

## APPLICANT WORKSHEET

Screening Date: \_\_\_\_\_

HSS CASE NUMBER: \_\_\_\_\_

Online Screening Location: \_\_\_\_\_

Online Screening ID #: \_\_\_\_\_

Please complete the following information. Enter the names of **everyone** living at your address. Start with Head of household first, co-applicant, your children (oldest to youngest) then everyone else living in your household. **PLEASE PRINT.**

Legal Name  Last, First	A g e	Social Security #  xxx-xx-xxxx	Alien ID #	Date of Birth  xx/xx/xxxx	Relation to you	S e x	E T N	R A C E	US Born Citizen Y/N	Birth Place (US State or Country)	Edu- cation (Grade)	Vet Y/N	Dis- abled Y/N

RACE: White, Black/African American, Native American, Asian/Pacific Islander, Other

ETHNnicity: Hispanic, Non-Hispanic

Maiden Name: \_\_\_\_\_

Circle One: (Mar) (Div) (Sep) (Wid) (Sgl)

Residence Address (Street, City, State & Zip): \_\_\_\_\_ Phone: \_\_\_\_\_

Mailing Address (Street/PO Box, City, State & Zip): \_\_\_\_\_

Contact Person: \_\_\_\_\_ Relationship: \_\_\_\_\_ Alternate Contact Number: \_\_\_\_\_

What do you need help with? \_\_\_\_\_

(for office use only)

Case Name: \_\_\_\_\_ Case Number: \_\_\_\_\_

HSS#12 (revised 04/20/10)



Screening Date:

Online

Screening ID#:

Income Sources	Y/N	Net Monthly Amount	Health Insurance Coverage	Active Y/N
Earnings from wages			Medicaid	
Earnings from Self Employment / Odd jobs			Medicaid with a Share of Cost (Medically Needy)	
			Florida KidCare	
			Major Medial Insurance	
TANF			HMO	
Social Security			Medicare or Medicare HMO	
SSI			VA Medical Services or Champus	
Worker's Comp			Coverage from a lawsuit settlement	
Unemployment			Worker's Comp for injury or illness	
Alimony			Other Coverage, Cancer Policy / Supplemental Disability Policy	
Child Support			<b>Application Pending for:</b>	<b>Pending Y/N</b>
Renters / Boarders				
Pension, Disability or Retirement				
Trust Account / Inheritance				
School Grants or Loans			Social Security (Retirement Benefits)	
Money from family members			Social Security (Disability Benefits, SSI or SSD)	
Other Source (enter type)			Veterans, Pension or Disability	
			Department of Children & Families	
			Florida KidCare	
<b>Subtotal</b>			Unemployment Compensation	
Less court ordered deductions			Victim of Crimes	
<b>Estimated Monthly Income and % of Poverty</b>	<b>%</b>		Lawsuit or Legal Settlement pending with an Attorney	
<b>Assets / Belongings / Possessions</b>	<b>Y/N</b>		<b>Value</b>	<b>Amount Unknown</b>
Checking / Savings / Credit Union				
CD's / Money Market / Deferred Comp / IRA's / Stock / Bonds				<input type="checkbox"/>
Property that is not your homestead				<input type="checkbox"/>
More than 1 vehicle, Recreational vehicles, boats motorcycles				<input type="checkbox"/>
Life Insurance with loan value				<input type="checkbox"/>
<b>Subtotal</b>				
<b>Total Estimated Assets</b>				

(for office use only)

Case Name:

Case Number:

HSS#12 (revised 04/20/10)



Complete the items below:	
Do you have Food Stamps?	Yes / No      Amount: \$ _____
Housing Status (check one)	<input type="checkbox"/> Own a Home <input type="checkbox"/> Rent <input type="checkbox"/> Homeless <input type="checkbox"/> Living with Family or Friends <input type="checkbox"/> Boarding Home <input type="checkbox"/> ALF <input type="checkbox"/> Jail Inmate <input type="checkbox"/> Housed in a Treatment Facility
	Mortgage or Rent Amount per Month: \$ _____
Primary language spoken? (check one)	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Creole <input type="checkbox"/> Russian <input type="checkbox"/> Other
Do any of the following apply?	<input type="checkbox"/> Migrant Laborer <input type="checkbox"/> Farmer <input type="checkbox"/> Seasonal Laborer <input type="checkbox"/> Does Not Apply
Active Section 8, Tampa or Plant City Housing Authority?	Yes / No
Agency Certified as Homeless?	Yes / No    (Referral from a homeless agency)
Have special medical needs during a disaster?	Yes / No
Need transportation to a disaster shelter?	Yes / No
Use Health Department Services?	Yes / No
Active with Job Services of Florida or Workforce?	Yes / No
Insurance available from employer you cannot afford?	Yes / No    (Historical Data, if exists)
OR	
Eligible for COBRA from previous employer?	Yes / No (If yes, send copy of COBRA paperwork in with requirements.)
Active with SHARE (Food or Electric)?	Yes / No

I certify the information I have given is correct and true. I understand there is a law providing for fine or imprisonment for anyone withholding or giving false information or receiving assistance to which he/she is not entitled. I am aware that I am responsible for cooperating and assisting fully in the determination of my eligibility. **I will return all requested information, and if approved, I will keep the worker informed of my current address and will report address changes by calling (813) 272-5040.** I will also report changes in household composition, report changes in earnings, assets and/or receipt of monies. I understand Health Care Services will verify the information provided in this application for the purpose of documenting and determining services for which I may qualify.

**Check the box(s) below and Sign and Print your name to certify your application.**

Head of Household's Acknowledgement:    Date: \_\_\_\_\_    Signature: \_\_\_\_\_

Name Printed: \_\_\_\_\_

Spouse / Co-Applicant's Acknowledgement: Date: \_\_\_\_\_    Signature: \_\_\_\_\_

Name Printed: \_\_\_\_\_

(for office use only)

Case Name: \_\_\_\_\_

Case Number: \_\_\_\_\_

HSS#12 (revised 04/20/10)

