# Medicaid Screening

1. **Have you been employed within the last 12 months? Yes / No**

2. **Have you experienced homelessness for at least 12 months in total over the past 3 years? Yes / No** (This can be multiple homeless episodes combined)

3. **Are you currently homeless? Yes / No**

| **Including yourself, how many people are in your household?** (Only include people you file taxes jointly with or claim as dependent on your taxes) | **What is the combined gross monthly income of everyone in your household?** (Gross income means how much you make before any taxes or deductions are taken. Please circle your household's size and household's income on the table below) |
|---|---|
| 1 | $0 – $1,769 a month / $1,849 if you're pregnant |
| 2 | $0 – $2,399 a month / $2,507 if you're pregnant |
| 3 | $0 – $3,028 a month / $3,165 if you're pregnant |
| 4 | $0 – $3,658 a month / $3,823 if you're pregnant |
| 5 | $0 – $4,288 a month / $4,481 if you're pregnant |
| 6 | $0 – $4,917 a month / $5,139 if you're pregnant |
| 7 | $0 – $5,547 a month / $5,797 if you're pregnant |
| 8 | $0 – $6,176 a month / $6,455 if you're pregnant |

**Name:** _____ **Date of Birth:** _____

**Phone number:** _____ **Email:** _____

DWS-ESD 114AR
Rev 12/2022

State of Utah
Department of Workforce Services

# AUTHORIZATION TO DISCLOSE MEDICAL ELIGIBILITY INFORMATION

Customer Name _____ Case # _____ Date of Birth ____/____/____

I _____ hereby give
*(Customer or Authorized Representative)*

Volunteers of America, Utah the authority to:
*(Name of Individual or Organization)*

(check only one box)

☐ Receive Medicaid, CHIP, UPP or Buyout eligibility information regarding my current application, ongoing case or a recent case denial or closure. This authorization is effective from the date this form is signed to whichever of the following occurs first:

- **The following date: _____; or**
- **The medical application is denied*; or**
- **30 days from the month the medical program is closed*.**

*If the application is denied or the case is closed, information disclosure will continue throughout the fair hearing process.

☑ Speak or act on my behalf as an authorized representative, which includes receiving Medicaid, CHIP, UPP or Buyout eligibility information regarding my current application, ongoing case or a recent case denial or closure. This authorization is effective from the date this form is signed until a written notification to revoke the authorization is received by the Department of Workforce Services.

1875 S Redwood Rd, Salt Lake City, UT 84104 / 801-355-2846 (Cornerstone Counseling)
**Address and Phone Number of Authorized Representative**

I understand that I may revoke this authorization at any time by sending a written notification to the Department of Workforce Services (DWS). I understand that a revocation is not effective to the extent that the Utah Department of Health and Human Services (DHHS), through its Division of Integrated Healthcare (DIH) or the DWS has relied on the disclosed health information.

I understand my rights and responsibilities described in the Notice of Privacy Practices. For a duplicate Notice of Privacy Practices, access the following URL - http://health.utah.gov/hipaa/privacy.htm.

I understand that I may refuse to sign this authorization. I also understand that the DWS cannot deny eligibility for benefits if I refuse to sign this authorization.

I understand that giving an individual authorized representative power allows them to act on my behalf, which includes making changes to my medical case and any changes that they make, I may be liable for if an overpayment is incurred.

I understand that, once information is disclosed pursuant to this authorization, it is possible that it will no longer be protected by medical privacy laws and could be disclosed by the person or agency that receives it.
**Note: DIH and DWS will not disclose controlled documents without the consent of their Legal Departments.**

By signing this form, I acknowledge I have been provided a copy of this signed authorization.

_____ _____
Signature of Customer, legal guardian or Authorized Representative Date

If signed by other than the customer; description of authority to serve: _____

_____

***Equal Opportunity Employer/Program***
Auxiliary aids (accommodations) and services are available upon request to individuals with disabilities by calling (801) 526-9240. Individuals with speech and/or hearing impairments may call Relay Utah by dialing 711. Spanish Relay Utah: 1-888-346-3162

DWS-ESD/WDD 114MC
Rev. 11/2025

State of Utah
Department of Workforce Services

# MYCASE AUTHORIZATION TO RELEASE INFORMATION TO A THIRD PARTY

Name: _____ Case Number: _____

I authorize the Department of Workforce Services (DWS) and the Department of Health and Human Services, Division of Integrated Healthcare (DIH) to release information contained in the myCase database to the following third party:

**NAME OF THE PERSON/ORGANIZATION BEING GRANTED ACCESS:** _____

1. **I grant the above-named third party access to my myCase information as follows: (CHECK ALL THAT APPLY)**

   ☑ **"Full Access:"** I grant access to update, alter, or otherwise make changes to my information, as well as view all case information. This includes completing and signing my case review.

   ☑ **"Notices:"** I grant access to view any notice that was sent to me by DWS, regardless of the type of benefits I will, or have received.

   ☑ **"Verifications:"** I grant access to view any request for verification that DWS has asked me to provide, regardless of the type of benefits that I will, or have received.

2. The third party may have access to my information for the following purpose: Volunteers of America, Utah
3. I understand that I am not required to grant access to any third party. I also understand that DWS and DIH cannot deny eligibility if I refuse to grant access to a third party.
4. I understand that I will be responsible for any overpayments that may occur as a result of incorrect information being provided by a third party that I authorized to update, alter or make changes to myCase information.
5. I understand that I may grant access to members of my household.
6. I understand I may grant access to individuals who are not members of my household, such as my primary care physician or other healthcare providers.
7. By granting access to myCase, I specifically authorize the DWS to share all information regarding my case, including my medical applications, medical cases, and any medical application or case which was denied or closed, to the above-named third party. I understand that if there is anything in my case that I do not want shared, I must not grant access to my case.
8. DWS may share limited information with my childcare provider(s) through the provider website. If I choose to grant my childcare provider access to view my case information, I specifically authorize access to information as it pertains to Child Care benefits to be paid to them for services provided. I understand if I grant my childcare provider access to notices and/or verifications, the provider will be able to view any notice and/or verification regarding all benefits I receive or have received.
9. I understand that once information is shared because of this authorization, the information may no longer be protected by privacy laws and could be re-disclosed by the person or agency that receives it.
10. I understand that DWS and DIH cannot control the information once it has been released to the above-named third party. As such, I specifically release DWS and DIH or any other state agency from any liability that results from the release or sharing of my information with those parties I have authorized to view, alter, or amend my information.
11. I understand that I may revoke this authorization at any time by removing authorization through my myCase account or by sending written notification to DWS. I also understand that a revocation will not change the fact that information may have already been shared before I revoked my consent. I also understand that DWS or another state agency may have relied on and acted on such information and that revocation may not affect the results of such action.
12. I understand that this authorization is effective from the date authorization is granted until I revoke access in myCase or provide written notification to DWS.

Access will be granted within one (1) business day.

Customer Signature: _____ Date: _____

Signature of Third-Party: Brett Burrows MC#: 4983102 Date: _____

Printed Name of Third-Party: Brett Burrows Phone: 385-271-2909

Signature of Third-Party: _____ MC#: _____ Date: _____

Printed Name of Third-Party: _____ Phone: _____

***Equal Opportunity Employer/Program***
Auxiliary aids (accommodations) and services are available upon request to individuals with disabilities by calling 801-526-9240. Individuals who are deaf, hard of hearing, or have speech impairments may call Relay Utah by dialing 711. Spanish Relay Utah: 1-888-346-3162.

## Declaration and Signature:

By signing this form, I confirm that:

- I have read the statements in the section above, or someone has read them to me.
- I understand and agree to those statements.
- Under penalty of perjury, I swear that the answers I give on this application are complete and correct.
- I am the person represented by the signature on this document.
- I know I may be subject to federal or state penalties if I give false or untrue information.
- Providing a Social Security Number and information pertaining to immigration or alien status is voluntary; however, any person who wants assistance but does not provide such information may not be eligible for benefits. Failure to provide this information will not subject the applicant to criminal charges.
- If you are an authorized representative you may sign here only if you and the applicant have completed and signed the authorized representative form (Attachment D)

D33522900011021

| Printed Name | Signature | Date |
|---|---|---|
| | | |

## M RENEWAL OF COVERAGE IN FUTURE YEARS

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Marketplace to use income data, including information from tax returns. I also agree to allow the Department of Workforce Services and the Department of Health and Human Services to use information from tax returns. I can opt out at any time. The Marketplace will send me a notice and let me make changes.

Yes, renew my eligibility automatically for the next
☐5 years (the maximum number of years allowed), or for a shorter number of years:
☐4 years ☐3 years ☐2 years ☐1 year ☐Don't use information from tax returns to renew my coverage.

## N VOTER REGISTRATION INFORMATION

☐Yes ☐No If you are not registered to vote where you live now, would you like to apply to register to vote today? If you do not check either of these boxes, we will assume you have decided not to register to vote at this time. You may fill out the application form in private. If you would like help in filling out the voter registration application form, we will help you. The decision to seek or accept help is yours. Choosing to register or declining to register to vote will not affect the amount of benefit that you will be provided by this agency. If you believe that someone has interfered with your right to register, your right to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Lt. Governor, State of Utah, PO Box 142220, SLC, UT 84114.

## O RETURN COMPLETED FORM TO:

You have now completed the application. Please return this completed application form and any needed attachments to:

Department of Workforce Services. PO Box 143245, SLC, UT 84114-3245
Toll-free Fax: 1-888-522-9505