



SFN 405 (Rev. 03-09)

Instructions For Application For Assistance

This application may be used to apply for Temporary Assistance for Needy Families (TANF), Child Care Assistance, Supplemental Nutrition Assistance Program (SNAP), Health Care Coverage and Basic Care. See the Guidebook for more information.

What Do I Need To Do To Get Assistance?

Follow these steps to apply for assistance.

Step 1. Fill out this application.

If you are applying for:

- Child Care Assistance - You need to complete Sections 1, 2 and 6.
- SNAP - You need to complete Sections 1, 2, 3, 4 and 6.
- Health Care Coverage - You need to complete Sections 1, 2, 3, 5 and 6. (Aid to the Blind, Healthy Steps, Medicaid, Medicare Savings Program)
- Basic Care – You need to complete Sections 1, 2, 3, 5 and 6.
- TANF - You need to complete all Sections.

Answer as many questions as you can. If you need help applying for assistance, you may have a friend, relative or someone else help you apply. Your local county social service office can also help you apply for assistance. If you need additional space, attach a separate sheet of paper.

Step 2. Return the application to your local county social service office.

If you cannot fill out the whole application today, turn in Section 1. **If you do not fill out all of Section 1, you have the right to file an incomplete application as long as it contains the applicant's name, address and signature of either the applicant or the authorized representative. If you are eligible, your assistance will start from the date we receive Section 1 or an incomplete application.**

Fill out and turn in the rest of the application as soon as you can. You can mail or drop off your application.

Step 3. Talk with us.

When we get your application for SNAP or TANF, we will set up an interview with you. For SNAP, a face-to-face interview may be waived in favor of a telephone interview on a case-by-case basis determined by household hardship reasons. Health Care Coverage and Child Care Assistance do not require an interview.

Appointment Date: _____ **Appointment Time:** _____

If you miss your appointment and still wish to apply, please contact the county social service office to schedule a second appointment.

To speed up the processing of your application, turn in verifications of the following items with your application. You may also bring verifications with you to your interview. Your worker will help you obtain these things if needed.

Verification of Alien or Citizenship Status such as (original documents required if applying for Health Care Coverage):

- Resident Alien Card (Form I-551)
- Employment Authorization Card (Form I-688A)
- Temporary Resident Card (Form I-688)
- Arrival-Departure Record (Form I-94)

You will be asked to provide information about the citizenship or immigration status for all persons for whom you want to receive assistance. If any of these persons do not want to give information about their citizenship or immigration status, they will not be eligible for benefits. Other household members may still get benefits if they are otherwise eligible. We will not share alien or citizenship information about non-applicants with the United States Citizenship and Immigration Service (USCIS).

Verification of the value of current assets such as:

- Annuities
- Business Accounts
- Certificates of Deposit
- Checking/Savings/Credit Union Accounts
- IRA/401K/KEOGH plans
- Life Insurance
- Real Property (Land, Rental Property, etc.)
- Saving Bonds
- Stocks/Bonds/Mutual Funds
- Trusts

If only applying for Child Care Assistance or Health Care Coverage for children and family coverage, you do not need to report or bring records of your assets.

Verification of expenses such as:

- Child/Dependent Care
- Court Ordered Payments (Child Support, Health Insurance Premiums, Other Support)
- Medical or Health Insurance Premiums (If applying for SNAP only, you do not need to provide information for household members under age 60 unless they are disabled.)
- Utility/Shelter Expenses (If applying for SNAP)
 - Heating and Cooling Costs
 - Home Owner's Insurance
 - House Payment
 - Other Utility Bills
 - Property Taxes
 - Rent (Receipt, Lease Agreement, Housing Assistance Contract)
 - Telephone Bill

Verification of income such as:

- Bonuses
- Child Support
- Commissions
- Lease Income
- Money from Friends, Relatives or Others
- Pay (Pay Stubs or Employer Statement)
- Pension/Retirement Benefits
- Rental Income
- Self-Employment Income
- Social Security Benefits
- Spousal Support
- SSI
- Unemployment Benefits
- Veterans'/Military Benefits
- Workers Compensation

Verification of other information such as:

- Identity (Birth Certificate, Driver's License, Work or School ID - original documents required if applying for Health Care Coverage)
- Age (Birth Certificate, Driver's License)
- Residence (Rent Receipts, Utility Bills, Lease)
- Social Security Numbers
- Verification of Pregnancy (Doctor's statement of due date)

To learn when you may get assistance, go to the General Information section of the Guidebook. If you have questions, contact your local county social service office.



SFN 405 (Rev. 03-09)

| Agency Use Only | |
|-------------------------|-----------------|
| Case Number: | Date Requested: |
| Date Received: | Interview Date: |
| Individual Interviewed: | |

Application For Assistance – Section 1

Check the assistance you are applying for. Sign and date below. If you would like more information on these programs, see the Guidebook. If you did not receive the Guidebook, contact your local county social service office.

- Temporary Assistance for Needy Families (TANF)** – Provides a monthly payment on behalf of children who are considered dependent and deprived of parental support.
- Child Care Assistance** – Helps adults continue working to support their families and helps teen parents remain in school by assisting with the costs of child care.
- Supplemental Nutrition Assistance Program (SNAP)** - formerly known as Food Stamps, helps people buy food for good health.

You may get SNAP within 7 days of your application date if any of the following are true:

- Your household's monthly income before taxes is \$150 or less; or
- You are a migrant or seasonal farm worker; or
- Your household's monthly rent/mortgage and utilities are more than your household's income before taxes.

- Health Care Coverage** – Assistance available for families with children, pregnant women, elderly, or disabled people to help pay medical bills and health insurance premiums.

Check the Health Care Coverage(s) you are applying for:

- Aid to the Blind** – Assists with treatment for people who are not eligible for Medicaid and are in danger of losing their vision or require restorative eye services.
- Healthy Steps (State Children's Health Insurance Program - SCHIP)** – Provides premium-free health insurance coverage to uninsured children.
- Medicaid** – Pays for health services for families with children, pregnant women and people who are elderly or disabled.
- Medicare Savings Program** – Assists with Medicare Part B premium, coinsurance and deductibles.
- Basic Care Assistance** – Helps pay for care in licensed basic care facilities.

Tell Us About You

| | | |
|---------------------------------|-------------------------|--------------------|
| First Name: | Middle Initial: | Last Name: |
| Address Where You Live: | | |
| City: | State: | Zip Code: |
| Mailing Address (if different): | | |
| Home Telephone Number: | Work or Message Number: | Cell Phone Number: |
| Direction to Home (if rural): | | |

Sign And Date Application Here

Signature of Applicant: _____ Date: _____

Other Signature (Spouse, Guardian or Other Adult): _____ Date: _____

List other names that have been used by household members (maiden name, prior married name or nicknames): _____

List household members temporarily out of the home: _____

Why are they out of the home? _____ Date expected to return: _____

List household members who are disabled: _____

List household members who are a veteran, or a dependant or spouse of a veteran: _____

Have household members received assistance in another state (cash, food, medical assistance)? Yes No

If yes, when? _____ Which city, county and state? _____

List household members who are boarders (paying someone to provide meals): _____

Tell Us About Students In Your Home

List each household member age 14 or older who is a student or planning to attend school.

| Student Name | Name of School | PT - Part Time FT - Full Time |
|--------------|----------------|----------------------------------|
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Can You Choose Someone To Help You Get SNAP?

If you are applying for SNAP you can have someone help you, if you wish. This person can fill out your application, answer questions for you, give information at your interview, and buy your food with an EBT card. We will be able to share information with this person.

If you choose to have someone help you, fill in the boxes below with their information:

| | | | |
|----------|-------|-------------------|-----------|
| Name: | | Telephone Number: | |
| Address: | City: | State: | Zip Code: |

Help Us Decide If You Can Receive SNAP Within Seven Days

If you are applying for SNAP, completing this section may help you receive benefits within seven days:

Are you a migrant or seasonal farm worker? Yes No

About how much total earned income will your household receive this month before taxes (gross)? _____

About how much total unearned income or other money will your household receive this month? _____



How much is your household's monthly rent, lot rent and house payment? _____

Check all the utilities your household is responsible for:

Heating Cooling Electricity Telephone Water Sewer Garbage

Do household members receive heating assistance (LIHEAP)? Yes No

Do household members plan to apply for heating assistance (LIHEAP)? Yes No

Do you have a North Dakota Electronic Benefit Transfer (EBT) card  or  for SNAP? Yes No

Have you received EBT training? Yes No

Have household members received tribal commodities last month or this month? Yes No

Do household members purchase and prepare meals separately? Yes No

If yes, who? _____

| Agency Use Only – Expedited Formula | | |
|--|---|---|
| <p>If:</p> <p style="text-align: center;">Income below \$150/Month</p> <p>Wages, Child Support, SSI, Disability, Retirement, Veterans Benefits, Unemployment, Workers Compensation</p> | <p>If not:</p> <p style="text-align: center;">Monthly</p> <p>Gross Income _____</p> <p style="text-align: center;">Would be less than:</p> <p>Rent/Mortgage _____</p> <p>Appropriate Utility Standard + _____</p> <p style="text-align: right;">= _____</p> | <p>HLSU – Any of the following:</p> <ul style="list-style-type: none"> • Heating • Cooling • LIHEAP <p>LUSA – Two of the following</p> <ul style="list-style-type: none"> • Water • Sewer • Garbage • Electric • Telephone <p>MU – One of the following:</p> <ul style="list-style-type: none"> • Water • Sewer • Garbage • Electric <p>TL – Telephone Only</p> |
| <p>Was the screening for expedited service completed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the household eligible for expedited service? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Was the Identity of applicant verified? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | | <p>Workers Initials:</p> |

| |
|------------------------|
| Agency Use Only |
| Case Number: _____ |
| Date Received: _____ |

Application For Assistance – Section 2

Complete Section 2 if you are applying for:

- **Basic Care**
- **Child Care Assistance**
- **Health Care Coverage**
- **SNAP**
- **TANF**

Your Name: _____

Tell Us About The Income/Money Your Household Receives

Self-Employment

Are any household members self-employed? Yes No

If yes, list the household member, name and type of business and date business started: _____

Employment

Are any household members employed? Yes No

If yes, list information about pay from employment such as wages, commissions, bonuses, and incentives for all household members including children:

| Household Members | Employer | Hours Worked Per Week | Hourly Pay | This Month's Pay Before Taxes (Gross) | Next Month's Pay Before Taxes (Gross) | Amount of Tips | Date of Next Check | How Often Paid | Day or Dates Paid |
|-------------------|----------|-----------------------|------------|---------------------------------------|---------------------------------------|----------------|--------------------|-----------------|-------------------|
| | | | | | | | | Use Codes Below | |
| | | | | | | | | | |
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How Often Paid Codes:
M – Monthly 2X – Twice a Month W – Weekly EX – Every Two Weeks Other, specify: _____

Day Paid Codes:
M – Monday T – Tuesday W – Wednesday TH – Thursday F – Friday S – Saturday SU – Sunday

Has any household member received commissions, bonuses or incentives other than those included above within the last year? Yes No

If yes, list the household member, date received and amount. _____

Unearned Income or Other Money Received

The following is a list of different kinds of unearned income. Check yes for each unearned income or other money received by household members. Check no, if not received.

- | | |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No BIA/Tribal General Assistance | <input type="checkbox"/> Yes <input type="checkbox"/> No Oil/Mineral Rights/Royalties |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bingo/Gambling Winnings | <input type="checkbox"/> Yes <input type="checkbox"/> No Pension/Retirement Benefits |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Child Support or Spousal Support | <input type="checkbox"/> Yes <input type="checkbox"/> No Railroad Retirement Benefits |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Contract Sale or Rental Income | <input type="checkbox"/> Yes <input type="checkbox"/> No Social Security Benefits |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Income from Tribes | <input type="checkbox"/> Yes <input type="checkbox"/> No Supplemental Security Income (SSI) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Income from Roomer/Boarder | <input type="checkbox"/> Yes <input type="checkbox"/> No TANF |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Individual Indian Monies (IIM) | <input type="checkbox"/> Yes <input type="checkbox"/> No Unemployment Benefits |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Insurance/Lawsuit Settlement | <input type="checkbox"/> Yes <input type="checkbox"/> No Veterans'/Military Benefits |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Interest/Dividend Income | <input type="checkbox"/> Yes <input type="checkbox"/> No Workers' Compensation |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Money from Friends, Relatives or Others | Other, specify: _____ |

For all items checked yes, fill in the boxes below:

| Type of Unearned Income or Other Money Received | Household Member | How Often Received | Amount This Month | Amount Next Month |
|---|------------------|--------------------|-------------------|-------------------|
| | | | | |
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Have household members applied for benefits not yet received (Social Security, SSI, Workers' Compensation, Unemployment Compensation, Veterans'/Military Benefits)? Yes No

If Yes, explain: _____

Tell Us If You Have Child Care Needs

Does or will your household have child care expenses? Yes No If yes, when? _____

What is the monthly billed amount? _____ What amount do you pay? _____

Child Care Assistance can help pay child care expenses for the month prior to the application. Would you like help paying for last month's child care expenses? Yes No

Check the reason for needing child care:

- High School Employment Vocational Training/College Other, specify: _____

If attending college or vocational training, list household members who have a previous degree: _____

Are you already receiving Child Care Assistance? Yes No If no, have you applied? Yes No

Does anyone help you pay your child care expenses? Yes No

If yes, list who is paying and how much they pay: _____

Do you expect changes in the above expenses next month? Yes No If yes, explain: _____

Application For Assistance – Section 3

Complete Section 3 if you are applying for:

- **Basic Care**
- **Health Care Coverage**
- **SNAP**
- **TANF**

Tell Us The Value Of Your Household's Assets

If you are applying for Health Care Coverage for a child or pregnant woman, answer one of these questions. Answering the question may help North Dakota get additional funding for Health Care Programs. Your answer will not affect your eligibility or the amount of your benefits.

If you **live alone**, is the value of all assets more than \$3,000? (Do not count the value of one vehicle, your home, clothing, household goods, and real property used as part of your business.) Yes No

If you **live with someone**, is the value of all assets more than \$6,000? (Do not count the value of one vehicle, your home, clothing, household goods, and real property used as part of your business.) Yes No

Tell Us About Your Household's Assets

If you are applying for Medicaid for someone who is disabled or age 65 or older, or if you are applying for Basic Care, SNAP or TANF, you must complete the Vehicles and Other Assets sections.

Vehicles

List vehicles (car, truck, motor home, snowmobile, motorcycle, 3 wheeler/4 wheeler, boat or other watercraft, camper, trailer, etc.) owned, jointly owned or being purchased for all household members, even if the vehicle is not running or not in your possession. Include vehicles licensed through North Dakota, tribal motor vehicle or another state.

| Make/Model | Year | Value | Amount Owed | Licensed | Owners |
|------------|------|-------|-------------|---|--------|
| | | \$ | \$ | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | \$ | \$ | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | \$ | \$ | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | \$ | \$ | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | \$ | \$ | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | \$ | \$ | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Other Assets

Check yes by the assets owned, jointly owned or being purchased by household members. Check no, if none.

- | | |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Annuities | <input type="checkbox"/> Yes <input type="checkbox"/> No No Individual Indian Monies Accounts |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Assets Owned with Another Person | <input type="checkbox"/> Yes <input type="checkbox"/> No Life Estate/Life Lease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Burial Plots | <input type="checkbox"/> Yes <input type="checkbox"/> No Mineral Rights (Oil, Gas, Gravel, Coal, etc.) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Burial Space Items (Casket, Vault, Marker, etc.) | <input type="checkbox"/> Yes <input type="checkbox"/> No Notes or Contract for Deed |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Business Accounts | <input type="checkbox"/> Yes <input type="checkbox"/> No Prepaid Funeral Plans |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Business Inventory/Equipment | <input type="checkbox"/> Yes <input type="checkbox"/> No Real Property (Land, Rental Property, Buildings, etc.) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cash on Hand | <input type="checkbox"/> Yes <input type="checkbox"/> No Retirement Funds (IRA/KEOGH/401K) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Certificates of Deposit | <input type="checkbox"/> Yes <input type="checkbox"/> No Safety Deposit Box |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Checking/Credit Union Accounts | <input type="checkbox"/> Yes <input type="checkbox"/> No Savings Bonds |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Farm Equipment, Livestock, Stored Grain | <input type="checkbox"/> Yes <input type="checkbox"/> No Savings/Credit Union Accounts |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Home/Mobile Home (Not Owner occupied) | <input type="checkbox"/> Yes <input type="checkbox"/> No Stocks/Bonds/Mutual Funds |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Home/Mobile Home (Owner Occupied) | <input type="checkbox"/> Yes <input type="checkbox"/> No Trusts |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Income Producing Tools/Equipment | Other, specify: _____ |

For all items checked yes, fill in the boxes below:

| Type of Asset | Location/Description | Total Value | Amount Owed | Owners |
|---------------|----------------------|-------------|-------------|--------|
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List household members who have made arrangements for funeral expenses or gave money, property, or insurance to someone else to pay for funeral expenses: _____

Explain: _____

Do you expect changes in assets next month? Yes No

If yes, explain: _____

Transfer of Assets

Have household members sold, given away or transferred anything of value within the past:

3 months? Yes No

If yes, list the items: _____ Date: _____

5 years? Yes No

If yes, list the items: _____ Date: _____

Tell Us About Court Ordered Expenses

Is any household member court ordered to pay child support, health insurance, or other support payments? Yes No

If yes, who? _____ Who are the payments for? _____

Amount court ordered: _____ Amount paid: _____

Application For Assistance – Section 4

Complete Section 4 if you are applying for:

- **SNAP**
- **TANF**

Tell Us About Your Housing Expenses

Check yes by each expense household members have during any time of the year. Check no, if none.

- | | |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Air Conditioning or Central Air <input type="checkbox"/> Yes <input type="checkbox"/> No Condo Fees <input type="checkbox"/> Yes <input type="checkbox"/> No Electricity <input type="checkbox"/> Yes <input type="checkbox"/> No Garbage <input type="checkbox"/> Yes <input type="checkbox"/> No Heating (gas, propane, electric, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No Homeowners Insurance (not in house payment) <input type="checkbox"/> Yes <input type="checkbox"/> No No House Payment (mortgage) | <input type="checkbox"/> Yes <input type="checkbox"/> No Lot Rent <input type="checkbox"/> Yes <input type="checkbox"/> No Property Taxes (not in house payment) <input type="checkbox"/> Yes <input type="checkbox"/> No Rent <input type="checkbox"/> Yes <input type="checkbox"/> No Sewer/Septic Tank Installation or Maintenance <input type="checkbox"/> Yes <input type="checkbox"/> No Telephone/Cell Phone <input type="checkbox"/> Yes <input type="checkbox"/> No Use of a Garage <input type="checkbox"/> Yes <input type="checkbox"/> No Water/Well Installation or Maintenance |
|--|--|

For all items checked yes, fill in the boxes below:

| Type of Expense | Who Pays the Expense | Total Amount | Amount Household Member Pays |
|-----------------|----------------------|--------------|------------------------------|
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Do household members work off part of an expense (rent, lot rent, utilities, etc.)? Yes No

If yes, list the expense and the amount worked off: _____

Do household members receive heating assistance (LIHEAP)? Yes No

Do household members plan to apply for heating assistance (LIHEAP)? Yes No

Do you expect changes in expenses (rent, lot rent, utilities, etc.) next month? Yes No

If yes, explain: _____

Does anyone help you pay these expenses (government agency, family member, etc.)? Yes No

If yes, list the expense, who is paying the expense and the amount they pay: _____

Agency Use Only

Household is entitled to one of the following mandatory utility standards:

- | | |
|---|--|
| <input type="checkbox"/> HL SU (heating/cooling/LIHEAP) <input type="checkbox"/> LU SA (water, sewer, garbage, electricity, telephone) | <input type="checkbox"/> MU (water, sewer, garbage, electricity) <input type="checkbox"/> TL (telephone only) |
|---|--|

Tell Us About Expenses For Elderly Or Disabled Household Members

Do household members, who are disabled or age 60 or older, pay health insurance or medical expenses? Yes No

If yes, who? _____

Health insurance amount: _____ Medical expense amount: _____

Does anyone help you pay these expenses? Yes No If yes, explain: _____

Do household members pay representative payee fees? Yes No

Do you expect changes in expenses next month? Yes No If yes, explain: _____

Tell Us About Your Household's Work Information

List household members who are unable to work: _____

Reason: _____

List household members who stopped their employment within the last 30 days: _____

When: _____ Employer: _____

Check the reason for leaving: Laid Off Quit Fired Leave of Absence Strike
 Illness Injury Other, specify: _____

When did the household member receive their last paycheck? _____

List household members who reduced their work hours within the last 30 days: _____

When: _____ Reason: _____

List household members who refused work within the last 30 days: _____

When: _____ Reason: _____

Tell Us About Illegal Activities And Disqualifications

Have you or any member of your household been convicted of fraudulently receiving duplicate SNAP or TANF benefits in any State after September 22, 1996? Yes No

Are you or any member of your household hiding or running from the law to avoid prosecution, being taken into custody, going to jail, or violating a condition of parole or probation? Yes No

Have you or any member of your household been convicted of a felony under Federal or State law for possession, use or distribution of a controlled drug substance (felony drug conviction) or for a crime committed while under the influence of a controlled drug substance after August 22, 1996? Yes No

Have you or any member of your household been convicted of buying or selling SNAP benefits over \$500 after September 22, 1996? Yes No

Have you or any member of your household been convicted of trading SNAP benefits for guns, ammunitions, or explosives after September 22, 1996? Yes No

Have you or any member of your household been convicted of trading SNAP benefits for drugs after September 22, 1996? Yes No

Are you or any household member participating in SNAP or TANF in another location? Yes No

Are you or is any household member disqualified or have you or any household member ever been disqualified from SNAP or TANF for providing incorrect information or failing to provide information that affected SNAP or TANF eligibility or benefits? Yes No

Application For Assistance – Section 5

Complete Section 5 if you are applying for:

- **Basic Care**
- **Health Care Coverage**
- **TANF**

Tell Us About Your Household

I/We have lived in North Dakota since (month, day, year): _____

Do you intend to remain in North Dakota? Yes No

List any children whose father's name is not listed on the birth certificate: _____

List each household member who is pregnant: _____

How many babies are due? _____ When is the due date? _____

How was pregnancy determined? Physician Public Health Agency Home Pregnancy Test

Other, specify: _____

List the father of the unborn baby: _____

Do you pay for guardianship or conservator services? Yes No

Do both parents (natural or adoptive) live together in the home with a child under age 19? Yes No

If yes, list the name of the parent who had the most income from employment or self-employment in the past 24 months: _____

Tell Us About Parents Not Living In The Home

List each child under age 21 whose parents do not live in the home:

| Name of Child Whose Parent Is Not Living in the Home | Name of Parent Who Is Not Living in the Home | Parent's Date of Birth | Parent's Social Security Number | Reason Parent Is Not Living in the Home Use Codes Below |
|---|---|--|---------------------------------------|---|
| | Mother: | | | |
| | Father: | | | |
| | Mother: | | | |
| | Father: | | | |
| | Mother: | | | |
| | Father: | | | |
| | Mother: | | | |
| | Father: | | | |
| AB - Abandoned AN - Legally Annulled AS - Attending School DE - Deceased | DI - Divorced JP - Jail/Prison LW - Looking for Work MC - Medical Care | MS - Military Service NM - Never Married PR - Parental Rights Terminated SE - Separated | | WO - Working Out of Town or State |

Tell Us About Your Life Insurance

Does any household member have life insurance? Yes No If yes, fill in the boxes below:

| Name of Insured Person | Name and Address of Company | Policy Number | Face Value | Owners |
|------------------------|-----------------------------|---------------|------------|--------|
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Tell Us About Your Medical Bills

Medicaid can help pay medical bills, including prescription costs, for up to three months prior to the month of your application. Would you like help paying any of these bills? Yes No

If yes, list each month: _____

Medicaid can allow unpaid medical bills older than three months to reduce your out-of-pocket costs. Do household members have unpaid medical bills older than three months? Yes No

If yes, explain: _____

Tell Us About Your Primary Care Provider (PCP)

Your primary care provider (PCP) is the doctor, clinic or HMO you see for medical care. List the doctor for each household member except for those age 65 or older, a refugee or disabled. If you do not have a primary doctor, list the clinic or HMO.

| Household Member | Name of PCP |
|------------------|-------------|
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Tell Us About Your Health Insurance Coverage

List household members who have health insurance:

| Persons Covered | Policy Holder Name and Address | Health Insurance Name and Address | Effective Date | Policy Number | Group Number | Monthly Premium | Type of Coverage Use Codes Below |
|-----------------|--------------------------------|-----------------------------------|----------------|---------------|--------------|-----------------|----------------------------------|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

- List all that apply
- | | | | |
|-----------------------------|---------------------|---------------------|--------------------------------------|
| A - Hospital | E - Vision | I - HMO Insurance | M - Medicine Supplement/Advantage |
| B - Doctor | F - Nursing Home | J - Court Ordered | N - Drug Insurance |
| C - Major Medical/Lab/X-Ray | G - Cancer | K - Medicare Part A | P - Workers Compensation or Accident |
| D - Dental | H - Champus/Tricare | L - Medicare Part B | V - Veterans |
| | | | W Medicare Part D |

Does anyone outside the household pay the premium? Yes No

If yes, who: _____

Do household members expect changes in health insurance coverage? Yes No

If yes, explain: _____

Does any household member's employer offer health insurance? Yes No

If yes, does the employer pay 50% or more of the premium? Yes No

If yes, list the name of the insurance? _____

Did anyone in your household have health insurance canceled or stopped within the last six months? Yes No

If yes, who: _____ Date coverage ended: _____

Reason: _____

Tell Us If You Receive Help With Your Medical Costs

Does anyone help pay your medical costs? Yes No

If yes, explain: _____

Do household members have medical problems due to an accident? Yes No

If yes, list the date and type of the accident: _____

Do household members have a pending legal action from which they may receive money or medical benefits (including inheritance)? Yes No

Tell Us Where You Got This Application

Where did you get this Health Care Coverage application (check only one)?

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> 1-877-KIDS-NOW | <input type="checkbox"/> Daycare | <input type="checkbox"/> Insurance Agent | <input type="checkbox"/> School |
| <input type="checkbox"/> Capitol in Bismarck | <input type="checkbox"/> Faith-Based Organization | <input type="checkbox"/> Internet | <input type="checkbox"/> Social Service Agency |
| <input type="checkbox"/> Caring for Children | <input type="checkbox"/> Food Pantry | <input type="checkbox"/> Medical Provider | <input type="checkbox"/> WIC |
| <input type="checkbox"/> Community Resource Coordinator | <input type="checkbox"/> Friend/Relative | <input type="checkbox"/> Pharmacy | <input type="checkbox"/> Other |
| | <input type="checkbox"/> Head Start | <input type="checkbox"/> Public Health Agency | |

Tell Us How You Found Out About Health Care Coverage

How did you find out about Health Care Coverage in North Dakota (check only one)?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Business/Service Club | <input type="checkbox"/> Food Pantry | <input type="checkbox"/> Medical Provider | <input type="checkbox"/> Radio |
| <input type="checkbox"/> Capitol in Bismarck | <input type="checkbox"/> Friend/Relative | <input type="checkbox"/> Newspaper/Magazine/Newsletter | <input type="checkbox"/> Social Service Agency |
| <input type="checkbox"/> Caring Program | <input type="checkbox"/> Head Start | <input type="checkbox"/> Pharmacy | <input type="checkbox"/> Television |
| <input type="checkbox"/> Daycare | <input type="checkbox"/> Insurance Agent | <input type="checkbox"/> Public Health Agency | <input type="checkbox"/> WIC |
| <input type="checkbox"/> Faith-Based Organization | <input type="checkbox"/> Internet | | <input type="checkbox"/> Other |

Information About Other Services For Children and Families

Caring For Children

If children listed on this application are not eligible for Health Care Coverage through either the Medicaid or Healthy Steps program, they may be eligible for the Caring for Children program. The North Dakota Caring Foundation, a private nonprofit organization, offers this program.

If you have children who are not eligible for Health Care Coverage through either Medicaid or Healthy Steps program, we may forward information from this application to the Caring for Children program. They will determine if any of the children listed are eligible for their program. If you do not want us to send the information to the North Dakota Caring Foundation, please check below:

- Check this box if you **do not** want us to forward information to the Caring for Children program.

Please note that the North Dakota Department of Human Services or county social services do not determine eligibility for the Caring for Children program and any appeal of their decision regarding this program must be made to the North Dakota Caring Foundation.

Child Support Enforcement

Child Support Enforcement (CSE) may help children get financial and medical coverage from parents who do not live in the home and who are or can be court ordered to provide financial or medical coverage.

Medical Coverage

If a child is eligible for Medicaid and a parent does not live in the home, we may make a referral to CSE. We will not make a referral for children who are eligible for Healthy Steps (Children's Health Insurance Program (SCHIP)). If you have a child eligible for the Healthy Steps Program and you would like assistance with CSE, please contact them at 1-800-231-4255.

Temporary Assistance for Needy Families (TANF)

If you receive TANF and one parent is not living in the home, your family will automatically be referred to CSE. You must cooperate with CSE in establishing paternity and in establishing and enforcing child support.

If you are interested in receiving Medicaid or TANF coverage for yourself and/or your children and you do not want assistance from CSE because your cooperation might not be in the best interest of your child (example: domestic violence situation), you may claim "good cause". If you do, a form SFN 446, will be sent to you to provide additional information so we can decide if there is "good cause".

Are you interested in claiming "good cause" for not cooperating with CSE? Yes No

Claiming "good cause" does not affect you or your child's eligibility for Medicaid and TANF.

Failure to cooperate with CSE does not affect your child's eligibility for Medicaid. However, if you choose not to cooperate with CSE efforts and you have not claimed "good cause" or your claim of "good cause" has been "denied, you will not be eligible for Medicaid coverage and TANF benefits. However, your children will continue to be eligible for Medicaid or Healthy Steps coverage, provided they meet all other program requirements.

Application For Assistance – Section 6

Read and sign Section 6 if you are applying for any one of the following:

- Basic Care
- Child Care Assistance
- Health Care Coverage
- SNAP
- TANF

Read The Following Information

I have received, reviewed and understand my rights and responsibilities as explained in the Guidebook.

I declare under penalty of law, the information on this application is correct. This includes information about identity, citizenship and alien status of the household members applying for assistance.

I understand that alien status information and other information will be verified when discrepancies are found. Verification received may affect eligibility and level of benefits.

I understand the information I provide on or with this application is subject to verification by federal, state and local officials to determine if the information is correct. If any of the information is incorrect, assistance may be denied and I may be subject to criminal prosecution for knowingly providing incorrect information.

I agree to report to the county social service office any changes in income, assets, or living arrangements as required.

I understand I will not receive a deduction for any allowable expenses I do not report and verify.

I understand that unless I have indicated otherwise for the Caring for Children program, in the 'Other Services' section above, information may be forwarded to the Caring for Children program so they can determine if any of the children listed on this application are eligible for their program.

I have been informed my household is authorized to receive TANF Information and Referral services. I have been given the Guidebook that has information about these services.

An individual who breaks any of the rules on purpose can be barred from SNAP for one year to permanently, fined up to \$250,000, imprisoned up to 20 years or both. An individual may also be subject to prosecution under other applicable federal and state laws and may also be barred from SNAP for additional 18 months if court ordered.

Any member of the household who intentionally breaks the rules may not get SNAP benefits for one year for the first offense, two years for the second offense and permanently for the third offense.

If a court of law finds you guilty of using or receiving benefits in a transaction involving the sale of a controlled substance, you will not be eligible for benefits for two years for the first offense, and permanently for the second offense.

If a court of law finds you guilty of having used or received benefits in a transaction involving the sale of firearms, ammunition or explosives you will be permanently ineligible to participate in SNAP upon the first offense.

If a court of law finds you guilty of having trafficked benefits for and aggregate amount of \$500 or more, you will be permanently ineligible to participate in SNAP upon the first offense.

If you are found to have made a fraudulent statement or representation with respect to the identity or place of residence in order to receive multiple SNAP benefits simultaneously, you will be ineligible to participate in SNAP for a period of 10 years.

In accordance with Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited for discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food and Nutrition Act and USDA policy, discrimination is prohibited also on the basis of religion and political beliefs.

To file a complaint of discrimination, contact USDA or HHS. Write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). Write HHS, Director, Office of Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TTY). USDA and HHS are equal opportunity providers and employers.

Authorization To Release Information

I/We authorize any person having custody or knowledge of the information relating to me or other household members to disclose any requested information, including confidential information other than protected health information, to any authorized agent of the North Dakota Department of Human Services. I also authorize the North Dakota Department of Human Services and the carrier providing Healthy Steps insurance to release to each other information regarding any services or benefits I received under Healthy Steps. This authorization will remain valid until canceled in writing or until coverage ends. A copy of this authorization is as valid as the original.

Sign and Date the Application Here

Signature of Applicant: _____ Date: _____

Other Signature (Spouse, Guardian or Other Adult): _____ Date: _____