



# General Instructions for Completing the Statement of Need

## PLEASE READ THIS PAGE CAREFULLY BEFORE FILLING OUT THIS FORM

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.

### Answer All Questions

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 yellow-boxed area beneath the question. 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

Write "SEE PAGE 25" if you run out of space. Turn to page 25, 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 a separate sheet, if necessary.

### Read pages 25, 26 and 27

These pages contain important information about your Rights and Responsibilities.

### About the Interview

Page 3 has a list of "Things to Bring for Your Interview." Be sure to bring all the documents listed.

### 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" blocks. 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 shown in these questions, you will get the maximum amount of food stamps allowed for your household. 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 can ask for assistance in getting documentation of the deductions and/or expenses from your agency representative. The agency representative may assist you by contacting other people for confirmation if you are having trouble getting written proof of deductions and/or expenses.

# STATEMENT OF NEED

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. The person filling out this document is the primary information source, and will usually be the FIP and/or Food Stamp recipient unless other arrangements are made with your agency representative.

Do not write in blue shaded areas. On the following pages list all members of your household. All of your answers must be complete, clear and correct before your application will be processed. If they are not, the form may be returned to you for more information. If you do not understand a question, see your agency representative for help. If you need more space to report information, use page 25 titled, “**For Applicant/Recipient Use Only**”.

## ELECTRONIC BENEFIT TRANSFER (EBT) CARD

FIP cash assistance and Food Stamp 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.

### THINGS TO BRING FOR YOUR INTERVIEW

- Birth Certificate for all household members
- Copy of marriage license, child support orders, proof of child support and/or alimony payments, divorce decree
- Death certificate of deceased parent for any dependent child for whom you may be applying or for any deceased MA applicant
- Proof of pregnancy, if pregnant
- Social Security numbers for all household members and absent parents
- If not a U.S. Citizen, proof of Immigration status
- Proof of identity (driver’s license, rent receipt, etc.)
- Life insurance policies and Burial contracts
- Proof of health insurance coverage
- Veteran’s claim number
- Pay stubs, pay envelopes, earnings statement and/or proof of last date worked and last pay
- Self-employed persons: Current Federal tax return, three current months bookkeeping records, or sales and expenditures records
- Proof of income from rental property
- 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
- Trust and annuity documents
- Deeds for any home or property
- Rent receipt/mortgage payment (including home insurance, taxes, and other shelter expenses)
- Proof of medical expenses such as: medications, hospital bills, doctor bills, or insurance premiums
- Child care receipts
- Utility receipts
- Vehicle registration (s)
- Copy of Power of Attorney or guardianship
- Public Assistance/MA/Food Stamp closing notice from another state

**If you try and are unable to obtain any of the above, the Agency will assist any cooperating households.**

### FOOD STAMPS (FS)

Your Food Stamp application will be considered from the date the signed form is received. If you are found eligible for food stamp 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 (FIP) (GPA)

If you are applying for FIP or GPA and are determined eligible for FIP or GPA benefits, those benefits will be determined from the date the signed application is received.

### MEDICAL ASSISTANCE (MA)

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**

**1****List everyone who lives in your home now.***(Be sure to list everyone, including any unborn children, even if they do not want assistance.)***HOUSEHOLD**

	Last Name (Maiden) First Initial				Relation to you	Assistance asked for <input checked="" type="checkbox"/>					Date Of Birth	Ver
	FS	FIP	MA	GPA		NONE						
1											___/___/___	
2											___/___/___	
3											___/___/___	
4											___/___/___	
5											___/___/___	
6											___/___/___	
7											___/___/___	
8											___/___/___	
9											___/___/___	
10											___/___/___	
11											___/___/___	
12											___/___/___	

**1a***If there are more people in your household, please list them on page 25 marked, "for applicant/recipient use only".*

Are you or is 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  If YES, Name of household member(s) \_\_\_\_\_ Date \_\_\_\_\_ State \_\_\_\_\_

Have you or anyone in your household ever been found by the Department through its 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 one's identity or place of residence in order to receive multiple benefits simultaneously under assistance from the Family Independence Program(TANF), Food Stamp Program, or Medical Assistance Program? YES  NO   
 If YES, Name of household member(s) \_\_\_\_\_ Date of finding/conviction \_\_\_\_\_ State \_\_\_\_\_

# MEMBERS

												MEMB	
	Social Security Number	Ver	Sex	Marital Status	Last Grade Completed	U.S. Citizen	Citizenship Date	Ver	Rel	Ver	Eth	Work Part	Tax Dep
1 (cont.)	____/____/____		F <input type="checkbox"/> M <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>							
2 (cont.)	____/____/____		F <input type="checkbox"/> M <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>							
3 (cont.)	____/____/____		F <input type="checkbox"/> M <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>							
4 (cont.)	____/____/____		F <input type="checkbox"/> M <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>							
5 (cont.)	____/____/____		F <input type="checkbox"/> M <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>							
6 (cont.)	____/____/____		F <input type="checkbox"/> M <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>							
7 (cont.)	____/____/____		F <input type="checkbox"/> M <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>							
8 (cont.)	____/____/____		F <input type="checkbox"/> M <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>							
9 (cont.)	____/____/____		F <input type="checkbox"/> M <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>							
10 (cont.)	____/____/____		F <input type="checkbox"/> M <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>							
11 (cont.)	____/____/____		F <input type="checkbox"/> M <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>							
12 (cont.)	____/____/____		F <input type="checkbox"/> M <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>							

*If there are more people in your household, please list them on page 25 marked, "for applicant/recipient use only".*

**ANSWER THIS IF YOU ARE APPLYING FOR FOOD STAMPS** and you live in a household with children under eighteen (18) and more than one adult parent or adult who has parental control over the children.

Your household must choose an adult parent of children living in the household, or an adult who has parental control over children under 18 years of age living in the household, to be the head of the household. All adult members must agree to the selection.

If you live in such a household, please designate the head of the household here. Name \_\_\_\_\_

**1b**

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	Initial	Veteran's Status		Applied for Veteran's Benefits	Date of Service	Serial Number	V.A. Claim Number
			Veteran	<input type="checkbox"/>	Yes <input type="checkbox"/>	___/___/___		
			Dependent	<input type="checkbox"/>	No <input type="checkbox"/>			
			Survivor	<input type="checkbox"/>				
			Veteran	<input type="checkbox"/>	Yes <input type="checkbox"/>	___/___/___		
			Dependent	<input type="checkbox"/>	No <input type="checkbox"/>			
			Survivor	<input type="checkbox"/>				
			Veteran	<input type="checkbox"/>	Yes <input type="checkbox"/>	___/___/___		
			Dependent	<input type="checkbox"/>	No <input type="checkbox"/>			
			Survivor	<input type="checkbox"/>				

**2**

Is there anyone in your household who is NOT a U.S. Citizen?

Yes No 

If yes, complete the boxes below about each person who is not a U.S. citizen.

ALIE

Last Name	First Name	Initial	Country of Origin	Alien Registration Number	Immigration Number
Alien Status:	<input type="checkbox"/> Refugee	Date of Entry	_____	INS Status Date	_____
	<input type="checkbox"/> Permanent Resident	Date of Entry	_____	Permanent Residence Date	_____
	<input type="checkbox"/> Other	Date of Entry	_____	INS Status Date	_____
Name of Sponsor			Sponsor's Address		Alien
Reside in RI Prior to 8/22/96			Yes <input type="checkbox"/>	No <input type="checkbox"/>	Origin
			Reside in RI Prior to 7/1/97	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Last Name	First Name	Initial	Country of Origin	Alien Registration Number	Immigration Number
Alien Status:	<input type="checkbox"/> Refugee	Date of Entry	_____	INS Status Date	_____
	<input type="checkbox"/> Permanent Resident	Date of Entry	_____	Permanent Residence Date	_____
	<input type="checkbox"/> Other	Date of Entry	_____	INS Status Date	_____
Name of Sponsor			Sponsor's Address		Alien
Reside in RI Prior to 8/22/96			Yes <input type="checkbox"/>	No <input type="checkbox"/>	Origin
			Reside in RI Prior to 7/1/97	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**3** 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      Drug Treatment Center      Hospital      Assisted Living Facility  
Group Home      Alcohol Treatment Center      Shelter for Battered Women      Dormitory

If yes, complete the boxes below about each person. G R O P

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

**4** Are you or anyone in the household who is sixteen (16) or older in school or a job-training program? Yes   
No

If yes, complete the boxes below about each person. S C H L

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 FIP	Count FS	MA	GPA

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 FIP	Count FS	MA	GPA

**5** 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. P A R E

Parent's Last Name	First Name	Initial	Child's Last Name	First Name	Initial	Ver	Child's Last Name	First Name	Initial	Ver
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**6** 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. E A T S

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

**7** 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	Ver	Last Name	First Name	Initial	Date Baby is Due	Ver
			___/___/___					___/___/___	

**8** 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	Ver	Review	Blind
Has this person applied for SSI or Social Security Benefits (RSDI)?				Yes [ ]	No [ ]				

**9** 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

Last Name	First Name	Initial	Social Security Number	Sex	Date of Birth	Date of Death	Ver				
			___/___/___	Male [ ] Female [ ]	___/___/___	___/___/___					
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

**10**

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

Yes No 

List as Absent Parent present or former husband for children born during that marriage, or within 10 months of a final decree of divorce from that husband. If divorce decree or court order excludes your husband or former husband as father of any of the child(ren) listed in the application, you need to list the biological father of the child(ren) and provide copies of the decree or order with this application.

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

Absent Parent's Last Name		First Name		Initial	Sex M [ ] F [ ]	Absent Parent's Social Security No. ____/____/____		Absent Parent's Birth Date ____/____/____		
Absent Parent's Address					Absent Parent's Telephone Number					
Employer Name				Employer Address			Is this absent parent disabled and/or a veteran? Yes [ ] No [ ]		Coop	
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 ____/____/____			Absent Parent's Marital Status Never Married [ ] Divorced [ ] Widowed [ ] Married [ ] Separated [ ] Unknown [ ]				
Child(ren) of the absent 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)			P
1.							Yes [ ] No [ ]	Support [ ] Health Cov [ ] Paternity [ ]	Date _____ Date _____ Date _____	
2.							Yes [ ] No [ ]	Support [ ] Health Cov [ ] Paternity [ ]	Date _____ Date _____ Date _____	
3.							Yes [ ] No [ ]	Support [ ] Health Cov [ ] Paternity [ ]	Date _____ Date _____ Date _____	
4.							Yes [ ] No [ ]	Support [ ] Health Cov [ ] Paternity [ ]	Date _____ Date _____ Date _____	
5.							Yes [ ] No [ ]	Support [ ] Health Cov [ ] Paternity [ ]	Date _____ Date _____ Date _____	

Absent Parent's Last Name		First Name		Initial	Sex M [ ] F [ ]	Absent Parent's Social Security No. ____/____/____		Absent Parent's Birth Date ____/____/____		
Absent Parent's Address					Absent Parent's Telephone Number					
Employer Name				Employer Address			Is this absent parent disabled and/or a veteran? Yes [ ] No [ ]		Coop	
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 ____/____/____			Absent Parent's Marital Status Never Married [ ] Divorced [ ] Widowed [ ] Married [ ] Separated [ ] Unknown [ ]				
Child(ren) of the absent 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)			P
1.							Yes [ ] No [ ]	Support [ ] Health Cov [ ] Paternity [ ]	Date _____ Date _____ Date _____	
2.							Yes [ ] No [ ]	Support [ ] Health Cov [ ] Paternity [ ]	Date _____ Date _____ Date _____	
3.							Yes [ ] No [ ]	Support [ ] Health Cov [ ] Paternity [ ]	Date _____ Date _____ Date _____	
4.							Yes [ ] No [ ]	Support [ ] Health Cov [ ] Paternity [ ]	Date _____ Date _____ Date _____	
5.							Yes [ ] No [ ]	Support [ ] Health Cov [ ] Paternity [ ]	Date _____ Date _____ Date _____	

# Question 10 (continued)

If yes, complete the boxes below about each absent parent and the children in this household of each absent parent.							A B S P		
Absent Parent's Last Name		First Name		Initial	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Absent Parent's Social Security No. ____/____/____		Absent Parent's Birth Date ____/____/____	
Absent Parent's Address					Absent Parent's Telephone Number				
Employer Name				Employer Address			Is this absent parent disabled and/or a veteran? Yes <input type="checkbox"/> No <input type="checkbox"/>		Coop
Were the parents of the child(ren) married to each other? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, date married ____/____/____			Are the parents of the child(ren) currently married to each other? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, date divorced ____/____/____			Absent Parent's Marital Status Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown <input type="checkbox"/>			
Child(ren) of the absent parent living in this household. Child's Last Name				State of Birth	Is child support, health coverage or paternity court ordered? (If yes, list date)				P
First		Initial			Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____		
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____		
						Paternity <input type="checkbox"/>	Date _____		
1.					Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____		
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____		
						Paternity <input type="checkbox"/>	Date _____		
2.					Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____		
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____		
						Paternity <input type="checkbox"/>	Date _____		
3.					Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____		
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____		
						Paternity <input type="checkbox"/>	Date _____		
4.					Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____		
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____		
						Paternity <input type="checkbox"/>	Date _____		
5.					Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____		
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____		
						Paternity <input type="checkbox"/>	Date _____		

Absent Parent's Last Name							First Name		Initial	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Absent Parent's Social Security No. ____/____/____		Absent Parent's Birth Date ____/____/____	
Absent Parent's Address							Absent Parent's Telephone Number							
Employer Name					Employer Address				Is this absent parent disabled and/or a veteran? Yes <input type="checkbox"/> No <input type="checkbox"/>		Coop			
Were the parents of the child(ren) married to each other? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, date married ____/____/____				Are the parents of the child(ren) currently married to each other? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, date divorced ____/____/____				Absent Parent's Marital Status Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown <input type="checkbox"/>						
Child(ren) of the absent parent living in this household. Child's Last Name					State of Birth	Is child support, health coverage or paternity court ordered? (If yes, list date)					P			
First		Initial			Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____							
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____							
						Paternity <input type="checkbox"/>	Date _____							
1.					Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____							
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____							
						Paternity <input type="checkbox"/>	Date _____							
2.					Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____							
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____							
						Paternity <input type="checkbox"/>	Date _____							
3.					Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____							
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____							
						Paternity <input type="checkbox"/>	Date _____							
4.					Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____							
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____							
						Paternity <input type="checkbox"/>	Date _____							
5.					Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____							
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____							
						Paternity <input type="checkbox"/>	Date _____							

**11**

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.

UNEM

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

**12**

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

Yes No 

If yes, complete the boxes below.

QUIT

Last Name	First Name	Initial	Reason for leaving job	Date left job _____/_____/_____	Pri	GC
Employer's Name			Employer's Address			
If anyone in the household has answered yes to this question, complete the section below for everyone age 16 or older in the household who has worked in the past two (2) months.						
Last Name	First Name	Initial	Gross earnings last month \$ _____	Gross earnings this month \$ _____	Total gross earning both months \$ _____	
Last Name	First Name	Initial	Gross earnings last month \$ _____	Gross earnings this month \$ _____	Total gross earning both months \$ _____	

**13**

Are you or anyone in the household on strike?

Yes No 

If yes, complete the boxes below about each person.

STRK

Last Name	First Name	Initial	Date strike began / /	Employer's Name	Employer's Address	Type
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**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 \$
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**15**

Do you, your spouse, or anyone in the household have his/her name on any accounts such as the types listed below?

Yes No **EXAMPLES**

Checking account   Credit union account   Savings certificate   Trust   Burial Set Aside   Annuity   IRA  
 Savings account   Money market account   Certificate of deposit   Keogh Plan   Retirement Accounts   College 529 Plan

If yes, complete the boxes below for each account.

BANK

Last Name	First Name	Initial	Type of account	Account number					Amount \$	Type
Co-owner name Address			Financial Institution ----- Address	Ver	Count FIP	Count FS	Count MA	Count GPA	MA Lien	

Last Name	First Name	Initial	Type of account	Account number					Amount \$	Type
Co-owner name Address			Financial Institution ----- Address	Ver	Count FIP	Count FS	Count MA	Count GPA	MA Lien	

Last Name	First Name	Initial	Type of account	Account number					Amount \$	Type
Co-owner name Address			Financial Institution ----- Address	Ver	Count FIP	Count FS	Count MA	Count GPA	MA Lien	

Last Name	First Name	Initial	Type of account	Account number					Amount \$	Type
Co-owner name Address			Financial Institution ----- Address	Ver	Count FIP	Count FS	Count MA	Count GPA	MA Lien	

Last Name	First Name	Initial	Type of account	Account number					Amount \$	Type
Co-owner name Address			Financial Institution ----- Address	Ver	Count FIP	Count FS	Count MA	Count GPA	MA Lien	

**15a**

Did you, your spouse, or anyone in the household receive a Social Security or 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 Camper Boat Snowmobile Truck Recreational Vehicle Motorcycle

If yes, complete the boxes below for each vehicle.

CARS

Owner's Last Name	First Name	Initial	Vehicle	Make	Model	Year	Blue book value \$ _____			
What is the vehicle used for?	Amount owed \$ _____	Ver	Vehicle ID Number	Registration Number	Count FIP	Count FS	Count MA	Count GPA	MA Lien	
Insurance Company										

Owner's Last Name	First Name	Initial	Vehicle	Make	Model	Year	Blue book value \$ _____			
What is the vehicle used for?	Amount owed \$ _____	Ver	Vehicle ID Number	Registration Number	Count FIP	Count FS	Count MA	Count GPA	MA Lien	
Insurance Company										

Owner's Last Name	First Name	Initial	Vehicle	Make	Model	Year	Blue book value \$ _____			
What is the vehicle used for?	Amount owed \$ _____	Ver	Vehicle ID Number	Registration Number	Count FIP	Count FS	Count MA	Count GPA	MA Lien	
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  
BondsPersonal Property (antiques, collections, jewelry, etc.)  
Life Insurance

Burial Contract

If yes, complete the boxes below.

RESO

**STOCKS, BONDS, OTHER**

Last Name	First Name	Initial	Type of Resource	Count FIP	Count FS	Ver
Co-owner's Last Name	First Name	Initial	Co-owner's Address	Count MA	Count GPA	MA Lien

Last Name	First Name	Initial	Type of Resource	Count FIP	Count FS	Ver
Co-owner's Last Name	First Name	Initial	Co-owner's Address	Count MA	Count GPA	MA Lien

Last Name	First Name	Initial	Type of Resource	Count FIP	Count FS	Ver
Co-owner's Last Name	First Name	Initial	Co-owner's Address	Count MA	Count GPA	MA Lien

**LIFE INSURANCE**

Last Name	First Name	Initial	Company Name	Policy Number	Type	Count FIP	Count FS	Ver
Owned By			Face Value	Cash Value	Loan Amount	Count MA	Count GPA	MA Lien

Last Name	First Name	Initial	Company Name	Policy Number	Type	Count FIP	Count FS	Ver
Owned By			Face Value	Cash Value	Loan Amount	Count MA	Count GPA	MA Lien

Last Name	First Name	Initial	Company Name	Policy Number	Type	Count FIP	Count FS	Ver
Owned By			Face Value	Cash Value	Loan Amount	Count MA	Count GPA	MA Lien

**BURIAL CONTRACT**

Last Name	First Name	Initial	Value	Irrevocable	Effective Date	Count FIP	Count FS	Ver
Funeral Home			Funeral Home Address			Count MA	Count GPA	MA Lien

Last Name	First Name	Initial	Value	Irrevocable	Effective Date	Count FIP	Count FS	Ver
Funeral Home			Funeral Home Address			Count MA	Count GPA	MA Lien

**18**

Do you, your spouse, or anyone in the household own any interest in any property such as land, buildings, life estate, time share, etc?

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			Ver	
				\$		\$				
How is the property owned? Solely <input type="checkbox"/> Jointly <input type="checkbox"/> Other <input type="checkbox"/>			Address of Property		Count FIP	Count FS	Count MA	Count GPA	MA Lien	Review Date
Is this property your home? Yes <input type="checkbox"/> No <input type="checkbox"/> ; The home of your spouse? Yes <input type="checkbox"/> No <input type="checkbox"/> ; Your dependents? Yes <input type="checkbox"/> No <input type="checkbox"/>										

**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

(Food Stamp eligibility is affected by transfers only within the past three (3) months.)

EXAMPLES

House  
Car

Bank Accounts  
Stocks

Bonds

If yes, complete the boxes below.

TRAN

Last Name	First Name	Initial	Resource Transferred			
Amount Transferred \$ _____	Date Transferred ____/____/____	What did you receive in return?	Allow FIP	Allow FS	Allow MA	Allow GPA

Last Name	First Name	Initial	Resource Transferred			
Amount Transferred \$ _____	Date Transferred ____/____/____	What did you receive in return?	Allow FIP	Allow FS	Allow MA	Allow GPA

Last Name	First Name	Initial	Resource Transferred			
Amount Transferred \$ _____	Date Transferred ____/____/____	What did you receive in return?	Allow FIP	Allow FS	Allow MA	Allow GPA

**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 into a trust within the last sixty(60) months?

Yes   
No

If yes, you must provide copies 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

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. JINC

Last Name			First Name			Initial			How often paid?			Employer Name		
Date Job Began / /			Day of Week Paid			Job held			[ ] Weekly      [ ] Every two weeks			Employer Address		
									[ ] Twice a month      [ ] Monthly					
									[ ] Other (how often)					
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	Recur	Ver							
1 <sup>st</sup>	/ /	/ /		\$	\$									
2 <sup>nd</sup>	/ /	/ /		\$	\$									
3 <sup>rd</sup>	/ /	/ /		\$	\$									
4 <sup>th</sup>	/ /	/ /		\$	\$	Count	Count							
5 <sup>th</sup>	/ /	/ /		\$	\$	FS	FIP							
Did you receive earned income tax credit in your paycheck? Yes [ ] No [ ]						Count	Count							
Is this an On the Job training program? Yes [ ] No [ ]						MA	GPA							
Is this job part of a work study program? Yes [ ] No [ ]						No. of hours	Expected Gross Earnings	Tips/Commissions						
Will this income be received in the following month? Yes [ ] No [ ]							\$	\$						

Last Name			First Name			Initial			How often paid?			Employer Name		
Date Job Began / /			Day of Week Paid			Job held			[ ] Weekly      [ ] Every two weeks			Employer Address		
									[ ] Twice a month      [ ] Monthly					
									[ ] Other (how often)					
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	Recur	Ver							
1 <sup>st</sup>	/ /	/ /		\$	\$									
2 <sup>nd</sup>	/ /	/ /		\$	\$									
3 <sup>rd</sup>	/ /	/ /		\$	\$									
4 <sup>th</sup>	/ /	/ /		\$	\$	Count	Count							
5 <sup>th</sup>	/ /	/ /		\$	\$	FS	FIP							
Did you receive earned income tax credit in your paycheck? Yes [ ] No [ ]						Count	Count							
Is this an On the Job training program? Yes [ ] No [ ]						MA	GPA							
Is this job part of a work study program? Yes [ ] No [ ]						No. of hours	Expected Gross Earnings	Tips/Commissions						
Will this income be received in the following month? Yes [ ] No [ ]							\$	\$						

## Question 20 (continued)

Last Name		First Name		Initial	How often paid? [ ] Weekly [ ] Every two weeks		Employer Name	
Date Job Began ____/____/____		Day of Week Paid		Job held	[ ] Twice a month [ ] Monthly		Employer Address	
					[ ] Other (how often) _____			
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	Recur	Ver
1 <sup>st</sup>	____/____/____	____/____/____			\$	\$		
2 <sup>nd</sup>	____/____/____	____/____/____			\$	\$		
3 <sup>rd</sup>	____/____/____	____/____/____			\$	\$		
4 <sup>th</sup>	____/____/____	____/____/____			\$	\$	Count	Count
5 <sup>th</sup>	____/____/____	____/____/____			\$	\$	FS	FIP
Did you receive earned income tax credit in your paycheck? Yes [ ] No [ ]							Count	Count
Is this an On the Job training program? Yes [ ] No [ ]							MA	GPA
Is this job part of a work study program? Yes [ ] No [ ]					List the number of hours you expect to be paid for next month.			
					No. of hours	Expected Gross Earnings	Tips/Commissions	
Will this income be received in the following month? Yes [ ] No [ ]						\$	\$	

**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 about each person who is injured.

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		

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 each person who receives the rent. R I N C

Last Name	First Name	Initial	Hours worked per week maintaining property	Total Number Of Units	Freq	Ver	Recur	Count FIP	Count FS	Count MA	Count GPA
Total Rent Received? \$ _____			How often? _____								
Does the person listed above live here? Yes [ ] No [ ]				Will the income be received in the following months? Yes [ ] No [ ]							
Rental Expense		How Often?	Rental Expense		How Often?		Rental Expense		How Often?		
Mortgage Principal	\$ _____	_____	Water	\$ _____	_____		Electric	\$ _____	_____		
Mortgage Interest	\$ _____	_____	Sewage	\$ _____	_____		Oil	\$ _____	_____		
Taxes	\$ _____	_____	Garbage	\$ _____	_____		Repairs	\$ _____	_____		
Insurance	\$ _____	_____	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 each person taking care of children. Attach documentation if you wish to claim actual expenses. D C I N

Last Name	First Name	Initial	Total Amount Received per week \$ _____	Number of weeks worked	Hours worked per week			Number of children cared for			
Will this income be received in the following months? Yes [ ] No [ ]					Freq	Ver	Recur	Count FIP	Count FS	Count MA	Count GPA

**24**

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

Yes   
No

If yes, complete the boxes below about each person. Attach documentation if you wish to claim actual expenses. R B I N

Name of person receiving payment			Number of hours worked per week							Recur
Last Name	First Name	Initial	Will this income be received in the following months? Yes [ ] No [ ]							
Names of Roomer/Boarders	Amount Received/How Often	Includes		Date Received	Freq	Ver	Count FIP	Count FS	Count MA	Count GPA
	\$ _____ 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.

**B U S I**

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 [ ]	Ver	Recur	Count FIP	Count FS	Count MA	Count GPA

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 [ ]	Ver	Recur	Count FIP	Count FS	Count MA	Count GPA

**26****RESERVED****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.

**S T I N**

Last Name	First Name	Initial	Amount received \$ _____	Period covered by grant/loan From _____ to _____	Date received ____/____/____		Date of last payment ____/____/____		
Type of Grant/Loan	Will this income be received in the following months? Yes [ ] No [ ]			Recur	Ver	Count FIP	Count FS	Count MA	Count GPA

Last Name	First Name	Initial	Amount received \$ _____	Period covered by grant/loan From _____ to _____	Date received ____/____/____		Date of last payment ____/____/____		
Type of Grant/Loan	Will this income be received in the following months? Yes [ ] No [ ]			Recur	Ver	Count FIP	Count FS	Count MA	Count GPA

**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	Lump Sum	Strike Benefits	Workers' Compensation
Earned Income Tax Credit Refund	Military Allotment	TDI	
Foster Care	Out of State Assistance	Trust Funds	

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

U N E A

Last Name	First Name	Initial	Amount/How Often \$ _____ per _____	Date Income Received ____/____/____	Claim Number					
Type of Income	Will this income be received in the following months? Yes [ ] No [ ]		Type	Freq	Ver	Recur	Count FIP	Count FS	Count MA	Count GPA

Last Name	First Name	Initial	Amount/How Often \$ _____ per _____	Date Income Received ____/____/____	Claim Number					
Type of Income	Will this income be received in the following months? Yes [ ] No [ ]		Type	Freq	Ver	Recur	Count FIP	Count FS	Count MA	Count GPA

Last Name	First Name	Initial	Amount/How Often \$ _____ per _____	Date Income Received ____/____/____	Claim Number					
Type of Income	Will this income be received in the following months? Yes [ ] No [ ]		Type	Freq	Ver	Recur	Count FIP	Count FS	Count MA	Count GPA

Last Name	First Name	Initial	Amount/How Often \$ _____ per _____	Date Income Received ____/____/____	Claim Number					
Type of Income	Will this income be received in the following months? Yes [ ] No [ ]		Type	Freq	Ver	Recur	Count FIP	Count FS	Count MA	Count GPA

If anyone in the household expects income in the future, fill in the boxes below for that person(s).

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

**28a**

Has anyone in the household ever received SSI and Social Security or RSDI in the same month?

Yes   
No

If yes, complete the box below.

Last Name	First Name	Initial	Year Received
-----------	------------	---------	---------------

\*(If you report and provide proof of your expenses shown in questions 29 through 38, you will get the maximum amount of food stamps allowed for your household. 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)

Yes

**29** Do you, your spouse, or anyone in the household pay for someone to baby-sit or care for a child or disabled adult who lives in the home? 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 _____			Amount of out-of-pocket Payment or co-payment \$ _____ per _____		
Name of person in care	Adult/Child Adult [ ] Child [ ]	Will this cost continue? Yes [ ] No [ ]		Freq	Type	Recur	Count FIP	Count FS	Count MA	Count GPA
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 _____			Amount of out-of-pocket Payment or co-payment \$ _____ per _____		
Name of person in care	Adult/Child Adult [ ] Child [ ]	Will this cost continue? Yes [ ] No [ ]		Freq	Type	Recur	Count FIP	Count FS	Count MA	Count GPA
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?	Freq	Ver
Last Name	First Name	Initial	Who is the person claiming?	Type of claim made Child Support [ ] Alimony [ ] Other tax dependent [ ]	Amount Paid \$ _____ How Often?	Freq	Ver

**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. R E N T

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			Type	Freq	Ver

**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	Type	Ver
			<b>First Mortgage</b> Principal \$ _____ per _____ Interest \$ _____ per _____ Includes Taxes [ ] Insurance [ ]			
			<b>Second Mortgage</b> Principal \$ _____ per _____ Interest \$ _____ per _____ Includes Taxes [ ] Insurance [ ]			
			Taxes \$ _____ per _____ (if not included in the mortgage)	Does anyone share the cost of this expense? Yes [ ] No [ ]		
			Insurance \$ _____ per _____	If yes, name the person sharing the expenses		
			Lot Rental \$ _____ per _____	What is the amount paid		
			Other \$ _____ per _____	By this person? \$ _____		

**33**

Do you, your spouse, or anyone in the household pay all, or a share of, the fuel or utilities?

Yes   
No

Did you get a Low Income Home Energy Assistance Act Grant at your current address in the last twelve (12) months?

Yes   
No

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

Last Name	First Name	Initial	Utility	Amount Paid/How Often	Used to Heat/Cool	Freq	Ver
			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 [ ]						LIHEAA	Ver
If yes, name of the person(s) sharing the heating or cooling costs _____						SUA	
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.

R B E X

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

**35**

If you are applying for food stamps, is there anyone in the household who is age sixty (60) or over or disabled, who incurs any medical expenses not covered by health insurance?

Yes   
No

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

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

F M E D

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

**IF YOU ARE APPLYING FOR FOOD STAMPS ONLY,  
DO NOT COMPLETE QUESTIONS 36, 37, OR 38 BELOW.**

**36**

Are you, your spouse, or anyone in the household covered by Medicare?

Yes   
No

If yes, complete the boxes below about each person.

M E D I

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

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

**37**

Are you, your spouse, or anyone in the household covered by a health insurance program or HMO other than Medicare, Medicaid, RItCare or RItShare?

Yes   
No

If no, is anyone eligible to be covered by a health plan offered by his or her employer?  Yes  No

If no, has anyone declined or voluntarily terminated health insurance coverage within the last four (4) months?  Yes  No

EXAMPLES    BlueCross/Blue Shield                      United HealthCare of New England  
                    BlueChip    Neighborhood Health Plan of RI

If yes, complete the boxes below. INSU

Policy Holder's name			Health Insurance Provider	Type of Coverage	Family <input type="checkbox"/>		If premium paid by you		
Last Name	First Name	Initial			Individual <input type="checkbox"/>	Amount/How Often			
Policy Number	Group Number		Is insurance provided by employer? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, name of employer providing insurance			Code	Type	Freq.
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			Health Insurance Provider	Type of Coverage	Family <input type="checkbox"/>		If premium pad by you		
Last Name	First Name	Initial			Individual <input type="checkbox"/>	Amount/How Often			
Policy Number	Group Number		Is insurance provided by employer? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, name of employer providing insurance			Code	Type	Freq.
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. MED X

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 # \_\_\_\_\_

## RIGHTS AND RESPONSIBILITIES

Of Applicants/Recipients of Family Independence Program (FIP),  
Food Stamps (FS), Medical Assistance (MA), and General Public Assistance (GPA)

### RIGHTS

**You have a RIGHT** to request, and if found eligible, to receive Financial or Medical Assistance or Food Stamps 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. Hearing forms, on which you may file your complaint, are available in every local and state office. 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 food stamps, thirty (30) days from the date you receive a written notice for FIP, Child Care, and Medical Assistance, and (10) days from the date you receive a written notice for GPA.

**You have a RIGHT** to refuse to provide information on your racial/ethnic heritage.

# RIGHTS AND RESPONSIBILITIES (continued)

Of Applicants/Recipients of Family Independence Program (FIP),  
Food Stamps (FS), Medical Assistance (MA), and General Public Assistance (GPA)

## RIGHTS

**You have a RIGHT** to non-discriminatory treatment. 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 Stamp Act; the Age Discrimination Act of 1975; the U.S. Department of Health and Human Services implementing regulation (45 C.F.R. Parts 80 and 84) and the U.S. Department of Education implementing regulation (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 Rhode Island Department of Human Services (DHS), does not discriminate on the basis of race, color, national origin (Limited English Proficiency persons), age, sex, disability, religion, or political beliefs, in acceptance for or provision of services, employment or treatment in its educational and other programs and 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 laws, regulations and DHS' discrimination complaint procedures for resolution of complaints of discrimination, contact DHS at 600 New London Avenue #57, 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; and 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 DHS' civil rights compliance.

Inquiries concerning the application of Title IX and 34 C.F.R Part 106 to DHS may also be made directly to the Assistant Secretary for Civil Rights, U.S. Department of Education, Washington, D.C. 20202 or the Office for Civil Rights, U.S. Department of Education, Region I, Boston, MA 02109.

To file a complaint of discrimination for Food Stamps, write to USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410, or call 1-866-632-9992 (for deaf/hearing impaired 711). USDA is an Equal Opportunity provider and employer.

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.

**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.

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 Food Stamp 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.

## 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 FIP Cash you must tell us immediately (within five (5) days) when a child leaves your household for any reason. For FS, if you are a simplified reporter, you must report when your income exceeds 130% of the Federal Poverty Level.**

**You have a RESPONSIBILITY** to provide Social Security numbers for yourself and your household, or to apply, if you are required to, for them as a condition of eligibility. Your Social Security number, as well as the Social Security numbers of all members of your household for whom you receive assistance, will be used in computer matching with the Department of Labor and Training, the Social Security Administration, the Internal Revenue Service, the Food and Nutrition Services, 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 Food Stamps, GPA, Child Care, FIP, and/or Medical Assistance. Social Security numbers are also used to prevent a person or family from receiving duplicate benefits under any program, to make mass changes in federal benefits easier to implement, and to determine the accuracy and reliability of information given to the Department by applicants for and recipients of assistance.

**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 food stamps allowed for your household. 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.

# DECLARATION OF APPLICANT/RECIPIENT

(Applicant must Read and Sign)

**I. FAMILY INDEPENDENCE PROGRAM, MEDICAL ASSISTANCE, AND GENERAL PUBLIC ASSISTANCE.**

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, 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 Department of Human Services. The Department of Human Services 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 Department of Human Services.

**b.) Regarding Amounts Recoverable from a Third Party**

I have assigned any and all rights to the Department of Human Services, 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 medical assistance 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 medical assistance 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 Medical Assistance Reimbursement**

The Department of Human Services may place a lien upon the estate of a Medical Assistance 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 Medical Assistance paid on behalf of a Medical Assistance 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 Department of Human Services. 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.

**e.) Regarding Annuities**

Under federal law, the State must be a beneficiary for any annuities I purchased or transacted on or after February 8, 2006.

I understand that as a condition of receiving FIP benefits, all persons for whom I am requesting FIP, unless exempt by law, are required to comply with the Family Independence 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 to provide documents to prove what I've said. 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 can authorize someone outside your home 1) to get your food stamp 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	Initial
Address	City	Zip

**III. FOOD STAMP PENALTY WARNINGS**

I understand that:

1. Any member of my household who intentionally breaks a food stamp rule can be barred from the Food Stamp 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 food stamp benefits in a transaction involving the sale of a controlled substance (as defined in section 102 of the Controlled Substances Act) firearms, ammunitions or explosives shall be permanently ineligible for the Food Stamp program upon the first occasion of such violation.
3. Individuals convicted of trafficking food stamp benefits of five hundred dollars (\$500) or more shall be permanently disqualified from the Food Stamp program.
4. Individuals found by the Department of having made, or convicted in a Federal or State court of having made, a fraudulent statement or representation with respect to their identity or place of residency in order to receive multiple benefits simultaneously under the Food Stamp program shall be disqualified for a ten (10) year period.

**DO NOT** give false information or hide information to get or continue to get food stamp benefits.

**DO NOT** trade or sell EBT cards.

**DO NOT** use food stamp benefits to buy ineligible items, such as alcoholic drinks and tobacco.

**DO NOT** use someone else's EBT card for your household.

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.

**IV. PENALTIES FOR PERJURY**

**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 CERTIFY, under penalty of perjury, that all of the information contained in this application is true.

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

