Required ACP Documents Guide

This guide provides guidance to the type of documents you would need to submit for the National Verifier to continue your ACP approval.

Please click on the name of the qualifying program to get to the details needed for your next step:

- **Medicaid**
- **Supplemental Nutrition Assistance Program (SNAP)**
- **Qualifying based on Household Income**
- **Education-related qualifying programs**
- **Other programs**

Make sure to:

- Have all your documents **current**, & **not expired**
- **Never** upload the original document, only **upload copies** or **pictures** of your document

If you qualify through: **Medicaid**

Your state could have a **different name for Medicaid**, check pages **4-5** for program's name per state.

Check that your documents have the following information clearly stated:

- Your **Name** or **Dependent's Name**
- The name of the **Qualifying Program**
- The name of the **Government** or **Tribal Agency** that issued the document
- An issue date within the last **12 months** or a **future expiration date.**

You will need the following document:

✔ Approval or Benefit Letter for Medicaid:

Name of [State] Department

Medicaid Approval letter

Qualifying Individual Medicare

Name: _____

Address: _____

_____

Date: _____

BG#: _____

HH#: _____

You have been approved for Medicaid to pay your monthly Medicare. This also means that Social Security will stop taking the amount out of your Social Security check.

Beneficiary Name	Beneficiary ID#	Begin date

You are eligible for this benefit only through December 31 of this year.

- To be eligible for this benefit next year, you must reapply. We will mail you an application in October.

  The federal government only gives Medicaid a limited amount of money to help people in this program; therefore we process applications on a first come first served basis.
- Please allow 90 – 120 days for this benefit to start. At that time, you will receive a refund check from the Social Security Administration for the months you paid for the premium out of your check while eligible for this benefit.
- Please call [redacted] (TTY [redacted]) if your address changes or if you have a question about this letter.

For your reference:

Other known names for Medicaid in different states:

State	Name of Medicaid in the State
Arizona	Arizona Health Care Cost Containment System **(AHCCCS)**
California	Medi-Cal
Colorado	Health First Colorado
Connecticut	Connecticut Medicaid
Delware	Diamond State Health Plan **(PLUS)**
Florida	Statewide Medicaid Managed Care Program
Hawaii	Med-QUEST
Illinois	HealthChoice Illinois
Indiana	State Health Insurance Assistance Program **(SHIP)**
Iwoa	IA Health Link
Kansas	KanCare Medical Assistance Program
Louisiana	Bayou Health Healthy Louisiana
Maine	MaineCare
MaryLand,Michigan	Medical Assistance
Massachusetts	MassHealth
Minnesota	MinnesotaCare / Medical Assistance

State	Name of Medicaid in the State
Mississippi	MississippiCAN
Missouri	MO HealthNet
Nebraska	ACCESSNebraska
New Jersey	New Jersey FamilyCare
New Mexico	Centennial Care
New York	Medicaid Managed Care
North Carolina	Division of Medical Assistance **(DMA)**
North Dakota	North Dakota Medicaid Expansion Program
Oklahoma	SoonerCare
Oregon	Oregon Health Plan
Pennsylvania	Medical Assistance
Rhode Island	RI Medical Assistance Programs
South Carolina	Healthy Connections
Tennessee	TennCare
Vermont	Green Mountain Care
Washington, Washington DC	Apple Health / DC Medicaid
Wisconsin	ForwardHealth/BadgerCare
Wyoming	EqualityCare

If you qualify through:

Supplemental Nutrition Assistance Program (SNAP)

Other known names for **SNAP**:

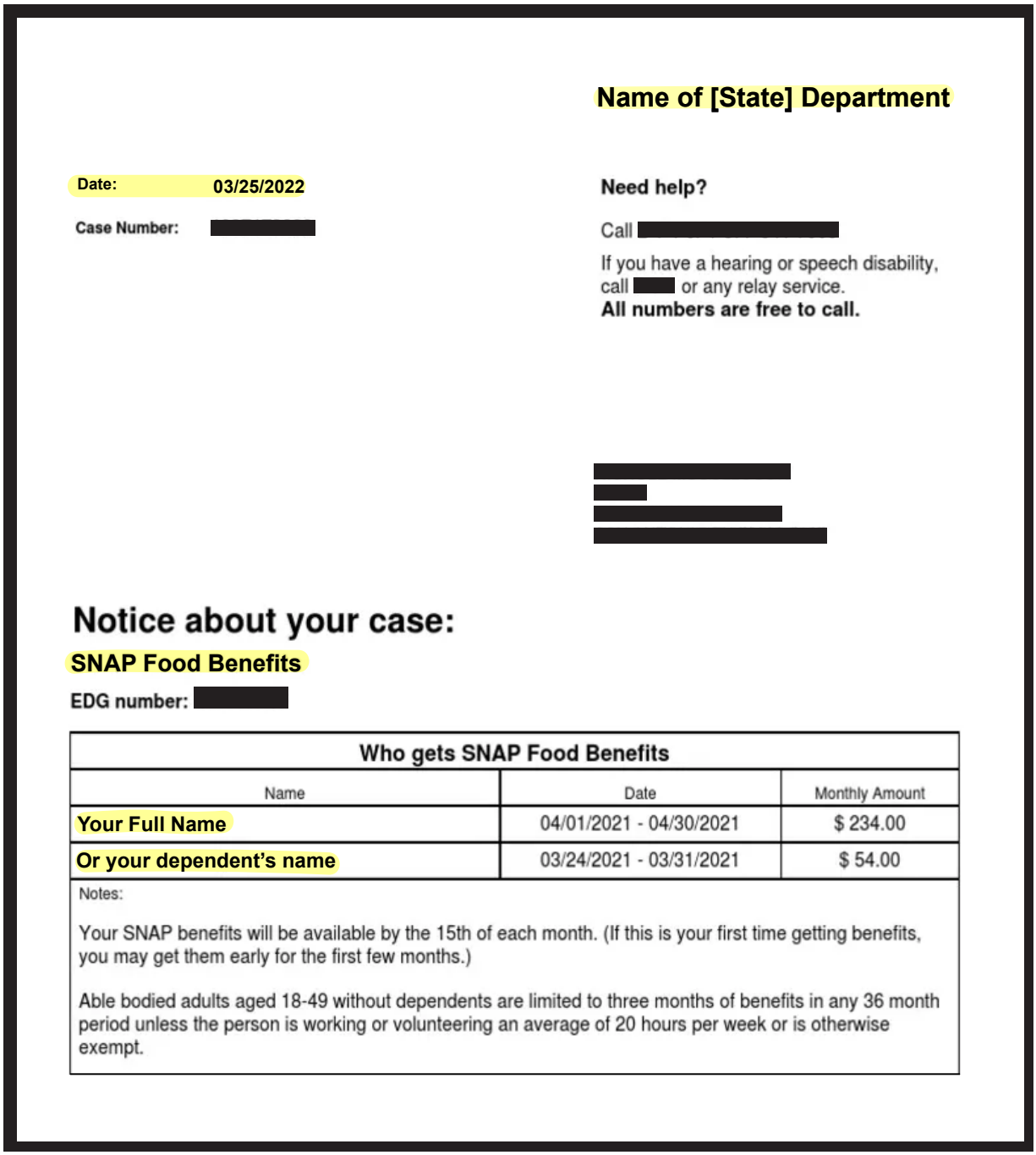
(***Food Asssistance Program***, ***Food Stamp Program***, ***Food Supplemental Program***, ***Nutrition Assistance***, ***CalFresh***, ***Food & Nutrition Services***, ***3SquaresVT***, ***Basic Food Program***, ***FoodShare***)

Check that your documents have the following information clearly stated:

- Your **Name** or **Dependant's Name**
- The name of the **Qualifying Program**
- The name of the **Government** or **Tribal Agency** that issued the document
- An issue date within the last **12 months** or a **future expiration date**

You will need the following document:

✔ Approval or Benefit Letter for SNAP:



Name of [State] Department

Date: 03/25/2022

Case Number: [redacted]

Need help?

Call [redacted]

If you have a hearing or speech disability, call [redacted] or any relay service.
All numbers are free to call.

[redacted]

Notice about your case:

SNAP Food Benefits

EDG number: [redacted]

Who gets SNAP Food Benefits		
Name	Date	Monthly Amount
Your Full Name	04/01/2021 - 04/30/2021	$ 234.00
Or your dependent's name	03/24/2021 - 03/31/2021	$ 54.00

Notes:

Your SNAP benefits will be available by the 15th of each month. (If this is your first time getting benefits, you may get them early for the first few months.)

Able bodied adults aged 18-49 without dependents are limited to three months of benefits in any 36 month period unless the person is working or volunteering an average of 20 hours per week or is otherwise exempt.

If you qualify **based on Household Income:**

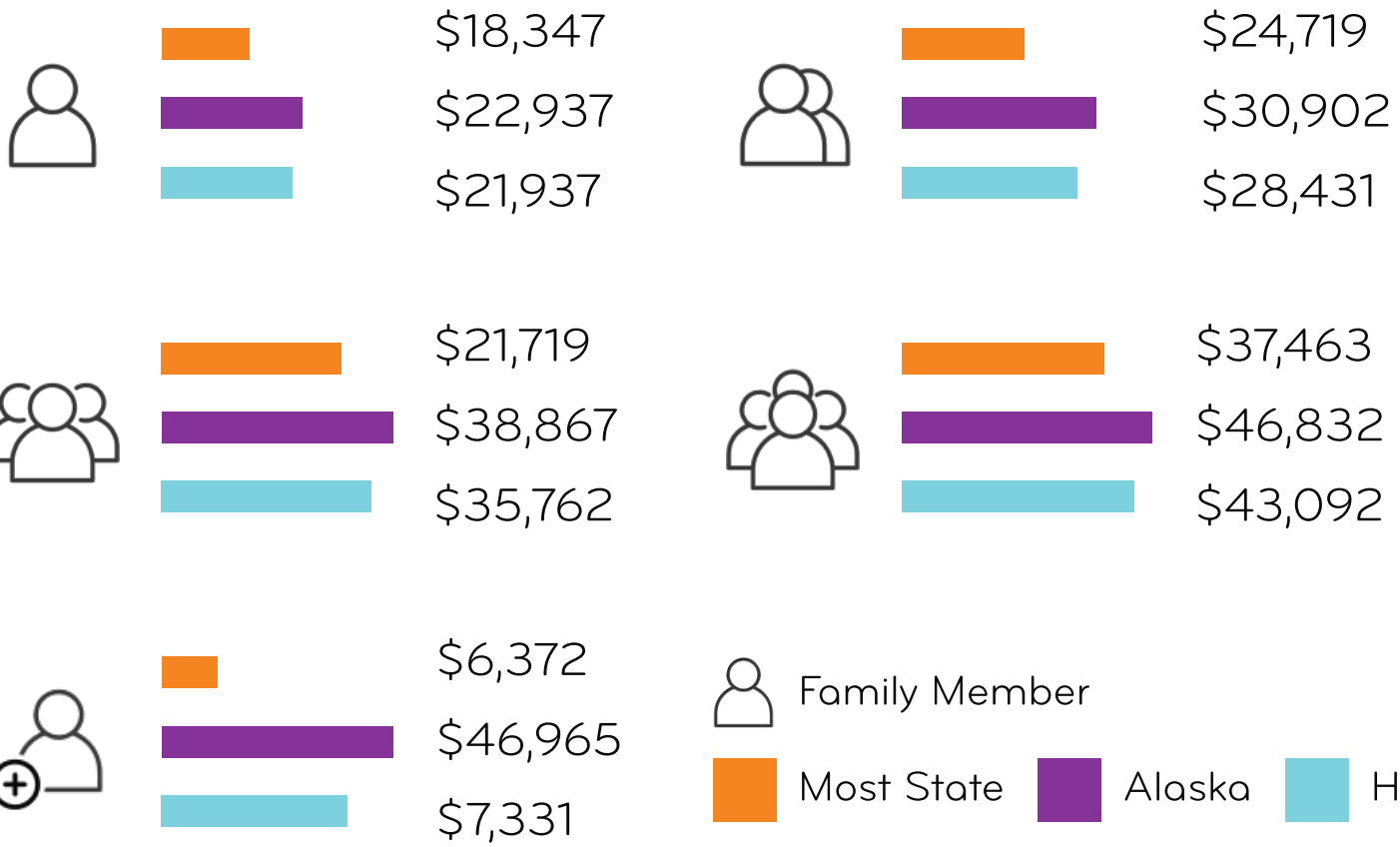
Provide documentations that show your annual income and be sure to include your household size on the income documentation.

Check that your documents have the following information clearly stated:

- Your **Name** or **Dependent's Name**
- Current income information *(Monthly or annual income amount)*
- **3 consecutive months** of paystubs *(if provided)*
- An issue date within the last **12 months** or **prior year tax document.**

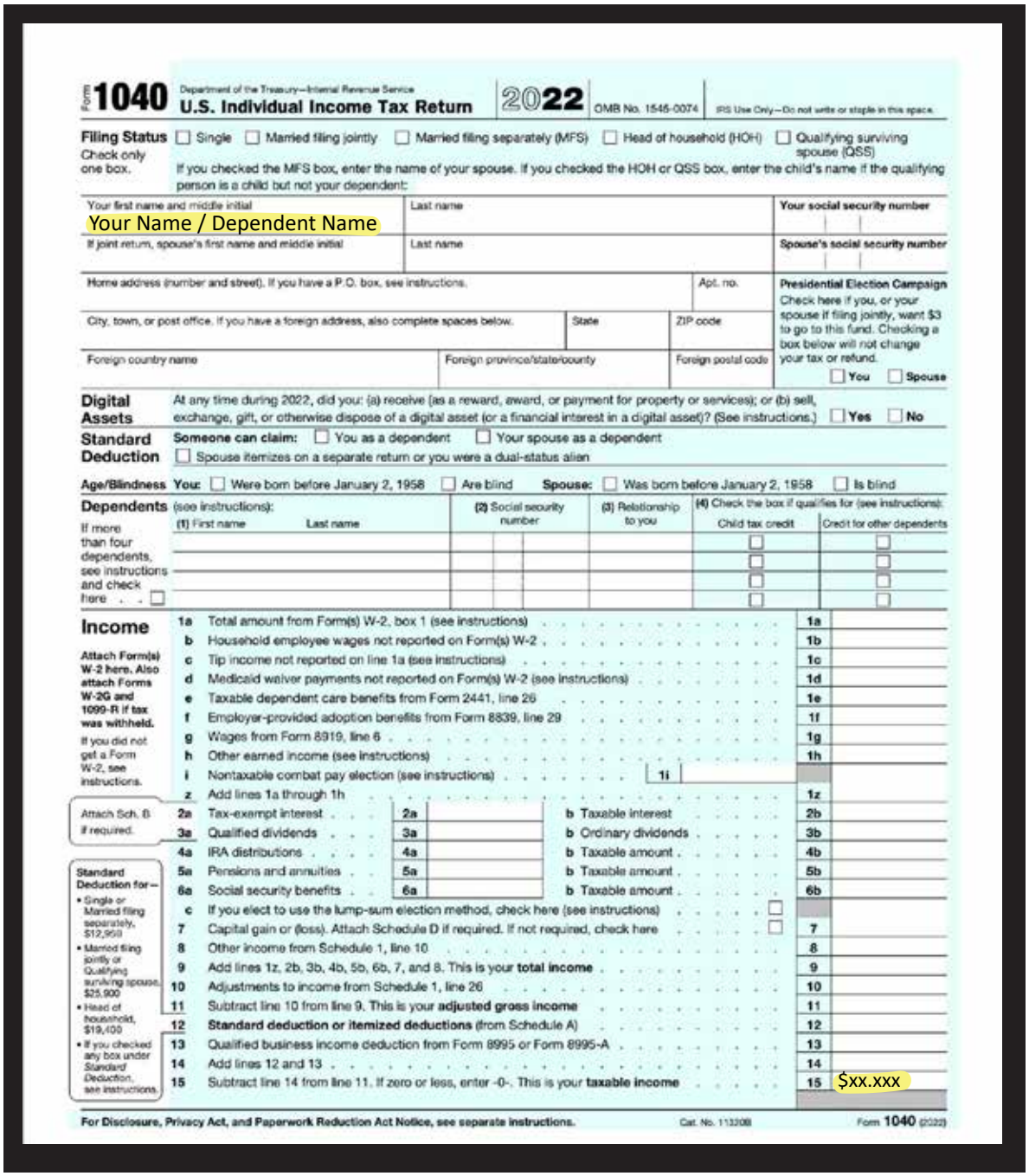
Household size guide:

Based on household income



You will need the following documents:

- Prior year's state, federal, or Tribal tax return or a Social Security Benefit Statement.



Form **1040** Department of the Treasury—Internal Revenue Service **U.S. Individual Income Tax Return** **2022** OMB No. 1545-0074 IRS Use Only—Do not write or staple in this space.

Filing Status Check only one box. ☐ Single ☐ Married filing jointly ☐ Married filing separately (MFS) ☐ Head of household (HOH) ☐ Qualifying surviving spouse (QSS)

If you checked the MFS box, enter the name of your spouse. If you checked the HOH or QSS box, enter the child's name if the qualifying person is a child but not your dependent:

Your first name and middle initial	Last name	Your social security number
Your Name / Dependent Name		
If joint return, spouse's first name and middle initial	Last name	Spouse's social security number

Home address (number and street). If you have a P.O. box, see instructions. Apt. no.

City, town, or post office. If you have a foreign address, also complete spaces below. State ZIP code

Foreign country name Foreign province/state/county Foreign postal code

Presidential Election Campaign Check here if you, or your spouse if filing jointly, want $3 to go to this fund. Checking a box below will not change your tax or refund. ☐ You ☐ Spouse

Digital Assets At any time during 2022, did you: (a) receive (as a reward, award, or payment for property or services); or (b) sell, exchange, gift, or otherwise dispose of a digital asset (or a financial interest in a digital asset)? (See instructions.) ☐ Yes ☐ No

Standard Deduction **Someone can claim:** ☐ You as a dependent ☐ Your spouse as a dependent

☐ Spouse itemizes on a separate return or you were a dual-status alien

Age/Blindness **You:** ☐ Were born before January 2, 1958 ☐ Are blind **Spouse:** ☐ Was born before January 2, 1958 ☐ Is blind

Dependents (see instructions): If more than four dependents, see instructions and check here ☐

(1) First name Last name	(2) Social security number	(3) Relationship to you	(4) Check the box if qualifies for (see instructions): Child tax credit	Credit for other dependents
			☐	☐
			☐	☐
			☐	☐
			☐	☐

Income

Attach Form(s) W-2 here. Also attach Forms W-2G and 1099-R if tax was withheld.

If you did not get a Form W-2, see instructions.

1a	Total amount from Form(s) W-2, box 1 (see instructions)		1a
b	Household employee wages not reported on Form(s) W-2		1b
c	Tip income not reported on line 1a (see instructions)		1c
d	Medicaid waiver payments not reported on Form(s) W-2 (see instructions)		1d
e	Taxable dependent care benefits from Form 2441, line 26		1e
f	Employer-provided adoption benefits from Form 8839, line 29		1f
g	Wages from Form 8919, line 6		1g
h	Other earned income (see instructions)		1h
i	Nontaxable combat pay election (see instructions) 1i		
z	Add lines 1a through 1h		1z
2a	Tax-exempt interest 2a	b Taxable interest	2b
3a	Qualified dividends 3a	b Ordinary dividends	3b
4a	IRA distributions 4a	b Taxable amount	4b
5a	Pensions and annuities 5a	b Taxable amount	5b
6a	Social security benefits 6a	b Taxable amount	6b
c	If you elect to use the lump-sum election method, check here (see instructions) ☐		
7	Capital gain or (loss). Attach Schedule D if required. If not required, check here ☐		7
8	Other income from Schedule 1, line 10		8
9	Add lines 1z, 2b, 3b, 4b, 5b, 6b, 7, and 8. This is your **total income**		9
10	Adjustments to income from Schedule 1, line 26		10
11	Subtract line 10 from line 9. This is your **adjusted gross income**		11
12	**Standard deduction or itemized deductions** (from Schedule A)		12
13	Qualified business income deduction from Form 8995 or Form 8995-A		13
14	Add lines 12 and 13		14
15	Subtract line 14 from line 11. If zero or less, enter -0-. This is your **taxable income**		15 $xx.xxx

Attach Sch. 8 if required.

Standard Deduction for—
- Single or Married filing separately, $12,950
- Married filing jointly or Qualifying surviving spouse, $25,900
- Head of household, $19,400
- If you checked any box under *Standard Deduction*, see instructions.

For Disclosure, Privacy Act, and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 11320B Form **1040** (2022)

If you qualify through:

(***Federal Pell Grant***, ***Free & Reduced-Price School Lunch Program or School Breakfast Program***, ***USDA Community Eligibility Provision (CEP)***)

Check that your documents have the following information clearly stated:

- Your **Name** or **Dependent's First & Last Name**
- The name of the **Qualifying Program**
  (not required for Community Eligibility Provision)
- The **name of the school** or **school district**
- A **current** award year *(Pell Grant)*
- **Dated** for the **current school year** or the **school year immediatley preceding the application** *(for school lunch or breakfast qualifying programs)*
- **Address** & **Contact information** for the **school, school year** for which the student is enrolled *(required for Community Eligibility Provision)*

You will need the following documents:

- A letter from the school or school district that confirm a member of household receives free & reduced-price school lunch or school year immediately preceding the application

[Name of School / School District]

Notification of Eligibility for Free & Reduced-Price School Meals

School Year 2022-2023

Dear Parent/Guardian:

You applied for free or reduced-price school for the following child(ren):
[Name of Child]

Your application was:

☑ Approved for free school meals because your income is within the free school meal eligibility limits. Your child(ren) will receive school meals at no cost.

☑ Approved for reduced-price school meals because your income is over the free school limit but within the reduced price school meal eligibility limits. There is no cost for breakfast or lunch for all qualifying reduced-price students.

☐ Denied for the following reasons:

- ☐ Income over the allowable amount
- ☐ Incomplete application because of _____
- ☐ Other: _____

- For enrollment in a CEP school – School documentation demonstrating the student is enrolled in a CEP School for the relevant school year (student must still be enrolled in the CEP school at the time of the application)

[Name of School / School District]

School Attendance / Enrollment Verification

School Year 2022-2023

Student Name: _____

Date of Birth: _____

This form may be used by parent/caregiver relatives to verify school attendance when a student is enrolled & attending [School Name].

Thereby authorize:

[School Name] to release the attendance/enrollment information required herein for above-name student. and the county to contact the school concerning attendance or enrollment.

Parent/Caregiver signature: _____

Date: _____

The above-named student is:

☑ In regular attendance

☐ Chronic truant

[School Stamp or label here]

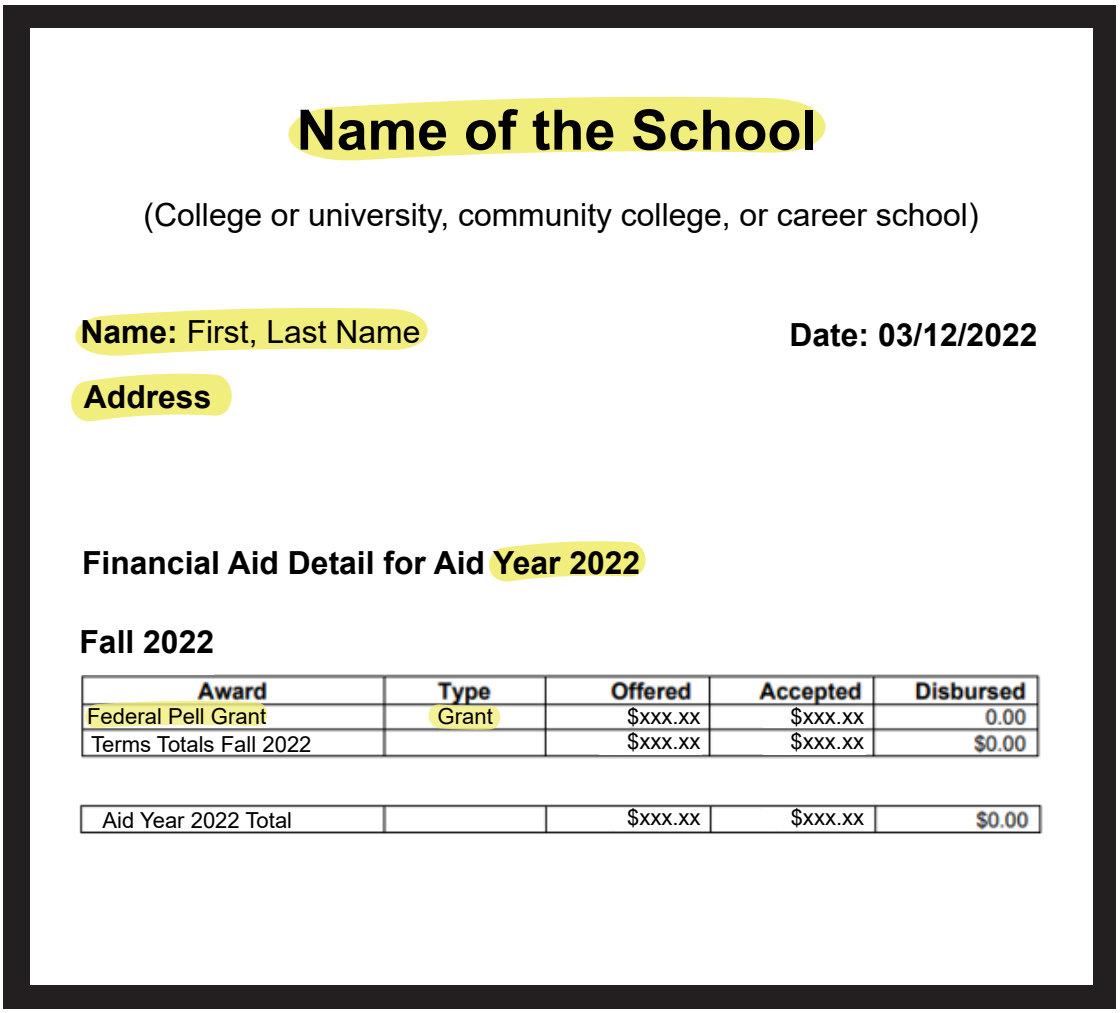
Signature: _____

Date: _____

Title: _____

Telephone: _____

- For Federal Pell Grants, written confirmation from a student's school (college or university, community college, or career school) or the Department of Education that the student has received a Pell Grant for the current award year.



Name of the School

(College or university, community college, or career school)

Name: First, Last Name

Date: 03/12/2022

Address

Financial Aid Detail for Aid Year 2022

Fall 2022

Award	Type	Offered	Accepted	Disbursed
Federal Pell Grant	Grant	$xxx.xx	$xxx.xx	0.00
Terms Totals Fall 2022		$xxx.xx	$xxx.xx	$0.00

Aid Year 2022 Total		$xxx.xx	$xxx.xx	$0.00

If you qualify through:

(**Supplemental Nutrition Assistance Program (SNAP), Medicaid, Supplemental Security Income (SSI), Federal Public Housing Assistance, Veterans Pension or Surviors Pension, Special Supplemental Nutrition Program for Women, Infants & Children (WIC)**)

If you live on Tribal lands, you might qualify through:

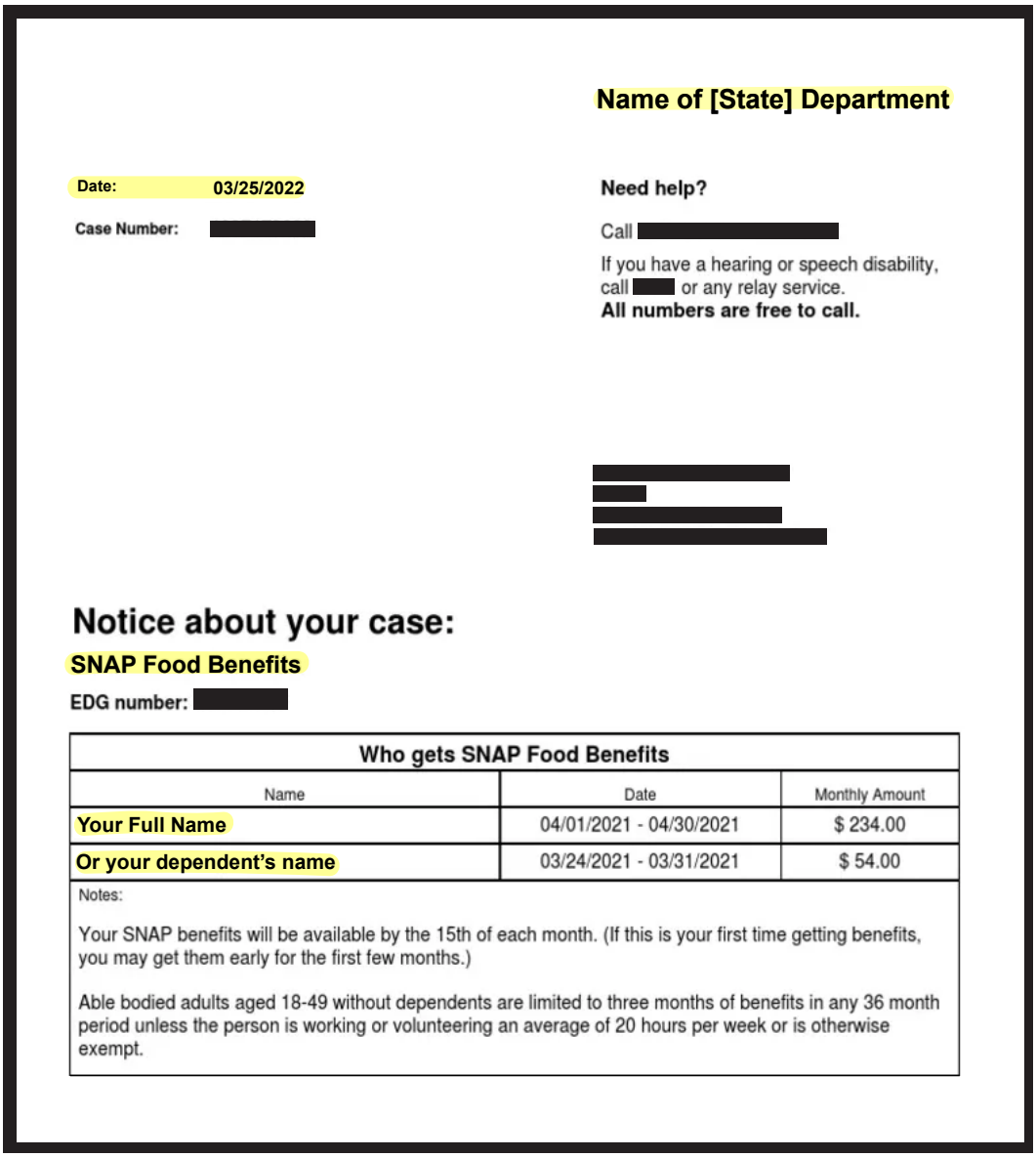
(**Bureau of Indian Affairs (BIA) General Assistance, Tribally-Administered Temporary Assistance for Needy Families (TANF), Tribal Head Start, Food Distribution Program on Indian Reservations**)

Check that your documents have the following information clearly stated:

- Your **Name** or **Dependent's Name**
- The name of the **Qualifying Program**
- The name of the **Government** or **Tribal Agency** that issued the document
- An issue date within the last **12 months** or a **future expiration date**

You will need the following documents:

✔ Approval or Benefit Letter for SNAP or Medicaid:



Name of [State] Department

Date: 03/25/2022

Case Number: [redacted]

Need help?

Call [redacted]

If you have a hearing or speech disability, call [redacted] or any relay service.
All numbers are free to call.

[redacted]

Notice about your case:

SNAP Food Benefits

EDG number: [redacted]

Who gets SNAP Food Benefits		
Name	Date	Monthly Amount
Your Full Name	04/01/2021 - 04/30/2021	$ 234.00
Or your dependent's name	03/24/2021 - 03/31/2021	$ 54.00

Notes:

Your SNAP benefits will be available by the 15th of each month. (If this is your first time getting benefits, you may get them early for the first few months.)

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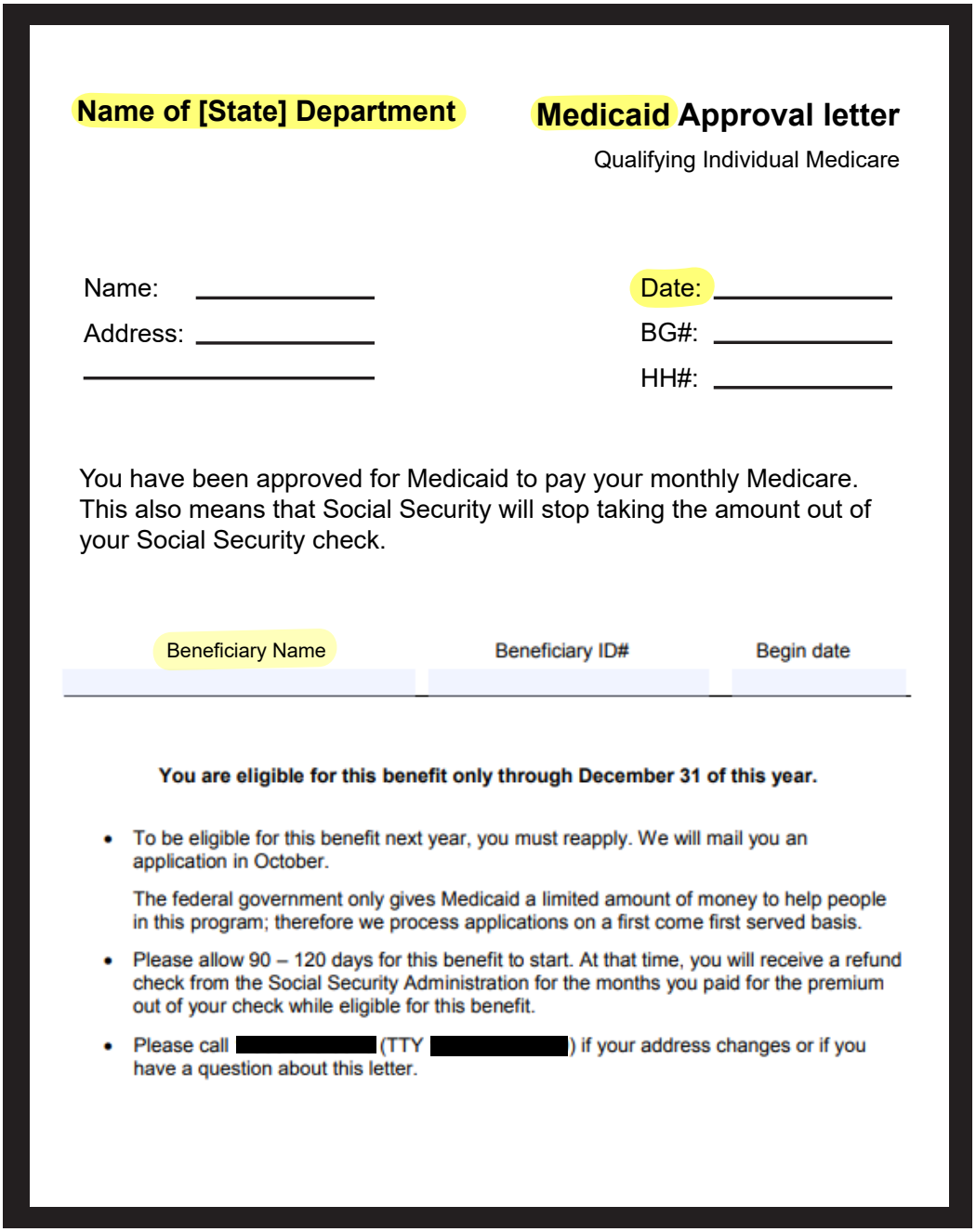

Name of [State] Department

Medicaid Approval letter

Qualifying Individual Medicare

Name: _____

Address: _____

_____

Date: _____

BG#: _____

HH#: _____

You have been approved for Medicaid to pay your monthly Medicare. This also means that Social Security will stop taking the amount out of your Social Security check.

Beneficiary Name	Beneficiary ID#	Begin date

You are eligible for this benefit only through December 31 of this year.

- To be eligible for this benefit next year, you must reapply. We will mail you an application in October.

  The federal government only gives Medicaid a limited amount of money to help people in this program; therefore we process applications on a first come first served basis.
- Please allow 90 – 120 days for this benefit to start. At that time, you will receive a refund check from the Social Security Administration for the months you paid for the premium out of your check while eligible for this benefit.
- Please call [redacted] (TTY [redacted]) if your address changes or if you have a question about this letter.

- ✔ Screenshot of Online Portal
- ✔ Survivors Benefit Summary Letter

For more information, you can visit the **Affordable Connectivity Website.**
https://www.affordableconnectivity.gov/wp-content/uploads/ACP-Acceptable-Documentation-Guide-English.pdf