

READ THE FOLLOWING BEFORE YOU COMPLETE PART 4 & 5

PLEASE CHECK ✓ IF YOU ARE PARTICIPATING IN ONE OF THE FOLLOWING PROGRAMS AND BRING THE AWARD OR ELIGIBILITY LETTER OR CARD AS PROOF.

- __ Medicaid
- __ Project AIDS Care (PAC)
- __ Food Stamps

- __ Temporary Assistance for Needy Families (TANF)
- __ Women, Infants and Children (WIC)
- __ Name Other: _____

SKIP PARTS 4 & 5 IF YOU HAVE PROOF OF ELIGIBILITY FOR ONE OF THE ABOVE PROGRAMS.

PART 4. Household Monthly Income

Household Income means gross income from all sources received by the applicant and the applicant's spouse (if married). This includes other adult persons living in the home, if they have joint financial arrangements with the applicant, such as banking (checking and savings) accounts, mortgage agreements, business or other personal finances. **DO NOT INCLUDE**, adults in the home with separate finances, live-in aides or persons under 16 years of age.

HOUSEHOLD MONTHLY INCOME BEFORE TAXES AND DEDUCTIONS

Name (First & Last)	Relationship of person to you	Monthly Work Income	Monthly Social Security	Monthly SSI Retirement Income	Unemployment Child Support, Public Assistance, Other	Monthly Totals	Check if No Income*
		\$	\$	\$	\$	\$	
	Applicant						
Total Monthly Household Income						\$ _____	

*If you checked NO INCOME provide a statement as to how food, clothing and shelter are being provided for you.

PART 5. Cash and Items of Value

- Do you have a checking bank account? Yes ___ No ___ If yes, how much? \$ _____
- Do you have a savings bank account? Yes ___ No ___ If yes, how much? \$ _____ How many cars do you have? ___
- Do you have more than 1 home? Yes ___ No ___ Do you own property (other than your personal residence)? Yes ___ No ___
- Do you own a business? Yes ___ No ___ Name and Address: _____
- List other items of value such as Certificates of Deposits, Treasury Bills Other: _____

PART 6. Rights and Responsibilities (Please Initial by Each Item Below)

- I understand that I am responsible for giving truthful and correct information on this application and during the application process to the best of my knowledge and failure to be truthful may prevent or delay a determination of eligibility to receive services.
- I understand if I knowingly give information that is not true or withhold information and receive services that I am not eligible to receive, I may be lawfully punished and have to pay the Department of Health back for services.
- I understand the information I provide may be verified, which may include computer matching and the information I give about my income may be checked,
- I understand that the information will be kept confidential in accordance with Florida and Federal law.
- I understand not all services I am eligible to receive may be available, accessible or funded, and I may not meet specific Program Qualifications for some programs.
- I understand that at any time during the application process I can be denied eligibility if my actions are uncooperative, disruptive of office procedures, threatening or hostile towards staff.
- I understand the Department of Health, eligibility staff cannot discriminate because of race, color, sex, age, disability, religion, nationality or political beliefs.
- I understand I have the right to ask for a Fair Hearing if I think the decision on my case was unfair or incorrect.

SIGNATURE REQUIRED _____ **Date** _____

FOR ELIGIBILITY STAFF ONLY

Date Stamped Receipt of Application: _____ Walk-In ___ Mail ___ Other _____
 Date of Appointment: _____ Eligibility Staff: _____
 Date Determined Eligible: _____ Date Referred to: Case Management ___ ADAP ___ AICP ___ HOPWA ___ Other: _____ Date _____
 Date Determined Ineligible: _____ Date Supervisory Review: _____ Fair Hearing Information Provided _____