North Dakota Department of Human Services
SFN 407 (Rev. 01-2018)

☐ **HEALTH CARE COVERAGE REVIEW (HCC)**
☐ **SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)**

FOR OFFICE USE ONLY
Date Received:
Date Interviewed:
Person Interviewed:

IMPORTANT: DO NOT COMPLETE, DATE, OR SIGN BEFORE THE 1ST OF THE MONTH

CASE NUMBER:
CASE NAME:

RETURN COMPLETED FORM TO:

Telephone:

You may fill out and submit this review online. Go to https://apply.dhs.nd.gov to start your review.

- Log in with your State of ND Login account to see your available reviews. If it is your first time using the system to complete a review, you will have to enter your authorization code.
- You may also choose to fill out the review using a one-time guest user login. Your authorization code is also required.

Authorization Code:

HEALTH CARE COVERAGE REVIEW: This form is used to determine continued eligibility for Health Care Coverage. Read and answer all questions carefully. You may have a friend, relative, or the county social service agency help you complete this form. This review is for . **IT MUST BE COMPLETED, SIGNED, AND RETURNED TO THE OFFICE ABOVE BY** . Failure to return the form and required proof on time may result in your case being closed effective . Information of individuals applying for HCC will be sent to the Health Insurance Marketplace for an eligibility determination for help paying for private health insurance.

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) REVIEW: Your SNAP review period ends on . This form is used to determine if you will continue to receive benefits and be assigned another review period. You have the right to file this application **IMMEDIATELY** as long as it contains your name, address, and signature of a responsible household member **OR** authorized representative.

Signature____ Date____________________.

Address______________________________ City__________________ State______ Zip______

AUTHORIZED REPRESENTATIVE: You can give a trusted person permission to talk with us about this review and allow this person to see your information. This individual can act on your behalf on matters related to this review, including giving and getting information, signing your review and acting for you on all future matters with this agency. This person is called an "authorized representative." If you ever need to change your authorized representative, contact your county social service office.

For HCC, if the person you give this permission is a legally appointed representative for someone on this application, submit proof with the application.

If this review is for SNAP, this person can also give information at your interview and buy your food with an EBT card.

Would you like someone to be your authorized representative? ☐ Yes ☐ No If yes, please complete the following:

First Name ____________________ Middle Initial ____ Last Name __________________ Suffix ____

Address ________________________________ Apartment/Unit Number ________________

City ____________________ State ____________ Zip Code __________ Phone Number __________

By signing, you authorize this person to serve as your "authorized representative".

Signature____ Date____________________.

If you file your review form after your review period expires, your benefits will be prorated from the date you file it. You may get your prorated benefit within seven (7) days of the date you file ONLY if any of the following exists: 1) Monthly rent/mortgage and utilities are more than your household's gross monthly income; 2) Gross monthly income is less than $150; 3) You are a migrant or seasonal farm worker.

NOTIFICATIONS – by opting to receive text message or e-mail notifications, you agree to the following:

A text message or e-mail notification will be sent to the cell phone number or e-mail address you entered when a review or full application is needed to determine eligibility or continued eligibility for the program(s) you are enrolled in. Cell phone carrier text message rates may apply and DHS will not be liable for any text message charges. You are responsible for notifying your case worker of any changes to your e-mail address, cell phone carrier or cell phone number, or if your cell phone is lost or stolen.

Please note that unencrypted e-mail and text messaging is NOT a secure form of communication. There is some risk that any Protected Health Information (PHI) and other confidential information that may be contained in such e-mail or text messages may be misdirected, disclosed to, or intercepted by, unauthorized third parties. I consent and accept the risk in transmitting PHI and other confidential information via unencrypted e-mail or text messaging.

Would you like to receive text message notifications? ☐Yes ☐No	If yes, list cell phone number:

Cell Phone Provider: ☐ AT&T ☐ T-Mobile ☐ Cricket ☐ Sprint ☐ Verizon Wireless ☐ Other (please specify):

Would you like to receive e-mail notifications? ☐Yes ☐No	If yes, list e-mail address:

CHANGE OF ADDRESS - PROOF OF RESIDENCE AND UTILITY BILLS ARE REQUIRED FOR SNAP HOUSEHOLDS ONLY

Have you moved since your last report? ☐Yes ☐No	If yes, new address:
Mailing address if different:	Date moved:

HOUSEHOLD MEMBERS - List all persons in your household starting with you, then your spouse, your children (including unborn children), other adults and children living in your home. If you need additional space, continue on a separate sheet of paper.

NAME (Last, First, Middle Initial)	RELATIONSHIP	AGE	NAME (Last, First, Middle Initial)	RELATIONSHIP	AGE
	SELF				

Has anyone moved into your household or do you expect anyone to move in? ☐Yes ☐No If yes, complete the following:

Name:	Social Security Number:	Birth date:
Date person moved in:	Relationship:	Racial Heritage (optional):

U.S. Citizen or U.S. National ☐ Yes ☐ No	If no, do they have eligible immigration status? ☐ Yes ☐ No If yes, list document type and document ID number:

Have they lived in the U.S. since 1996? ☐ Yes ☐ No If no, date they entered the U.S.:

Did this person reside in foster care at age 18 or older? ☐ Yes ☐ No If yes, list when and what state:

Are they active-duty in the U.S. military? ☐ Yes ☐ No If no, are they a veteran, spouse or parent of a veteran? ☐ Yes ☐ No

Do household members purchase and prepare meals separately? ☐ Yes ☐ No If yes, who:

Has anyone moved out of your household or do you expect anyone to move out? ☐Yes ☐No If yes, complete the following:

Name:	Date person left:	Is the member expected to return? ☐ Yes ☐ No If yes, date expected to return:

Are you a migrant or seasonal farm worker? ☐ Yes ☐ No

Have household members received commodities from the Tribal Food Distribution Program on Indian Reservations? ☐ Yes ☐ No If yes, who?

Have you or any household member had a disqualification from the Tribal Food Distribution Program? ☐ Yes ☐ No If yes, list members:

ILLEGAL ACTIVITIES AND DISQUALIFICATION – SNAP HOUSEHOLDS ONLY

Have you or any member of your household been convicted of fraudulently receiving duplicate SNAP or TANF benefits in any State after September 22, 1996? ☐ Yes ☐ No

Are you or any member of your household hiding or running from the law to avoid prosecution, being taken into custody or going to jail, for a felony crime or attempted felony crime, or violating a condition of parole or probation? ☐ Yes ☐ No

Have you or any member of your household been convicted of buying or selling SNAP benefits of $500 or more after September 22, 1996? ☐ Yes ☐ No

Have you or any member of your household been convicted of trading SNAP benefits for guns, ammunitions or explosives after September 22, 1996? ☐ Yes ☐ No

Have you or any household members been convicted of trading SNAP benefits for drugs after September 22, 1996? ☐ Yes ☐ No

Are you or any household members participating in SNAP or TANF in another location? ☐ Yes ☐ No

Are you or is any household member disqualified or been disqualified from SNAP or TANF for providing incorrect information or failing to provide information that affected SNAP or TANF eligibility or benefits? ☐ Yes ☐ No

SCHOOL STATUS

Is anyone currently attending school, boarding school, college or training? ☐ Yes ☐ No If yes, complete this section **for all household members age 14 or older**.

Name	Last Grade Completed	Name of School or Training Site	PT – Part Time FT – Full Time

Has any household member's school or training status changed or is expected to change? ☐ Yes ☐ No
If yes, explain:

Has any household member dropped out of school? ☐ Yes ☐ No If yes, explain:

ASSETS

CHECKING/SAVINGS/OTHER LIQUID ASSETS: Does anyone in the household have cash, checking, savings, debit card accounts certificates of deposit, IRA's, annuities, burial accounts? ☐ Yes ☐ No If yes, complete the following and provide current proof of all accounts. Include all assets owned jointly with another person even if they do not live with you.

NAME(S) ON ACCOUNT	NAME OF FINANCIAL INSTITUTION	TYPE OF ACCOUNT	TODAY'S BALANCE

Has anyone made arrangements for funeral expenses or given money, property, or insurance to someone else to pay for funeral expenses for any household member? ☐ Yes ☐ No

If yes, explain:

OTHER ASSETS: Does anyone in the household own farm equipment, a home/mobile home, income producing tools/equipment, life estate/life lease, mineral rights, notes or contract for deed, real property, retirement funds, savings bonds, trusts, etc. ☐ Yes ☐ No If yes, complete the following and provide current proof of the value of these assets.

TYPE OF ASSET	LOCATION/ DESCRIPTION	TOTAL VALUE	AMOUNT OWED	OWNERS

VEHICLES: Do any household members own a vehicle? ☐ Yes ☐ No If yes, complete this section.

OWNER'S NAME	YEAR	MAKE/ MODEL	LICENSED (Yes/No)	STATE LICENSED IN	VALUE	AMOUNT OWED
					$	$

LIFE INSURANCE: (Not required for SNAP only cases) Does anyone have life insurance? ☐ Yes ☐ No If yes, complete the following:

NAME OF INSURED PERSON	NAME AND ADDRESS OF COMPANY	POLICY NUMBER	FACE VALUE	CASH SURRENDER VALUE	OWNERS

ASSET CHANGES: Did anyone in your household **receive, buy or inherit any assets or sell, give away, or transfer any assets** such as cash, land, buildings, mobile home, contract for deed, mineral acres, life insurance proceeds, stocks, bonds, burial account, trust account, IRA or KEOGH plan, livestock, vehicles, machinery, tools, etc. in the last 3 months for SNAP and 12 months for Health Care Coverage? ☐ Yes ☐ No

If yes, explain and provide proof:	Date:

Are any of these assets subject to a "transfer at death"? ☐ Yes ☐ No If yes, describe property and approximate value:

TAX FILER INFORMATION: (Not required for SNAP only cases)

Have any household members filed federal income taxes? ☐ Yes ☐ No If yes, did they claim any of the following deductions:
☐ Alimony ☐ Student Loan Interest ☐ Tax Deductible Tuition and Fees ☐ Other Deductions
Reporting these could make the cost of health insurance lower. Provide a copy of your most recent Federal Income Tax Form.

Do any household members plan to file a Federal Income Tax Form next year? ☐ Yes ☐ No
If yes, will they file jointly with a Spouse? ☐ Yes ☐ No If yes, list name of spouse:

Will they claim any dependents? ☐ Yes ☐ No | Will any dependents file a tax return? ☐ Yes ☐ No If yes, who and explain why:

Will any household members be claimed as a dependent on someone's tax return? ☐ Yes ☐ No If yes, complete the following:

Name of tax filer:	Relationship to tax filer:	Tax filer's address:

Do any household members age 19 or older claim primary responsibility for a child under age 19? ☐ Yes ☐ No If yes:

Name of responsible person:	Name of child:

UNEARNED INCOME: This section must be completed for each household member including all children and stepparents. Check each item "yes" or "no." If "yes," show the amount received, who received it, date received, and attach proof. The amount must be shown for both **LAST MONTH** and **NEXT MONTH**.

				LAST MONTH		**NEXT MONTH**	
	Yes	**No**	**Received By**	**Amount**	**Date(s)**	**Amount**	**Date(s)**
BIA General Assistance							
Bingo/Gambling Winning							
Child Support/Spousal Support							
Individual Indian Monies (IIM)*							
Interest/Dividend Income							
Money from Friends, Relatives or Others							
Retirement (Type):							
Rental Income/Contract for Deed							
Social Security							
Supplemental Security Income (SSI)							
TANF							
Unemployment Benefits							
Veterans Benefits/Military Allotment							
Worker's Compensation							
Other (List Type)							

** IIM information is not required for Health Care Coverage.*

Has anyone applied for benefits not yet received? (For example: Social Security, SSI, Workers Compensation, Unemployment Benefits) ☐ Yes ☐ No	If Yes, who and what was applied for:

EARNED INCOME (Wages or Salary): Is any household member (including children) working? ☐ Yes ☐ No

If yes, complete this section. List information about full-time, part-time, seasonal, or temporary employment for all household members. If space is needed to list more jobs, enter them on a separate sheet of paper. The amount must be shown for both **LAST MONTH** and **NEXT MONTH**. **PROOF OF ALL INCOME MUST BE PROVIDED.**

Household Member's Name	Employer	Gross Amount for	Hours Worked Per Week	Salary/ Hourly Wage	Amount of Tips/ Commission	How Often Paid	Day(s) of Week/ Month Paid	Date of Next Paycheck

NEXT MONTH:

Has any household member received commissions, bonuses or incentives other than those included above in the last twelve months? ☐ Yes ☐ No If yes, list the household member, date received and amount: ______________________

Does anyone outside the household deposit money into a household member's bank account? ☐ Yes ☐ No If yes, explain:
____

Has anyone's employment stopped or have work hours been reduced within the last 30 days? ☐ Yes ☐ No	If Yes, Who___

Last day of work?	Was the person: ☐ Laid Off ☐ Fired ☐ Quit ☐ Other	Why?___

When did this person receive their last paycheck?___ **Proof Must be Provided**

Has anyone started employment since last report? ☐ Yes ☐ No

If yes, Who___ When___ Where___

When will the first check be received?___ How often paid?___

SELF EMPLOYMENT:

Is any household member self-employed? ☐ Yes ☐ No

If yes, name of business: Type of business:

A complete copy of the most current Federal Income Tax Return must be provided. If you do not have a current tax return that includes the self employment business, provide income and expense ledgers.

Does anyone in your household expect a change in self employment income **NEXT MONTH**? ☐ Yes ☐ No
If yes, explain___

EXPENSES - SNAP HOUSEHOLDS ONLY

Does your household have any of the following expenses? Check yes or no for each item and list amounts. **Proof of current expenses must be provided.** You will not receive a deduction for any allowable expense you fail to report and verify.

CURRENT EXPENSES	YES	NO	Total Amount	Amount You Pay
Rent/Mortgage (circle one)				
Lot Rent				
Do you pay separately for the use of a garage?				
Is anyone working off any part of the rent?				
Does any government agency pay any part of your rent?				
Property taxes (not included in mortgage)				
Homeowners Insurance (not included in the mortgage)				
Electricity				
Heating costs (gas/propane/electric, etc.)				
Water/Well installation or maintenance				
Sewer/Septic tank installation or maintenance				
Garbage				
Telephone/Cell Phone				
Are you responsible for air conditioning costs anytime during the year?				
Do you receive heating assistance (LIHEAP)?				

AGENCY USE

Household is entitled to one of the following mandatory utility standards:
☐ HL SU (Heating/Cooling/LIHEAP) ☐ MU (water, sewer, garbage, electricity)
☐ LU SA (Water, sewer, garbage, electricity, telephone) ☐ TL (Telephone only)

EXPENSES - Proof of current expenses must be provided. You will not receive a deduction for any allowable expense you fail to report and verify.

Does any household member pay court ordered child or spousal support, health insurance premiums, or other support payments?
☐ Yes ☐ No If yes, who is making the payment?

Who are the payments for:	Court ordered amount:	Amount you pay:
Does your household have child care expenses? ☐ Yes ☐ No	Billed amount:	Amount you pay:
Are you receiving Child Care Assistance? ☐ Yes ☐ No	Have you applied for Child Care Assistance? ☐ Yes ☐ No	
Do you expect any changes in these expenses next month? ☐ Yes ☐ No	If yes, please explain:	
Does anyone help you pay any of these expenses? ☐ Yes ☐ No	If yes, please list what expenses, who is paying, and how much they are paying:	

MEDICAL EXPENSES	**YES**	**NO**	**Total Amount**	**Amount You Pay**
Do household members who are age 60 or older or disabled pay health insurance premiums? If yes, who:				
Do household members who are age 60 or older or disabled pay medical expenses? **Medical expenses include doctor, dental and eye care visits, hospital bills, in-home care, nursing home care, prescriptions, medical supplies, hearing aids, eyeglasses and contacts, and the cost of transportation and lodging to obtain medical treatment.* If yes, who:				

Do household members pay adult dependent care? ☐ Yes ☐ No

Do you expect any changes in expenses next month? ☐ Yes ☐ No

If yes, please explain:

Does anyone help you pay these expenses? ☐ Yes ☐ No If yes, please list expense, who pays and how much paid:

Does anyone in the household pay representative payee fees? ☐ Yes ☐ No

If yes, who:	Amount paid:

Does anyone in the household pay guardianship fees? ☐ Yes ☐ No

If yes, who:	Amount paid:

HEALTH INSURANCE – NOT REQUIRED FOR SNAP ONLY HOUSEHOLDS

Is any household member enrolled in health coverage from one of the following:

Medicaid ☐ Yes ☐ No If yes, who:	Healthy Steps ☐ Yes ☐ No If yes, who:
Peace Corp ☐ Yes ☐ No If yes, who:	

Does anyone have health insurance coverage from another source? ☐ Yes ☐ No If yes, complete the following:

Person(s) Covered	**Policy Holder Name and Address**	**Health Insurance Name, Address & Phone Number**	**Effective Date**	**Policy Number**	**Group Number**	**Monthly Premium**

*** Types of Coverage: (Circle all that apply)**

A - Hospital
B - Doctor
C - Major Medical/Lab/Xray
D - Dental
E - Vision
F - Nursing Home
G - Cancer
H – Champ VA/TriCare
I - HMO Insurance
J - Court Ordered
K - Medicare part A
L - Medicare part B
M - Medicare Supplement
N - Drug Insurance
P – Worker's Comp/Accident
V - Veteran's
W - Medicare Part D

Does anyone outside of the household pay the premium? ☐ Yes ☐ No	If yes, who:
Does anyone expect changes in health insurance coverage? ☐ Yes ☐ No	If yes, explain:
Is this policy a COBRA coverage? ☐ Yes ☐ No If yes, date COBRA coverage began:	Date or expected date COBRA coverage will end:
Is this policy a limited benefit plan (school accident policy)? ☐ Yes ☐ No	Is this a state employee benefit plan? ☐ Yes ☐ No

Do any household members have a long-term care insurance policy that has paid out benefits for long-term care services (nursing care, basic care or assisted living)? ☐ Yes ☐ No If yes, who:

How much has the policy paid in benefits?	This information may allow you to protect additional assets.

INFORMATION AND REFERRAL

If my household is eligible for TANF Information & Referral Services, my household has been notified and authorized to receive TANF Information and Referral Services.

PLEASE READ

- In addition to completing this form, **You must report changes that could affect eligibility. For SNAP, changes must be reported by the 10th day of the month following the month the change occurs. For Medicaid, changes must be reported within 10 days from the time you learn of the change.**
- Household benefits may increase, reduce, stay the same, or end as a result of the answers you give on this report. You will be notified in writing of changes and the reason for such change.
- This report will be incomplete if not signed and dated, required questions are not answered, and necessary proof are not attached.
- You will be asked to provide Social Security Numbers (SSNs) for all persons whom you want assistance. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the review process. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778. Providing or applying for an SSN is voluntary; however, any person who wants assistance but who doesn't want to give information about their SSN will not be eligible for benefits. Other household members may still get benefits if they are otherwise eligible.

  SSNs are used to check income and other information to see who's eligible for help. The social security number is also used to check the identity of the household members, to prevent duplicate participation, to monitor compliance with program regulations, for claim collection, for official examination by Federal or State agencies, and to help make mass changes. The social security number is also used to check information in our records against other Federal, State or local governments computer matching systems participating in the Income and Eligibility Verification System, including but not limited to the Internal Revenue Service, Social Security Administration, and the Department of Labor, which may affect eligibility and the level of benefits.

  Use of social security numbers provided for SNAP and TANF benefits may be disclosed to law enforcement for purposes of apprehending fleeing felons.

  For SNAP, 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. Information requested may also be used and verified through collateral contacts when discrepancies are found.

  We will not share your SSN with the United States Citizenship and Immigration Services (USCIS).

- State and Federal Laws provide for a fine and/or imprisonment for any person who fraudulently receives or attempts to receive assistance to which they are not entitled.
- The alien status of any household member may be subject to verification by the United States Citizenship and Immigration Services (USCIS) through the submission of information from the application to INS, and that the information received from USCIS may affect the household's eligibility and level of benefits.
- This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion and political beliefs.

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

  The U.S Department of Agriculture also prohibits discrimination against its customers, on the basis of race, color, national origin, age, disability, sex, gender, identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in any program or activity conducted or funded by the Department. (Not all prohibited basis will apply to all programs.)

  If you wish to file a Civil Rights program complaint of discrimination with USDA, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter by mail to U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

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

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

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 509-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

USDA and HHS are equal opportunity providers and employers.

PENALTY WARNING FOR SNAP RECIPIENTS

- Do not give false, inaccurate, or incomplete information.
- Do not buy ineligible items such as alcohol or tobacco with SNAP benefits
- Do not trade or sell your EBT card.
- Do not use or have in your possession another person's EBT card or SNAP benefits.

Any member of your household may be removed from SNAP for:

- One year for violating a SNAP rule;
- Two years for a second violation; or first conviction for buying, selling, or trading SNAP for a controlled substance.
- Ten years for a conviction for making a fraudulent statement with respect to identity or representation with respect to identity or place of residence in order to receive multiple benefits at the same time.
- Lifetime for violating a SNAP rule a third time; or a second conviction for buying, selling, or trading SNAP for a controlled substance; convicted of buying or selling SNAP benefits of $500 or more. If a court of law finds a household member guilty of trading SNAP for firearms, ammunition, or explosives, the individual is permanently barred from the program.
- In addition, any household member may be removed by a court for an additional 18 months; or prosecuted and fined up to $250,000 or imprisoned up to 20 years or both.
- A SNAP recipient who is subject to the work requirements and fails to comply with the requirements may lose SNAP benefits.

Receiving SNAP or HCC benefits has no bearing on any other programs time limits that may apply to your household. If you are applying for or already receiving TANF benefits, the time limits and other requirements that apply to receipt of TANF do not apply to receipt of SNAP or HCC benefits. If you no longer receive TANF or if your case is closed for TANF because of the lifetime limit, because you started work, or for some other reason, you may still qualify for SNAP and HCC benefits.

ESTATE RECOVERY

State and Federal law requires the Department of Human Services to make claims against the estate of some Medicaid recipients. A claim will be made against the estate of: (1) any recipient who was age 55 or older when the Medicaid benefits were provided: (2) any recipient who has been permanently institutionalized and received services regardless of age: or (3) against the estate of a spouse of any Medicaid recipient who was age 55 or older or permanently institutionalized when the Medicaid benefits were paid. The claim is for the amount of Medicaid benefits issued to a person age 55 or older or if permanently institutionalized. Effective August 1, 2015, the department CANNOT file a claim against the estate to recover payments made on behalf of recipients who received coverage through a private carrier. Individuals eligible under the Medicaid Expansion coverage receive their coverage through a private carrier.

AUTHORIZATION TO RELEASE INFORMATION

I/We authorize any person having custody or knowledge of the information relating to me or other household members to disclose any requested information, including confidential information other than protected health information, to any authorized agent of the North Dakota Department of Human Services. I authorize the North Dakota Department of Human Services and carrier providing Healthy Steps insurance to release to each other information regarding any services or benefits I received under Healthy Steps. This authorization will remain valid until assistance ends or until revoked in writing. I/we authorize Child Support to release any records of child support payments that I/we have made or received. A copy of this authorization is as valid as the original.

SIGNATURE

I certify under penalty of perjury, that the information contained on this report is true, including the information concerning citizenship and alien status of members applying for benefits.

<table>
<tr><td rowspan="3">You or your authorized representative may request a fair hearing orally or in writing if you disagree with any action taken on your case. Your case may be presented at the hearing by any person you choose. We will consider this report without regard to race, color, sex, handicap, religion, national origin or political belief.</td><td>SIGNATURE</td><td>DATE</td></tr>
<tr><td colspan="2">TELEPHONE NUMBER</td></tr>
<tr><td colspan="2">WITNESS IF YOU SIGNED WITH AN X</td></tr>
</table>