Division of Family Resources

Understanding the DFR & Medicaid Application Process

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https://www.ifcem.com/CitizenPortal/applic | State of Indiana [... | Main | Kuns, Heather - Outlook Web ... | Case Home: LIEU TRAN - 104... | msn | FSSA Benefits Portal

File Edit View Favorites Tools Help

System Dashboard - FSSA ... | Home - Eligibility Modern... | HP - See What's Hot | In Progress - All Documents | Suggested Sites | Web Slice Gallery | In Progress - All Documen... | SMART | FACTS | OPS | Work Instruction Log - All...

Indiana Family and Social Services Administration

Click here if visually or hearing impaired

Division of Family Resources

Welcome to the Benefits Portal

- Am I Eligible to Receive Benefits
- Apply for Health Coverage, SNAP, and/or Cash Assistance online
- Print an Application for Health Coverage, SNAP, and/or Cash Assistance
- Request for an Application for Health Coverage, SNAP, and/or Cash Assistance to be mailed to you
- Access / Print Your Online Application
- Check Status / Print Proof of Your Eligibility
- Report a Change
- For HIP Plan Providers Only

Quick Links

- Health Insurance Marketplace
- Help finding a job
- Child care assistance
- Child support benefits
- Social Security
- EBT
- More Benefits

Apply for Benefits Online

Apply online for SNAP (Food Assistance), Cash Assistance and/or Health Coverage. To print an application or have one mailed to you click on the appropriate links above.

Apply Online

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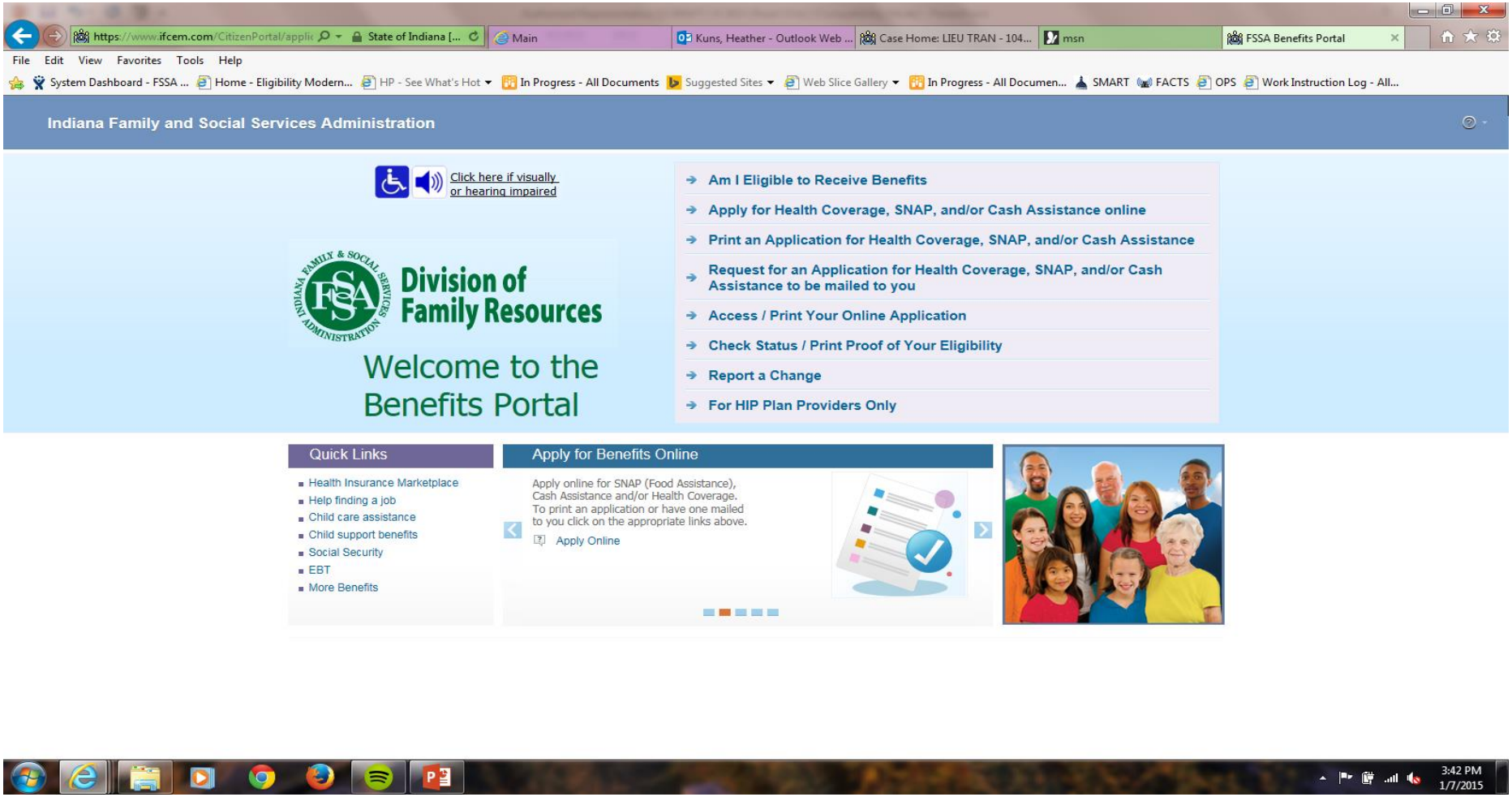
In the benefits portal client are able to perform any of the functions listed



How to apply for assistance?

•Applications can be completed on line via the benefit portal

•Applicants can apply at any local office and staff are available to assist with completing applications on line

•Separate applications for Health Coverage and SNAP (Food Stamp)/TANF (Cash Assistance)

•If applying for Health Coverage estimated time to complete the application is approximately 45 minutes.
• The following information is recommended in completing the application.
•Names, date of birth and social security numbers
•Employer and income information
•Tax filing status and tax dependant information
•Current health insurance information including policy numbers

•If applying for SNAP/TANF estimated time to complete the application is approximately 20 minutes.

What is an Authorized Representative?

• An Authorized Representative is an individual whom is familiar with all aspects of the applicant's or assistance groups circumstances.

• They can complete the interview on behalf of the applicant/recipient.

•The representative assumes responsibility for the accuracy of the information provided.

• Anyone whom wishes to become an authorized representative must complete the following form and the applicant/recipient must also provide their consent

•Authorized Representative can receive notices and they can file an appeal on behalf of the client

AUTHORIZED REPRESENTATIVE FOR HEALTH COVERAGE

State Form 55366 (R / 10-13) / DFR 2123HC

"DFRAZAE01"

Section 1

If you want someone to act on your behalf in applying for benefits and/or act for you on an ongoing basis, this form must be completed. Be sure to select the function(s) that the representative is being authorized to do. You can select more than one representative and choose the same or different functions. Complete ONE form per authorized representative. Both you and your representative must sign and date this form.

Section 2

Name of Representative (*Please print clearly*):

Check association with applicant/recipient. *Please select ONE (1).*

☐	Attorney	☐	Eligibility Assistance Company	☐	Friend	☐	Family
☐	Institution of Residence	☐	Waiver Case Manager	☐	Other (*Specify*): _____		

Mailing Address (*number and street, city, state, and ZIP code*):

FUNCTION	FUNCTION DESCRIPTION	SELECT THE FUNCTION(S) THE AUTHORIZED REPRESENTATIVE WILL DO: HEALTH COVERAGE
APPLY	• Sign application and be interviewed. • Provide all required proof of information necessary to determine eligibility for benefits. • Receive the Notice of the application decision. • Speak on applicant's behalf at a hearing if the application decision is appealed.	Apply ☐
ONGOING	• Report changes. • Attend periodic redeterminations. • Receive the appointment notices and any redetermination mail-in forms. **NOTE:** Do not check this function if the representative will not continue to act on recipient's behalf after the application decision is made.	Ongoing ☐

In agreeing to be the authorized representative, I understand that I am expected to be knowledgeable of the applicant's/recipient's circumstances and that this authorization can be revoked by the applicant/recipient at any time.

Signature:	Date (*mm/dd/yyyy*):	Telephone ((###) ###-####):

Section 3

I authorize this representative to act for me in taking care of the functions and program eligibility process which I have checked above. (If applicant/recipient is medically incapable to sign authorization, provide medical documentation.) I understand that I am responsible for the information anyone acting as my authorized representative gives, including any information that may be incorrect. I also understand that if at any time I wish to stop the person(s) I chose from being my authorized representative, it is my responsibility to contact the Division of Family Resources.

Applicant/Recipient Name	Applicant/Recipient Signature	Date (*mm/dd/yyyy*):

Case Number (*Optional*):

Authorized Representative Form Section 1

- **FOR HEALTH COVERAGE** State Form 55366 (R / 10-13) / DFR 2123HC
- **Section 1**
- If you want someone to act on your behalf in applying for benefits and/or act for you on an ongoing basis, this form must be completed.
- Be sure to select the function(s) that the representative is being authorized to do.
- You can select more than one representative and choose the same or different functions. Complete ONE form per authorized representative.
- Both you and your representative must sign and date this form.

Authorized Representative Form Section 2

- **Section 2**
- Name of Representative (*Please print clearly):*
- Check association with applicant/recipient. *Please select ONE (1).*
- Attorney Eligibility Assistance Company Friend Family
- Institution of Residence Waiver Case Manager Other (*Specify):* _____
- Mailing Address (*number and street, city, state, and ZIP code):*
- **SELECT THE FUNCTION(S) THE AUTHORIZED**
- **REPRESENTATIVE WILL DO:**
- **FUNCTION FUNCTION DESCRIPTION HEALTH COVERAGE**
- **APPLY**
- • Sign application and be interviewed.
- • Provide all required proof of information necessary to determine eligibility for
- benefits.
- • Receive the Notice of the application decision.
- • Speak on applicant's behalf at a hearing if the application decision is appealed.
- **Apply**
- **ONGOING**
- • Report changes.
- • Attend periodic redeterminations.
- • Receive the appointment notices and any redetermination mail-in forms.
- **NOTE: Do not check this function if the representative will not continue to act on**
- recipient's behalf after the application decision is made.
- **Ongoing**
- **In agreeing to be the authorized representative, I understand that I am expected to be knowledgeable of the applicant's/recipient's circumstances and that this**
- **authorization can be revoked by the applicant/recipient at any time.**
- Signature: D

Authorized Representative form for Health Coverage Section 3 Applicant Information

- **I authorize this representative to act for me in taking care of the functions and program eligibility process which I have checked above.**

- **(If applicant/recipient is medically incapable to sign authorization, provide medical documentation.)**

- **I understand that I am responsible for the information anyone acting as my**
- **authorized representative gives, including any information that may be incorrect.**

- **I also understand that if at any time I wish to stop the person(s) I chose from**
- **being my authorized representative, it is my responsibility to contact the Division of Family Resources.**

- Applicant/Recipient Name Applicant/Recipient Signature Date (*mm/dd/yyyy):*

- Case Number (*Optional):*
- *

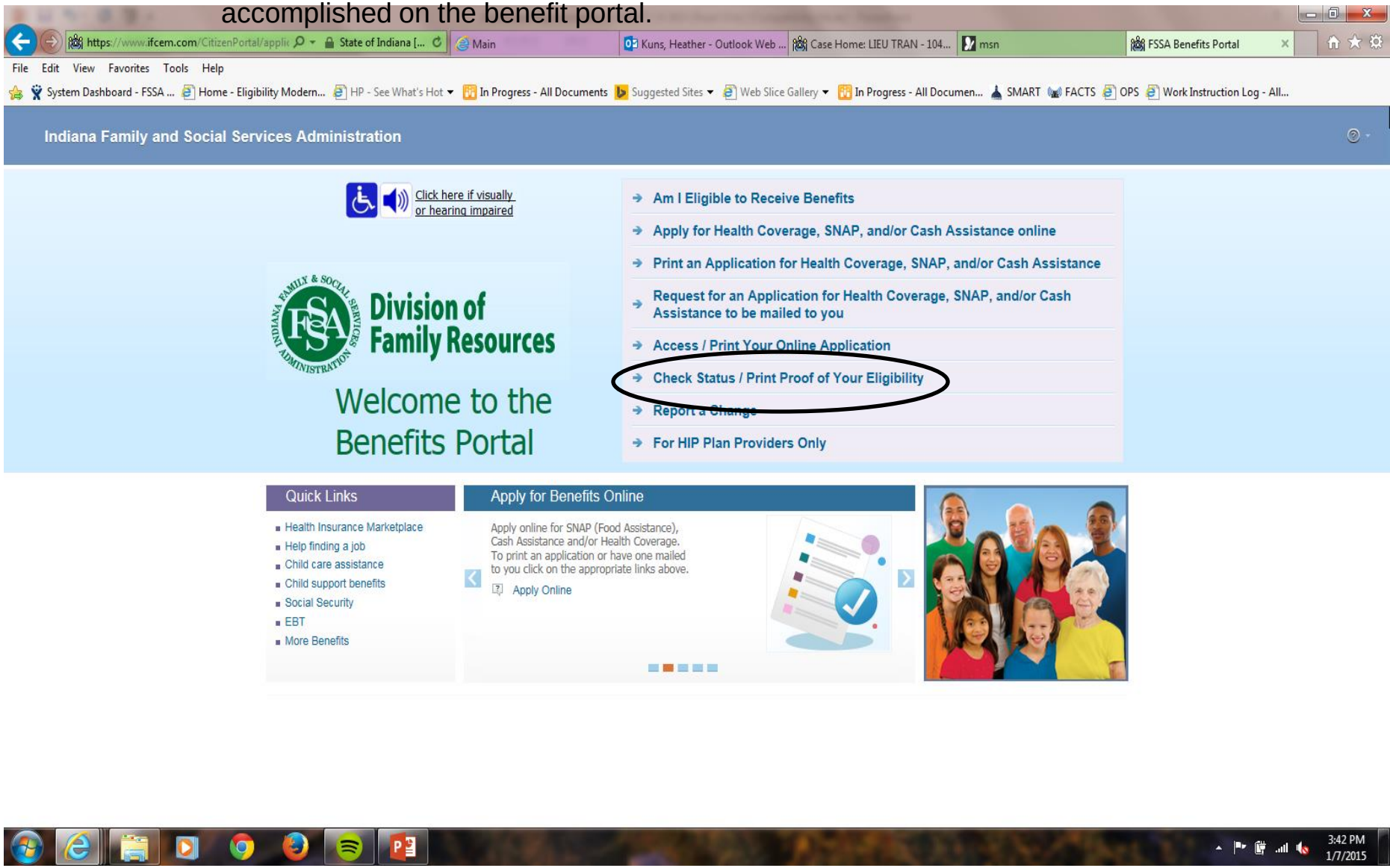
Authorization for Disclosure of Personal Health information This form can be used to authorize an individual or agency to obtain information for a specific reason or specified amount of time

- **AUTHORIZATION FOR DISCLOSURE OF PERSONAL AND HEALTH INFORMATION - DFR**
- State Form 54621 (2-11)
- FAMILY AND SOCIAL SERVICES ADMINISTRATION / DIVISION OF FAMILY RESOURCES
- **Purpose**
- For you to authorize the disclosure of your personal information, which may include health information, to persons or organizations outside of the Division of Family Resources (DFR). Your privacy is protected by state and federal privacy laws. As such, we need your explicit permission to make the requested disclosure. Please complete each section of this form.
- **Your Name and Identification Information**
- Name
- Address
- City State ZIP Code
- Telephone ( ) E-mail Address
- Date of Birth Last 4 Digits of Social Security #
- **What personal information, including health information, are we to disclose?**
- Please describe the type of information we are allowed to disclose; for example, your contact information, your benefits status, your current eligibility status and/or historical status, or "as requested by the authorized person/organization."1
- **What is the purpose of the requested disclosure of your personal information?**
- Please describe the purpose for the disclosure (e.g., assistance with obtaining or using FSSA benefits/services, legal assistance, the person is involved in my use of FSSA benefits/services, or simply "at my request").
- **To whom are we authorized to disclose your personal information?**
- Please state the names of the individuals or organizations, including contact information.
- 1 *If the personal information to be disclosed is identified "as requested by the authorized person/organization", then we will rely on them to identify what information is to be disclosed when receiving their request for disclosure; we will also rely on them to specify the minimum amount of personal information, including health information, that is reasonably necessary to accomplish the purpose of the request.*

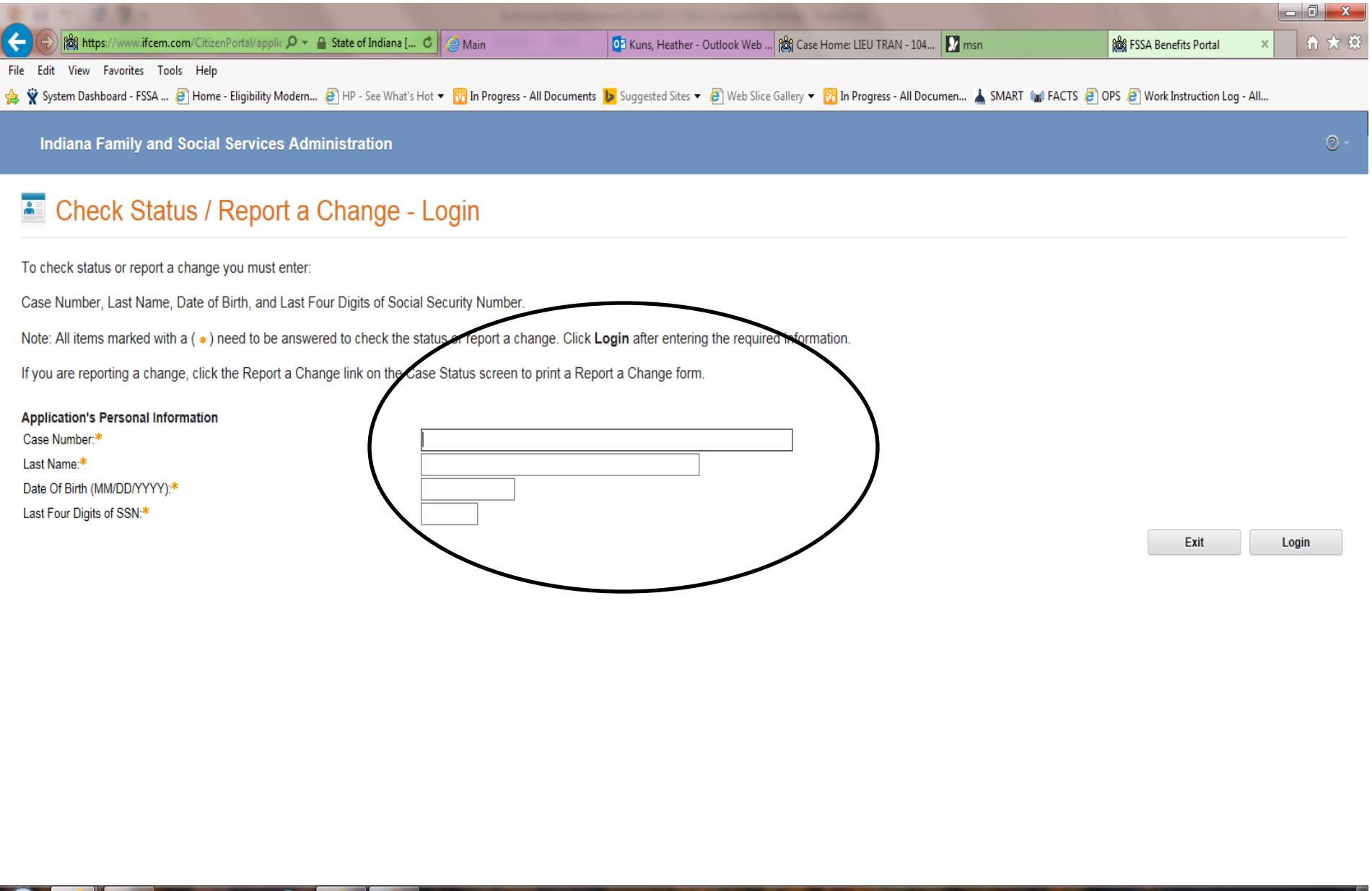
Authorization for Disclosure of Personal Health information cont'd

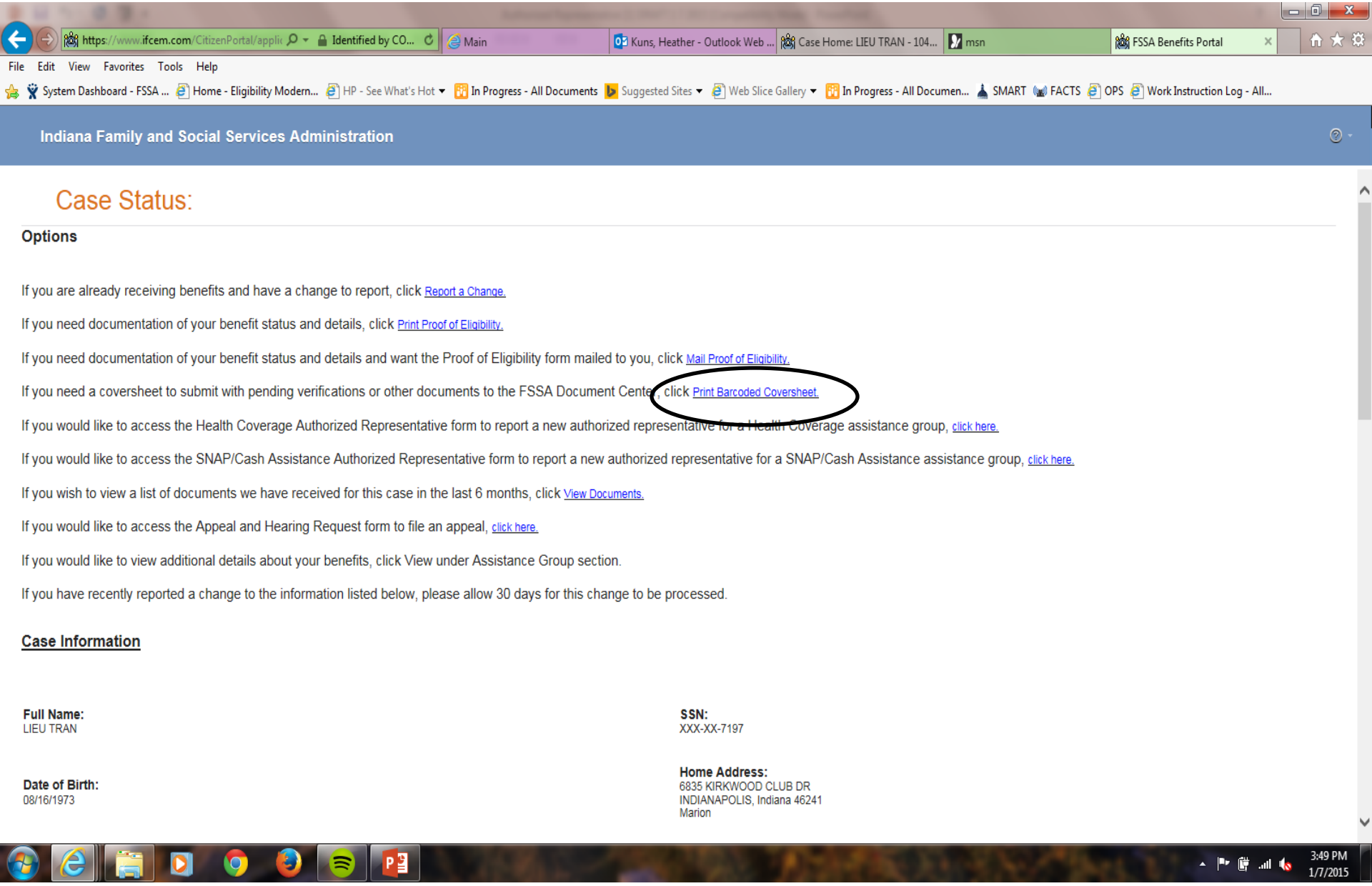
- **Which DFR program areas are you authorizing to disclose your personal information?**
- ☐Medicaid Eligibility ☐Supplemental Nutrition Assistance Program (SNAP)/Food Stamps ☐Child Care Assistance
- ☐Temporary Assistance for Needy Families (TANF) ☐Other
- **Expiration Date or Event**
- This authorization will automatically expire sixty (60) calendar days from the date you sign it. You may specify an earlier or later expiration date, or you may specify an event upon which this authorization will expire (e.g., "when my concern has been addressed"). Please select one of the following three:
- ☐Allow to automatically expire in sixty (**60) calendar days** ☐Expire on this date (month, day and year):
- ☐Expire on this event:
- **Right to Revoke**
- You have the right to revoke this authorization at any time. You may revoke this authorization by giving written notice, including e-mail notice, to the DFR contact below. Any disclosures of your personal information, including health information, which we may have made under this authorization prior to revocation will not be affected (they were made while this authorization was still in effect).
- **Further Disclosure**
- Once we disclose your personal information, including health information, to the above persons/organizations, the information may no longer be protected under state or federal privacy laws. We cannot control what these persons/organizations do with your information.
- **Signature**
- Having had full opportunity to read and consider the contents of this authorization, including my rights and the risks of further disclosure as described above, I am authorizing DFR to disclose my personal information, including health information, to the persons or organizations I have identified above. I understand DFR will disclose only that information which is necessary to accomplish the stated purpose of the disclosure. The information disclosed will be limited to the minimum necessary. I also understand that I am under no obligation to sign this authorization. I also understand that the services and benefits provided to me by or through DFR will not be affected whether or not I sign this form.
- Signature Date *If this authorization is signed by an individual's personal representative on behalf of the individual, please complete the following:*

If you are an authorized representative or are assisting a client whom needs to check the status of their case, this is accomplished on the benefit portal.



The following information is needed to access the case

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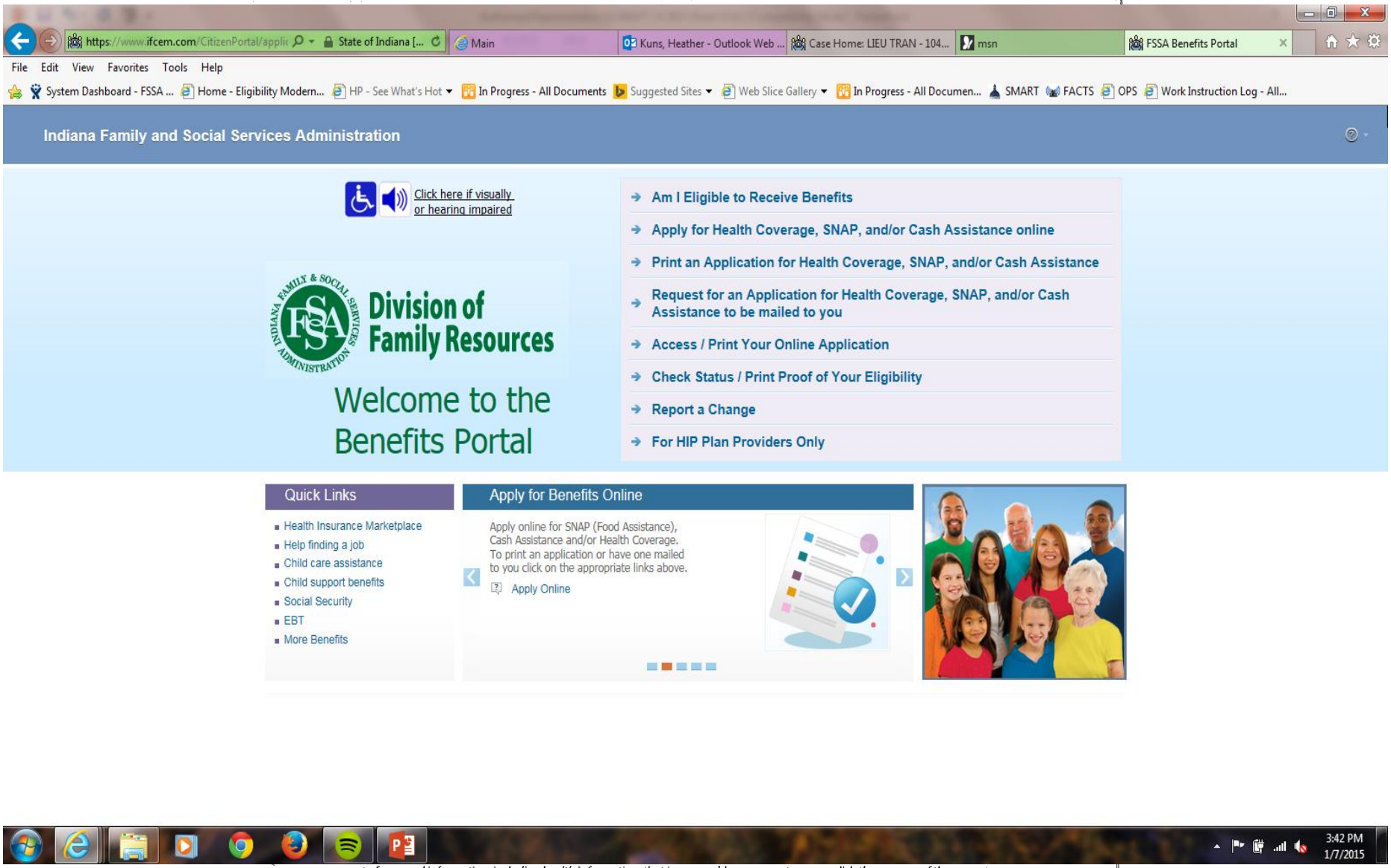
Kuns, Heather - Outlook Web ...
Case Home: LIEU TRAN - 104...
msn
FSSA Benefits Portal
File Edit View Favorites Tools Help
System Dashboard - FSSA ...
Home - Eligibility Modern...
HP - See What's Hot
In Progress - All Documents
Suggested Sites
Web Slice Gallery
In Progress - All Documen...
SMART
FACTS
OPS
Work Instruction Log - All...
Indiana Family and Social Services Administration
Case Status:
Options
If you are already receiving benefits and have a change to report, click Report a Change.
If you need documentation of your benefit status and details, click Print Proof of Eligibility.
If you need documentation of your benefit status and details and want the Proof of Eligibility form mailed to you, click Mail Proof of Eligibility.
If you need a coversheet to submit with pending verifications or other documents to the FSSA Document Cente, click Print Barcoded Coversheet.
If you would like to access the Health Coverage Authorized Representative form to report a new authorized representative for a Health Coverage assistance group, click here.
If you would like to access the SNAP/Cash Assistance Authorized Representative form to report a new authorized representative for a SNAP/Cash Assistance assistance group, click here.
If you wish to view a list of documents we have received for this case in the last 6 months, click View Documents.
If you would like to access the Appeal and Hearing Request form to file an appeal, click here.
If you would like to view additional details about your benefits, click View under Assistance Group section.
If you have recently reported a change to the information listed below, please allow 30 days for this change to be processed.
Case Information
Full Name:
LIEU TRAN
SSN:
XXX-XX-7197
Date of Birth:
08/16/1973
Home Address:
6835 KIRKWOOD CLUB DR
INDIANAPOLIS, Indiana 46241
Marion
3:49 PM
1/7/2015



amount of personal information, including health information, that is reasonably necessary to accomplish the purpose of the request.

Thank You

Questions?

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