RHODE ISLAND DEPARTMENT OF HUMAN SERVICES
APPLICATION FOR ASSISTANCE (DHS-2)

General Instructions for Completing this Application

You can ask for help in completing this form. You can ask for the form and notices to be translated. If you have a disability or condition that makes it hard for you to understand or answer questions on this application, we can help. Please let us know by speaking with a DHS representative or calling the DHS Information Line at 462-5300.

If you would like to apply for Medicaid affordable health care coverage, you must complete a different application.
Health care coverage is available for families with income up to 133% of the Federal Poverty Level (FPL), children and pregnant women with income up to 250% of the FPL and childless adults age 19 to 64 with income up to 133% FPL. Adults with disabilities who do not need long term services and supports or adults who do not meet criteria for a disability determination or have too much money in the bank may apply for affordable health care coverage. **You can apply for health care coverage in the following ways:**

- online at www.healthyrhode.ri.gov
- calling the HRSI Contact Center at 1-855-840-4774
- in-person, at a local DHS Office
- mailing in a paper application. Applications can be found online at www.dhs.ri.gov under "What's New?" or "Forms and Applications"

Answer All Questions

If you answer all the questions on the assistance application, we can determine if you are eligible for ALL programs. The program symbols below will appear next to each of the questions on the application. These symbols tell you which questions you must answer for each program. If the symbol for the program(s) you are applying for appears next to the question, you must answer that question.

RI Works (RIW) Cash Assistance: The RIW Program gives cash assistance for a limited number of months to families in need of support, as well as those who are unable to work, or in training or looking for a job. Applicants for RIW must be responsible for the support and care of a child under age 18, or between 18 and 19 if enrolled full-time in and expected to complete secondary school prior to their 19th birthday. RIW cash assistance requires an interview with an eligibility worker and a meeting with a Social Caseworker to complete an employment plan.

Supplemental Nutrition Assistance Program (SNAP): The SNAP program helps low income households buy the food needed to stay healthy. You may be able to get SNAP benefits within 7 days if your household has little or no income, your rent or housing costs are higher than your income/resources, or if you are a seasonal or migrant farmworker. All other households will receive an eligibility determination within 30 days of the application filing date. You will need to participate in an interview over the telephone or in the office before you can be granted SNAP benefits.

Medicaid: Long Term Services and Supports: Medicaid Long Services and Supports (LTSS) are available for individuals age 65 and older and for individuals with disabilities. You must meet both the financial and functional/clinical "level of care" need to qualify for eligible LTSS. The types of services available include Nursing Home Care or Home and Community Based Services. Services include but are not limited to homemaker/CNA services, Environmental modifications, Case Management, Assisted Living, Personal care services (self-directed care), respite, minor home modifications and shared living/RIte at Home. The type of services you receive depends on your level of care needs.

Medicaid/Health Coverage for Aged, Blind and Disabled (ABD) and Working Adults with Disabilities/Sherlock Plan: To qualify for Medicaid under the ABD category, an individual or member of a couple must be age 65 years or older, blind or disabled. Your income, resources and health needs will determine if you are eligible. Individuals who receive Retirement, Survivors and Disability Insurance (RSDI) or Supplemental Security Income (SSI) based on disability meet the criteria for disability. For all others, a disability review must be completed and determination of disability must be made before eligibility for Medicaid based on disability can be established. **Medicaid for Working People with Disabilities Program/Sherlock Plan:** People eligible under this category are entitled to the full scope of Medicaid benefits, home and community-based services, and services needed to facilitate and/or maintain employment. To be found eligible for this program, a person must be at least eighteen (18) years of age, meet the Medicaid requirements for eligibility based on a disability, have proof of active, paid employment and meet the income and resources standards.

General Public Assistance (GPA) Program: GPA is available for adults age 19-64 years of age who have very limited income and resources and have an illness or medical condition that keeps them from working. Sometimes, adults who have a current pending application for Supplemental Security Income (SSI) may be determined eligible for GPA benefits. A determination for Medicaid affordable care coverage must be completed prior to a determination of eligibility under a disability. GPA applicants can apply for affordable healthcare coverage by completing the UHIP LF-1, Application for Health Care Coverage or by applying online at www.healthsourceri.com.

Child Care Assistance Program (CCAP): Child Care Assistance is only available to families with earnings up to 180% of the federal poverty level for your family size and only available to cover hours of employment or short-term training. Families may be required to pay a co-payment based on their family size, income level, and number of children. For parents that participate in the Rhode Island Works Program, there is no income limit for child care because if a family is eligible for RI Works, they already meet the income requirements for the Child Care Assistance Program (CCAP). Prior to enrollment, RI Works applicants or participants who are not employed must discuss child care options with a Social Worker as part of the assessment process and the development of the employment plan. For families not participating in the RI Works Program, eligibility for child care assistance is based on working at least 20 hours per week at or above Rhode Island's minimum wage.

Medicare Premium Payment Program (MPP): Eligibility for the Medicare Premium Payment Program (MPP) is based on income and helps adults over age 65 and disabled adults pay all or some of the costs of Medicare Part A and Part B premiums, deductibles and co-payments. Medicare Part A is hospital insurance coverage and Medicare Part B is for physician services, durable medical equipment and outpatient services.

RI SSI State Supplemental Payment Program (SSP): The State of Rhode Island supplements the Federal SSI benefit rate for eligible persons. Supplemental Security Income (SSI) is a federal program that provides monthly benefits to people who are age 65 or older, blind or disabled and who have low income and limited resources. Authorization of the monthly SSP for current SSI recipients will be completed automatically. New applicants who are eligible for the Federal SSI will be automatically authorized for the SSP when they apply at the SSA. Applicants for SSP who have been denied through SSA for excess income will need to meet the income, resource, age and/or disability standards (age 65 or older, disabled or blind). If an applicant is eligible based on income and is claiming a disability which has not been reviewed or determined by the SSA, the SSP Unit will send a referral to the Medical Assistance Review Team (MART) for a disability determination.

Katie Beckett: Katie Beckett provides Medicaid/health insurance coverage to children under age 19 who have long-term disabilities or complex medical needs. Katie Beckett enables children to be cared for at home instead of in an institution. With Katie Beckett, only the child's income and resources, not the parents', are used to determine eligibility. **If you are applying for Katie Beckett, you only need to provide information for the applicant child—you do not need to fill in information about other household members.**

This form consists of 38 questions. Except for Question 1, each is followed by a section of boxes used for filling in the required information. Respond to each question by indicating either YES or NO with a check mark in the box next to the question.

IF the answer is YES [ ]
Supply the requested information by writing in the space available or in the yellow-boxed area beneath the question. Do not write in the blue shaded areas. You must provide the information asked for EVERY household member whether or not you are requesting assistance for her or him.

IF the answer is NO [ ]
THE QUESTION DOES NOT APPLY TO YOU OR ANYONE IN YOUR HOUSEHOLD. With the exception of Question 38, leave the yellow box blank, and move on to the next question.

IF you need more space to answer questions
"SEE PAGE 26" if you run out of space. Turn to page 26, where there are boxes to write in additional information. Indicate in one of the boxes, which question you are referring with its number. You may also attach separate sheets of paper, if necessary.

Read pages 27-30
These pages contain important information about your Rights and Responsibilities.

About the Interview
Page 3 of the instructions has a list of "Things You May Need to Provide for Your Interview or Submit for Benefit Approval".

About the Questions

Question 1.
List yourself on the first line providing all the requested information. Then list all persons who live with you, one person per line. Indicate how each person is related to you (for example "son", "cousin", etc.) in the "Relationship" block. You must list each person who lives in your home REGARDLESS OF WHETHER OR NOT YOU ARE SEEKING ASSISTANCE FOR THAT PERSON.

Question 1a. through 13.
Complete the information in the yellow areas for each person requesting assistance. These questions follow the list of household members (Question 1.) and ask for personal information about everyone listed in Question 1. If the answer to any of these questions is YES [ ] complete the information asked for in the yellow shaded area. When doing so, write the names of household members exactly as they appear in Question 1.

Question 14. through 19.
These questions ask about the financial assets (such as bank accounts) of all household members. If the answer to any of these questions is YES [ ], complete the information asked for in the yellow shaded area. When doing so, write the name of household members exactly as they appear in Question 1.

Questions 20. through 28.
These questions ask about the income of all household members. If the answer to any of these questions is YES [ ], complete the information asked for in the yellow shaded area. When doing so, write the names of household members exactly as they appear in Question 1.

Questions 29. through 38.
These questions ask about shelter and miscellaneous expenses and medical coverage of all household members. If the answer to any of these questions is YES [ ], complete the information asked for in the yellow shaded area. When doing so, write the name of household members exactly as they appear in Question 1. If you report and provide proof of your expenses as listed in questions 29 - 38, it may help you get more benefits from SNAP. If you do not report an expense or provide proof , then we will assume that you do not want this expense to be counted. You can ask for assistance in getting documentation of the deductions and/or expenses from your DHS worker.

Appointing an Authorized Representative: If you would like to appoint an authorized representative to act on behalf of the household in applying for program benefits or using the benefits you may do so on pages 1 and/or 29.

This document should be filled out by you or an adult member of your household, or a relative, friend or authorized representative who knows the financial situation of all household members.

On the following pages list all members of your household. If you answer "Yes" to a question, your answers must be complete, clear and correct before your application will be processed. If they are not, additional information may be requested. If you do not understand a question, please call for assistance. If you need more space to report information, use page 26 titled, "**For Client Use Only".**

ELECTRONIC BENEFIT TRANSER (EBT) CARD

RIW cash assistance and SNAP benefits are issued through the Electronic Benefit Transfer (EBT) process. You can get your benefits by using your EBT card. You will receive more information about this process from your local office.

DOCUMENTS YOU MAY NEED TO PROVIDE FOR YOUR INTERVIEW OR SUBMIT FOR BENEFIT APPROVAL

- Award letters or proof of Social Security, SSI, UCB, TDI, Worker's Compensation, etc.
- Bank statements for checking accounts, savings accounts, certificates of deposit, credit union accounts, or stocks and bonds
- Birth Certificate for all household members
- Child care receipts
- Copy of child support orders, proof of child support and/or alimony payments, divorce decree, marriage license
- Death certificate of deceased parent for any dependent child for whom you may be applying or for any deceased Medicaid applicant
- Deeds for any home or property
- Proof of identity (driver's license, rent receipt, etc.)
- If not a U.S. Citizen, proof of Immigration status
- Proof of income from rental property
- Proof of medical expenses such as: medications, hospital bills, doctor bills, or insurance premiums
- Proof of health and or dental insurance coverage and premium amount paid
- Life insurance policies and Burial contracts
- Passport or Certificate of Naturalization or other documentation to prove Citizenship and Identity
- Pay stubs, pay envelopes, earnings statement and/or proof of last date worked and last pay
- Pensions and any other unearned income
- Proof of pregnancy, if pregnant
- Copy of Power of Attorney or guardianship
- Public Assistance/MA/SNAP closing notice from another state
- Rent receipt/mortgage payment (including home insurance, taxes, and other shelter expenses)
- Self-employed persons: Federal tax return, bookkeeping records, or sales and expenditures records
- Social Security numbers for all household members and absent parents
- Trust documents, complete annuity contract and promissory notes
- Utility receipts
- Vehicle registration (s)
- Veteran's claim number

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

Your SNAP application will be considered from the date the signed form is received. If you are found eligible for SNAP benefits, those benefits will be determined from the date your signed application is received by the agency. You will be sent a written request for any verification missing from your application. Your application will be denied if the missing verification is not received within ten (10) days of the written request

FINANCIAL ASSISTANCE (RIW) (GPA) (CCAP)(SSP)
If you are applying for RIW GPA, CCAP or SSP and are determined eligible for benefits, those benefits will be determined from the date the signed application is received.

MEDICAID
Medical benefits for adults may be provided for up to three (3) months prior to the month in which the signed application is received provided all factors of eligibility are met for each month.

DO NOT WRITE IN BLUE SHADED AREAS

WRITE IN YELLOW SHADED AREAS ONLY

Your DHS Office Depends On Where You Live and Which Benefits You Have Requested:

OFFICE	ADDRESS	TELEPHONE
Cranston Adult Service/Long Term Services and Supports Office **Serves:** Adult/LTSS for Cranston, Charlestown, Coventry, East Greenwich, Exeter, Foster, Hopkinton, Johnston, Narragansett, New Shoreham, North Kingstown, Richmond, Scituate, South Kingstown, Warwick, West Greenwich, West Warwick, Westerly	Bldg. #55, Howard Avenue, Cranston, RI 02920	462-5182 Office 462-6675 Referrals
DHS Information Line (Statewide)		462-5300 (TTY) 462-3363
Disability Determination Services (Statewide)	Office of Rehabilitation Services (ORS) 40 Fountain Street., Providence, RI 02903	222-3182 (TTY) 222-1389
East Providence Adult Service/Long Term Services and Supports Office **Serves:** Adult/LTSS for Barrington, Central Falls, East Providence, Pawtucket, Warren	Providence Regional Family Center, 206 Elmwood Avenue, Providence, RI 02907	415-8459
Katie Beckett Unit (Statewide)	74 West Road, Hazard Bldg. Ground Level, Cranston, RI 02920	462-0760 462-0754
Newport Office/Long Term Services and Supports Office **Serves:** Jamestown, Little Compton, Middletown, Newport, Portsmouth, Tiverton, Warren	Newport Regional Family Center, 272 Valley Road Middletown, RI 02842	851-2100 (Toll Free) 1-800-675-9397 CCAP 851-2138
Office of Rehabilitation Services **Vocational Rehabilitation Services** (Statewide)	40 Fountain Street, Providence, RI 02903	421-7005 (Spanish Line) 272-8090 (TTY) 421-7016*
Pawtucket Office **Serves:** Barrington, Bristol, Central Falls, East Providence, Pawtucket, Warren **GPA:** North Providence	Pawtucket Regional Family Center 249 Roosevelt Avenue, Pawtucket, RI 02860	721-6600 (Toll Free) 1-800-984-8989 CCAP 721-6644
Providence Office **Providence A/LTSS Waiver Unit** **Providence Nursing Home LTSS** **Providence LTSS- Home and Community Based Services** **Serves:** North Providence, Providence **GPA:** Foster, Johnston, Scituate, Providence	Providence Regional Family Center, 206 Elmwood Avenue, Providence, RI 02907	415-8200 415-8455 (LTSS) 415-8524(LTSS) 415-8521 (SNAP) (TTY) 222-7032 CCAP 415-8255
Services for the Blind & Visually Impaired (Statewide)	40 Fountain Street, Providence, RI 02903	222-2300 (TTY) 421-7016
South County Family Center **Serves:** Charlestown, Coventry, East Greenwich, Exeter, Hopkinton, Narragansett, New Shoreham, North Kingstown, Richmond, South Kingstown, West Greenwich, Westerly	South County Regional Family Center Oliver Stedman Center 4808 Tower Hill Road, Suite G1, Wakefield RI 02879	782-4300 (Toll Free) 1-800-862-0222 CCAP 782-4303
Veterans Home (Statewide)	480 Metacom Ave., Bristol, RI 02809	253-8000 (ext. 695) (TTY) 254-1345
Warwick Office **Serves:** Warwick, West Warwick **GPA:** Charlestown, Coventry, Cranston, East Greenwich, Exeter, Hopkinton, Jamestown, Little Compton, Middletown, Narragansett, Newport, New Shoreham, North Kingstown, Portsmouth, Richmond, South Kingstown, Tiverton, Warwick, West Warwick, Westerly	Warwick Regional Family Center 195 Buttonwoods Avenue, Warwick, RI 02886	736-1400 (Toll Free) 1-800-282-7021 CCAP 736-1423
Woonsocket Office/Long Term Services and Supports Office **Serves:** Burriville, Cumberland, Foster, Glocester, Lincoln, North Providence, North Smithfield, Smithfield, Woonsocket (GPA: all but Foster)	450 Clinton Street, Woonsocket, RI 02895	235-6200 LTSS 235-6241 (TTY) 235-6490 (Toll Free) 1-800-510-6988 CCAP 235-6223

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES
APPLICATION FOR ASSISTANCE

Do you speak English? ☐ Yes ☐ No If No, what is the primary language spoken?_____

Can you read and write in English? ☐ Yes ☐ No Do you need an Interpreter? ☐ Yes ☐ No

If you do not speak English, does any adult member of the household speak English? ☐ Yes ☐ No

I want to apply for:

☐ CASH ASSISTANCE (RHODE ISLAND WORKS PROGRAM- RIW)

☐ SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

☐ MEDICAID: LONG-TERM SERVICES AND SUPPORTS

☐ MEDICAID/HEALTH COVERAGEFORAGE 65 AND OVER, BLIND OR DISABLED ANORRKING ADULTS WITH DISABILITIES (SHERLOCK PLAN)

☐ GENERAL PUBLIC ASSISTANCE (GPA)

☐ CHILD CARE ASSISTANCE PROGRAM (CCAP)

☐ MEDICARE PREMIUM PAYMENT PROGRAM (MPP)

☐ RI SSI STATE SUPPLEMENTAL PAYMENT PROGRAM (SSP)

☐ KATIE BECKETT: MEDICAID/HEALTH COVERAGE FOR CHILDREN WITH SEVERE DISABILITIES

_____ _____ _____ _____
First Name **M.I.** **Last Name** **Maiden Name**

Social Security #_____-_____-_____ **Date of Birth**_____/_____/_____

MARITAL STATUS: Single ☐ **Married** ☐ **Divorced** ☐ **Other** ☐ **GENDER: Male** ☐ **Female** ☐

Residence Address _____
Street/Route Apt./Floor City State Zip

Mailing Address_____
(if different) Street/Route Apt/Floor PO Box City/Town State Zip

If you are applying for SNAP benefits, how would you like to be interviewed? Check one of the boxes:

Telephone Interview ☐ (DHS will call you) (OR) **In-Office Interview** ☐

Telephone Number : Day _____ **Evening** _____

If you wish to authorize someone other than yourself to apply on your behalf, please indicate below:

I want _____to apply on my behalf. _____ _____
(Name of Individual) *(Daytime Phone #)* *(Evening Phone #)*

Is anyone who wants assistance pregnant? ☐ Yes ☐ No If Yes, Name of Person: _____ Due Date:_____

YOU MAY GET SNAP BENEFITS, IF ELIGIBLE, WITHIN 7 DAYS IF: your income, cash and money in the bank add up to less than your monthly housing expense; or your monthly income is less than $150 and your money in the bank and liquid resources are less than $100; or you are a migrant or seasonal farm worker.

a. How much money do members of your household have in cash or money in the bank? $_____

b. What is the total amount of income from any source (including unearned income such as Child Support, SSI, TDI, Unemployment, or SSDI, etc.) you expect your household to receive this month? $_____

c. What is your current monthly rent/mortgage payment? $_____ **Utilities? $**_____

d. Is anyone in your household a migrant or seasonal farm worker? ☐ **Yes** ☐ **No**

_____ _____
Applicant's Signature Date

****You may tear off this sheet and submit JUST the front and backside of this page with Name Address and Signature to allow us to date stamp and initiate this application. To determine ongoing benefit eligibility, you must sign and complete the remainder of this application.**

HOUSEHOLD COMPOSITION ***If you are applying for SNAP, list everyone who lives in your home now, even if they do not want assistance. If you applying for any other program, only enter the information below for the applicant, his/her, spouse and any dependents. If you are applying for the Katie Beckett Program, enter the information below for the child only.***

Last Name	**First Name**	**D.O.B.** (mm/dd/yyyy)	**Relationship**	**S.S.N.** *(Only required if member is applying for benefits. If you are applying for child care only, this is needed for the child(ren))*	**U.S. Citizen?** **Answer Yes or No** *(Only required if member is applying for benefits. If you are applying for child care only, this is needed for the child(ren))*

I live in a (Check one):

☐ 01 Elderly/disabled housing
☐ 02 Drug/alcohol rehab center
☐ 03 Disabled/blind group home
☐ 04 Battered Women's shelter
☐ 05 Shelter
☐ 06 Own home/trailer
☐ 07 Rent home/apt/trailer
☐ 08 Living in another's home/apt
☐ 09 No permanent address
☐ 10 Halfway house
☐ 11 Homeless: lobby, street, car
☐ 12 Residential care and assisted living
☐ 13 Long-Term Care Facility
☐ 99 Other (specify)_____

Did you move to Rhode Island within the last three (3) months? ☐ Yes ☐No If Yes, Date: _____

If Yes, what was your reason for moving here? *(check one)*

☐ L Looking for Employment
☐ D Domestic Violence
☐ R Close to Relatives
☐ O Other_____(please specify)
☐ W To get Cash, SNAP/Food Stamps, and/or Medical

Which State did you move from? _____ Are you receiving assistance from another State? ☐ Yes ☐ No

Information for SNAP applicants:

You may file your application immediately as long as we have your name, address and the signature of a responsible household member or your authorized representative on this application. If you are determined eligible, benefits will be calculated from the date we receive this form in our office. We are required to verify information you provide and take action on your application within thirty (30) days of the filing date unless you are entitled to expedited service. To determine whether or not you are eligible, you must be interviewed. The application filing date for pre-release applicants is the date of release from the institution.

Under penalty of perjury, I attest that all of the information contained in this application is true. I understand that I am breaking the law if I give wrong information and can be punished under federal law, state law or both.

Signature of Applicant or Recipient	Date	Signature of Authorized Representative	Date
Signature of Spouse or other parent of child(ren)	Date	Signature of Guardian, Conservator or Holder of Power of Attorney	Date

WITHDRAWAL OF APPLICATION ***FOR AGENCY USE ONLY***

After participating in the screening interview, I do not wish to make an application for ☐ RIW, ☐ SNAP, ☐ Medicaid, ☐ GPA, ☐ CCAP, ☐ MPP, ☐ SSP or ☐ Katie Beckett at this time. I understand that I may apply again at any time. I understand that this application will be denied and a notice of denial will be sent to me. Please state your reason for withdrawing your application: _____

_____

_____ _____

Applicant's Signature Date

Agency Representative's Name:	Date Screened	Intake/Interview Date
Program(s):	Case ID	

1a

Have you or has any member of your household been convicted of:

a) a felony under federal or state law for possession, use or distribution of a controlled drug substance (felony drug conviction) after August 22, 1996? **YES** ☐ **NO** ☐

b) trading SNAP benefits for drugs after September 22, 1996? **YES** ☐ **NO** ☐

c) buying or selling SNAP benefits over $500 after September 22, 1996? **YES** ☐ **NO** ☐

d) fraudulently receiving duplicate SNAP benefits in any state after September 22, 1996? **YES** ☐ **NO** ☐

e) trading SNAP benefits for guns, ammunitions or explosives after September 22, 1996? **YES** ☐ **NO** ☐

Are you or any one in your household fleeing to avoid prosecution, custody, or confinement after conviction under the law of the place from which you are fleeing, for a crime or attempt to commit a crime that is a felony under the law of the place from which you are fleeing or which, in the case of New Jersey, is a high misdemeanor under the state of New Jersey or violating a condition of probation or parole imposed under a federal or state law? **YES** ☐ **NO** ☐

Have you or anyone in your household ever been found through an Administrative Hearing process of having made, or been convicted in a Federal or State court of having made, a fraudulent statement or representation with respect to your identity or place of residence in order to receive multiple Supplemental Nutrition Assistance Program benefits simultaneously? **YES** ☐ **NO** ☐

Have you or any member of your household been barred from participating in the SNAP/Food Stamp Program in another state? **YES** ☐ **NO** ☐

1b

The Rhode Island Department of Human Services (DHS) uses an Interactive Voice Response (IVR) system to make "appointment reminder calls" to remind you of a scheduled phone or office interview appointment. The reminders are for SNAP and Rhode Island Works certification and recertification appointments. Two days before your scheduled appointment, the IVR will automatically contact the number you have written on this application, unless you chose to opt out.

Check here if you would ***not*** like to receive information about next steps in the application process from an automated telephone system: ☐

1c

If you live in a household with a minor child(ren) (under eighteen), is there more than one adult parent or adult who shares parental control/rights over the child(ren)? **YES** ☐ **NO** ☐

If you live in such a household, please designate an adult parent or an adult who has parental control of the child(ren) as the head of the household here. Name_____

1d

Have you previously applied for, or received any type of assistance payments, benefits or SNAP/Food Stamp benefits in R.I. or in another state? **YES** ☐ **NO** ☐

If Yes, under what name? _____Where? _____When? _____Type? _____

1 List everyone who lives in your home now.

(***If you are applying for SNAP, list everyone who lives in your home now, even if they do not want assistance. If you applying for any other program, enter the information below only for the applicant, his/her, spouse and any dependents. If you are applying for the Katie Beckett Program, enter the information below for the child only).***

HOUSEHOLD

	Last Name First Initial	Relation to you	Assistance asked for ☑										Date of Birth
			SNAP	RIW	MA LTSS	MA ABD	GPA	CCAP	MPP	SSP	Katie Beckett	None	
1													____/____/____
2													____/____/____
3													____/____/____
4													____/____/____
5													____/____/____
6													____/____/____
7													____/____/____
8													____/____/____
9													____/____/____

If there are more people in your household, please list them on page 35 marked, "for client use only".

MEMB

MEMBERS

***Race and Ethnicity**
We ask you to provide this information so we can make sure that all people are able to get the benefits they are entitled to and we are not discriminating against anyone. You do not have to provide this information. If you choose not to provide this information, it will not affect your eligibility for benefits. You may select more than one category under "race".

	Social Security # *(Provide this information only if the person is requesting benefits. If you are applying for child care only, this is needed for the child(ren))*	**Gender**	**Marital Status** *(check one)*	**U.S. Citizen?** *(Provide this information only if the person is requesting benefits If you are applying for child care only, this is needed for the child(ren))*	**Is this person Hispanic or Latino? ***	**Race*** (You may select more than one race)
1	_____/____/_____	F ☐ M ☐	☐ Single ☐ Married ☐Divorced/Separated ☐ Widowed	Yes ☐ No ☐	Hispanic ☐ Not Hispanic ☐	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White
2	_____/____/_____	F ☐ M ☐	☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed	Yes☐ No ☐	Hispanic ☐ Not Hispanic ☐	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White
3	_____/____/_____	F ☐ M ☐	☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed	Yes ☐ No ☐	Hispanic ☐ Not Hispanic ☐	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White
4	_____/____/_____	F ☐ M ☐	☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed	Yes ☐ No ☐	Hispanic ☐ Not Hispanic ☐	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White
5	_____/____/_____	F ☐ M ☐	☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed	Yes ☐ No ☐	Hispanic ☐ Not Hispanic ☐	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White
6	_____/____/_____	F ☐ M ☐	☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed	Yes ☐ No ☐	Hispanic ☐ Not Hispanic ☐	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White
7	_____/____/_____	F ☐ M ☐	☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed	Yes ☐ No ☐	Hispanic ☐ Not Hispanic ☐	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White
8	_____/____/_____	F ☐ M ☐	☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed	Yes ☐ No ☐	Hispanic ☐ Not Hispanic ☐	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White
9	_____/____/_____	F ☐ M ☐	☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed	Yes ☐ No ☐	Hispanic ☐ Not Hispanic ☐	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

If there are more people in your household, please list them on page 26 marked, "for client use only".

2 Are you, your spouse, or anyone in the household a military veteran, a dependent of a veteran, or a survivor of a veteran?

Yes ☐
No ☐

If yes, complete the boxes below about each person.

Last Name	First Name	Middle Initial	Veteran's Status		Applied for Veteran's Benefits	Date of Service	Serial Number	V.A. Claim Number
			Veteran Dependent Survivor	[ ] [ ] [ ]	Yes [ ] No [ ]	___/___/___		
			Veteran Dependent Survivor	[ ] [ ] [ ]	Yes [ ] No [ ]	___/___/___		
			Veteran Dependent Survivor	[ ] [ ] [ ]	Yes [ ] No [ ]	___/___/___		

3 Were you, your spouse, or anyone in the household born outside the U.S?

Yes ☐
No ☐

(If you are applying for Child Care or Katie Beckett, answer this question for the applicant child only.)

**The alien status of applicant household members is subject to verification by USCIS (formerly known as INS) through the submission of information from this application to USCIS. Submitted information received from USCIS may affect your household's eligibility and level of benefits.

If yes, complete the boxes below about each person that is requesting benefits who is not a U.S. citizen. | ALIE

Last Name	First Name	Middle Initial	Country of Origin	Alien Registration Number	Immigration Number

Alien Status:			
[ ] Refugee/Granted Aylum	Date of Entry _____	USCIS Status Date	_____
[ ] Permanent Resident	Date of Entry _____	Permanent Residence Date	_____
[ ] Other	Date of Entry _____	USCIS Status Date	_____

Name of Sponsor	Sponsor's Address
Did this individual reside in the US prior to 8/22/96?	Yes [ ] No [ ]

Last Name	First Name	Middle Initial	Country of Origin	Alien Registration Number	Immigration Number

Alien Status:			
[ ] Refugee/Granted Asylum	Date of Entry _____	USCIS Status Date	_____
[ ] Permanent Resident	Date of Entry _____	Permanent Residence Date	_____
[ ] Other	Date of Entry _____	USCIS Status Date	_____

Name of Sponsor	Sponsor's Address
Did this individual reside in the US prior to 8/22/96?	Yes [ ] No [ ]

4 Are you, your spouse, or anyone in the household in a group living arrangement such as the types listed below? Yes ☐ No ☐

EXAMPLES
Shelter for Homeless
Group Home
Drug Treatment Center
Alcohol Treatment Center
Hospital
Shelter for Battered Women
Assisted Living Facility
Dormitory

If yes, complete the boxes below about each person. GROP

Last Name	First Name	Middle Initial	Name of Facility	Type
Last Name	First Name	Middle Initial	Name of Facility	Type

5 Are you or anyone in the household who is sixteen (16) or older in high school, college, vocational school or a job-training program? Yes ☐ No ☐

If yes, complete the boxes below about each person. SCHL

Last Name	First Name	Initial	School/Training Program	Address						
Check One	Full Time [ ]	Half Time [ ]	Less than Half Time [ ]	Date of Completion	Type	Status	Ver	Count RIW	Count SNAP	MA	GPA

Last Name Initial	First Name	School/Training Program	Address						
Check One	Full Time [ ]	Half Time [ ]	Less than Half Time [ ]	Date of Completion	Type	Status	Ver	Count RIW	Count SNAP	MA	GPA

6 Besides you or your spouse, is there anyone in the household who has children under age twenty-two (22) who also lives in the household? Yes ☐ No ☐

If yes, complete the boxes below about each person. PARE

Parent's Last Name	First Name	Initial	Child's Last Name	First Name	Initial	Child's Last Name	First Name	Initial

7 Is there anyone who lives with you who purchases and prepares food separately? Yes ☐ No ☐

If yes, list the people who do not eat with you. EATS

Last Name	First Name	Initial	Last Name	First Name	Initial	Last Name Initial	First Name

8 Are you or anyone in the household pregnant? Yes ☐ No ☐

If yes, complete the boxes below about the pregnant person.	P R E G

Last Name First Name Initial	Date Baby is Due	Last Name First Name Initial	Date Baby is Due
	____/____/____		____/____/____

9 Are you, your spouse, or anyone in the household mentally or physically ill, incapacitated, disabled or blind? Yes ☐ No ☐

If yes, complete the boxes below about each person.	D I S A

Last Name First Name Initial	Medical problem (describe)	Caused by an accident? Yes [ ] No [ ]
Is this person active with the Office of Rehabilitation Services or Services for the Blind?	Yes [ ] No [ ]	Factor Review
Has this person applied for SSI or Social Security Benefits (RSDI)?	Yes [ ] No [ ]	Ver Blind
If this person is a parent who is not working, does this person's disability make him/her unable to care for the child(ren)?	Yes [ ] No [ ]	

Last Name First Name Initial	Medical problem (describe)	Caused by an accident? Yes [ ] No [ ]
Is this person active with the Office of Rehabilitation Services or Services for the Blind?	Yes [ ] No [ ]	Factor Review
Has this person applied for SSI or Social Security Benefits (RSDI)?	Yes [ ] No [ ]	Ver Blind
If this person is a parent who is not working, does this person's disability make him/her unable to care for the child(ren)?	Yes [ ] No [ ]	

10 Are there children in the household whose parents are deceased? Yes ☐ No ☐

If yes, complete the boxes below about each person.	D E C P

Name of Deceased Parent: Last Name First Name Initial	Social Security Number _____/_____/_____	Gender Male [ ] Female [ ]	Date of Birth ___/___/___	Date of Death ___/___/____	Ver

List the children of this deceased parent in the spaces below.

Last Name First Name Initial	P	Last Name First Name Initial	P	Last Name First Name Initial	P
Last Name First Name Initial	P	Last Name First Name Initial	P	Last Name First Name Initial	P

11 Are there child(ren) in the household who do not have both parents (natural or adoptive) living with them?

Yes ☐
No ☐

State law assumes a child born during the time a couple is married or within 10 months of a final decree of divorce to be their child. List as the non-custodial parent, the present or former spouse of children born during that time. If divorce decree or court order excludes your spouse or former spouse as father of any of the child(ren) listed in the application, you need to list the biological parent of the child(ren) and provide copies of the decree or order with this application.

If yes, complete the boxes below about each non-custodial parent and the children in this household of each non-custodial parent. | A B S P

Non-custodial Parent's Last Name First Name Initial	Sex M [ ] F [ ]	Non-custodial Parent's SSN _____/____/_____	Birth Date ____/____/_____
Non-custodial Parent's Address		Non-custodial Parent's Telephone Number	
Employer Name	Employer Address		Is this parent disabled and/or a veteran? Yes [ ] No [ ]
Were the parents of the child(ren) married to each other? Yes [ ] No [ ] If yes, date married _____/_____/_____	Are the parents of the child(ren) currently married to each other? Yes [ ] No [ ] If no, date divorced _____/_____/_____	Non-custodial Parent's Marital Status Never Married [ ] Divorced [ ] Widowed [ ] Married [ ] Separated [ ] Unknown [ ]	

Child(ren) of this parent living in this household. Child's Last Name First Initial	State of Birth	Is child support, health coverage or paternity court ordered? (If yes, list date.)	
1.		Yes [ ] No [ ]	Support [ ] Date _____ Health Cov [ ] Date_____ Paternity [ ] Date_____
2.		Yes [ ] No [ ]	Support [ ] Date _____ Health Cov [ ] Date_____ Paternity [ ] Date_____
3.		Yes [ ] No [ ]	Support [ ] Date _____ Health Cov [ ] Date_____ Paternity [ ] Date_____
4.		Yes [ ] No [ ]	Support [ ] Date _____ Health Cov [ ] Date_____ Paternity [ ] Date_____

We ask information about the non-custodial parent so that we can seek child support from him/her. If you fear that you or your child will be harmed by the non-custodial parent if you help us in this process, you may be excused from cooperating. We will refer you to a Domestic Violence Advocate who can discuss this with you and help with safety planning. Check this box if you fear harm to either you or your child if you help us collect child support. ☐

Non-custodial Parent's Last Name First Name Initial	Sex M [ ] F [ ]	Non-custodial Parent's SSN _____/____/_____	Parent's Birth Date ____/____/_____
Non-custodial Parent's Address		Non-custodial Parent's Telephone Number	
Employer Name	Employer Address		Is this parent disabled and/or a veteran? Yes [ ] No [ ]
Were the parents of the child(ren) married to each other? Yes [ ] No [ ] If yes, date married _____/_____/_____	Are the parents of the child(ren) currently married to each other? Yes [ ] No [ ] If no, date divorced _____/_____/_____	Non-custodial Parent's Marital Status Never Married [ ] Divorced [ ] Widowed [ ] Married [ ] Separated [ ] Unknown [ ]	

Child(ren) of the parent living in this household. Child's Last Name First Initial	State of Birth	Is child support, health coverage or paternity court ordered? (If yes, list date.)	
1.		Yes [ ] No [ ]	Support [ ] Date _____ Health Cov [ ] Date_____ Paternity [ ] Date_____
2.		Yes [ ] No [ ]	Support [ ] Date _____ Health Cov [ ] Date_____ Paternity [ ] Date_____
3.		Yes [ ] No [ ]	Support [ ] Date _____ Health Cov [ ] Date_____ Paternity [ ] Date_____
4.		Yes [ ] No [ ]	Support [ ] Date _____ Health Cov [ ] Date_____ Paternity [ ] Date_____

We ask information about the non-custodial parent so that we can seek child support from him/her. If you fear that you or your child will be harmed by the non-custodial parent if you help us in this process, you may be excused from cooperating. We will refer you to a Domestic Violence Advocate who can discuss this with you and help with safety planning. Check this box if you fear harm to either you or your child if you help us collect child support. ☐

Question 11 (continued)

Non-custodial Parent's Last Name First Name Initial	Sex M [ ] F [ ]	Non-custodial Parent's SSN _____/____/_____	Parent's Birth Date ____/____/_____
Non-custodial Parent's Address		Non-custodial Parent's Telephone Number	
Employer Name	Employer Address	Is this parent disabled and/or a veteran? Yes [ ] No [ ]	
Were the parents of the child(ren) married to each other? Yes [ ] No [ ] If yes, date married _____/_____/_____	Are the parents of the child(ren) currently married to each other? Yes [ ] No [ ] If no, date divorced _____/_____/_____	Non-custodial Parent's Marital Status Never Married [ ] Divorced [ ] Widowed [ ] Married [ ] Separated [ ] Unknown [ ]	

Child(ren) of the parent living in this household. Child's Last Name First Initial	State of Birth	Is child support, health coverage or paternity court ordered? (If yes, list date.)	
1.		Yes [ ] No [ ]	Support [ ] Date _____ Health Cov [ ] Date_____ Paternity [ ] Date_____
2.		Yes [ ] No [ ]	Support [ ] Date _____ Health Cov [ ] Date_____ Paternity [ ] Date_____
3.		Yes [ ] No [ ]	Support [ ] Date _____ Health Cov [ ] Date_____ Paternity [ ] Date_____
4.		Yes [ ] No [ ]	Support [ ] Date _____ Health Cov [ ] Date_____ Paternity [ ] Date_____
5.		Yes [ ] No [ ]	Support [ ] Date _____ Health Cov [ ] Date_____ Paternity [ ] Date_____

We ask information about the non-custodial parent so that we can seek child support from him/her. If you fear that you or your child will be harmed by the non-custodial parent if you help us in this process, you may be excused from cooperating. We will refer you to a Domestic Violence Advocate who can discuss this with you and help with safety planning. Check this box if you fear harm to either you or your child if you help us collect child support: ☐

Non-custodial Parent's Last Name First Name Initial	Sex M [ ] F [ ]	Non-Custodial Parent's SSN _____/____/_____	Parent's Birth Date ____/____/_____
Non-custodial Parent's Address		Non-custodial Parent's Telephone Number	
Employer Name	Employer Address	Is this parent disabled and/or a veteran? Yes [ ] No [ ]	
Were the parents of the child(ren) married to each other? Yes [ ] No [ ] If yes, date married _____/_____/_____	Are the parents of the child(ren) currently married to each other? Yes [ ] No [ ] If no, date divorced _____/_____/_____	Non-custodial Parent's Marital Status Never Married [ ] Divorced [ ] Widowed [ ] Married [ ] Separated [ ] Unknown [ ]	

Child(ren) of the parent living in this household. Child's Last Name First Initial	State of Birth	Is child support, health coverage or paternity court ordered? (If yes, list date.)	
1.		Yes [ ] No [ ]	Support [ ] Date _____ Health Cov [ ] Date_____ Paternity [ ] Date_____
2.		Yes [ ] No [ ]	Support [ ] Date _____ Health Cov [ ] Date_____ Paternity [ ] Date_____
3.		Yes [ ] No [ ]	Support [ ] Date _____ Health Cov [ ] Date_____ Paternity [ ] Date_____
4.		Yes [ ] No [ ]	Support [ ] Date _____ Health Cov [ ] Date_____ Paternity [ ] Date_____
5.		Yes [ ] No [ ]	Support [ ] Date _____ Health Cov [ ] Date_____ Paternity [ ] Date_____

We ask information about the non-custodial parent so that we can seek child support from him/her. If you fear that you or your child will be harmed by the non-custodial parent if you help us in this process, you may be excused from cooperating. We will refer you to a Domestic Violence Advocate who can discuss this with you and help with safety planning. Check this box if you fear harm to either you or your child if you help us collect child support: ☐

12 Are you or any other parent in the household unemployed or working only part time? (please check one) ☐ Unemployed ☐ Part-time

Yes ☐
No ☐

If yes, complete the boxes below.	U N E M

Last Name First Name Initial	Did this person receive unemployment compensation in the last 12 months?	Yes [ ] No [ ]	Dates Received: From _____ to_____	UC	Ver
Did this person refuse a job or training program offer in the last 30 days?	Yes [ ]	No [ ]		Allow	
Has this person registered with the Department of Labor and Training (D.L.T.)?	Yes [ ]	No [ ]		Ver	

List the hours and weeks worked in the past 30 days below. List all the jobs held in the past five(5) years.

Work Week	Date	No. of days Worked	Hours Worked	Employer's Name	Employer's Address	Dates of Employment	Amount Earned
Week one (1)						From _____ To _____	
Week two (2)						From _____ To _____	
Week three (3)						From _____ To _____	
Week four (4)						From _____ To _____	
Week five (5)						From _____ To _____	

Last Name First Name Initial	Did this person receive unemployment compensation in the last 12 months?	Yes [ ] No [ ]	Dates Received: From _____ to_____	UC	Ver
Did this person refuse a job or training program offer in the last 30 days?	Yes [ ]	No [ ]		Allow	
Has this person registered with the Department of Labor and Training (D.L.T.)?	Yes [ ]	No [ ]		Ver	

List the hours and weeks worked in the past 30 days below. List all the jobs held in the past five(5) years.

Work Week	Date	No. of days Worked	Hours Worked	Employer's Name	Employer's Address	Dates of Employment	Amount Earned
Week one (1)						From _____ To _____	
Week two (2)						From _____ To _____	
Week three (3)						From _____ To _____	
Week four (4)						From _____ To _____	
Week five (5)						From _____ To _____	

13 Did you or anyone in the household leave a job in the last sixty (60) days or is anyone on strike?

Yes ☐
No ☐

If yes, complete the boxes below.	Q U I T/STRK

Last Name First Name Initial	Reason for leaving job	Date left job/Date Strike Began _____/_____/_____
Employer's Name	Employer's Address	

Questions 14-19 b ask about resources-- money and things you own.

IF YOU ARE APPLYING FOR SNAP ONLY, DO NOT FILL OUT QUESTIONS 14-19b UNLESS OTHERWISE INSTRUCTED BY YOUR DHS WORKER DURING YOUR INTERVIEW. PLEASE CONTINUE TO QUESTION 20.

14 Do you, your spouse, or anyone in the household have any cash? Yes ☐ No ☐

If yes, complete the boxes below about each person with cash. CASH

Last Name	First Name	Initial	Amount	Last Name	First Name	Initial	Amount
			$_____				$_____

15 Do you, your spouse, or anyone in the household have his/her name on any accounts such as the type listed below? Yes ☐ No ☐

EXAMPLES:

Checking account	Credit union account	Savings certificate	IRA	Mutual Funds	
Savings account	Money market account	Certificate of deposit	Annuity	Trust	Burial Set Aside

If yes, complete the boxes below for each account. BANK

Last Name	First Name	Initial	Type of account	Account number	Amount
Co-owner name Address			Financial Institution Address		$_____

Last Name	First Name	Initial	Type of account	Account number	Amount
Co-owner name Address			Financial Institution Address		$_____

Last Name	First Name	Initial	Type of account	Account number	Amount
Co-owner name Address			Financial Institution Address		$_____

Last Name	First Name	Initial	Type of account	Account number	Amount
Co-owner name Address			Financial Institution Address		$_____

Last Name	First Name	Initial	Type of account	Account number	Amount
Co-owner name Address			Financial Institution Address		$_____

15a Did you, your spouse, or anyone in the household receive a Social Security, Retirement, Survivors and Disability (RSDI) lump sum in the past 6 months?

Yes ☐
No ☐

If yes, complete box below.

Last Name	First Name	Initial	Amount received	Date received
			$_____	____/____/____

16 Do you, your spouse, or anyone in the household own, and/or have registered in his/her name any vehicle such as the types listed below?

Yes ☐
No ☐

EXAMPLES: Car, Boat, Truck, Motorcycle, Camper, Snowmobile, Recreational Vehicle

If yes, complete the boxes below for each vehicle. | C A R S

Owner's Last Name	First Name	Initial	Vehicle	Make	Model	Year	Blue book value $_____
What is the vehicle used for? *(ex: work, everyday use, transportation for disabled household member)*	Amount owed $_____		Vehicle ID Number				Registration Number
Insurance Company							

Owner's Last Name	First Name	Initial	Vehicle	Make	Model	Year	Blue book value $_____
What is the vehicle used for? *(ex: work, everyday use, transportation for disabled household member)*	Amount owed $_____		Vehicle ID Number				Registration Number
Insurance Company							

Owner's Last Name	First Name	Initial	Vehicle	Make	Model	Year	Blue book value $_____
What is the vehicle used for? *(ex: work, everyday use, transportation for disabled household member)*	Amount owed $_____		Vehicle ID Number				Registration Number
Insurance Company							

17 Do you, your spouse, or anyone in the household own any items of value?

Yes ☐

No ☐

(Include any items of value not listed in questions 14, 15 or 16)

EXAMPLES: Stocks, Bonds, Personal Property (antiques, collections, jewelry, etc.), Life Insurance, Reverse Mortgages, Burial Contract, Long-term Care Insurance

If yes, complete the boxes below. RESO

STOCKS, BONDS, OTHER

Last Name	First Name	Initial	Type of Resource
Co-owner's Last Name	First Name	Initial	Co-owner's Address

Last Name	First Name	Initial	Type of Resource
Co-owner's Last Name	First Name	Initial	Co-owner's Address

Last Name	First Name	Initial	Type of Resource
Co-owner's Last Name	First Name	Initial	Co-owner's Address

LIFE INSURANCE/LONG-TERM CARE INSURANCE

Last Name	First Name	Initial	Company Name	Policy Number	Type
Owned By			Face Value	Cash Value	Loan Amount

Last Name	First Name	Initial	Company Name	Policy Number	Type
Owned By			Face Value	Cash Value	Loan Amount

Last Name	First Name	Initial	Company Name	Policy Number	Type
Owned By			Face Value	Cash Value	Loan Amount

BURIAL CONTRACT

Last Name	First Name	Initial	Value	Irrevocable	Effective Date ____/____/_____
Funeral Home			Funeral Home Address		

Last Name	First Name	Initial	Value	Irrevocable	Effective Date ____/____/_____
Funeral Home			Funeral Home Address		

18 Do you, your spouse, or anyone in the household own any interest in any property such as land, buildings, life estate, timeshare, etc? *(Unless you are applying for LTSS, do not report the home in which you live)*

Yes ☐
No ☐

If yes, complete the boxes below about each person. **PROP**

Owner's Last Name First Name Initial	Type of property (describe)	Cash Value $_____	Amount Owed $_____
How is the property owned? Solely ☐ Jointly ☐ Life Estate ☐ Other ☐	Address of Property		
Is this property your home? Yes ☐ No ☐; The home of your spouse? Yes ☐ No ☐; Your dependents? Yes☐ No ☐			

19 Have you, your spouse, or anyone in the household given away, sold, deeded, or transferred to anyone or any entity, any items of value in the past sixty (60) months?

Yes ☐
No ☐

If you are applying for SNAP benefits only and asked to answer this question, report the items of value that were transferred within the last three (3) months.

If yes, complete the boxes below. **TRAN**

Last Name First Name Initial		Resource Transferred
Amount Transferred $_____	Date Transferred _____/_____/_____	What did you receive in return?
Last Name First Name Initial		Resource Transferred
Amount Transferred $_____	Date Transferred _____/_____/_____	What did you receive in return?
Last Name First Name Initial		Resource Transferred
Amount Transferred $_____	Date Transferred _____/_____/_____	What did you receive in return?

19a Are you named as a beneficiary (primary, secondary, etc.) on any trust?

Yes ☐
No ☐

If yes, you must provide copies of the trust even if you are not currently receiving any payments from the trust.

Principal amount and date established	Amount of payments to you	Frequency of payments to you
$_____ Date ____/____/_____	$_____	

19b Have you, your spouse, or anyone acting on your behalf (including a court) established a trust or put any money or other resource into a trust within the last sixty (60) months?

Yes ☐
No ☐

Has any property come out of a trust within the last sixty (60) months?

Yes ☐
No ☐

If yes, you must provide copies of the trust and describe all such transactions into or out of the trust.

Established by	Date established _____/_____/_____	Amount $_____

20 Do you or anyone in the household have or expect income from a job this month?

Yes ☐
No ☐

Note: If you are self-employed, you will be asked to provide that information in question 25.

EXAMPLES	Salaries/Wages	Commissions	National Guard	Army Reserve
	Work Study	Job Training	Sheltered Workshop	US Military

If yes, complete the boxes below about each person. J I N C

Last Name	First Name	Initial	Employer Name and Address

Date Job Began/Will Begin	Type of Work	Day of Week Paid
_____/_____/_____		

How Often Paid: ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Other_____

List the gross amount paid on each pay day this month.

Pay Day	Date Paid	Pay period end date	Hours worked per pay period	Gross wages before taxes	Tips/Commissions
1st	_____/_____/_____	_____/_____/_____		$	$
2nd	_____/_____/_____	_____/_____/_____		$	$
3rd	_____/_____/_____	_____/_____/_____		$	$
4th	_____/_____/_____	_____/_____/_____		$	$

Did you receive earned income tax credit in your paycheck? ☐ Yes ☐ No | Is this job part of a work study program? ☐ Yes ☐ No

Is this an On the Job training program? ☐ Yes ☐ No | Will this income be received in the following month? ☐ Yes ☐ No

List the number of hours you expect to be paid for next month:

Number of Hours:_____ Expected Gross Earnings:_$_____ Tips/Commissions: $_____

Work/School/Training Schedule (Child Care only)

Day	Start Time	End Time
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

If your schedule varies, please explain how (you may send additional documentation to verify).

Question 20 (Continued)

Last Name	First Name	Initial	Employer Name and Address

Date Job Began/Will Begin	Type of Work	Day of Week Paid
_____/_____/_____		

How Often Paid: ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Other_____

List the gross amount paid on each pay day this month.

Pay Day	Date Paid	Pay period end date	Hours worked per pay period	Gross wages before taxes	Tips/Commissions
1st	_____/_____/_____	_____/_____/_____		$	$
2nd	_____/_____/_____	_____/_____/_____		$	$
3rd	_____/_____/_____	_____/_____/_____		$	$
4th	_____/_____/_____	_____/_____/_____		$	$

Did you receive earned income tax credit in your paycheck? ☐ Yes ☐ No | Is this job part of a work study program? ☐ Yes ☐ No

Is this an On the Job training program? ☐ Yes ☐ No | Will this income be received in the following month? ☐ Yes ☐ No

List the number of hours you expect to be paid for next month:

Number of Hours:_____ Expected Gross Earnings:_$_____ Tips/Commissions: $_____

Work/School/Training Schedule (Child Care only)

Day	Start Time	End Time
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

If your schedule varies, please explain how (you may send additional documentation to verify).

Question 20 (Continued)

Last Name First Name Initial	Employer Name and Address

Date Job Began/Will Begin	Type of Work	Day of Week Paid
_____/_____/_____		

How Often Paid: ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Other_____

List the gross amount paid on each pay day this month.

Pay Day	Date Paid	Pay period end date	Hours worked per pay period	Gross wages before taxes	Tips/Commissions
1st	_____/_____/_____	_____/_____/_____		$	$
2nd	_____/_____/_____	_____/_____/_____		$	$
3rd	_____/_____/_____	_____/_____/_____		$	$
4th	_____/_____/_____	_____/_____/_____		$	$

Did you receive earned income tax credit in your paycheck? ☐ Yes ☐ No | Is this job part of a work study program? ☐ Yes ☐ No

Is this an On the Job training program? ☐ Yes ☐ No | Will this income be received in the following month? ☐ Yes ☐ No

List the number of hours you expect to be paid for next month:

Number of Hours:_____ Expected Gross Earnings:_$_____ Tips/Commissions: $_____

Work/School/Training Schedule (Child Care only)

Day	Start Time	End Time
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

If your schedule varies, please explain how (you may send additional documentation to verify).

21 Do you, your spouse, or anyone in the household have an outstanding claim or lawsuit for injuries or illness sustained due to an automobile accident, workers' compensation claim, etc, or for any lawsuit in which you may receive money? Yes ☐ No ☐

If yes, complete the boxes below. SETT

Last Name First Name Initial	Type of Claim (describe)	Date of Incident ____/____/____	Workers' Compensation Yes [ ] No [ ]
Person (or company) responsible Address	Insurance Company	Attorney Name	
	Address	Address	

22 Do you, your spouse, or anyone in the household receive income from rent?

Yes ☐
No ☐

If yes, complete the boxes below about the person who receives the rent. RINC

Last Name	First Name	Initial	Total Number of Units
Does the person listed above live here? ☐ Yes ☐ No		Hours worked per week maintaining property: _____	
Total rent received $_____ How often? _____		Will the income be received in the following months? ☐ Yes ☐ No	

Rental Expense	How Often?	Rental Expense	How Often?	Rental Expense	How Often?
Mortgage $_____	_____	Water $_____	_____	Electric $_____	_____
		Sewage $_____	_____	Oil $_____	_____
Taxes $_____	_____	Garbage $_____	_____	Repairs $_____	_____
		Gas $_____	_____	Other $_____	_____

23 Do you, your spouse, or anyone in the household have income from taking care of children in your home?

Yes ☐
No ☐

If yes, complete the boxes below about the person taking care of children. Attach documentation of child care-related business expenses. DCIN

Last Name First Name Initial	Total Amount Received per week $_____	Number of weeks worked	Hours worked per week
Will this income be received in the following months? Yes [ ] No [ ]			Number of Children Cared For

24 Do you, your spouse, or anyone in the household receive payment from roomers or boarders?

Yes ☐
No ☐

If yes, complete the boxes below. Attach documentation if you wish to claim actual expenses. RBIN

Name of person receiving payment Last Name First Name Initial	Number of hours worked per week Will this income be received in the following months? Yes [ ] No [ ]		
Names of Roomer/Boarders	Amount Received/How Often	Includes	Date Received
	$_____ per_____	Room only [ ] Board (1-2 meals) [ ] Board (3 meals) [ ]	_____/_____/_____
	$_____ per_____	Room only [ ] Board (1-2 meals) [ ] Board (3 meals) [ ]	_____/_____/_____
	$_____ per_____	Room only [ ] Board (1-2 meals) [ ] Board (3 meals) [ ]	_____/_____/_____

25 Do you, your spouse, or anyone in the household receive income from self-employment? Yes ☐ No ☐

EXAMPLES Farming Fishing Out-of-home day care Door-to-door sales Home Sales

If yes, complete the boxes below about each person. BUSI

Last Name First Name Initial	Gross Income/How Often $_____per_____	Expenses $_____	Average number of hours worked per week
Type of Business	Name of Business	Will this income be received in the following months? Yes [ ] No [ ]	

Please complete the following information about the days and hours spent working at a self-owned business (Child Care only)

Day	Start Time	End Time
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		
If your schedule varies, please explain how (you may send additional documentation to verify).		

Last Name First Name Initial	Gross Income/How Often $_____per_____	Expenses $_____	Average number of hours worked per week
Type of Business	Name of Business	Will this income be received in the following months? Yes [ ] No [ ]	

Please complete the following information about the days and hours spent working at a self-owned business (Child Care only)

Day	Start Time	End Time
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		
If your schedule varies, please explain how (you may send additional documentation to verify).		

26 Are you under 20 and do not have a high school diploma or GED? Yes ☐ No ☐

27 Do you, your spouse, or anyone in the household receive a student grant, scholarship, educational loan or VA educational benefits? Yes ☐ No ☐

If yes, complete the boxes below using separate lines for each source. Please bring verification for all tuition and fees. **STIN**

Last Name First Name Initial	Amount received $_____	Period covered by grant/loan From_____ to_____	Date received _____/_____/_____
Type of Grant/Loan	Date of last payment _____/_____/_____	Will this income be received in the following months? Yes [ ] No [ ]	

28 Do you, or your spouse, or anyone in the household receive or expect to receive, income such as the type below? Yes ☐ No ☐

EXAMPLES:

Adoption Subsidy	Gifts, Prizes, Inheritance, Lottery	Railroad Retirement	Unemployment Compensation
Alien Sponsorship	In-kind Shelter	Retirement Pensions	VA Aid and Attendance
Annuities	Other in-kind	Section 8 Utility Payment	VA Basic Benefits
Alimony	Income Tax Refund	Social Security (RSDI)	VA Compensation
Child Support	Insurance and Lawsuit Claim	SSI	VA Improved Pension
Dividends, Interest	Strike Benefits	Workers' Compensation	IRA Distributions
Earned Income Tax Credit Refund	Military Allotment	TDI	Promissory Note
Foster Care	Out of State Assistance	Trust Funds	

If yes, complete the boxes below for each type of income that person receives. **UNEA**

Last Name First Name Initial	Amount/How Often $_____per_____	Date Income Received _____/_____/_____
Claim Number *(if applicable)*	Type of Income	Will this income be received in the following months? Yes [ ] No [ ]

Last Name First Name Initial	Amount/How Often $_____per_____	Date Income Received _____/_____/_____
Claim Number *(if applicable)*	Type of Income	Will this income be received in the following months? Yes [ ] No [ ]

Last Name First Name Initial	Amount/How Often $_____per_____	Date Income Received _____/_____/_____
Claim Number *(if applicable)*	Type of Income	Will this income be received in the following months? Yes [ ] No [ ]

Last Name First Name Initial	Amount/How Often $_____per_____	Date Income Received _____/_____/_____
Claim Number *(if applicable)*	Type of Income	Will this income be received in the following months? Yes [ ] No [ ]

If anyone in the household expects income in the future, fill in the box below for that person.

Last Name First Name Initial	Type of income Expected	Expected Date income will be received _____/_____/_____

28a After April 1977, did you ever get an SSI check at the same time that you got social security, or did you get SSI in the month just before social security started? Yes ☐ No ☐

If yes, complete the box below.

Last Name	First Name	Initial	Year Received

(If you report and provide proof of your expenses you list in 29 -38, it can help you get more benefits from SNAP. If you do not report an expense or provide proof, then we will assume that you do not want this expense to be counted.)

29 Do you, your spouse, or anyone in the household pay for someone to care for children, elderly, or disabled adults due to work, training, looking for work or schooling? Yes ☐ No ☐

If yes, complete the boxes below about each person who paid for daycare. D C E X

Name of person paying for care	Day Care is needed because s/he is: Working [ ] In school/ training [ ] Looking for work [ ]	Is this cost subsidized Yes [ ] No [ ]	If yes, amount of subsidy? $_____per_____
Name of person in care	Adult/Child Adult [ ] Child [ ]	Amount of out-of-pocket Payment or co-payment $_____per_____	Will this cost continue? Yes [ ] No [ ]
Name of Day/Adult Care Provider		Address of Provider	

Name of person paying for care	Day Care is needed because s/he is: Working [ ] In school/ training [ ] Looking for work [ ]	Is this cost subsidized Yes [ ] No [ ]	If yes, amount of subsidy? $_____per_____
Name of person in care	Adult/Child Adult [ ] Child [ ]	Amount of out-of-pocket Payment or co-payment $_____per_____	Will this cost continue? Yes [ ] No [ ]
Name of Day/Adult Care Provider		Address of Provider	

30 Do you, your spouse, or anyone in the household pay child support, alimony, or claim as a tax dependent any persons not living in this household? Yes ☐ No ☐

If yes, complete the boxes below about each person who pays child support, alimony, or claims someone as a tax dependent. S U P P

Last Name First Name Initial	Who is the person claiming?	Type of claim made: Child Support [ ] Alimony [ ] Other tax dependent [ ]	Amount Paid $_____ How Often? _____
Last Name First Name Initial	Who is the person claiming?	Type of claim made: Child Support [ ] Alimony [ ] Other tax dependent [ ]	Amount Paid $_____ How Often? _____

31 Do you, your spouse, or anyone in the household, or anyone outside the household, pay rent, or a share of the rent, for the apartment, house, mobile home, or shelter where you live? Yes ☐ No ☐

If yes, complete the boxes below about each person who pays rent. **RENT**

Last Name First Name Initial	Total Rent amount/how often $_____per_____	Amount paid by you $_____	Included in Rent Heat [ ] Utilities [ ]
Is the rent subsidized? (i.e., Section 8)? Yes [ ] No [ ]	If yes, the amount of the subsidy is $_____ per_____	Does anyone share the cost of the rent? Yes [ ] No [ ]	If yes Name_____ Amount$_____
Landlord's Name	Landlord's Address		
Landlord's Telephone Number			

32 Do you, your spouse, or anyone in the household pay all or a share of a mortgage payment, property taxes, insurance, or other costs of the house, condo, or mobile home where you live? Yes ☐ No ☐

If yes, complete the boxes below about each person who pays a homeowner cost. **HOME**

Last Name First Name Initial	Homeowner Expenses/How Often	Mortgage Holder & Address
	First Mortgage Principal $_____per_____ Interest $_____per_____ Includes Taxes [ ] Insurance [ ]	Does anyone share the cost of this expense? Yes [ ] No [ ]
	Second Mortgage Principal $_____per_____ Interest $_____per_____ Includes Taxes [ ] Insurance [ ]	If yes, name the person sharing the expense:
	Taxes $_____per_____ (if not included in the mortgage)	What is the amount paid by this person? $_____
	Insurance $_____per_____	
	Lot Rental $_____per_____	
	Other $_____per_____	

33 Did you get a LIHEAP (Low Income Home Energy Assistance Program) Grant at your current address in the last twelve (12) months. Yes ☐ No ☐

33a

Do you, your spouse, or anyone in the household pay all, or a share of, the fuel or utilities? Yes ☐ No ☐

If yes, complete the boxes below about each person who pays a utility cost. UTIL

Last Name First Name Initial	Utility	Amount Paid/How Often	Used to Heat/Cool
	Oil	$_____per_____	Heat [ ] Cool [ ]
	Gas	$_____per_____	Heat [ ] Cool [ ]
	Wood or Coal	$_____per_____	Heat [ ] Cool [ ]
	Electric	$_____per_____	Heat [ ] Cool [ ]
	Telephone	$_____per_____	
	Water	$_____per_____	
	Sewer	$_____per_____	
	Rubbish Removal	$_____per_____	
	Other	$_____per_____	

Does anyone share the heating or cooling costs in your home? Yes [ ] No [ ]

If yes, name of the person(s) sharing the heating or cooling costs_____

What is the amount of the heating/cooling costs this person pays? $_____

34

Do you, your spouse, or anyone in the household pay for room and/or board? Yes ☐ No ☐

If yes, complete the boxes below about each person who pays room and/or board. RBEX

Last Name First Name Initial	Amount Paid/How Often	What does the room/board cover?
	$_____ per_____	Room only [ ] Board(1-2 meals) [ ] Board(3meals) [ ]

35

Is there anyone in the household who is age sixty (60) or older or disabled, who incurs any medical expenses not covered by health insurance? Yes ☐ No ☐

EXAMPLES: Health insurance premiums, Medicare premiums, Hearing aids, Eyeglasses, Dental care, Transportation to medical treatment or services, Prescription Drugs

If yes, complete the boxes below about each person who has medical expenses. FMED

Last Name First Name Initial	Type of medical expense	Amount Incurred	When do you expect this to end?
		$_____ How Often? _____	
Last Name First Name Initial	Type of medical expense	Amount Incurred	When do you expect this to end?
		$_____ How Often? _____	
Last Name First Name Initial	Type of medical expense	Amount Incurred	When do you expect this to end?
		$_____ How Often? _____	

36

Are you, your spouse, or anyone in the household covered by Medicare? Yes ☐ No ☐

If yes, complete the boxes below about each person. MEDI

Last Name First Name Initial	Medicare Claim Number		MPP	QDWI
	_____-_____-_____			
Part A begin date (month/day/year)	Part A Premium $	Who pays this expense?	PAYOR	
Part B begin date (month/day/year)	Part B Premium $	Who pays this expense?	PAYOR	BUY IN

37 Is there a child or adult applying for Medicaid covered by a health insurance, Long-Term Care insurance, dental insurance program or HMO other than Medicare, Medicaid, RIteCare or RIteShare?

Yes ☐
No ☐

EXAMPLES: BlueCross/Blue Shield, BlueChip, United HealthCare of New England, Neighborhood Health Plan of RI, Delta Dental, BCBS Dental

If yes, complete the boxes below. INSU

Policy Holder's name Last Name First Name Initial	Health and/ or Dental Insurance Name	Type of Coverage	Family [ ] Individual [ ]	If premium paid by you Amount/How Often $_____per_____

Policy Number	Group Number	Is insurance provided by employer? Yes [ ] No [ ]	If yes, name of employer providing insurance:	Code	Type	Req

Please list below person(s) covered by this policy.

Last Name First Name Initial	Relation	Individual's Policy Number	Begin Date	End Date
			___/___/___	___/___/___
			___/___/___	___/___/___
			___/___/___	___/___/___
			___/___/___	___/___/___

Policy Holder's name Last Name First Name Initial	Health and/ or Dental Insurance Name	Type of Coverage	Family [ ] Individual [ ]	If premium paid by you Amount/How Often $_____per_____

Policy Number	Group Number	Is insurance provided by employer? Yes [ ] No [ ]	If yes, name of employer providing insurance:	Code	Type	Req

Please list below person(s) covered by this policy.

Last Name First Name Initial	Relation	Individual's Policy Number	Begin Date	End Date
			___/___/___	___/___/___
			___/___/___	___/___/___
			___/___/___	___/___/___
			___/___/___	___/___/___

38 Do you, your spouse, or anyone in the household have any unpaid medical bills?

Yes ☐
No ☐

If yes, did you have any medical coverage when the bills were incurred?

Yes ☐
No ☐

If you have any unpaid medical bills, complete the boxes below about each person who received medical treatment. MEDX

Last Name First Name Initial	Date of Service	Who do you owe?	Amount Owed
	_____/_____/_____		$ _____
	_____/_____/_____		$ _____
	_____/_____/_____		$ _____

FOR APPLICANT/RECIPIENT USE ONLY

Use this page to add information about questions 1 through 38. Be sure to include the question number.

Question #_____ Page # _____

Question #_____ Page # _____

Question #_____ Page # _____

Question #_____ Page # _____

Question #_____ Page # _____

RIGHTS AND RESPONSIBILITIES

DHS-2
Rev: 11-15

Of Applicants/Recipients of RI Works Program (RIW), Supplemental Nutrition Assistance Program (SNAP), Medicaid, Medicare Premium Payment Program (MPP), Child Care Assistance, General Public Assistance (GPA), RI SSI State Supplemental Payment Program (SSP), and Katie Beckett

RIGHTS

You have a RIGHT to request, and if found eligible, to receive Financial or Medicaid or Supplemental Nutrition Assistance Program benefits based on policies and standards established under State laws.

You have a RIGHT to appeal and to receive a Hearing before a Hearing Officer of the Department if you are dissatisfied with any Department decision, or if the Department delays in making a decision. If you request a Hearing, your appeal will be heard promptly. You may be represented by a lawyer or any other person you select to appear on your behalf. If you are not satisfied with any Department decision regarding your application, you have a right to request a hearing. You must request a hearing within ninety (90) days from the date you receive a written notice for Supplemental Nutrition Assistance Program benefits, thirty (30) days from the date you receive a written notice for RIW, Child Care, and Medicaid, and (10) days from the date you receive a written notice for GPA.

Non-discrimination Statement: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794), Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), and Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Food and Nutrition Act of 2008, the Age Discrimination Act of 1975, the U.S. Department of Health and Human Services implementing regulations (45 C.F.R. Parts 80 and 84) and the U.S. Department of Education implementing regulations (34 C.F.R. Parts 104 and 106), and the U.S. Department of Agriculture, Food and Nutrition Services (7 C.F.R. 272.6); the Department of Human Services (DHS), does not discriminate on the basis of race, color, national origin, disability, religion, political beliefs, age, religion or gender in acceptance for or provision of services, employment or treatment, in its education and other program activities. Under other provisions of applicable law, DHS does not discriminate on the basis of sexual orientation, gender identity or expression. For further information about these non-discrimination laws, regulations and complaint procedures for resolution of complaints of discrimination, contact DHS at 57 Howard Avenue, Cranston, Rhode Island 02920, telephone number 462-2130 (for deaf/hearing impaired 462-6239 or 711). The Community Relations Liaison Officer is the coordinator for implementation of Title VI, the Office of Rehabilitation Services (ORS) Administrator or his/her designee is the coordinator for implementation of the Title IX, Section 504, and ADA. The Director of DHS or his/her designee has the overall responsibility for civil rights compliance for all agency programs.

You have a RIGHT to confidentiality. The Department uses information about you and other members of your household only for purposes directly related to the administration of the programs and in compliance of the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information.

DHS has my consent to use or disclose protected health information for the purposes of treatment, payment and health care operations in accordance with DHS notice of privacy practices.

The Department does not release information about you or other members of your household without your consent except as provided in Rhode Island General Laws 40-6-12 and 40-6-12.1, and regulations set forth in the DHS and SNAP Policy Manuals. Any person found guilty of violating the provisions of Rhode Island General Laws 40-6-12 shall be deemed guilty of a misdemeanor. Violators are subject to a maximum fine of two hundred dollars ($200), or imprisonment of up to six (6) months, or both.

You have a RIGHT to file a joint application for more than one program or file a separate application for SNAP benefits without applying for other program benefits. All SNAP applications, regardless of whether they are joint applications or separate applications, must be processed for SNAP purposes in accordance with SNAP procedural, timeliness, notice, and fair hearing requirements. No household shall have its SNAP denied solely on the basis that its application to participate in another program has been denied or its benefits under another program have been terminated without a separate determination by the Department that the household failed to satisfy a SNAP eligibility requirement. Households that file a joint application for SNAP and another program and are denied benefits for the other program shall not be required to resubmit the joint application or to file another application for SNAP, but shall have its SNAP eligibility dtermined based on the joint application in accordance with the SNAP processing time frames from the date the joint application was accepted by the Department.

RESPONSIBILITIES

You have a RESPONSIBILITY to supply the Department with accurate information about your income, resources and living arrangements.

You have a RESPONSIBILITY to tell us immediately (within ten (10) days) of any changes in your income, resources, family composition, or any other changes that affect your household. For RIW Cash and CCAP, you must tell us immediately (within five (5) days) when a child leaves your household for any reason. For SNAP, if you are a simplified reporter, you must report changes in income which bring the household's gross income in excess of the applicable SNAP Gross Income Eligibility Standard for your household size. If you are unsure about your reporting requirements, contact you DHS worker.

You have a RESPONSIBILITY if you are applying for CCAP, to find a suitable child care provider for your child(ren) and to make appropriate arrangements to have your child(ren) attend that provider. The Department of Human Services will pay only for those hours when you are either at work or involved in a DHS approved education/training activity, and the cost of any child care in excess of those hours is your sole responsibility. If found eligible, you may be responsible for a share of the child care cost (co-payment) and you are responsible to make such payment directly to your child care provider. If you are not found eligible, you have 30 days from the written notice to request a hearing in writing to appeal your ineligibility. If the decision of the hearing is not in your favor, DHS is not responsible for any of the child care costs that you may have incurred with your child care provider. By signing this form, you are authorizing the Department of Human Services to inform the child care provider(s) after you have been notified if your child care assistance has been approved, discontinued or denied.

You have a RESPONSIBILITY to provide Social Security numbers (or proof that you have applied for one) for yourself and your household, or to apply, if you are required to, for them as a condition of eligibility. The collection of information on the application, as well as the Social Security numbers of all members of your household for whom you receive assistance, is authorized under the Food and Nutrition Act of 2008 (formerly the Food Stamp Act), as amended, 7 U.S.C. 2011-2036. This information will be used to determine whether your household is eligible or continues to be eligible to participate in SNAP, MA, RIW, GPA and/or CCAP. The Department will verify this information through computer matching with the Department of Labor and Training, the Social Security Administration, the Internal Revenue Service, the Food and Nutrition Service, and other governmental and non-governmental entities authorized by law, regulation or contract, and they will be subject to verification by Federal, State, and local officials. The income and eligibility information obtained from these agencies will be used to make sure your household is eligible for and receiving the correct amount of SNAP benefits, GPA, Child Care, RIW, and/or Medicaid. This information will also be used to monitor compliance with program regulations and for program management. This information may be disclosed to other Federal and State agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law. If a claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies as well as private claims collection agencies for claims collection action. Providing the requested information is voluntary. However, failure to provide a SSN will result in the denial of benefits to each individual failing to provide a SSN. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible household members.

You have a RESPONSIBILITY to report and provide proof of your expenses shown in questions 29 through 38 in order to get the maximum amount of SNAP benefits allowed. Failure to report or provide proof of your expenses will be regarded as your statement that you do not want to receive a deduction for the unreported or unproven expense.

You have a RESPONSIBILITY to cooperate fully with State and Federal personnel conducting quality control reviews.

Only U.S. citizens and certain legal immigrants may be eligible for SNAP benefits. If there are non-citizens living with you who are not eligible, you may still apply for and receive benefits for other eligible household members. You are not required to provide immigration information for people not applying for benefits, but you may need to provide other information for those people, such as, income and resources.

RIW Restrictions on Use of EBT Cash Benefits and Penalties: Pursuant to Section 4004 of Public Law 112-96, it is prohibited for a TANF recipient to use their TANF cash assistance benefits received under RI Works, Rhode Island General Laws 40-5.2 et seq., in any electronic benefit transfer transaction (EBT) in:

- any liquor store; or
- any casino, gambling casino, or gaming establishment; or
- any retail establishment which provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment.

Any person receiving cash assistance through the RI Works Program who uses an EBT card in violation of the above standards shall be subject to the following penalties:

- For the first violation, the household will be sent a warning that a prohibited transaction occurred;
- For the second violation, the household will be charged a penalty in the amount of the EBT transaction that occurred at the prohibited location;
- For the third and all subsequent violations, the household will be charged a penalty in the amount of the EBT transaction that occurred at the prohibited location AND for the month following the month of infraction, the amount of cash assistance to which an otherwise eligible recipient family is entitled shall be reduced by the portion of the family's benefit attributable to any parent who utilized the EBT card in a restricted location. For a family size of two (2), the benefit reduction due to noncompliance with use of EBT at a restricted location shall be computed utilizing a family size of three (3), in which the parent's portion equals one hundred five dollars ($105).

RIW/SNAP EBT Card Replacement Provisions:
Cardholders who request four (4) or more replacement EBT cards within a twelve (12) month period may be referred to the Fraud Unit for investigation of misuse or abuse of the EBT card. Documented violations may result in one or more of the following actions:

- Disqualification from the program;
- Recovery through recoupment/restitution; and/or
- Referral for criminal prosecution

In all cases, the agency shall act to protect households containing homeless persons, elderly or disabled members, victims of crimes, and other vulnerable persons who may lose electronic benefits transfer cards but are not committing fraud.

RI WORKS PROGRAM, MEDICAID, CHILD CARE ASSISTANCE AND GENERAL PUBLIC ASSISTANCE.
LIENS AND ASSIGNMENTS

I understand that pursuant to Rhode Island General Law, Sections 40-6-9, 40-6-10, or 40-8-15, without the necessity of signing any document:

a.) Regarding Child Support and Establishment of Paternity
I have assigned any and all rights that I may have for and on behalf of myself, and for and on behalf of my child or children, to the Department of Human Services (DHS), against any person failing to provide for support, maintenance, and medical care for myself and my minor child or children for whom assistance is paid by the DHS. The DHS is authorized to perform the act of instituting suit to establish paternity and/or to collect support for myself or my child or children who receive or received assistance from the DHS. **b.) Regarding Amounts Recoverable from a Third Party**
I have assigned any and all rights to the DHS, for and on behalf of myself and any person for whom I may legally act, for amounts recoverable from a third party equal to the amount of financial assistance and Medicaid provided as a result of accident, injury, or illness.

c.) Regarding Amounts Recoverable from Workers' Compensation
The Department of Human Services may place a lien upon any pending award, order, or settlement, which I may be entitled to under the provisions of the Rhode Island Workers Compensation Act, Chapters 28-29 through 28-38 of the Rhode Island General Laws. The purpose of the lien is to secure reimbursement to the Department for financial and Medicaid payments made to me or on my behalf for the period of time for which my workers' compensation award, order, or settlement is made.

d.) Regarding Lien on Deceased Recipient's Estate for Medicaid Reimbursement
The DHS may place a lien upon the estate of a Medicaid recipient who was fifty-five (55) years of age or older at the time of death. R.I.G.L. 40-8-15 provides that the total sum of Medicaid paid on behalf of a Medicaid recipient who was fifty-five (55) years of age or older at the time of receipt of such assistance shall be a debt to the state and shall constitute a lien upon the estate of the recipient in favor of the DHS. However, the lien shall not be effective and shall not apply to the estate of a recipient who is survived by a spouse, or a child who is under the age of twenty-one (21) or a child who is blind or permanently and totally disabled as defined in Title XVI (SSI) of the Social Security Act.

I understand that as a condition of receiving RIW benefits, all persons from whom I am requesting RIW, unless exempt by law, are required to comply with the RIW Program requirements.

I understand that this application will serve as authorization to the Department of Human Services to obtain from Medical providers information that is pertinent to me or any person included in this application for as long as the case remains open.

I understand and agree that the DHS office may contact other persons or organizations to obtain the necessary proof of my eligibility and level of benefits.

II. AUTHORIZED REPRESENTATIVE

You have a RIGHT to name an authorized representative. An authorized representative is a person designated by the head of the household or the spouse, or any other responsible member of the household, to act on behalf of the household in applying for program benefits, or using the benefits. The authorized representative for benefits may or may not be the same individual designated as an authorized representative for the application process or for meeting reporting requirements. The authorized representative designation must be made in writing.

You can authorize someone outside your home 1) to get your SNAP benefits for you and/or 2) to use them to buy food for you. If you would like to authorize such representative(s), write the person's name below.

_____
Last Name First Name Middle Initial

_____ _____
Address City Zip Telephone Number

III. SNAP PENALTY WARNINGS

I understand that:

1. Any member of my household who intentionally breaks a SNAP rule will be barred from the SNAP from one year to permanently, fined up to $250,000, imprisoned up to 20 years or both. S/he may also be subject to prosecution under other applicable Federal and State laws. S/he may also be barred from the SNAP for an additional 18 months if court ordered. Any member of my household who intentionally breaks a SNAP rule can be barred from the Supplemental Nutrition Assistance Program:

*For a period of one (1) year for the first violation, with the exceptions in numbers 2. and 3. below;
*For a period of two (2) years after the second violation, with the exception in number 3. below; and,
*Permanently for the third occasion of any intentional program violation.

2. Individuals found by a Federal, State, or local court to have used or received SNAP benefits in a transaction involving the sale of firearms, ammunitions or explosives shall be permanently ineligible for the Supplemental Nutrition Assistance Program upon the first occasion of such violation.

3. Individuals found to have made a fraudulent statement or representation with respect to the identity or place of residence of the individual in order to receive multiple SNAP benefits simultaneously shall be ineligible to participate in the Supplemental Nutrition Assistance Program for a period of ten (10) years.

4. Individuals found guilty by a Federal, State or local court of law for using or receiving benefits in a transaction involving the sale of a controlled substance (as defined in section 102 of the Controlled Substances Act (21 U.S.C. 802)) will not be eligible for benefits for two years for the first offense, and permanently for the second offense.

5. Individuals found guilty by a court of law for buying or selling illegal drugs or certain prescription drugs in exchange for SNAP benefits will be prohibited from participating in the SNAP for 24 months for the first offense and permanently for the second offense.

6. An individual convicted by a Federal, State, or local court of having trafficked benefits for an aggregate amount of $500 or more shall be permanently ineligible to receive SNAP benefits upon the first occasion of such violation.

DO NOT give false information or hide information to get or continue to get SNAP benefits.
DO NOT trade or sell EBT cards.
DO NOT use SNAP benefits to buy ineligible items, such as alcoholic drinks and tobacco.
DO NOT use someone else's EBT card for your household.
DO NOT pay for food purchased on credit with SNAP benefits. Doing so could result in disqualification from the program.

DHS can use or share information on this application for the administration of DHS programs, as well as the administration of other federally funded assistance programs in accordance with state and federal law, contract and regulation.
DHS can release non-identifying information for research purposes. Any release of identifying information shall be done in accordance with state and federal law.

I understand the questions on this application and the penalty for hiding or giving false information or breaking any of the rules listed in this Penalty Warning.

I certify under penalty of perjury that my answers are correct, including information about citizenship and alien status, and complete to the best of my knowledge and belief. I know that under the state of Rhode Island General Laws, Section 40-6-15, a maximum fine of $1,000, or imprisonment of up to five (5) years, or both, may be imposed for a person who obtains or attempts to obtain, or aids or abets any person to obtain, public assistance to which s/he is not entitled, or who willfully fails to report income, resources or personal circumstances or increases therein which exceed the amount previously reported. I attest to the identity of the minor children identified herein and that all of the information contained in this application is true. I understand that I am breaking the law if I give wrong information and can be punished under federal law, state law or both.

Signature of Applicant or Recipient	Date	Signature of Authorized Representative	Date
Signature of Spouse or other parent of child(ren)	Date	Signature of Person Helping you Complete this Form	Date
Signature of Guardian, Conservator or Holder of Power of Attorney	Date	Signature of Agency Representative	Date

FOR AGENCY USE ONLY

COMMENTS	INITIALS	DATE

Notice to Applicant
Registering to Vote in Rhode Island

The State Board of elections urges all of its citizens to register to vote. Your vote will benefit you and your family.

Included in this packet of forms is a voter registration form. If you would to register to vote, complete and sign the form and mail it to your local Board of Canvassers. (directory listed on the back of the form)

Register to vote

- If you are not registered to vote where you live today, complete the enclosed form.

- Applying to register or declining to register to vote will not affect the amount of assistance provided by this agency.

- If you would like help in completing the voter registration application form, you can bring it with you when you return the other completed forms in this package, or go to the local Board of Canvassers in the city/town where you live. (City/Town directory is on the back of the voter registration form.) The decision whether to seek or accept help is yours.

- If you believe that someone has interfered with your right to register or 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 Voter Registration Coordinator, 50 Branch Avenue, Providence, RI 02904 or (401)222-2345.

RHODE ISLAND
VOTER REGISTRATION FORM

Please print clearly in ink. All information is required unless marked optional.

YOU MAY USE THIS FORM TO:

- Register to vote in Rhode Island.
- Change your name and/or address on your registration.
- Choose a political party or change parties.

TO REGISTER TO VOTE IN RI YOU MUST BE:

- A legal resident of Rhode Island.
- A citizen of the United States.
- At least 16 years of age.
  (You must be at least 18 years of age to vote on Election Day.)

INSTRUCTIONS

Box 2: **REQUIRED.** Rhode Island citizens who are at least 16 years of age may pre-register to vote using this form. If you fail to check either of these boxes, this form will be returned to you. If you checked NO to either of these statements, do not complete this form.

Box 3: If you are registering to vote for the first time in Rhode Island by mail or if someone else turns this form in for you, it is **REQUIRED** that you provide your driver's license number or state ID number issued by the RI Department of Motor Vehicles (DMV). If you do not have either, you must provide the last 4 digits of your Social Security Number. If you do not provide the above information or it cannot be verified, you will be required to provide identification to an election official before voting. Acceptable forms of identification are on the Board of Elections website at http://www.elections.ri.gov or contact your local Board of Canvassers (see reverse side of this form).

Box 5: A person may have only one legal residence. You must register from your legal residence. A post office box or rural route may only be used as a "Mailing Address" in Box 6.

Box 9: If you want to affiliate to vote, choose a party. If you leave Box 9 blank, you will be listed as unaffiliated.

Box 10: You must SIGN and DATE the registration form. If you fail to sign and date the form, it will be returned to you.

Box 11: If you are updating your voter registration because you legally changed your name, enter your previous legal name.

Box 12: If you are updating your voter registration because of an address change, enter your previous address, **even if out-of-state.**

You will receive an acknowledgement receipt of this voter registration form within 3 weeks. If you do not receive it, contact your local Board of Canvassers (see reverse side for list). For questions and deadlines relating to this form, visit the Board of Elections website at http://www.elections.ri.gov or contact your local Board of Canvassers (see reverse side for list).

(This form may be reproduced)

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1. Check Boxes that Apply: ☐ New Voter Registration ☐ Address Change ☐ Party Change ☐ Name Change

2. I am a U.S. Citizen and resident of Rhode Island. ☐ Yes ☐ No

I am at least 16 years of age. (You must be at least 18 years of age to vote.) ☐ Yes ☐ No

If you checked NO to either of these statements, do not complete this form.

3. RI driver's license or ID Number: _____

If you do not have a RI driver's license or ID, enter last 4 digits of your social security number: _____

If you do not enter either number, see instructions for Box 3.

4. Last Name | Suffix (if any) | First Name | Middle Name (or initial)

5. Home Address (Do not enter a post office box) | Apt. | City/Town | State: RI | ZIP Code

6. Mailing Address (If different from Box 5) | Apt. | City/Town | State | ZIP Code

7. Date of Birth (mm/dd/yyyy) Month Day Year

8. Phone No./ E-mail Address (optional)

9. Party Affiliation: ☐ Democrat ☐ Moderate ☐ Republican ☐ Unaffiliated ☐ Other_____

10. I swear or affirm that:

- I am not incarcerated in a correctional facility upon a felony conviction.
- I am not presently judged "mentally incompetent" to vote by a court of law.
- The information I have provided is true to the best of my knowledge under penalty of perjury. If I have provided false information, I may be fined, imprisoned, or (if not a U.S. citizen) deported from or refused entry into the United States.

Official Use For Barcode

PLEASE SIGN FULL NAME OR PLACE MARK BELOW

Signed _____ **Date:** (mm/dd/yyyy)

Are you interested in working at the polls? ☐

Warning: If you sign this form and know it to be false, you can be convicted and fined up to $5,000 or jailed up to 10 years.

11. PREVIOUS NAME (if different from Box 4)

12. PREVIOUS ADDRESS OF REGISTRATION (City/Town, State, ZIP & County)

02/2012 Regs
Form Revised 12/2012

Return Address

_____

_____

_____

Postage Required Post Office will not deliver without proper postage.

Mail To: **BOARD OF CANVASSERS**

_____

_____

_____

**********FOLD HERE & TAPE AT TOP**********

INSTRUCTIONS FOR MAILING THE VOTER REGISTRATION FORM

An applicant who chooses to mail his/her voter registration form shall do so in the following manner:

1. Fold the form at the dotted line and tape the bottom to the top of the form.
2. From the list below, locate the address of the board of canvassers in the city or town in which you are registering to vote and insert that address in the appropriate space beneath **"Mail To: BOARD OF CANVASSERS"** on the addressed side of the voter registration form. Insert your return address in the space provided.

NOTICE: *It is against the law for anyone to interfere with your privacy in registering to vote or in choosing a political party. If you believe someone has interfered with your right to register or not register, or with your privacy in making this decision, or in choosing a political party, you may file a complaint with the State Board of Elections, 50 Branch Avenue, Providence, Rhode Island 02904.*

LOCAL BOARDS OF CANVASSERS

Barrington Town Hall, 283 County Rd., Barrington, RI 02806

Bristol Town Hall, 10 Court St., Bristol, RI 02809

Burrillville Town Hall, 105 Harrisville Main St., Harrisville, RI 02830

Central Falls City Hall, 580 Broad St.., Central Falls, RI 02863

Charlestown Town Hall, 4540 S. County Trail, Charlestown, RI 02813

Coventry Town Hall, 1670 Flat River Rd., Coventry, RI 02816

Cranston City Hall, 869 Park Ave., Cranston, RI 02910

Cumberland Town Hall, 45 Broad St., Cumberland, RI 02864

East Greenwich Town Hall, PO Box 111, East Greenwich, RI 02818

East Providence City Hall, 145 Taunton Ave., East Providence, RI 02914

Exeter Town Hall, 675 Ten Rod Rd., Exeter, RI 02822

Foster Town Hall, 181 Howard Hill Rd., Foster, RI 02825

Glocester Town Hall 1145 Putnam Pike PO Drawer B, Glocester, RI 02814

Hopkinton Town Hall, 1 Town House Rd., Hopkinton, RI 02833

Jamestown Town Hall, 93 Narragansett Ave., Jamestown, RI 02835

Johnston Town Hall, 1385 Hartford Ave., Johnston, RI 02919

Lincoln Town Hall, 100 Old River Rd., PO Box 100, Lincoln, RI 02865

Little Compton Town Hall, PO Box 226, Little Compton, RI 02837

Middletown Town Hall, 350 East Main Rd., Middletown, RI 02842

Narragansett Town Hall, 25 Fifth Ave., Narragansett, RI 02882

New Shoreham Town Hall, PO Drawer, 220 Block Island, RI 02807

Newport City Hall, 43 Broadway, Newport, RI 02840

N. Kingstown Town Hall, 80 Boston Neck Rd., North Kingstown, RI 02852

North Providence Town Hall, 2000 Smith St., North Providence, RI 02911

North Smithfield Municipal Annex, 575 Smithfield Rd., North Smithfield, RI 02896

Pawtucket City Hall, 137 Roosevelt Ave., Pawtucket, RI 02860

Portsmouth Town Hall, 2200 East Main Rd., Portsmouth, RI 02871

Providence City Hall, 25 Dorrance St., Providence, RI 02903

Richmond Town Hall, 5 Richmond Townhouse Rd., Wyoming, RI 02898

Scituate Town Hall, PO Box 328, North Scituate, RI 02857

Smithfield Town Hall, 64 Farnum Pike, Smithfield, RI 02917

S. Kingstown Town Hall, 180 High St., Wakefield, RI 02879

Tiverton Town Hall, 343 Highland Rd., Tiverton, RI 02878

Warren Town Hall, 514 Main St., Warren, RI 02885

Warwick City Hall, 3275 Post Rd., Warwick, RI 02886

W. Greenwich Town Hall 280 Victory Highway, W. Greenwich, RI 02817

West Warwick Town Hall, 1170 Main St., West Warwick, RI 02893

Westerly Town Hall, 45 Broad St., Westerly, RI 02891

Woonsocket City Hall, P.O. Box B, 169 Main St., Woonsocket, RI 02895

Voter Registration Questions May Be Addressed To:

Rhode Island Board of Elections
50 Branch Avenue
Providence, RI 02904
elections@elections.ri.gov