or uses medical, mental or educational services other than usual for children of the same age. Otherwise check "No One".

☐ No One

☐

Josh (3 yrs)

## More Information About Children in Your Home

Please check the box for any child who are current with their immunization(shot) requirements. Otherwise check "No One".

☐ No One

☐

Josh (3 yrs)

Please check the box for any child who would like to get child health check up services. Otherwise, check "No One".

☐ No One

☐

Josh (3 yrs)

Please check the box for any child who has been declared an adult by a judge. Otherwise check "No One".

## More Information About Children in Your Home

Please check the box for any child who are current with their immunization(shot) requirements. Otherwise, check "No One".

☐ No One

☐

Josh (3 yrs)

Please check the box for any child who would like to get child health check up services. Otherwise, check "No One".

☐ No One

☐

Josh (3 yrs)

Please check the box for any child who has been declared an adult by a judge. Otherwise check "No One".

☐ No One

☐

Josh (3 yrs)

Please check the box for any child who is a foster child. Otherwise check "No One".

☐ No One

☐

Josh (3 yrs)

## *Migrant Farm-Worker

Is anyone in your household a migrant or seasonal farm-worker? ○ Yes ○ No

When complete, click NEXT.

Previous | Save & Exit | Next

## Other Household Information

Please provide us the following information about your household.

### *Renal Dialysis

Please check the box for anyone who is in renal dialysis. Otherwise, check "No One".

☐ No One


### *School Enrollment

Please check the box for anyone who is attending school, including college and technical school. Otherwise, check "No One".

☐ No One


### *Fleeing Felon/Probation/Parole violation

Please check the box for anyone who is fleeing the law due to a felony or probation or parole violation on or after 8/22/1996. Otherwise, check "No One".

☐ No One


### *Drug Trafficking or Trading Food Assistance

Please check the box for anyone who has 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, or who has 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. Otherwise, Check "No One".

☐ No One


### *Food/Cash/Medical Assistance Conviction

Please check the box for anyone who has been convicted of receiving Food, Cash or Medical Assistance in more than one state at the same time on or after 8/22/1996. Otherwise, check "No one".

☐ No One


### *Benefits Received

Please check the box for anyone who has received Food, Cash or Medical Assistance from another state or source. Otherwise, check "No one".

☐ No One


### *SSI Benefits

Please check the box for anyone who got SSI Benefits in the past but is not receiving them now. Otherwise, check "No One".

☐ No One


### *Daily Living Assistance

Please check the box for anyone that needs help with activities of daily living through personal assistance services, a nursing home, or other medical facility. Otherwise, check "No One".

☐ No One

## About Children in Your Home

To help you get access to specialized care, please answer the next three questions for children 20 or younger. Answer "yes" if they have a chronic and serious medical, behavioral, or other medical condition that has lasted or is expected to last at least 12 months and they meet the conditions described in the question.
Please check the box for any child who is limited in any way in ability to do things most children of the same age can do. Otherwise, check "No One".

☐ No One
☑

Josh (3 yrs)

Please check the box for any child who needs special therapy for emotional, developmental or behavioural problems. Otherwise check "No One".

☐ No One
☑

Josh (3 yrs)

Please check the box for any child who needs or uses medical, mental or educational services other than usual for children of the same age. Otherwise check "No One".

☐ No One
☑

Josh (3 yrs)

## More Information About Children in Your Home

Please check the box for any child who are current with their immunization(shot) requirements. Otherwise check "No One".

☐ No One
☑

Josh (3 yrs)

Please check the box for any child who would like to get child health check up services. Otherwise, check "No One".

## More Information About Children in Your Home

Please check the box for any child who are current with their immunization(shot) requirements. Otherwise check "No One".

☐ No One
☑

Josh (3 yrs)

Please check the box for any child who would like to get child health check up services. Otherwise, check "No One".

☐ No One
☑

Josh (3 yrs)

Please check the box for any child who has been declared an adult by a judge. Otherwise check "No One".

☐ No One
☑

Josh (3 yrs)

Please check the box for any child who is a foster child. Otherwise check "No One".

☐ No One
☑

Josh (3 yrs)

## *Migrant Farm-Worker

Is anyone in your household a migrant or seasonal farm-worker? ◉ Yes ○ No

When complete, click NEXT.

Previous | Save & Exit | Next

Hello, **JANE**. Your ACCESS Online number is: **800150685**

21% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Before You Begin | People

## School Enrollment

You've told us that **Jane** is enrolled in a school. Please complete the following school enrollment information.

**School Enrollment Details**

Click here to read or print the Notice of Learnfare Requirements.

* Please select Jane's school enrollment status:

- ○ Full-time
- ○ Half-time
- ○ Less-than half
- ○ Three-qtrs time

* What is the name of Jane's school?
If Jane is home schooled enter "home schooled".

What is Jane's school district? <Click here to choose>

* What is Jane's school type? <Click here to choose>

If attending high school or equivalent, enter the expected graduation date. (mm/dd/yyyy)

If attending an institute of higher learning, is this person participating in a work study program? ○ Yes ○ No

What is Jane's education level? <Click here to choose>

When complete, click NEXT.

< Previous | Save & Exit | Next >

Hello, JANE. Your ACCESS Online number is: 800150685

21% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Before You Begin | People

## School Enrollment

You've told us that Jane is enrolled in a school. Please complete the following school enrollment information.

### School Enrollment Details

Click here to read or print the Notice of Learnfare Requirements.

* Please select Jane's school enrollment status:

- ○ Full-time
- ○ Half-time
- ○ Less-than half
- ○ Three-qtrs time

* What is the name of Jane's school?
If Jane is home schooled enter "home schooled".

What is Jane's school district? <Click here to choose>

* What is Jane's school type? <Click here to choose>

If attending high school or equivalent, enter the expected graduation date. (mm/dd/yyyy)

If attending an institute of higher learning, is this person participating in a work study program? ○ Yes ○ No

What is Jane's education level? <Click here to choose>

When complete, click NEXT.

<< Previous | Save & Exit | Next >>

Hello, **JANE**. Your ACCESS Online number is: **800150685**

21% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Before You Begin | People

## School Enrollment

You've told us that **Jane** is enrolled in a school. Please complete the following school enrollment information.

**School Enrollment Details**

Click here to read or print the Notice of Learnfare Requirements.

* Please select Jane's school enrollment status:

- ○ Full-time
- ◉ Half-time
- ○ Less-than half
- ○ Three-qtrs time

* What is the name of Jane's school?
If Jane is home schooled enter "home schooled". DCF University

What is Jane's school district? Leon

* What is Jane's school type? Graduate school

If attending high school or equivalent, enter the expected graduation date. (mm/dd/yyyy)

If attending an institute of higher learning, is this person participating in a work study program? ◉ Yes ○ No

What is Jane's education level? Awarded Bachelors Degree

When complete, click NEXT.

<< Previous | Save & Exit | Next >>

Hello, JANE. Your ACCESS Online number is: 860150685

22% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Before You Begin | People

## Supplemental Security Income (SSI) Details

You have already given us some information about John. Please provide more information about John.

**Supplemental Security Income (SSI) Details**

| | |
|---|---|
| * Did John ever get SSI and Social Security benefits at the same time? | ○ Yes ○ No |
| * Did John get SSI in the month before getting Social Security benefits? | ○ Yes ○ No |
| * Has John been entitled to Social Security widow (widower) benefits? | ○ Yes ○ No |
| * Has John been required by Social Security to file for widow (widower) benefits? | ○ Yes ○ No |
| * Is John getting Social Security benefits under a parents coverage? | ○ Yes ○ No |
| * Does John get Social Security benefits due to a change in definition of childhood disability? | ○ Yes ○ No |
| * Did John get SSI benefits prior to age 60? | ○ Yes ○ No |

When complete, click NEXT.

« Previous | Save & Exit | Next »

Hello, JANE. Your ACCESS Online number is: 800150685

22% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Before You Begin | People

## Supplemental Security Income (SSI) Details

You have already given us some information about John. Please provide more information about John.

**Supplemental Security Income (SSI) Details**

| | |
|---|---|
| * Did John ever get SSI and Social Security benefits at the same time? | (•) Yes ( ) No |
| * Did John get SSI in the month before getting Social Security benefits? | (•) Yes ( ) No |
| * Has John been entitled to Social Security widow (widower) benefits? | (•) Yes ( ) No |
| * Has John been required by Social Security to file for widow (widower) benefits? | (•) Yes ( ) No |
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| * Does John get Social Security benefits due to a change in definition of childhood disability? | (•) Yes ( ) No |
| * Did John get SSI benefits prior to age 60? | (•) Yes ( ) No |

When complete, click NEXT.

Previous | Save & Exit | Next

Hello, JANE. Your ACCESS Online number is: 800150685

23% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Before You Begin | People

# Discounted Phone Service

Please provide the information below.

## Discounted Phone Service

Do you want to get a discount of at least $9.25 per month on your phone service from the Lifeline Assistance Program?

If your application is approved, your information can be given to the Public Service Commission (PSC) for automatic enrollment in Florida's Lifeline Assistance program. All personal information given to PSC will be kept confidential.

* Do you want Lifeline Assistance?
- ○ Yes
- ○ No
- ○ Already receive Lifeline Assistance.

If yes, do you have phone service? ○ Yes ○ No

If you have phone service, whose name is the phone bill?

○ No One

○ Josh (3 yrs)

○ Jane (31 yrs)

○ John (33 yrs)

When complete, click NEXT.

Previous | Save & Exit | Next

Hello, JANE. Your ACCESS Online number is: 880150685

23% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Before You Begin | People

# Discounted Phone Service

Please provide the information below.

## Discounted Phone Service

Do you want to get a discount of at least $9.25 per month on your phone service from the Lifeline Assistance Program?

If your application is approved, your information can be given to the Public Service Commission (PSC) for automatic enrollment in Florida's Lifeline Assistance program. All personal information given to PSC will be kept confidential.

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- (●) Yes
- ( ) No
- ( ) Already receive Lifeline Assistance.

If yes, do you have phone service? (●) Yes ( ) No

If you have phone service, whose name is the phone bill?

( ) No One

( ) Josh (3 yrs) (●) Jane (31 yrs) ( ) John (33 yrs)

When complete, click NEXT.

Previous | Save & Exit | Next

# Telephonic Service Provider

You have already given us some information. Please provide more information.

## Telephonic Service Provider

**You said you wanted a discount on your phone service. Answer these questions so we can make a referral. If your telephone company is not listed in the drop down box, it does not offer Lifeline as this time.**

* What is name of your phone company? <Click here to choose>

* What is your phone number?

Please call your phone company if you have Lifeline questions.

Lifeline is a federal benefit. Willfully making false statements to obtain the benefit can result in fines, imprisonment, disenrollment or being barred from the program.

Only one Lifeline service is available per household. A household is defined, for purposes of the Lifeline program, as any individual or group of individuals who live together at the same address and share income and expenses.

A household is not permitted to receive Lifeline benefits from multiple providers.

Violation of the one-per-household limitation constitutes a violation of the Lifeline rules and will result in the subscriber's disenrollment from the program.

Lifeline is a non-transferable benefit and the subscriber may not transfer his or her benefit to any other person.

* Is the residential address listed on this application ○ Permanent ○ Temporary ?(check one)

I certify, that:

I will notify my Lifeline provider within 30 days if I no longer participate in a qualifying DCF assistance program, if I receive more than one Lifeline benefit, or if another member of my household is receiving a Lifeline benefit;

If I move to a new address, I will provide that new address to my Lifeline provider within 30 days;

If I provided a temporary residential address in this application, I will be required to verify my temporary residential address every 90 days with my Lifeline provider;

My household will receive only one Lifeline service and, to the best of my knowledge, my household is not already receiving a Lifeline service;

The information contained in this application is true and correct to the best of my knowledge;
I acknowledge that providing false or fraudulent information to receive Lifeline benefits is punishable by law; and,

I acknowledge that I may be required by my Lifeline provider to recertify my continued eligibility for Lifeline at any time, and my failure to re-certify as to my continued eligibility will result in disenrollment and the termination of my Lifeline benefits.

I understand that my name, telephone number, and address may be provided to the local telephone company, the appropriate federal or State agency, or Universal Service Administrative Company (USAC) (the administrator of the program) and/or its agents for the purpose of verifying my eligibility and verifying that my household does not receive more than one Lifeline benefit.

☐ I certify that I have read and understand.

When complete, click NEXT.

« Previous | Save & Exit | Next »

# Telephonic Service Provider

You have already given us some information. Please provide more information.

## Telephonic Service Provider

**You said you wanted a discount on your phone service. Answer these questions so we can make a referral. If your telephone company is not listed in the drop down box, it does not offer Lifeline as this time.**

*What is name of your phone company?: ACCESS Wireless (Cell phone)

*What is your phone number?: (850) 717-1212

Please call your phone company if you have Lifeline questions.

Lifeline is a federal benefit. Willfully making false statements to obtain the benefit can result in fines, imprisonment, disenrollment or being barred from the program.

Only one Lifeline service is available per household. A household is defined, for purposes of the Lifeline program, as any individual or group of individuals who live together at the same address and share income and expenses.

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Violation of the one-per-household limitation constitutes a violation of the Lifeline rules and will result in the subscriber's disenrollment from the program.

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*Is the residential address listed on this application: (•) Permanent ( ) Temporary ?(check one)

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If I move to a new address, I will provide that new address to my Lifeline provider within 30 days;

If I provided a temporary residential address in this application, I will be required to verify my temporary residential address every 90 days with my Lifeline provider;

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The information contained in this application is true and correct to the best of my knowledge;
I acknowledge that providing false or fraudulent information to receive Lifeline benefits is punishable by law; and,

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☑ **I certify that I have read and understand.**

When complete, click NEXT.

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Hello, JANE. Your ACCESS Online number is: 800150685

25% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Before You Begin | People

# Migrant Details

You have told us that someone in your household is a migrant or seasonal farm-worker. Please provide the information below.

## Migrant Details

| | |
|---|---|
| * Has all of your household income recently stopped? | ○ Yes ○ No |
| * Do you have new source of income? | ○ Yes ○ No |
| When will you get paid from the new source? (mm/dd/yyyy) | |
| What is the amount you will get from the new source? | |

When complete, click NEXT.

Previous | Save & Exit | Next

Hello, JANE. Your ACCESS Online number is: 800150685

25% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Before You Begin | People

# Migrant Details

You have told us that someone in your household is a migrant or seasonal farm-worker. Please provide the information below.

## Migrant Details

| | |
|---|---|
| * Has all of your household income recently stopped? | (•) Yes ( ) No |
| * Do you have new source of income? | (•) Yes ( ) No |
| When will you get paid from the new source? (mm/dd/yyyy) | 05/30/2018 |
| What is the amount you will get from the new source? | $100.00 |

When complete, click NEXT.

Previous | Save & Exit | Next

# Household Member Summary

Here is a summary of what you've told us. If a section below has a checkmark, you have given us all the information we have asked for. You are not required to give all the information before you submit the application.

- If you would like to change your answers, click on the "Change" icon under "Options".
- If you need to add information for an individual, choose the person's name from the dropdown box and then click the "Add" button.
- If you would like to remove something, click the "Remove" icon under "Options".

Once you're reviewed this summary and all the information is correct, click the "Next" button at the bottom of the page.

## Review Your Answers: People In Your Home Summary

| Who | Gender | Date of Birth | Living Arrangement | Citizen | Florida Resident | Section Complete? | Options |
|---|---|---|---|---|---|---|---|
| John (33 yrs) | Male | 01/01/1985 | Home/apartment/trailer | Yes | Yes | ✓ | or |
| Jane (31 yrs) | Female | 01/01/1987 | Home/apartment/trailer | Yes | Yes | ✓ | |
| Josh (3 yrs) | Male | 01/01/2015 | Home/apartment/trailer | Yes | Yes | ✓ | or |

Rights and Responsibilities reviewed? (•) Yes ( ) No

HIPAA statement reviewed? (•) Yes ( ) No

### Add a Person to the Household

To add another person to the household, click the "Add" button. ADD +

## Review Your Answers: Disability Details

| Who | Disability Decided? | Denied by SSA? | Denial Date | Section Complete? | Options |
|---|---|---|---|---|---|
| Josh (3 yrs) | Yes | Yes | 2/24/2018 | ✓ | or |
| Jane (31 yrs) | Yes | Yes | 2/24/2018 | ✓ | or |
| John (33 yrs) | Yes | Yes | 12/24/2017 | ✓ | or |

## Review Your Answers: Alias Name or Social Security Number Details

| Who | Alias Name | Alias SSN | Section Complete? | Options |
|---|---|---|---|---|
| Jane (31 yrs) | Jane Doe | | ✓ | or |
| | | 123456789 | ✓ | or |

### Add an Alias for a Person

To add another alias for a person, click the "Add" button.

Name: <Click here to Choose> ADD +

## Review Your Answers: Pregnancy

### Add Pregnancy for a Person

To add a pregnancy for a person, click the "Add" button.

Name: <Click here to Choose>

ADD +

## Review Your Answers: Relationship Summary

| | Target | Relationships | Buys and eats food with? | Section Complete? | Options |
|---|---|---|---|---|---|
| John (33 yrs) | Josh | Father | Yes | ✔ | |
| Jane (31 yrs) | John | Wife | Yes | ✔ | |
| Jane (31 yrs) | Josh | Mother | Yes | ✔ | |

## Review Your Answers: Tax Information

| | Who | Files Taxes? | Jointly? | Dependents | Section Complete? | Options |
|---|---|---|---|---|---|---|
| John (33 yrs) | John | Yes | Yes | | ✔ | |
| Jane (31 yrs) | Jane | Yes | Yes | Josh Doe | ✔ | |

## Review Your Answers: Tax dependents Outside of the Household

### Add Tax dependent Outside the Household

To add another tax dependent outside of the household for a tax filer, click the "Add" button.

Name: <Click here to Choose>

ADD +

## Review Your Answers: School Enrollment

| | School Name | School Type | Section Complete? | Options |
|---|---|---|---|---|
| Jane (31 yrs) | DCF University | Graduate school | ✔ | or |

### Add a person who is enrolled in school

To add another person who is enrolled in school, click the "Add" button.

Name: <Click here to Choose>

ADD +

## Supplemental Security Income (SSI) Details

| | Name | SSI and SSA Benefits | SS Widow (widower) Benefits | SSI Benefits Prior to Age 60 | Section Complete? | Options |
|---|---|---|---|---|---|---|
| John (33 yrs) | John | Yes | Yes | Yes | ✔ | or |

### Add a person who has SSI benefits

To add another person who has SSI benefits, click the "Add" button.

Name: <Click here to Choose>

ADD +

## Review Your Answers: Migrant Details

## Review Your Answers: Migrant Details

| Household Income Stopped? | New Source? | Amount | Section Complete? | Options |
|---|---|---|---|---|
| Yes | Yes | $100.00 | ✓ | |

## Review Your Answers: Discounted Phone Service Details

| Who | Lifeline Assistance | Service Provider | Section Complete? | Options |
|---|---|---|---|---|
| Jane (31 yrs) | Yes | ACCESS Wireless (Cell phone) | ✓ | |

## Review Your Answers: Renal Dialysis

Please review your answers for anyone who is in renal dialysis and modify your selection as needed.

☐ No One

☑ John (33 yrs) ☐ Jane (31 yrs) ☐ Josh (3 yrs)

## Review Your Answers: Fleeing Felon/Probation/Parole violation

Please review your answers for anyone who is fleeing the law due to felony or probation or parole violation and modify your selection as needed.

☐ No One

☑ John (33 yrs) ☐ Jane (31 yrs)

## Review Your Answers: Drug Trafficking or Trading Food Assistance

Please review your answers for anyone who has been convicted of drug trafficking felony or trading food assistance and modify your selection as needed.

☐ No One

☐ John (33 yrs) ☑ Jane (31 yrs)

## Review Your Answers: Food/Cash/Medical Assistance Conviction

Please review your answers for anyone who has been convicted of receiving Food, Cash or Medical Assistance in more than one state at the same time and modify your selection as needed.

☐ No One

☑ John (33 yrs) ☐ Jane (31 yrs)

## Review Your Answers: Benefits Received

Please review your answers for anyone who has received Food, Cash or Medical Assistance from another state and modify your selection as needed.

☐ No One

☐ John (33 yrs) ☑ Jane (31 yrs) ☐ Josh (3 yrs)

## Review Your Answers: Daily Living Assistance

Please review your answers for anyone that needs help with activities of daily living through personal assistance services, a nursing home or other medical facility and modify your selection as needed.

☐ No One

☐ John (33 yrs) ☑ Jane (31 yrs) ☐ Josh (3 yrs)

## Review Your Answers: Children Related

To help you get access to specialized care, please answer the next three questions for children 20 or younger. Answer "yes" if they have a chronic and serious medical, behavioral, or other medical condition that has lasted or is expected to last at least 12 months and they meet the conditions described in the question.
Please review your answers for any children who are limited in any way in ability to do things most children of the same age can do and modify your selection as needed.

☐ No One

☑ Josh (3 yrs)

Please review your answers for any children who need special therapy for emotional, development or behavioral problems and modify your selection as

## Review Your Answers: Children Related

To help you get access to specialized care, please answer the next three questions for children 20 or younger. Answer "yes" if they have a chronic and serious medical, behavioral, or other medical condition that has lasted or is expected to last at least 12 months and they meet the conditions described in the question.
Please review your answers for any children who are limited in any way in ability to do things most children of the same age can do and modify your selection as needed.

☐ No One

☑

Josh (3 yrs)

Please review your answers for any children who need special therapy for emotional, development or behavioral problems and modify your selection as needed.

☐ No One

☑

Josh (3 yrs)

Please review your answers for any children who need or use medical, mental or educational services than usual for children of the same age and modify your selection as needed.

☐ No One

☑

Josh (3 yrs)

## Review Your Answers: More Information About Children In Your Home

Please review your answers for any children who are current with their immunization (shot) requirements and modify your selection as needed.

☐ No One

☑

Josh (3 yrs)

Please review your answers for anyone who a judge declared an adult and modify your selection as needed.

☐ No One

☑

Josh (3 yrs)

Please review your answers for anyone who a judge declared an adult and modify your selection as needed.

☐ No One

☑

Josh (3 yrs)

Please check the box for any child who is a foster child. Otherwise check "No One".

☐ No One

☑

Josh (3 yrs)

When complete, click NEXT.

Previous | Save & Exit | Next

## Liquid Assets

Please tell us about the people in your home who have liquid assets. Liquid assets are things like cash, bank accounts (checking or savings accounts), stocks, bonds, retirement accounts, trust funds, mutual funds, pre-paid funeral expenses, or certificates of deposit. Include all annuities even if not yet receiving income from them, continuing care retirement, life care community contracts or any other liquid assets not listed. If someone owns an asset with another person, please check the box for just one owner. Later we'll ask about who else owns the asset.

**Note:** Please be sure to answer the questions for everyone in your home, even if they are not applying for assistance. Depending on your situation, we may need this information in order to approve you for assistance. If we find that your situation does not require us to use this information, then we won't use it to determine your eligibility. (Information will not be used to determine Food Assistance eligibility).

### Cash

Please check the box for anyone who has cash on hand and not in the bank. Otherwise, check "No One".

☐ No One

☐ Josh (3 yrs) ☐ Jane (31 yrs) ☐ John (33 yrs)

### Bank Accounts

Please check the box for anyone who has a financial account. Otherwise, check "No One". Bank accounts include checking account, savings account, credit union account or saving certificate accounts.

☐ No One

☐ Josh (3 yrs) ☐ Jane (31 yrs) ☐ John (33 yrs)

### Other Liquid Assets

Please check the box for anyone who owns any other liquid assets. Otherwise, check "No One". Other liquid assets include stocks, bonds or trust funds, etc.

☐ No One

☐ Josh (3 yrs) ☐ Jane (31 yrs) ☐ John (33 yrs)

### Sold, Traded, Given Away or Transferred Assets

Please check the box for anyone who has sold, given away or transferred an asset in the last five years. If you are only applying for Food Assistance, check the box for anyone who has sold, given away or transferred as asset in the last three months. Otherwise, check "No One".

☐ No One

☐ Josh (3 yrs) ☐ Jane (31 yrs) ☐ John (33 yrs)

### Cash Settlements

Please check the box for anyone who has received a cash settlement in the last 3 months or is expecting to receive a cash settlement. Otherwise, check "No One". Settlements are payments received from accidents, insurance claims, inheritance, lottery winnings or any other type of cash payment.

☐ No One

☐ Josh (3 yrs) ☐ Jane (31 yrs) ☐ John (33 yrs)

When complete, click NEXT.

« Previous | Save & Exit | Next »

## Liquid Assets

Please tell us about the people in your home who have liquid assets. Liquid assets are things like cash, bank accounts (checking or savings accounts), stocks, bonds, retirement accounts, trust funds, mutual funds, pre-paid funeral expenses, or certificates of deposit. Include all annuities even if not yet receiving income from them, continuing care retirement, life care community contracts or any other liquid assets not listed. If someone owns an asset with another person, please check the box for just one owner. Later we'll ask about who else owns the asset.

**Note:** Please be sure to answer the questions for everyone in your home, even if they are not applying for assistance. Depending on your situation, we may need this information in order to approve you for assistance. If we find that your situation does not require us to use this information, then we won't use it to determine your eligibility. (Information will not be used to determine Food Assistance eligibility).

### *Cash

Please check the box for anyone who has cash on hand and not in the bank. Otherwise, check "No One".

☐ No One

| Josh (3 yrs) | Jane (31 yrs) | John (33 yrs) |
|---|---|---|
| ☐ | ☑ | ☐ |

### *Bank Accounts

Please check the box for anyone who has a financial account. Otherwise, check "No One". Bank accounts include checking account, savings account, credit union account or saving certificate accounts.

☐ No One

| Josh (3 yrs) | Jane (31 yrs) | John (33 yrs) |
|---|---|---|
| ☐ | ☐ | ☑ |

### *Other Liquid Assets

Please check the box for anyone who owns any other liquid assets. Otherwise, check "No One". Other liquid assets include stocks, bonds or trust funds, etc.

☐ No One

| Josh (3 yrs) | Jane (31 yrs) | John (33 yrs) |
|---|---|---|
| ☐ | ☑ | ☐ |

### *Sold, Traded, Given Away or Transferred Assets

Please check the box for anyone who has sold, given away or transferred an asset in the last five years. If you are only applying for Food Assistance, check the box for anyone who has sold, given away or transferred as asset in the last three months. Otherwise, check "No One".

☐ No One

| Josh (3 yrs) | Jane (31 yrs) | John (33 yrs) |
|---|---|---|
| ☐ | ☐ | ☑ |

### *Cash Settlements

Please check the box for anyone who has received a cash settlement in the last 3 months or is expecting to receive a cash settlement. Otherwise, check "No One". Settlements are payments received from accidents, insurance claims, inheritance, lottery winnings or any other type of cash payment.

☐ No One

| Josh (3 yrs) | Jane (31 yrs) | John (33 yrs) |
|---|---|---|
| ☐ | ☑ | ☐ |

When complete, click NEXT.

Hello, JANE. Your ACCESS Online number is: 900150685

28% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Liquid Assets | Other Assets

## More About Jane's Cash Asset

Please tell us more about Jane's cash

### Cash

* How much cash does Jane have on hand and not in the bank?

### Burial Assets

* Is Jane designating any of this asset for burial? ○ Yes ○ No

If yes, how much?

### Other Owners

* Please select the individual who owns part of this asset with Jane.

○ Josh (3 yrs) ○ John (33 yrs)

○ Someone outside of the home

○ Not jointly owned with anyone

If part owner, what percentage does this person own?

When complete, click NEXT.

Previous | Save & Exit | Next

Hello, JANE. Your ACCESS Online number is: 800150685

28% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Liquid Assets | Other Assets

## More About Jane's Cash Asset

Please tell us more about Jane's cash

**Cash**

*How much cash does Jane have on hand and not in the bank? $100.00

**Burial Assets**

*Is Jane designating any of this asset for burial? (•) Yes ( ) No

If yes, how much? $50.00

***Other Owners**

*Please select the individual who owns part of this asset with Jane.

( ) Josh (3 yrs) (•) John (33 yrs)

( ) Someone outside of the home

( ) Not jointly owned with anyone

If part owner, what percentage does this person own? 50

When complete, click NEXT.

<< Previous | Save & Exit | Next >>

Liquid Assets | Other Assets

## More about John's Bank Account

Please tell us more about John's bank account. If John has more than one account, please enter one at a time.

**Bank Account**

* Type of bank account:
* What is the amount that John has in the account?
Name of the bank:
Account number if known:

**Burial Assets**

* Is John designating any of this asset for burial? ○ Yes ○ No
If yes, how much?

**Other Owners**

* Please select the individual who owns part of this asset with John.

○  Josh (3 yrs)

○  Jane (31 yrs)

○ Someone outside of the home

○ Not jointly owned with anyone

If part owner, what percentage does this person own?

* Does John have any other bank accounts? ○ Yes ○ No

When complete, click NEXT.

Previous | Save & Exit | Next

# More about John's Bank Account

Please tell us more about John's bank account. If John has more than one account, please enter one at a time.

## Bank Account

| | |
|---|---|
| * Type of bank account: | Checking account |
| * What is the amount that John has in the account? | $100.00 |
| Name of the bank: | DCF Federal |
| Account number if known: | |

## Burial Assets

| | |
|---|---|
| * Is John designating any of this asset for burial? | (•) Yes ( ) No |
| If yes, how much? | $50.00 |

## *Other Owners

* Please select the individual who owns part of this asset with John.

( )  Josh (3 yrs)

(•)  Jane (31 yrs)

( ) Someone outside of the home

( ) Not jointly owned with anyone

If part owner, what percentage does this person own? 50

* Does John have any other bank accounts? ( ) Yes (•) No

When complete, click NEXT.

< Previous | Save & Exit | Next >

Hello, **JANE**. Your ACCESS Online number is: **880150685**

31% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Liquid Assets | Other Assets

## Other Liquid Assets

Please check the boxes to tell us which types of other assets each person owns. If an asset has more than one owner, you only need to tell us about that asset once. If you need to know more about a type of asset listed below, please click the Help button.

**Jane's Liquid Assets**

Jane (31 yrs)

- ☐ Burial Contracts
- ☐ Medicaid Qualified Trust
- ☐ Trust funds
- ☐ Christmas Club
- ☐ Other Asset
- ☐ IRA or Annuity
- ☐ Stocks or bonds
- ☐ Keogh plan
- ☐ Tax Shelter Accounts

When complete, click NEXT.

Previous | Save & Exit | Next

# ACCESS Florida

# ACCEPTANCE TEST

English | Español | Kreyòl

Hello, JANE. Your ACCESS Online number is: 800150685

31% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Liquid Assets | Other Assets

## Other Liquid Assets

Please check the boxes to tell us which types of other assets each person owns. If an asset has more than one owner, you only need to tell us about that asset once. If you need to know more about a type of asset listed below, please click the Help button.

**Jane's Liquid Assets**

Jane (31 yrs)

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- ☐ Medicaid Qualified Trust
- ☐ Trust funds
- ☐ Christmas Club
- ☑ Other Asset
- ☐ IRA or Annuity
- ☐ Stocks or bonds
- ☐ Keogh plan
- ☐ Tax Shelter Accounts

When complete, click NEXT.

<< Previous | Save & Exit | Next >>

CF-ES 2353 12/2013, 65A-1.205, F.A.C.

Liquid Assets | Other Assets

## More about Jane's Other Asset

Please tell us more about Jane's Other Asset. If Jane has more than one Other Asset, please enter one at a time.

**Other Asset**

* What is the amount of Jane's Other Asset?
Name of bank or company
Account number if known:

**Burial Assets**

* Is Jane designating any of this asset for burial? ○ Yes ○ No
If yes, how much?

**Other Owners**

* Please select the individual who owns part of this asset with Jane.

○  Josh (3 yrs)

○  John (33 yrs)

○ Someone outside of the home

○ Not jointly owned with anyone

If part owner, what percentage does this person own?

* Does Jane have any other Other Asset account? ○ Yes ○ No

When complete, click NEXT.

Previous | Save & Exit | Next

Liquid Assets | Other Assets

## More about Jane's Other Asset

Please tell us more about Jane's Other Asset. If Jane has more than one Other Asset, please enter one at a time.

**Other Asset**

* What is the amount of Jane's Other Asset? $100.00

Name of bank or company: DCF Federal

Account number if known:

**Burial Assets**

* Is Jane designating any of this asset for burial? (•) Yes ( ) No

If yes, how much? $50.00

**Other Owners**

* Please select the individual who owns part of this asset with Jane.

( ) Josh (3 yrs) (•) John (33 yrs)

( ) Someone outside of the home

( ) Not jointly owned with anyone

If part owner, what percentage does this person own? 50

* Does Jane have any other Other Asset account? ( ) Yes (•) No

When complete, click NEXT.

< Previous | Save & Exit | Next >

Hello, JANE. Your ACCESS Online number is: 800150685

33% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Liquid Assets | Other Assets

## More about **John's** Sold, Traded, Transferred, Given Away Resources

Please tell us more about the asset that John has sold, transferred, traded or gave away in the last 5 years.

*** Sold, Traded, Transferred, Given Away Resources**

* What is the type of asset? <Click here to choose>

* When was this asset sold, traded, transferred or given away(mm/dd/yyyy) ?

* What was the value of the asset at the time it was sold, given away or transferred?

* Whom was this asset sold, traded, transferred or given away to?

* Why was the asset sold, traded, transferred or given away?

* Did John sell, trade, transfer or give away any other assets? ○ Yes ○ No

When complete, click NEXT.

Previous | Save & Exit | Next

Hello, JANE. Your ACCESS Online number is: 800150685

33% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Liquid Assets | Other Assets

## More about **John's** Sold, Traded, Transferred, Given Away Resources

Please tell us more about the asset that John has sold, transferred, traded or gave away in the last 5 years.

***Sold, Traded, Transferred, Given Away Resources**

| | |
|---|---|
| * What is the type of asset? | Vehicles |
| * When was this asset sold, traded, transferred or given away(mm/dd/yyyy) ? | 04/24/2018 |
| * What was the value of the asset at the time it was sold, given away or transferred? | $5000.00 |
| * Whom was this asset sold, traded, transferred or given away to? | Neighbor |
| * Why was the asset sold, traded, transferred or given away? | No longer needed it |

* Did John sell, trade, transfer or give away any other assets? (●) Yes ( ) No

When complete, click NEXT.

Previous | Save & Exit | Next

Hello, JANE. Your ACCESS Online number is: 800150685

33% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Liquid Assets | Other Assets

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Please tell us more about the asset that John has sold, transferred, traded or gave away in the last 5 years.

***Sold, Traded, Transferred, Given Away Resources**

* What is the type of asset? <Click here to choose>
* When was this asset sold, traded, transferred or given away(mm/dd/yyyy) ?
* What was the value of the asset at the time it was sold, given away or transferred?
* Whom was this asset sold, traded, transferred or given away to?
* Why was the asset sold, traded, transferred or given away?

* Did John sell, trade, transfer or give away any other assets? ○ Yes ○ No

When complete, click NEXT.

Previous | Save & Exit | Next

Hello, **JANE**. Your ACCESS Online number is: **800150685**

33% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Liquid Assets | Other Assets

## More about **John's** Sold, Traded, Transferred, Given Away Resources

Please tell us more about the asset that John has sold, transferred, traded or gave away in the last 5 years.

***Sold, Traded, Transferred, Given Away Resources**

| | |
|---|---|
| * What is the type of asset? | Vehicles |
| * When was this asset sold, traded, transferred or given away(mm/dd/yyyy) ? | 04/24/2018 |
| * What was the value of the asset at the time it was sold, given away or transferred? | $5000.00 |
| * Whom was this asset sold, traded, transferred or given away to? | Neighbor |
| * Why was the asset sold, traded, transferred or given away? | No longer needed it |

* Did John sell, trade, transfer or give away any other assets? ○ Yes ◉ No

When complete, click NEXT.

Previous | Save & Exit | Next

Hello, JANE. Your ACCESS Online number is: 800150685

34% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Liquid Assets | Other Assets

## Cash Settlements

Please check the boxes to tell us which types of cash settlement payments each person received or is expecting to receive. If an asset has more than one owner, you only need to tell us about that asset once.

**Jane Cash Settlements**

Jane (31 yrs)

- ☐ Benefits
- ☐ Lottery
- ☐ Child Support
- ☐ Other
- ☐ Inheritance
- ☐ Law Suit

When complete, click NEXT.

Previous | Save & Exit | Next

34% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Liquid Assets | Other Assets

## Cash Settlements

Please check the boxes to tell us which types of cash settlement payments each person received or is expecting to receive. If an asset has more than one owner, you only need to tell us about that asset once.

**Jane Cash Settlements**

Jane (31 yrs)

- ☐ Benefits
- ☐ Lottery
- ☐ Child Support
- ☐ Other
- ☑ Inheritance
- ☐ Law Suit

When complete, click NEXT.

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# More about Jane's Inheritance Settlement

Please tell us more about Jane's Inheritance Settlement. If Jane has more than one inheritance settlement, please enter one at a time.

## Inheritance Cash Settlements

* What is the status of the Jane's Inheritance settlement? ○ Expected ○ Received

What is the amount of Inheritance settlement Jane received or is expecting to be receive? If unknown, leave blank.

* What is the date Jane received or is expecting to receive the Inheritance settlement(mm/dd/yyyy)? If you do not know the exact date, give us your best guess.

* Is the settlement payment from personal injury or wrongful death claim? ○ Yes ○ No

## Burial Assets

* Is Jane designating any of this asset for burial? ○ Yes ○ No

If yes, how much?

* Does Jane have any other Inheritance settlement? ○ Yes ○ No

When complete, click NEXT.

Previous | Save & Exit | Next

Liquid Assets | Other Assets

## More about Jane's Inheritance Settlement

Please tell us more about Jane's Inheritance Settlement. If Jane has more than one inheritance settlement, please enter one at a time.

### Inheritance Cash Settlements

* What is the status of the Jane's Inheritance settlement? (●) Expected ( ) Received

What is the amount of inheritance settlement Jane received or is expecting to be receive? If unknown, leave blank. $10000.00

* What is the date Jane received or is expecting to receive the inheritance settlement(mm/dd/yyyy)? If you do not know the exact date, give us your best guess. 12/24/2018

* Is the settlement payment from personal injury or wrongful death claim? (●) Yes ( ) No

### Burial Assets

* Is Jane designating any of this asset for burial? (●) Yes ( ) No

If yes, how much? $50.00

* Does Jane have any other inheritance settlement? ( ) Yes (●) No

When complete, click NEXT.

Previous | Save & Exit | Next

# Release of Financial Information

Please provide the information below.

## Release of Financial Information

Individuals requesting Medicaid on the basis of age 65 or older, blindness or disability must give the Department of Children and Families (DCF) permission to request financial records from financial institutions such as a bank, savings and loan or credit union and can grant permission electronically.

Parents of children under age 18 and spouses whose assets are required to be evaluated during the eligibility determination process for the aged, blind or disabled Medicaid programs must also give DCF their permission to request financial records from financial institutions. These individuals must sign the form CF-ES 2613 and return it to the Department.

Eligibility for benefits cannot be determined if all individuals whose assets are required to be reviewed fails to give permission or revokes permission without good cause. Proof of good cause must be provided to evaluate this exception.

By giving permission, the individual acknowledges that they grant permission and authorize any bank, building association, employer, insurance company, real estate company, government agency or any financial institution of any kind or character to disclose to any agent of the Department of Children and Families full information as to their bank accounts, earnings, insurance policies, property or benefits.

---

**The Applicant, or Designated Representative who has legal authority, or Power of Attorney, or Guardianship must make a selection.**

Individual requesting assistance:

- ○ I give permission for DCF to request my financial records.
- ○ I do not give permission for DCF to request my financial records.
- ○ I request a good cause exception from DCF not to request my financial records.
- ○ I do not have legal authority to give permission for DCF to request the applicant's financial records.

If you are a spouse or representative of an individual requesting assistance and do not have legal authority, or Power of Attorney, or Guardianship, please click on the link below, print the form, have it signed by the individual and return the form to the Department.

Click the link below to print the form CF-ES 2613

When complete, click NEXT.

# Release of Financial Information

Please provide the information below.

## Release of Financial Information

Individuals requesting Medicaid on the basis of age 65 or older, blindness or disability must give the Department of Children and Families (DCF) permission to request financial records from financial institutions such as a bank, savings and loan or credit union and can grant permission electronically.

Parents of children under age 18 and spouses whose assets are required to be evaluated during the eligibility determination process for the aged, blind or disabled Medicaid programs must also give DCF their permission to request financial records from financial institutions. These individuals must sign the form CF-ES 2613 and return it to the Department.

Eligibility for benefits cannot be determined if all individuals whose assets are required to be reviewed fails to give permission or revokes permission without good cause. Proof of good cause must be provided to evaluate this exception.

By giving permission, the individual acknowledges that they grant permission and authorize any bank, building association, employer, insurance company, real estate company, government agency or any financial institution of any kind or character to disclose to any agent of the Department of Children and Families full information as to their bank accounts, earnings, insurance policies, property or benefits.

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**The Applicant, or Designated Representative who has legal authority, or Power of Attorney, or Guardianship must make a selection.**

Individual requesting assistance:

- (●) I give permission for DCF to request my financial records.
- ( ) I do not give permission for DCF to request my financial records.
- ( ) I request a good cause exception from DCF not to request my financial records.
- ( ) I do not have legal authority to give permission for DCF to request the applicant's financial records.

If you are a spouse or representative of an individual requesting assistance and do not have legal authority, or Power of Attorney, or Guardianship, please click on the link below, print the form, have it signed by the individual and return the form to the Department.

Click the link below to print the form CF-ES 2613

When complete, click NEXT.

Before you click "Next" to move on to the other changes, please take a look at this page to make sure everything is correct.

-If you need to make a change, click on the "Change" icon under "Options".
-If you need to add information for an individual, choose the person's name from the dropdown box and then click the "Add" button.
-If you would like to remove something, click the "Remove" icon under "Options".

Once you have reviewed this summary and all the information is correct, click the "Next" Button at the bottom of the page.

## Review Your Answers: Cash

| Who | Amount | Section Complete? | Options |
|---|---|---|---|
| Jane | 100.00 | ✓ | or |

Jane (31 yrs)

### Add a Person Who Has Cash

To add a person in your household who has cash, please choose their name. Then click the "Add" button.

Name: < Click here to choose >

ADD +

## Review Your Answers: Bank Accounts

| Who | Account Type | Amount | Bank/Company Name | Account Number | Section Complete? | Options |
|---|---|---|---|---|---|---|
| John | Checking account | 100.00 | DCF Federal | | ✓ | or |

John (33 yrs)

### Add a Person Who Has a Bank Account

To add a person in your household who has cash, please choose their name. Then click the "Add" button.

Name: < Click here to choose >

ADD +

## Review Your Answers: Other Liquid Assets

| Who | Account Type | Amount | Bank/Company Name | Account Number | Section Complete? | Options |
|---|---|---|---|---|---|---|
| Jane | Other Asset | 100.00 | DCF Federal | | ✓ | or |

Jane (31 yrs)

### Add Other Liquid Asset

To add a person in your household who has cash, please choose their name. Then click the "Add" button.

Name: < Click here to choose >

Type: < Click here to choose >

ADD +

## Review Your Answers: Sold, Traded, Transferred or Given Away Assets

| Owner | Value | Amount Received | Reason for transfer | Section Complete? | Options |
|---|---|---|---|---|---|
| John | Vehicles | 5000.00 | No longer needed it | ✓ | or |
| John | Vehicles | 5000.00 | No longer needed it | ✓ | or |

John (33 yrs)

### Add Another Transaction

If someone else sold, traded, transferred or gave away another asset, please select the person. Then click the "Add" button.

Name: < Click here to choose >

ADD +

## Review Your Answers: Cash Settlements

| Owner | Asset Type | Amount | Section Complete? | Options |
|---|---|---|---|---|
| Jane | Inheritance | 10000.00 | ✔ | or |

Jane (31 yrs)

### Add a Cash Settlement

If someone else in your home has cash settlements, please choose the name of the owner and type of cash settlement. Then click the "Add" button.

Name: < Click here to choose >

Type: <Click here to choose>

ADD +

## Review Your Answers:Release of Financial Information

| Release of Financial Information | Section Complete? | Options |
|---|---|---|
| Authorized | ✔ | |

When complete, click NEXT.

<< Previous | Save & Exit | Next >>

## Other Assets

Please tell us about the people in your home who have other kinds of assets. If someone owns an asset with another person, please check the box for just one owner. Later we'll ask about who else owns the asset.

Note: Please be sure to answer the questions for everyone in your home, even if they are not applying for assistance. Depending on your situation, we may need this information in order to approve you for assistance. If we find that your situation does not require us to use this information, then we won't use it to determine your eligibility.

### *Life Insurance

Please check the box for anyone who owns a life insurance policy that has cash value. Otherwise, check "No One".

☐ No One

☐ Josh (3 yrs) ☐ Jane (31 yrs) ☐ John (33 yrs)

### *Vehicles

Please check the box for anyone who owns or co-own a vehicle. By vehicles, we mean licensed and unlicensed vehicles such as cars, trucks, vans, motorboats, motor homes, recreational vehicles, or motorcycles/mopeds etc. Otherwise, check "No One".

☐ No One

☐ Josh (3 yrs) ☐ Jane (31 yrs) ☐ John (33 yrs)

### *Real Estate

Please check the box for anyone who owns all or part of any property. By property, we means homestead property, inherited property, vacant lot, time-share, rental property, burial plots or any other property asset. Otherwise, check "No One".

☐ No One

☐ Josh (3 yrs) ☐ Jane (31 yrs) ☐ John (33 yrs)

### *Business Assets

Please check the box for anyone who owns all or part of business assets. Otherwise, check "No One"

☐ No One

☐ Josh (3 yrs) ☐ Jane (31 yrs) ☐ John (33 yrs)

When complete, click NEXT.

[redacted]

## Other Assets

Please tell us about the people in your home who have other kinds of assets. If someone owns an asset with another person, please check the box for just one owner. Later we'll ask about who else owns the asset.

Note: Please be sure to answer the questions for everyone in your home, even if they are not applying for assistance. Depending on your situation, we may need this information in order to approve you for assistance. If we find that your situation does not require us to use this information, then we won't use it to determine your eligibility.

### *Life Insurance

Please check the box for anyone who owns a life insurance policy that has cash value. Otherwise, check "No One".

☐ No One

| ☐ | ☐ | ☑ |
|---|---|---|
| Josh (3 yrs) | Jane (31 yrs) | John (33 yrs) |

### *Vehicles

Please check the box for anyone who owns or co-own a vehicle. By vehicles, we mean licensed and unlicensed vehicles such as cars, trucks, vans, motorboats, mofor homes, recreational vehicles, or motorcycles/mopeds etc. Otherwise, check "No One"

☐ No One

| ☐ | ☑ | ☐ |
|---|---|---|
| Josh (3 yrs) | Jane (31 yrs) | John (33 yrs) |

### *Real Estate

Please check the box for anyone who owns all or part of any property. By property, we means homestead property, inherited property, vacant lot, time-share, rental property, burial plots or any other property asset. Otherwise, check "No One"

☐ No One

| ☐ | ☐ | ☑ |
|---|---|---|
| Josh (3 yrs) | Jane (31 yrs) | John (33 yrs) |

### *Business Assets

Please check the box for anyone who owns all or part of business assets. Otherwise, check "No One".

☐ No One

| ☐ | ☑ | ☐ |
|---|---|---|
| Josh (3 yrs) | Jane (31 yrs) | John (33 yrs) |

When complete, click NEXT.

[redacted]

Hello, JANE. Your ACCESS Online number is: 800150685

38% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Liquid Assets | Other Assets

## Life Insurance

Please check the box to tell us what kind of life insurance each person has. If you aren't sure, please click the Help button to read more about each type of life insurance. If an asset has more than one owner, you only need to tell us about that asset once.

### John's Life Insurance

John (33 yrs)

- ☐ Group
- ☐ Term
- ☐ Whole Life
- ☐ Group/Term Policy
- ☐ Universal

When complete, click NEXT.

Previous | Save & Exit | Next

Hello, JANE. Your ACCESS Online number is: 800150685

38% Complete

Get Started | Assets | Income | Expenses | Finish&Submit

Liquid Assets | Other Assets

## Life Insurance

Please check the box to tell us what kind of life insurance each person has. If you aren't sure, please click the Help button to read more about each type of life insurance. If an asset has more than one owner, you only need to tell us about that asset once.

***John's Life Insurance**

John (33 yrs)

- [x] Group
- [ ] Term
- [ ] Whole Life
- [ ] Group/Term Policy
- [ ] Universal

When complete, click NEXT.

Previous | Save & Exit | Next

Liquid Assets | Other Assets

# More About John's Life Insurance

You have told us that John has Life Insurance. Please answer the questions below to tell us more about this Life Insurance.

## John Group Life Insurance

Please tell us more about John's Group life policy.

* What is the face value of this Group life policy? By face value, we mean the minimum benefit that will be paid out upon John's death. In most cases, this is the amount written on the policy.

What is the cash surrender value of this Group life policy? By cash surrender value, we mean the amount John would get if John canceled the policy.

* What is the policy number?

What is the loan amount?

What date was John's Term acquired?
Ex: mm/dd/yyyy

## Insurance Company

Please tell us more about John's insurance company.

Name:

Address line 1

Address line 2

City

State <Click here to choose>

Zip

## Burial Assets

* Is John designating any of this asset for burial? ○ Yes ○ No

If yes, how much?

* Does John have another Life Insurance policy? ○ Yes ○ No

When complete, click NEXT.

< Previous | Save & Exit | Next >

# More About **John's** Life Insurance

You have told us that John has Life Insurance. Please answer the questions below to tell us more about this Life Insurance.

## John Group Life Insurance

Please tell us more about John's Group life policy.

* What is the face value of this Group life policy? By face value, we mean the minimum benefit that will be paid out upon John's death. In most cases, this is the amount written on the policy. $50000.00

What is the cash surrender value of this Group life policy? By cash surrender value, we mean the amount John would get if John canceled the policy. $25000.00

* What is the policy number? 12345678

What is the loan amount?

What date was John's Term acquired? Ex: mm/dd/yyyy

## Insurance Company

Please tell us more about John's insurance company.

Name: DCF Life Insurance

Address line 1 1317 Winewood Blvd

Address line 2

City Tallahassee

State Florida

Zip 32399

## Burial Assets

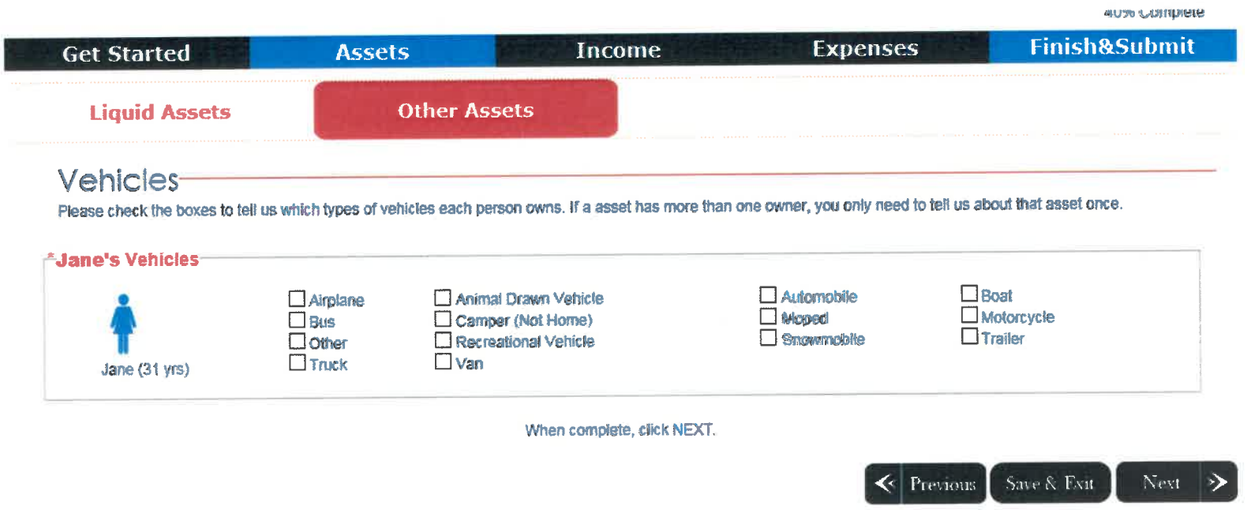
* Is John designating any of this asset for burial? (•) Yes ( ) No

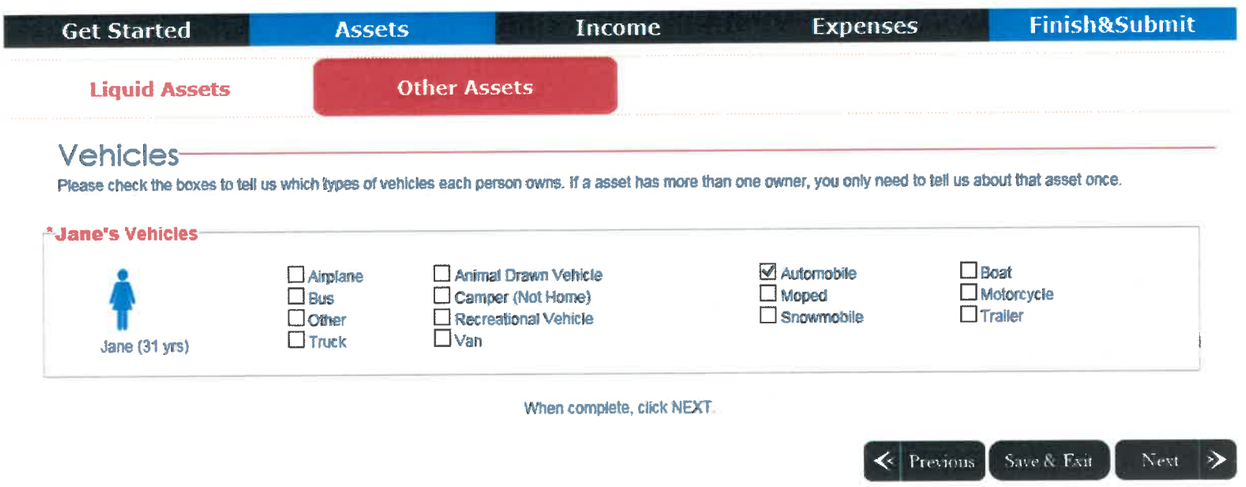
If yes, how much? $50.00

* Does John have another Life insurance policy? ( ) Yes (•) No

When complete, click NEXT.

<< Previous | Save & Exit | Next >>


40% Complete
Get Started
Assets
Income
Expenses
Finish&Submit
Liquid Assets
Other Assets
Vehicles
Please check the boxes to tell us which types of vehicles each person owns. If a asset has more than one owner, you only need to tell us about that asset once.
*Jane's Vehicles
Jane (31 yrs)
Airplane
Bus
Other
Truck
Animal Drawn Vehicle
Camper (Not Home)
Recreational Vehicle
Van
Automobile
Moped
Snowmobile
Boat
Motorcycle
Trailer
When complete, click NEXT.
Previous
Save & Exit
Next


Get Started
Assets
Income
Expenses
Finish&Submit
Liquid Assets
Other Assets
Vehicles
Please check the boxes to tell us which types of vehicles each person owns. If a asset has more than one owner, you only need to tell us about that asset once.
*Jane's Vehicles
Jane (31 yrs)
Airplane
Bus
Other
Truck
Animal Drawn Vehicle
Camper (Not Home)
Recreational Vehicle
Van
Automobile
Moped
Snowmobile
Boat
Motorcycle
Trailer
When complete, click NEXT.
Previous
Save & Exit
Next

## More About **Jane's** Vehicle.

You have told us that Jane has Vehicle. Please answer the questions below to tell us more about this Vehicle.

**Jane's Automobile**

Please tell us more about Jane's Automobile

* Year
Ex: yyyy

Make

Model

* Does this Automobile have a current tag? ○ Yes ○ No

What is the amount owed by Jane ?

What is the Fair market value of the Jane's Automobile?

Does Jane have access to and use of this Automobile ? ○ Yes ○ No

* How is this Automobile used? <Click here to choose>

**Other Owners**

Please select for anyone who owns the Automobile with Jane

○ Josh (3 yrs)

○ John (33 yrs)

○ Someone outside of the home
○ Not jointly owned with anyone

If part owner, what percentage does this person own?

* Does Jane have another Vehicle? ○ Yes ○ No

When complete, click NEXT.

Previous Save & Exit Next

# More About **Jane's** Vehicle.

You have told us that Jane has Vehicle. Please answer the questions below to tell us more about this Vehicle.

## Jane's Automobile

Please tell us more about Jane's Automobile

* Year: 2015 Ex: yyyy

Make: Toyota

Model: Camary

* Does this Automobile have a current tag? (•) Yes ( ) No

What is the amount owed by Jane ?

What is the Fair market value of the Jane's Automobile?

Does Jane have access to and use of this Automobile ? (•) Yes ( ) No

* How is this Automobile used? Employment/Training or School Transportation

## *Other Owners

Please select for anyone who owns the Automobile with Jane

( ) Josh (3 yrs) (•) John (33 yrs)

( ) Someone outside of the home
( ) Not jointly owned with anyone

If part owner, what percentage does this person own? 50

* Does Jane have another Vehicle? ( ) Yes (•) No

When complete, click NEXT.

Previous | Save & Exit | Next