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**	**Age**	**Social Security #** **xxx-xx-xxxx**	**Alien ID #**	**Date of Birth** **xx/xx/xxxx**	**Relation to you**	**Sex**	**ETHN**	**RACE**	**US Born Citizen Y/N**	**Birth Place (US State or Country)**	**Edu-cation** **(Grade)**	**Vet** **Y/N**	**Dis-abled** **Y/N**

RACE: White, **B**lack/African American, **N**ative American, **A**sian/Pacific Islander, **O**ther **ETHN**nicity: **H**ispanic, **N**on-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)

12 APPLICANT WORKSHEET-B

Screening Date: _____ **Online** **Screening ID#:** _____

Income Sources	Y/N	Net Monthly Amount
Earnings from wages		
Earnings from Self Employment / Odd jobs		
TANF		
Social Security		
SSI		
Worker's Comp		
Unemployment		
Alimony		
Child Support		
Renters / Boarders		
Pension, Disability or Retirement		
Trust Account / Inheritance		
School Grants or Loans		
Money from family members		
Other Source (enter type) _____		
Subtotal		
Less court ordered deductions		
Estimated Monthly Income and % of Poverty	**%**	

Health Insurance Coverage	Active Y/N
Medicaid	
Medicaid with a Share of Cost (Medically Needy)	
Florida KidCare	
Major Medial Insurance	
HMO	
Medicare or Medicare HMO	
VA Medical Services or Champus	
Coverage from a lawsuit settlement	
Worker's Comp for injury or illness	
Other Coverage, Cancer Policy / Supplemental Disability Policy	
Application Pending for:	**Pending Y/N**
Social Security (Retirement Benefits)	
Social Security (Disability Benefits, SSI or SSD)	
Veterans, Pension or Disability	
Department of Children & Families	
Florida KidCare	
Unemployment Compensation	
Victim of Crimes	
Lawsuit or Legal Settlement pending with an Attorney	

Assets / Belongings / Possessions	Y/N	Value	Amount Unknown
Checking / Savings / Credit Union			
CD's / Money Market / Deferred Comp / IRA's / Stock / Bonds			☐
Property that is not your homestead			☐
More than 1 vehicle, Recreational vehicles, boats motorcycles			☐
Life Insurance with loan value			☐
Subtotal			
Total Estimated Assets			

(for office use only)

Case Name: _____ **Case Number:** _____

HSS#12 (revised 04/20/10)

12 APPLICANT WORKSHEET-B

Screening Date: _____ **Online** **Screening ID#:** _____

Complete the items below:	
Do you have Food Stamps?	Yes / No Amount: $_____
Housing Status (check one)	☐ Own a Home ☐ Rent ☐ Homeless ☐ Living with Family or Friends ☐ Boarding Home ☐ ALF ☐ Jail Inmate ☐ Housed in a Treatment Facility
	Mortgage or Rent Amount per Month: $_____
Primary language spoken? (check one)	☐ English ☐ Spanish ☐ Vietnamese ☐ Creole ☐ Russian ☐ Other _____
Do any of the following apply?	☐ Migrant Laborer ☐ Farmer ☐ Seasonal Laborer ☐ 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:** _____

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