

# P E N N S Y L V A N I A

## Application for Benefits

**This is an application for cash, Medical Assistance and Food Stamp benefits. If you need this application in another language or someone to interpret, please contact your local County Assistance Office. Language assistance will be provided free of charge.**

**Esta es una solicitud de efectivo/asistencia médica y beneficios de cupones para alimentos. Si necesita esta solicitud en español o necesita que alguien se la interprete en otro idioma, comuníquese con la oficina de asistencia del condado (CAO) de su localidad. El servicio de intérprete se proporciona gratuitamente.**

Đây là mẫu đơn xin trợ cấp tiền mặt, Bảo Trợ Y Tế và Tem Phiếu Thực Phẩm. Nếu quý vị cần mẫu đơn bằng ngôn ngữ này hay cần người thông dịch, xin tiếp xúc với Văn Phòng Trợ Cấp Quận Hạt. Trợ giúp thông dịch sẽ được cung cấp miễn phí.

នេះជាសំបុត្រដាក់ពាក្យសុំប្រាក់ សំបុត្រពេទ្យ និង លុយប្លូតស្តែម (Food Stamp)។ ប្រសិនបើលោកអ្នកត្រូវការសំបុត្រដាក់ពាក្យសុំជាភាសានេះឬត្រូវការអ្នកណាម្នាក់ដោយបកប្រែសូមទាក់ទងការិយាល័យវិលវែររបស់លោកអ្នក។ ជំនួយខាងបកប្រែគឺជួយដោយឥតគិតថ្លៃ។

Настоящий документ является формой заявления на получение денежной и медицинской помощи, а также помощи продовольственными талонами (Food Stamps). Если вам нужна эта форма на русском языке или вам нужны услуги переводчика, обращайтесь в местное Бюро помощи (County Assistance Office). Помощь переводчика предоставляется бесплатно.

这是为现金、医疗协助及食物卷福利提出的申请。您如果需要使用此语言的申请或需要请人口译，请联系您的地方郡县协助办公室。语言协助免费提供。

## APPLICATION FOR BENEFITS

## COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE

- Read the entire application form.
- Print the requested information in the unshaded sections.
- If you need help completing this application, another person of your choosing can help you; you can get help from your County Assistance Office (CAO) or you can call the HELPLINE at 1-800-692-7462. If you are hearing impaired, call TDD 1-800-451-5886.
- We will accept your application during normal business hours.

You may apply for cash, Medical Assistance and/or food stamp benefits using this form. If we deny your application for cash and/or Medical Assistance benefits, or stop your cash and/or Medical Assistance benefits, you will not need to file a new application to receive or continue to receive food stamp benefits. If you or any of your children do not qualify for Medical Assistance, you or they may qualify for healthcare coverage through the Children's Health Insurance Program (CHIP) or the adultBasic program. You will not need to file a new application. A copy of this application will be provided to the Department of Insurance or to a CHIP or adultBasic contractor.

We will start your application if you complete your name, address and signature. **(Questions not marked optional must be answered before we can determine your eligibility.)**

You should complete the form, sign and date it. Bring it, have someone else bring it, or mail it to the CAO. Medical Assistance providers or other agencies approved by our Department may submit applications for Medical Assistance. If you return your application by mail, you will receive further instructions for completing the application process. We will tell you if a face-to-face interview is needed. You must prove your identity. If necessary, the CAO can help you to obtain proof of information.

We will tell you within 30 days after we receive your completed application whether or not you are eligible. Food stamp benefit eligibility starts from the date your application is received. If eligible for cash assistance, your benefits will begin on the date we receive all the information we requested. If an interview is required, and you do not appear or contact us within 30 days of application, your application will be denied.

The Department issues cash and food stamp benefits through the Electronic Benefits Transfer (EBT) System. This system allows you to use your EBT ACCESS card to obtain your cash benefits from certain Automatic Teller Machines (ATMs) 24 hours a day, or to buy items at stores that accept the card. The food stamp benefits on the EBT ACCESS card can be used for buying food or seeds and plants to grow food for personal consumption. You or your authorized representative must go to the CAO to obtain a personal identification number (PIN) and the EBT ACCESS card.

If you are applying for cash assistance, you and the caseworker who interviews you will complete an Agreement of Mutual Responsibility (AMR). The AMR stresses the temporary nature of cash assistance and describes the steps you agree to take that will help you support yourself and your family without welfare.

Your information is kept confidential; it is used only to administer the programs for which you may be eligible. Pages 13 and 17 of this document list your rights and responsibilities. Pages 17 and 18 will be given to you.

**You can apply online at:  
[www.compass.state.pa.us](http://www.compass.state.pa.us)**

**PLEASE READ REVERSE SIDE OF THIS PAGE**

# FOOD STAMPS NOW!



- DOES YOUR HOUSEHOLD HAVE \$100 OR LESS IN AVAILABLE CASH AND BANK ACCOUNTS AND EXPECT TO RECEIVE LESS THAN \$150 IN INCOME THIS MONTH?
- ARE YOU A MIGRANT OR SEASONAL FARM WORKER?
- ARE YOUR MONTHLY GROSS INCOME AND CASH ON HAND LESS THAN YOUR RENT/MORTGAGE AND UTILITY COSTS FOR THIS MONTH?

IF THE ANSWER TO ANY OF THESE QUESTIONS IS YES, YOU MAY HAVE A RIGHT TO EXPEDITED FOOD STAMPS. This means you can get Food Stamps within five days. Ask for more information by contacting the local County Assistance Office.

**FILE YOUR FOOD STAMP APPLICATION TODAY!** It is **YOUR RIGHT** to file an application today at **ANY TIME** before 5 p.m. The person at the County Assistance Office should date-stamp your application while you watch.

If you are denied expedited food stamps, you have the right to an agency conference within two working days with a supervisor at the County Assistance Office.

If you believe you are being denied your rights or services, or if the County Assistance Office does not take your application when you hand it in, and date-stamp it while you watch, ask to talk to a supervisor or call the HELPLINE toll free at 1-800-692-7462.

**YOU CAN GET FREE LEGAL HELP AT THE LOCAL LEGAL SERVICES OFFICE.**

This is an equal opportunity program. If you believe you have been discriminated against because of race, color, national origin, age, sex, disability, political beliefs, or religion, write:

**USDA, Director, Office of Civil Rights,  
Room 326-W, Whitten Building  
14th and Independence Ave, SW  
Washington, DC 20250-9410**

or call 202-720-5964 (Voice or TDD).

PLEASE READ AND REMOVE THIS PAGE BEFORE COMPLETING APPLICATION



**COMPLETE THIS PAGE FOR YOURSELF AND EVERYONE WHO LIVES AT YOUR ADDRESS, EVEN IF THEY ARE NOT APPLYING**

**FOR EDUCATION**

**TELL US THE HIGHEST GRADE LEVEL COMPLETED BY EACH PERSON**

USE 98 FOR CHILDREN WHO HAVE NOT COMPLETED FIRST GRADE

- 01-11 = ACTUAL GRADE LEVEL COMPLETED
- 12 = HIGH SCHOOL DIPLOMA, GED OR NEDP
- 13 = ASSOCIATE DEGREE
- 14 = BACHELOR'S DEGREE

- 15 = GRADUATE DEGREE (MASTER'S OR HIGHER)
- 16 = OTHER DEGREES, CERTIFICATES OR DIPLOMAS
- 98 = NO FORMAL EDUCATION
- 99 = UNKNOWN

Name any person who lives with you but is temporarily staying somewhere else. If you are applying for this person, list the person in the section below also.

**\*Responsibility to provide or apply for a Social Security Number (SSN).**

If you are applying for:

- Cash Assistance: You must provide or apply for a SSN for you or anyone for whom you are applying, and you must provide a SSN for anyone whose income or resources may affect the eligibility or benefit amount of you or anyone for whom you are applying.
- Food Stamp Benefits: You must provide or apply for a SSN for you or anyone for whom you are applying.
- Medical Assistance: You must provide or apply for a SSN for you or anyone for whom you are applying unless the person is an alien seeking emergency Medical Assistance only.

If you do not qualify for a SSN because of your immigration status, and you are not applying for assistance for yourself, your income and resources must still be considered in determining eligibility or benefit amount of the persons for whom you are responsible.

SSNs for any other individuals are not required. If you have any questions about providing a SSN, contact the County Assistance Office.

**PLEASE PRINT ALL INFORMATION**

COUNTY OFFICE USE		PRINT YOUR NAME FIRST		MIDDLE INITIAL	JR/SR I, II	ARE YOU APPLYING FOR THIS PERSON?	ALIAS MAIDEN NAME FORMER MARRIED NAME	BIRTHDATE	SEX	SOCIAL * SECURITY NUMBER	HOW IS EACH PERSON RELATED TO YOU?	EDUCATION
LINE #	FILE CLEARANCE	LAST NAME	FIRST NAME									
						<input type="checkbox"/> YES <input type="checkbox"/> NO					SELF	
						<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						



## VOTER REGISTRATION (Optional)

Are you or any other adult in your household interested in registering to vote? If the answer is "yes" enter name(s) below.

**To register you must: 1) Be at least age 18 on the day of the next election; 2) Be a citizen of the United States for at least one month PRIOR TO THE NEXT ELECTION; 3) Reside in Pennsylvania and the voting district at least one month prior to the next election.**

LINE NO CAO ONLY	LAST NAME	FIRST NAME

LINE NO CAO ONLY	LAST NAME	FIRST NAME

Your benefits will not be affected if you do not register. If you need help filling out the voter registration form, we will help you. The decision to seek or accept voter registration help is yours.

**DO NOT COMPLETE - COUNTY ASSISTANCE OFFICE USE**

<input type="checkbox"/> GIVEN TO CLIENT	/ DATE /	<input type="checkbox"/> HAND CARRIED TO COUNTY VOTER REGISTRATION	/ DATE /	<input type="checkbox"/> MAILED TO COUNTY VOTER REGISTRATION OFFICE	/ DATE /
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**CRIMINAL HISTORY INQUIRY - MANY PEOPLE WITH CRIMINAL RECORDS CAN STILL GET BENEFITS.**

**If you are applying for:**

- **cash assistance or food stamp benefits you must answer all of the following questions for yourself and anyone for whom you are applying.**
- **Medical Assistance only, you must answer question #1 for yourself and anyone else for whom you are applying.**

**If you answer "yes" to a question, name the household member to whom the answer applies.**

Have you or anyone for whom you are applying:

1.  Yes  No ever been issued a summons or warrant to appear as a defendant at criminal court? Household member(s) \_\_\_\_\_
2.  Yes  No ever been convicted for a felony or misdemeanor offense? Household member(s) \_\_\_\_\_
3.  Yes  No been convicted of a felony offense committed after August 22, 1996 related to possession, distribution and/or use of a controlled substance? Household member(s) \_\_\_\_\_
4.  Yes  No ever been convicted of welfare fraud? Household member(s) \_\_\_\_\_
5.  Yes  No ever received a court order to pay fines, costs or restitution related to a criminal conviction? Household member(s) \_\_\_\_\_
6.  Yes  No ever been on probation or parole or in an Accelerated Rehabilitative Disposition (ARD) program? Household member(s) \_\_\_\_\_
7.  Yes  No ever fled or are currently fleeing from law enforcement officials? Household member(s) \_\_\_\_\_

**ANSWER ALL YES AND NO QUESTIONS - FOR YES ANSWERS, COMPLETE THE UNSHADED BLOCKS**

The following information will be used to determine eligibility for benefits only; it will not be released to any other parties.

**RFUG**

YES  NO **Is anyone applying who is not a U.S. citizen?** **SKIP THIS BLOCK IF THIS APPLICATION IS FOR EMERGENCY MEDICAL BENEFITS ONLY.**

NAME OF PERSON WHO IS NOT A CITIZEN	DATE ENTERED THE U.S. MONTH DAY YEAR	FROM WHAT COUNTRY	ALIEN REGISTRATION NUMBER	INS SECTION

YES  NO **Does anyone listed above have a sponsor?**

SPONSOR NAME (Last, First, Middle)	PERSON / ORGANIZATION NAME	SPONSOR OR ORGANIZATION ADDRESS (Street, City, State, Zip Code)		

SPONSOR'S INCOME / RESOURCES	TYPE / SOURCE	HOW MUCH	HOW OFTEN

**SCH**

YES  NO **Is anyone a student? (elementary, middle, high school, college, training, or vocational school)**

NAME	NAME OF SCHOOL	GRADE	TYPE OF SCHOOL	PART TIME OR FULL TIME <input checked="" type="checkbox"/>	EXPECTED GRAD. DATE MONTH DAY YEAR
				<input type="checkbox"/> PART TIME   <input type="checkbox"/> FULL TIME	
				<input type="checkbox"/> PART TIME   <input type="checkbox"/> FULL TIME	
				<input type="checkbox"/> PART TIME   <input type="checkbox"/> FULL TIME	

**VET / SVI**

YES  NO **Is anyone a veteran or active in the military, national guard, or reserves?**

NAME	SOCIAL SECURITY NUMBER	BRANCH OF SERVICE	DATE ENTERED MONTH DAY YEAR	DATE LEFT MONTH DAY YEAR	VETERAN CLAIM #

YES  NO **Is anyone a widow, parent, spouse, or minor child of a veteran?**

NAME	NAME OF VETERAN	BRANCH OF SERVICE	DATE ENTERED MONTH DAY YEAR	DATE LEFT MONTH DAY YEAR	VETERAN CLAIM #

**DIS / INC**

YES  NO Is anyone disabled, seriously ill, or in need of medical attention?

YES  NO Is anyone receiving treatment or in need of help to overcome a drug or alcohol problem?

YES  NO Does anyone require health sustaining medication?

YES  NO Has anyone applied for or received, or is anyone currently receiving RSDI (Social Security) or Supplemental Security Income (SSI)?

YES  NO Did anyone's SSI stop because of an increase in or receipt of Social Security benefits?

YES  NO Does a parent have a physical or mental disability that affects the ability to care for a child?

YES  NO Is or has anyone been a victim of domestic violence?

NAME	DESCRIBE THE DISABILITY	DATE DISABILITY BEGAN MONTH DAY YEAR

**IF YOU ARE APPLYING FOR FOOD STAMPS ONLY, SKIP PAGES 6 AND 7**

**USE THIS PAGE FOR ANY PARENT AND/OR SPOUSE NOT LIVING IN YOUR HOUSEHOLD**

**ABS REL**

YES  NO Does any unmarried child under age 21 have a mother or father who is not living with you or who is deceased?

YES  NO Does anyone have a husband or wife who is not living with you or who is deceased?

**If you answered yes to either or both questions, give the following information for each relative. Complete a separate section for each relative.**

1	NAME OF RELATIVE (Last, First, Middle)		<input checked="" type="checkbox"/> IF DECEASED	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	RACE	BIRTHDATE (MM/DD/YYYY)	SOCIAL SECURITY #	HOW THIS PERSON IS RELATED TO YOU		
	ADDRESS (Street, City, State)							ZIP CODE	PHONE NUMBER	
	NAME OF RELATIVE'S EMPLOYER (Current or most recent)				EMPLOYER'S ADDRESS (Street, City, State)			ZIP CODE	PHONE NUMBER	
	NAMES FROM PAGE 2 THAT THIS PERSON IS RESPONSIBLE FOR				IF THE RELATIVE HAS MEDICAL INSURANCE FOR THESE DEPENDENTS, COMPLETE THE POLICY # AND COMPANY					
					POLICY NUMBER	NAME OF INSURANCE COMPANY				
	IF THIS RELATIVE PAYS SUPPORT OR IF HE SHOULD BE PAYING SUPPORT - COMPLETE THE FOLLOWING									
	FOR VOLUNTARY SUPPORT		HOW MUCH \$	HOW OFTEN		LAST DATE PAID (MM/DD/YYYY)		PAID TO WHOM		
	FOR COURT ORDERED SUPPORT		COURT ORDER #	AMOUNT \$	HOW OFTEN IT IS PAID	DATE OF ORDER (MM/DD/YYYY)	WHAT ARE THE SPECIAL TERMS -IF ANY		COUNTY COURT NAME	
	2	NAME OF RELATIVE (Last, First, Middle)		<input checked="" type="checkbox"/> IF DECEASED	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	RACE	BIRTHDATE (MM/DD/YYYY)	SOCIAL SECURITY #	HOW THIS PERSON IS RELATED TO YOU	
ADDRESS (Street, City, State)							ZIP CODE	PHONE NUMBER		
NAME OF RELATIVE'S EMPLOYER (Current or most recent)				EMPLOYER'S ADDRESS (Street, City, State)			ZIP CODE	PHONE NUMBER		
NAMES FROM PAGE 2 THAT THIS PERSON IS RESPONSIBLE FOR				IF THE RELATIVE HAS MEDICAL INSURANCE FOR THESE DEPENDENTS, COMPLETE THE POLICY # AND COMPANY						
				POLICY NUMBER	NAME OF INSURANCE COMPANY					
IF THIS RELATIVE PAYS SUPPORT OR IF HE SHOULD BE PAYING SUPPORT - COMPLETE THE FOLLOWING										
FOR VOLUNTARY SUPPORT		HOW MUCH \$	HOW OFTEN		LAST DATE PAID (MM/DD/YYYY)		PAID TO WHOM			
FOR COURT ORDERED SUPPORT		COURT ORDER #	AMOUNT \$	HOW OFTEN IT IS PAID	DATE OF ORDER (MM/DD/YYYY)	WHAT ARE THE SPECIAL TERMS -IF ANY		COUNTY COURT NAME		

ENTER INFORMATION FOR ADDITIONAL PARENTS AND/OR A SPOUSE NOT LIVING IN YOUR HOUSEHOLD ON THE NEXT PAGE

## USE THIS PAGE FOR ADDITIONAL PARENTS OR A SPOUSE NOT LIVING IN YOUR HOUSEHOLD.

NAME OF RELATIVE (Last, First, Middle)		<input type="checkbox"/> IF DECEASED	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	RACE	BIRTHDATE (MM/DD/YYYY)	SOCIAL SECURITY #	HOW THIS PERSON IS RELATED TO YOU		
ADDRESS (Street, City, State)							ZIP CODE	PHONE NUMBER	
NAME OF RELATIVE'S EMPLOYER (Current or most recent)				EMPLOYER'S ADDRESS (Street, City, State)			ZIP CODE	PHONE NUMBER	
3	NAMES FROM PAGE 2 THAT THIS PERSON IS RESPONSIBLE FOR			IF THE RELATIVE HAS MEDICAL INSURANCE FOR THESE DEPENDENTS, COMPLETE THE POLICY # AND COMPANY					
				POLICY NUMBER			NAME OF INSURANCE COMPANY		
	IF THIS RELATIVE PAYS SUPPORT OR IF HE SHOULD BE PAYING SUPPORT - COMPLETE THE FOLLOWING								
	FOR VOLUNTARY SUPPORT	HOW MUCH \$	HOW OFTEN	LAST DATE PAID (MM/DD/YYYY)	PAID TO WHOM				
FOR COURT ORDERED SUPPORT	COURT ORDER #	AMOUNT \$	HOW OFTEN IT IS PAID	DATE OF ORDER (MM/DD/YYYY)	WHAT ARE THE SPECIAL TERMS -IF ANY		COUNTY COURT NAME		
NAME OF RELATIVE (Last, First, Middle)		<input type="checkbox"/> IF DECEASED	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	RACE	BIRTHDATE (MM/DD/YYYY)	SOCIAL SECURITY #	HOW THIS PERSON IS RELATED TO YOU		
ADDRESS (Street, City, State)							ZIP CODE	PHONE NUMBER	
NAME OF RELATIVE'S EMPLOYER (Current or most recent)				EMPLOYER'S ADDRESS (Street, City, State)			ZIP CODE	PHONE NUMBER	
4	NAMES FROM PAGE 2 THAT THIS PERSON IS RESPONSIBLE FOR			IF THE RELATIVE HAS MEDICAL INSURANCE FOR THESE DEPENDENTS, COMPLETE THE POLICY # AND COMPANY					
				POLICY NUMBER			NAME OF INSURANCE COMPANY		
	IF THIS RELATIVE PAYS SUPPORT OR IF HE SHOULD BE PAYING SUPPORT - COMPLETE THE FOLLOWING								
	FOR VOLUNTARY SUPPORT	HOW MUCH \$	HOW OFTEN	LAST DATE PAID (MM/DD/YYYY)	PAID TO WHOM				
FOR COURT ORDERED SUPPORT	COURT ORDER #	AMOUNT \$	HOW OFTEN IT IS PAID	DATE OF ORDER (MM/DD/YYYY)	WHAT ARE THE SPECIAL TERMS -IF ANY		COUNTY COURT NAME		

**IF YOU HAVE MORE RELATIVES TO LIST - ASK THE RECEPTIONIST FOR AN EXTRA PAGE**

**ANSWER ALL YES AND NO QUESTIONS - FOR YES ANSWERS, COMPLETE THE UNSHADED BLOCKS**

**WRK HST**

- YES  NO 1. Does anyone in your household have a job?  
 YES  NO 2. Did you or anyone else in your household have a reduction in the number of hours worked?  
 YES  NO 3. Has anyone in your household worked in the last five years?

▶ If "yes" complete the unshaded blocks

NAME	EMPLOYER'S NAME	EMPLOYER'S ADDRESS (Street, City, State, Zip)	PHONE	START DATE MO / DAY / YR	END DATE MO / DAY / YR	# OF HOURS WORKED PER WEEK

YES  NO Is anyone on strike? If yes, who? ▶ When did the strike start? ▶ MO DAY YR

**SKIP THIS BLOCK IF YOU ARE APPLYING FOR FOOD STAMP BENEFITS ONLY**

**HIPP**

- YES  NO If you or anyone else in your household is employed, is medical insurance available through an employer for you or anyone in your family?  
 YES  NO Did the loss of a job within the last 30 days cause the loss of medical insurance for anyone in your household?  
 YES  NO Is there someone in your family who is pregnant?  
 YES  NO Is there someone in your family who is seriously ill?

NAME	ILLNESS	PREGNANCY DUE DATE

**SKIP THIS BLOCK IF YOU ARE APPLYING FOR MEDICAL ASSISTANCE ONLY AND ARE PREGNANT, UNDER AGE 21, OR HAVE A DEPENDENT CHILD UNDER AGE 21 LIVING WITH YOU**

**MISC**

Does anyone have any of the following resources?

- YES  NO Cash on hand (01)       YES  NO U.S. Savings Bonds (05)       YES  NO Family Savings Account (FSA)  
 YES  NO Savings Account (02)       YES  NO Christmas or Vacation Club (04)  
 YES  NO Checking Account (03)       YES  NO Stocks or Bonds (05)       YES  NO IRA, KEOGH or other retirement plan (27)  
 YES  NO Certificate of Deposit (26)       YES  NO Trust Fund (06)  
 YES  NO Savings Certificate (26)       YES  NO Boat / Snowmobile / Camper (14)

NAME OF OWNER	TYPE / ACCOUNT # / LOCATION OF THE RESOURCE	CURRENT VALUE	NAME OF OWNER	TYPE / ACCOUNT # / LOCATION OF THE RESOURCE	CURRENT VALUE
		\$			\$
		\$			\$

YES  NO Is anyone expecting money or any type of resource such as, but not limited to, an accident settlement, inheritance, trust fund or other resource?

If yes, type of resource ▶ Value ▶ When to be received, date ▶

YES  NO Has anyone sold, transferred, or given away a home, land, personal property or other resource in the past 36 months?

If yes, describe the type of property ▶ Value ▶ Date ▶

**SKIP THIS PAGE IF YOU ARE APPLYING FOR MEDICAL ASSISTANCE ONLY AND ARE PREGNANT, UNDER AGE 21, OR HAVE A DEPENDENT CHILD UNDER AGE 21 LIVING WITH YOU**

**ANSWER ALL YES AND NO QUESTIONS - FOR YES ANSWERS, COMPLETE THE UNSHADED BLOCKS**

**MV**

YES  NO **Does anyone own or is anyone buying a car, truck, or motorcycle?**

If you have a recreational vehicle such as a camper, boat or motor home, list it as a MISC. RESOURCE on page 8

NAME(S) OF OWNER	YEAR	MAKE	MODEL	LICENSED	LICENSE PLATE NUMBER	AMT OWED	MONTHLY CAR PAYMENT
				<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			

**INS**

YES  NO **Does anyone have a life insurance policy? (SKIP THIS BLOCK IF YOU ARE APPLYING FOR FOOD STAMP BENEFITS ONLY)**

POLICY OWNER	NAME OF INSURANCE COMPANY / POLICY NUMBER	FACE VALUE	CASH VALUE	WHO IS COVERED
			\$	
			\$	
			\$	
			\$	

YES  NO **Is anyone covered by an accident policy? (Do not list medical or car insurance here)**

<b>If Yes</b>	Insurance Company	Type of Policy (Accident, Dismemberment, disability etc.)
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**BRL**

YES  NO **Does anyone own a burial space or plot?**

OWNER OF SPACES	NUMBER OF SPACES	VALUE	AMOUNT OWED	NAME OF CEMETERY
		\$	\$	
		\$	\$	

YES  NO **Does anyone have a burial agreement with a bank or funeral home?**

OWNER OF AGREEMENT	BANK / FUNERAL HOME NAME	BANK / FUNERAL HOME ADDRESS (Street, City, State, Zip)

**SKIP THIS BLOCK IF YOU ARE APPLYING FOR MEDICAL ASSISTANCE ONLY AND ARE PREGNANT, UNDER AGE 21, OR HAVE A DEPENDENT CHILD UNDER AGE 21 LIVING WITH YOU**

**PROP**

YES  NO Does anyone own or is anyone buying a non-resident property or a non-resident mobile home?  
If yes, complete the unshaded blocks.

NAME	DATE PURCHASED	MARKET VALUE	NAMES ON DEED / AGREEMENT
	MONTH DAY YEAR	\$	
PROPERTY ADDRESS (Street, Township, City, State, Zip)			
NAME	DATE PURCHASED	MARKET VALUE	NAMES ON DEED / AGREEMENT
	MONTH DAY YEAR	\$	
PROPERTY ADDRESS (Street, Township, City, State, Zip)			

**MED EXP**

**List any UNPAID medical bills.**

NAME OF PERSON WITH BILL	FREQUENCY	AMOUNT TO BE PAID	WHO PROVIDED SERVICE	TYPE OF BILL (Dr., Hospital, Prescriptions, etc.)	DATE OF SERVICE
		\$			MONTH DAY YEAR
		\$			
		\$			

**List any medical bills PAID in the last three months prior to the month of the application and/or any paid in the month of application.**

NAME OF PERSON WHO PAID BILL	FREQUENCY	AMOUNT	WHO PROVIDED SERVICE	TYPE OF BILL (Dr., Hospital, Prescriptions, etc.)	DATE PAID
		\$			MONTH DAY YEAR
		\$			
		\$			
		\$			

**ANSWER ALL YES AND NO QUESTIONS - FOR YES ANSWERS, COMPLETE THE UNSHADED BLOCKS**

**SHEL**

YES  NO Do you pay for heating or cooling?

YES  NO Do you share expenses?

YES  NO Is the bill for heating and air conditioning mailed to someone living in your household?

If yes, with whom?

YES  NO Did you receive Energy Assistance (LIHEAP) since last October 1st?

What expenses are shared (rent/utilities or both)

YES  NO Do you have utility costs other than heating, cooling, or phone?

How much do you contribute?

YES  NO Are your meals included in your rent?

**LIST YOUR HOUSEHOLD EXPENSES**

EXPENSES	HOW MUCH	HOW OFTEN	EXPENSES	YES	NO	EXPENSES	YES	NO
RENT OR MORTGAGE	\$		TELEPHONE			WATER		
PROPERTY TAXES (City, County, School)	\$		ELECTRIC			SEWERAGE		
HOMEOWNER'S PROPERTY INSURANCE	\$		GAS			GARBAGE		
OTHER SUCH AS LOT RENT, CONDO FEES KEROSENE, ETC.	\$		OIL/COAL/WOOD			UTILITY INSTALLATION		

YES  NO Does anyone outside your household pay any of your expenses? If so, what?  How much? \$  To whom?

**INCOME**

YES  NO DOES ANYONE IN YOUR HOUSEHOLD HAVE ANY INCOME?

If yes, list any income you have already received this month or expect to receive this month

*Income includes,  
but is not limited to:*

WAGES  
SELF EMPLOYMENT  
BABYSITTING

ROOM AND BOARD  
RENT  
SOCIAL SECURITY

SSI  
SUPPORT  
SICK BENEFITS

UNEMPLOYMENT OR WORKER'S COMPENSATION  
MONEY FOR TRAINING  
DIVIDENDS OR INTEREST

PENSIONS  
COMMISSIONS  
UNION PAY

NAME	TYPE / SOURCE OF INCOME	HOW MUCH	HOW OFTEN	DATE RECEIVED
		\$		
		\$		
		\$		

**List benefits anyone has applied for but has not received such as Unemployment Compensation, Workers' Compensation, Social Security, or SSI.**

NAME	TYPE / SOURCE OF INCOME	DATE APPLIED			HOW MUCH	WHEN YOU EXPECT IT
		MONTH	DAY	YEAR		
		/	/		\$	
		/	/		\$	

**List the expenses related to the care of a child or disabled adult in your household, incurred by anyone who is working, looking for work or going to school or training.**

NAME OF PERSON WHO NEEDS CARE	NAME OF CARE GIVER	HOW MUCH	HOW OFTEN
		\$	
		\$	

**List information about child support that you or another household member pays to a person who does not live with you.**


NAME OF PERSON WHO PAYS	NAME OF CHILD	AMOUNT OF SUPPORT ORDER	AMOUNT ACTUALLY PAID	HOW OFTEN
		\$	\$	
		\$	\$	

**List the expenses anyone has in order to receive income, such as transportation or legal fees.**

NAME	ROUND TRIP MILES TO WORK	OTHER TRANSPORTATION COSTS	LEGAL FEES	BANK OR OTHER FEES

**COUNTY OFFICE USE ONLY**

- YES  NO Is anyone in the application group receiving food stamps and is not in a certified shelter for battered women and children?
- YES  NO Is there any postponed verification from a previous expedited issuance that the household must provide?
- YES  NO Are the household liquid resources equal to or less than \$100?
- YES  NO Is the countable monthly gross income less than \$150?
- YES  NO Is this a migrant or seasonal farm worker household?
- YES  NO Is the household destitute?
- YES  NO Are combined monthly gross income and liquid resources less than monthly shelter expenses?

EXPEDITED REVIEW	INITIALS	DATE
<input type="checkbox"/> ELIGIBLE		<input type="checkbox"/> DENIED - CLIENT NOTIFIED
REASON FOR DENIAL		
REGISTERED FOR CATEGORIES 		

## CLIENT'S RIGHTS

### RIGHT TO NONDISCRIMINATION

In accordance with Federal law and the Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs. For information on filing a complaint, refer to page 17.

### RIGHT TO APPEAL

You have the right to ask for a Pennsylvania Department of Public Welfare hearing to appeal a decision of or failure to act by the Department which affects your benefits or that you believe is unfair or incorrect. You may file the appeal at the County Assistance Office (CAO). At the appeal hearing, you may represent yourself, or someone else, such as a lawyer, friend, or relative may represent you.

### RIGHT TO AN AGENCY CONFERENCE

If you appeal, you may have an agency conference before the hearing. If you appeal because the Department decided that you are not eligible for expedited food stamp service, you have a right to an agency conference with a supervisor within two work days.

### RIGHT TO A WRITTEN NOTICE

We will give you a written notice explaining your benefits. If we deny, change, suspend, or stop benefits, we will explain the reason on the notice. You have 30 days (90 days for food stamps) from the date of the notice to ask for a hearing if you disagree with the action taken and/or the reasons given.

### RIGHT TO A CERTIFICATE OF CREDITABLE COVERAGE

You have the right to ask the Department to provide you with a Certificate of Creditable Coverage to verify your Medical Assistance coverage. Federal law limits when health coverage may be denied or limited for a pre-existing condition. If you enroll in a group health plan that excludes treatment for a pre-existing condition, you can be credited for the time you received Medical Assistance. You may request a certificate to verify your Medical Assistance coverage. Contact your case worker to request this certificate.

### RIGHT TO CONFIDENTIALITY

We keep information you give confidential and use it only to administer the programs you apply for and/or may be eligible for, such as the school lunch program, the Children's Health Insurance Program (CHIP), or adultBasic. Any person knowingly violating any of the rules and regulations of this Department shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay a fine, not exceeding one hundred dollars (\$100), or to undergo imprisonment, not exceeding six months, or both (62 P.S. Section 483). The CAO, when requested, must provide Federal, state and local law enforcement officials with the address, Social Security Number, and photograph (if available) of an individual who is fleeing to avoid prosecution, custody, or confinement for a felony or violating probation or parole.

### RIGHT TO CLAIM GOOD CAUSE

The law requires you to cooperate in establishing paternity for any child born out of marriage and get any support owed to you and/or any child(ren) for whom you want cash and/or Medical Assistance. The Department will excuse you from cooperating with the support requirements if you prove that it would not be in the best interest of you or the child(ren) for whom assistance is claimed. If you are not exempt from employment and training requirements, you must comply unless you have good cause. You must meet Semiannual Reporting requirements unless you have good cause.

## CLIENT RESPONSIBILITIES

### RESPONSIBILITY TO ACKNOWLEDGE LIABILITY OF REAL OR PERSONAL PROPERTY

If you are applying for cash assistance and have non-resident real property and/or personal property, we may require you to sign an agreement to repay benefits received by you, your spouse and minor children.

If you are age 55 or older and receive Medical Assistance to pay for nursing facility services, home and community-based waiver services and any related hospital and prescription drug service, you will be required to repay the cost of these services from your probate estate.

### RESPONSIBILITY TO PROVIDE INFORMATION

You must give true, correct and complete information. You must cooperate in documenting or proving the information you give. Cash assistance may be denied if you fail to provide certain verification. If you cannot provide proof, you should ask the CAO to help. You must cooperate fully with persons or investigators of the Department or the Office of Inspector General conducting investigations.

### RESPONSIBILITY TO REPORT CHANGES

For cash assistance and Medical Assistance, you must report changes in: the number of people in your household, address, unearned income, real property or other resources (such as bank accounts or life insurance). You must report any plans to leave the state, even temporarily. If you have no earned income, you must report new employment or new income from self-employment. If you have earned income, you must report if your gross monthly earned income is greater than \$100 more than the estimated gross monthly earned income used to determine your cash benefit. Your caseworker will explain your earned income reporting requirements. You must report changes within 10 calendar days of the date of the change.

For food stamp households that do not participate in Semiannual Reporting (SAR), you must report changes as described for cash and Medical Assistance with the exception of reporting changes of unearned income. You must report changes of monthly, unearned income greater than \$50.

For food stamp households that are participating in SAR, you must report if your household's total gross monthly income exceeds 130% of the Federal Income Poverty Guidelines (FPIGs) for your household size. The report must be made within 10 calendar days from the end of the month in which the gross monthly income exceeds the 130% FPIGs. Your caseworker will explain your specific income reporting requirement.

In addition, for food stamp households that contain an Able-Bodied Adult Without Dependents (ABAWD) that are participants in SAR, the household must report if the ABAWD work hours fall below an average of 20 hours weekly. An ABAWD means that you are able to work, you are between the age of 18 and 49, and you have no children under age 18 who live with you.

If you are proven to have failed, without good cause, to report earned income in a timely manner, you may not receive an earned income deduction on the unreported income. This may reduce the amount of cash assistance and/or food stamps to which you are entitled and increase the amount of the overpayment claim.

You can report changes to a member of the County Assistance Office in person, by telephone, by fax, or by mail.

### RESPONSIBILITY TO USE THE PA ACCESS CARD LAWFULLY

You may use the PA ACCESS card for services only during the period you are eligible. You must use the card only for the person who is eligible and you may get only the services that are needed and reasonable.

### RESPONSIBILITY TO PROVIDE SOCIAL SECURITY NUMBERS

For cash, Medical Assistance and/or food stamp benefits, you must provide a Social Security Number (SSN) for each person for whom you are applying. If you do not have an SSN you must apply for one. Refusal or failure to provide a SSN may result in disqualification. For cash benefits, we also will ask you to supply an SSN for anyone else whose income and/or resources affect your eligibility or amount of benefits. Your SSN is used to verify your identity and to prevent duplication of state and Federal benefits. Your SSN is used for computer matches to verify income and resources that may affect your eligibility and/or benefits. An alien who is applying for emergency Medical Assistance only is not required to provide a SSN. (42 U.S.C. §1320b-7).

# PROHIBITIONS AND PENALTIES

You must **not**:

- give false, incorrect, or incomplete information;
- trade, sell or alter your Electronic Benefit Transfer (EBT) Card or your PA ACCESS Card;
- use other people's EBT, or PA ACCESS Card;
- use your food stamp benefits to buy ineligible items such as alcoholic drinks or tobacco;
- use your food stamp benefits to buy illegal drugs, firearms, ammunition, or explosives; or
- use your food stamp benefits to pay for food already received, or for food to be received in the future. This means that you may not use your food stamp benefits to purchase food on credit.

Any member of your household who is found guilty by a court or an Administrative Disqualification hearing of breaking any of the above rules or who signs a voluntary disqualification consent agreement or waiver of Administrative Disqualification hearing will be barred from getting cash assistance or food stamp benefits for up to:

- 12 months for the first violation;
- 24 months for the second violation; and
- permanently for the third violation.

Any household member found guilty by a court of using food stamp benefits to buy illegal drugs will be disqualified for:

- 24 months for the first violation; and
- permanently for the second violation.

Any household member found guilty by a court of buying or selling food stamp benefits or other benefit instruments for cash or consideration other than food or the exchange of firearms, ammunition, explosives, or controlled substances in the amount of \$500 or more in food stamp benefits will be disqualified permanently.

Any household member found by a court or an Administrative Disqualification hearing of misrepresenting his identity or residence to receive multiple food stamp benefits will be disqualified for 10 years.

Any household member fleeing to avoid prosecution, custody, or confinement for a felony, or attempted felony, or violating a condition of probation or parole will be ineligible for cash assistance and food stamps until the situation is rectified.

An individual who has been sentenced for a felony or a misdemeanor offense and who has not satisfied the penalty imposed by the court is ineligible for cash assistance.

An individual is ineligible for cash assistance for a period of 10 years if he is convicted of fraudulent misrepresentation of residence for the purpose of receiving welfare benefits in two or more states.

Cash assistance will be reduced by amounts received by cashing an assistance check at a gambling casino, race track, bingo hall or other establishment that derives more than 50 percent of its gross revenues from gambling.

If you do not report changes as required, your benefits may be reduced or stopped. If you purposely fail to give correct information or report changes, you may be fined and/or put in jail. Improper use of the PA ACCESS Card for medical services and/or cash and food stamp electronic benefit transfers may result in a fine or imprisonment, or both.

If you are found guilty of violating these rules, or committing fraud, you also may be:

- fined up to \$250,000 for food stamps and up to \$15,000 for cash;
- jailed up to 20 years for food stamps and up to seven years for cash; and/or
- required to repay the benefits you received.

## FOOD STAMP WORK REQUIREMENTS / SANCTIONS

If you are physically and mentally fit, over 15 years of age and under 60 years of age, and not otherwise exempt, you may not refuse to register for employment; participate in an approved employment and training program unless you have good cause; accept employment unless you have good cause; provide sufficient information to your County Assistance Office about your employment status and job availability unless you have good cause or comply with workfare. Additionally, you must not voluntarily and without good cause quit your job or reduce the number of hours you work if, after the reduction, you are employed less than 30 hours per week.

If you or another member of your household violates any of the above work requirements, you or that person may be disqualified from receiving food stamps.

The minimum disqualification periods are: for the first violation, one month and thereafter until the failure to comply ceases; the second violation is three months and thereafter until the failure to comply ceases; and for the third and subsequent violations, six months and thereafter until the failure to comply ceases.

## CASH ASSISTANCE WORK REQUIREMENTS / SANCTIONS

A mandatory participant who fails to cooperate with the work or work-related activity requirement; accept a bona fide offer of employment; or who terminates employment; reduces earnings or fails, without good cause, to apply for work, is ineligible for cash assistance.

The period of the sanction is:

First occurrence - 30 days or until the failure to comply ceases, whichever is longer.

Second occurrence - 60 days or until the failure to comply ceases, whichever is longer.

Third occurrence - permanently.

If the reason for sanction occurs in the first 24 months of receipt of cash assistance, whether consecutive or interrupted, the sanction applies only to the individual.

If the reason for sanction occurs after the first 24 months of receipt of cash assistance, whether consecutive or interrupted, the sanction applies to the entire assistance group.

In place of the sanctions above, if an employed individual voluntarily, without good cause, reduces his earnings by not fulfilling the 20-hour work requirement during the first 24 months, the cash grant is reduced by the dollar value of the income that would have been earned if the recipient would have fulfilled his 20-hour work requirement, until the 20-hour requirement is met.

If an employed individual voluntarily, without good cause, reduces his earnings by not fulfilling the 20-hour work requirement after having received cash assistance for 24 months, the household is ineligible.

If you need someone outside your household to apply for food stamp benefits for you, complete this section.

FOOD STAMP AUTHORIZED REPRESENTATIVE NAME	SOCIAL SECURITY NUMBER
ADDRESS	PHONE NUMBER

If you need someone outside your household to obtain food stamp benefits or use food stamp benefits to buy food for you, complete this section.

FOOD STAMP AUTHORIZED REPRESENTATIVE NAME	SOCIAL SECURITY NUMBER
ADDRESS	PHONE NUMBER

**WHEN I SIGN THIS FORM I AGREE THAT:**

**AFFIDAVIT**

**WHEN I SIGN THIS FORM, I UNDERSTAND THAT:**

- I have read this application in full or someone has read it to me, and I understand the questions asked.
- I received a copy of my rights and responsibilities, and have read them or someone has read them to me; I understand, and agree with them.
- I will provide or cooperate in getting any information needed to prove my statements.
- I must report any changes in my circumstances within 10 calendar days for cash and Medical Assistance, and within 10 days for food stamps unless I am in Semiannual reporting for food stamps.
- I will cooperate with the requirements of the child support enforcement program as directed by the Department of Public Welfare (DPW).
- If I receive cash and/or Medical Assistance benefits, I give the state and/or the Domestic Relations Section the right to pursue and collect cash and/or medical support for me and others for whom I am applying.
- If I receive a check for my cash benefits, the worker has read the certification on the back of the check; and every time I sign a check, I am signing the certification.
- I am responsible for any fraudulent statements made on this application even if the application is submitted by someone acting on my behalf.
- I consent to, and will fully cooperate in the finger, photo, and signature imaging process. I understand that refusal to cooperate may result in the denial of benefits.
- I certify that, subject to penalties provided by law, the information I gave is true, correct, and complete to the best of my knowledge.
- I am authorizing DPW to release to the appropriate agency, information regarding my receipt of cash assistance, food stamp benefits and/or Medical Assistance as necessary to qualify my employer to receive Federal and/or State Tax Credits.
- If I receive cash assistance, I will be required to sign an Agreement of Mutual Responsibility which defines my plan to achieve self sufficiency.

- The Office of Inspector General may visit my residence within seven to 10 days from the date I signed the application for food stamps to confirm information I provided to the County Assistance Office.
- The State operates a fraud control program under which local, State, and Federal officials may verify the information I have given. Verification will include confirmation through the Pennsylvania State Police Criminal Record Files, the Administrative Office of Pennsylvania Court files and other records that are available.
- The State may obtain information about my circumstances from other sources, including computer matches and the U. S. Citizenship and Immigration Services except for persons applying for emergency Medical Assistance only.
- My Social Security Number will be used to obtain information to verify my circumstances and eligibility.
- My benefits may be reduced or terminated or I can be penalized (including charged with fraud) for giving false or misleading information or for not reporting changes that would affect my benefits.
- I am giving the State the right to seek, with or without legal action, payment from private or public health insurance or liable third party. The amount recovered will not exceed the amount paid by Medical Assistance.
- The State and Domestic Relations Section have the right to review all records of medical services paid for by Medical Assistance.
- Payment for medical services will be made directly to the provider, not to me. This includes payments from Medical Assistance.
- The law provides for automatic assignment to the State of support rights for myself and others for whom I am accepting cash assistance and/or Medical Assistance.
- If I receive cash benefits, all support including arrears will be paid to the State. When cash benefits stop, arrears may be paid to the State to repay the amount of cash and other reimbursable assistance that I received for my family. The amount of arrears paid to the State will not exceed the arrears assigned to the State or the total reimbursable assistance I received for my family, whichever is less. The total amount of reimbursement from child support and other sources will not exceed the total amount of reimbursable assistance received. If I receive medical benefits, medical support may be paid to the State. Medical support retained by the State will not be more than the amount paid under the Medical Assistance program.

CLIENT OR AUTHORIZED REPRESENTATIVE SIGNATURES	DATE	ID	PROVIDER / EMPLOYEE / WITNESS SIGNATURES	DATE
ADDRESS OF REPRESENTATIVE (Street, City, Zip)				PHONE NUMBER
SECOND WITNESS IF AN (X) IS SIGNED ABOVE	ADDRESS OF WITNESS			DATE

I WISH TO WITHDRAW MY APPLICATION FOR

CASH

FOOD STAMP BENEFITS

MEDICAL ASSISTANCE

OTHER

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

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# AFFIDAVIT

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- jailed up to 20 years for food stamps and up to seven years for cash; **and/or**
- required to repay the benefits you received

**FOOD STAMP WORK REQUIREMENTS / SANCTIONS** -- If you are physically and mentally fit, over 15 years of age and under 60 years of age, and not otherwise exempt, you may not refuse to register for employment; participate in an approved employment and training program unless you have good cause; accept employment unless you have good cause; provide sufficient information to your County Assistance Office about your employment status and job availability unless you have good cause or comply with workfare. Additionally, you must not voluntarily and without good cause quit your job or reduce the number of hours you work if, after the reduction, you are employed less than 30 hours per week.

If you or another member of your household violates any of the above work requirements, you or that person may be disqualified from receiving food stamps. Before a disqualification is imposed, you will receive a notice and will have the right to appeal and have a fair hearing.

The minimum disqualification periods are as follows: for the first violation, one month and thereafter until the failure to comply ceases; the second violation is three months and thereafter until the failure to comply ceases; and for the third and subsequent violations, six months and thereafter until the failure to comply ceases.

### CASH ASSISTANCE WORK REQUIREMENTS / SANCTIONS

A mandatory participant who fails to cooperate with the work or work-related activity requirement; accept a bona fide offer of employment; or who terminates employment; reduces earnings or fails to apply for work; without good cause, is ineligible for cash assistance.

The period of the sanction is:

First occurrence - 30 days or until the failure to comply ceases, whichever is longer.

Second occurrence - 60 days or until the failure to comply ceases, whichever is longer.

Third occurrence - permanently.

If the reason for sanction occurs in the first 24 months of receipt of cash assistance, whether consecutive or interrupted, the sanction applies only to the individual.

If the reason for sanction occurs after the first 24 months of receipt of cash assistance, whether consecutive or interrupted, the sanction applies to the entire assistance group.

In place of the sanctions above, if an employed individual voluntarily, without good cause, reduces his earnings by not fulfilling the 20-hour work requirement during the first 24 months, the cash grant is reduced by the dollar value of the income that would have been earned if the recipient would have fulfilled his 20-hour work requirement, until the 20-hour requirement is met.

If an employed individual voluntarily, without good cause, reduces his earnings by not fulfilling the 20-hour work requirement after having received cash assistance for 24 months, the household is ineligible.