Rhode Island Health and Human Services
Application for Assistance – Health Coverage/Medicaid Screen

Please read this sheet over if you are applying for health coverage, including Medicaid. If this is the right application for you, answer the questions below and return this form with your completed application. Your answers will help us process your application more effectively.

APPLICANT'S NAME _____ **SOCIAL SECURITY NUMBER** _____

What is the right Health Care/Medicaid application for me?	
This is the right health care/Medicaid application if you want:	**Medicaid long-term services and supports (LTSS).** For people who need help with everyday activities and the tasks necessary to live on their own. May be provided in a nursing facility, hospital, assisted living residence, community residences for people with developmental disabilities or chronic conditions, or in someone's home. **OR**
	Medicaid for elders and adults with disabilities (EAD). For people who need health coverage EXCEPT for LTSS. Must be 65 or older or 19 to 65 and have a disability and Medicare. Includes Sherlock coverage if working and have a disability **OR**
	Katie Beckett eligibility for children with serious disabilities/conditions (KB). (KB) Coverage for children up to age 19 who have serious disabilities and are cared for at home and do not qualify for Medicaid in another way.
This MAY NOT be the right application if you want ONLY:	**Medicaid or a private health plan with financial help to cover children, pregnant women, parents/caretakers or adults 19 to 64 who DO NOT have Medicare. You can APPLY ON-LINE AT:** www.healthyrhode.ri.gov or call **HealthSource RI at 1-855-840-4774.**

IF THIS IS THE RIGHT APPLICATION FOR YOU, check all that apply:

□ **Working adult with disabilities seeking Sherlock Plan eligibility.**

□ **Medicaid or private health plan and other benefits like child care, food assistance or RI Works.**

Applying for Medicaid LTSS and:

□ Adult with intellectual/developmental disabilities working with Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH)

□ Living in a nursing home, assisted living residence, BHDDH group home or other supportive residence.
Name of facility/residence _____ Date of Entry_____

□ Entering a nursing home, assisted living residence, BHDDH group home or other supportive residence.
Name of facility/residence _____ Date of Entry_____

□ Living in own home or returning soon to own or someone else's home.

□ Already have Medicaid, but looking for LTSS

□ Katie Beckett eligibility for a child under age 19

□ Working with community agencies, including through the Division of Elderly Affairs (DEA) or BHDDH
Name of agency _____ Contact Information _____

□ **Elder or adult with disability (age 19 to 64) eligible for or enrolled in Medicare**

□ I also need help paying my Medicare premiums costs

RETURN THIS SHEET WITH THE COMPLETED APPLICATION FOR ASSISTANCE

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES
APPLICATION FOR ASSISTANCE (DHS-2)
Application Mailing Address: RI Department of Human Services, P.O. Box 8709, Cranston, RI 02920-8787
General Instructions for Completing this Application

Getting Help with this Application
You can ask for help in completing this form. You can ask for the form and notices to be translated. If you have a disability or condition that makes it hard for you to understand or answer questions on this application, we can help. Please let us know by speaking with a DHS representative or calling the DHS Call Center at 1-855-MYRIDHS (1-855-697-4347).

Who Should Complete the Application?
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.

Answering the Questions
If you answer all the questions on the assistance application, we can determine if you are eligible for ALL programs. Instruction pages 3 and 4 provide a description of each program that you can apply for using this application. Small boxes with the program acronyms/initials will appear next to each of the questions on the application. These boxes with the acronyms/initials tell you which questions you must answer for each program. For example, if you are applying for child care assistance, answer those questions that have **CCAP** next to them.

If you are applying for SNAP only, although we encourage you to fill out as much of the application as possible, **we will accept your application if it is submitted with just a name, address and signature.**

Each question is followed by a section of boxes used for filling in the required information. Respond to each question by indicating either YES or NO with a check mark in the box next to the question. **IF the answer is YES** supply the requested information by writing in the space available beneath the question. You must provide the information asked for EVERY household member. If the question does not apply to you or anyone in your household, then the answer is NO. Leave the box blank and move on to the next question.

Securing your Application Date
The first page of this application can be detached and submitted with your signature to DHS to establish a start date and begin your application. You will need to complete and submit the rest of the application in order to receive benefits/coverage.

If you need more space to answer questions
Turn to page 27 if you run out of space where there are boxes to write in additional information. Indicate in one of the boxes which question you are referring with its number. You may also attach separate sheets of paper, if necessary.

Your Rights and Responsibilities/Signature Page
Read pages 28-32. These pages contain important information about your Rights and Responsibilities. All applicants are required to sign application page 32 before submitting the application. If you submit the first page only to secure your application date, you must sign application page 1 and then submit the rest of the application with a signature on application page 32.

Appointing an Authorized Representative
If you would like to appoint an authorized representative to act on behalf of the household in applying for program benefits or using the benefits you may do so on application page 2.

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

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

Note: The same document may be used to verify more than one category, for example, a driver's license can verify identity and address. If you are applying for Medicaid, we will verify your information with data sources as much as possible.

1. To verify your identity, age/date of birth, citizenship and/or immigration status *(All Programs)*

- ✓ Driver's License
- ✓ School or work Identification
- ✓ Immigration and Naturalization Documents (e.g., Green Card)
- ✓ Hospital birth records
- ✓ Birth Certificates
- ✓ U.S. Passport
- ✓ Any other documentation requested for citizenship, immigration status, or age may be used for verification of identity

2. To verify your Rhode Island residence *(All Programs except ACC, unless questionable)*

- ✓ Rent or mortgage receipts showing address
- ✓ Library card showing address
- ✓ Voter's registration card
- ✓ Lease agreement of letter from landlord
- ✓ Mail received with your home address (utility bills, bank statements)

3. To verify your income *(All Programs)*

- ✓ Check stubs (showing the last 30 days of income)
- ✓ Employer statement showing income before taxes, hourly work schedule and the number of hours worked for the past four weeks (if you get paid in cash or you do not have your check stubs)
- ✓ Social Security, Supplemental Security Income, or Veteran's Benefits award letter
- ✓ Other retirement or disability benefit award letters
- ✓ Proof of alimony received
- ✓ Proof of receipt of unemployment insurance benefits, temporary disability benefits (TDI), Veteran's Administration (VA) benefits.
- ✓ Previous tax returns
- ✓ Proof of self-employment income (includes rental income and freelance work): provide tax returns or self-employment ledger
- ✓ Child Support court order

4. To verify your resources *(RIW, GPA, EAD, LTSS, MPP, SSP, KB, CCAP if over $9,500)*

- ✓ Documentation of ownership of a trust
- ✓ Proof of rental properties
- ✓ Trust documents, property
- ✓ Stock and/or bonds
- ✓ Proof of ownership of real property other than your home.
- ✓ Vehicle registration including car, boat, truck, motorcycle, camper
- ✓ Proof of ownership of other income producing property
- ✓ Proof of ownership of a burial plot (if you own more than one)
- ✓ Bank accounts, savings accounts, credit union statements, CD's

5. To verify your dependent care expenses *(RIW, SNAP)*

- ✓ Proof of expenses related to child care or caring for incapacitated adult living in the home: receipts showing your out-of-pocket expenses

6. To verify your shelter costs *(SNAP, RIW, LTSS)*

- ✓ Rent, lease or mortgage documents
- ✓ Statement from landlord
- ✓ Property taxes statement
- ✓ Statement from U.S. Department of Housing and Urban Development (HUD)
- ✓ Proof of property insurance
- ✓ Receipts or statement from utility company
- ✓ Statement from person who shares shelter costs

7. To verify your child support expenses *(SNAP, ACC)*

- ✓ Child support that you pay: income summary if child support is deducted from wages or income
- ✓ Copy of court order

8. To verify your medical expenses not covered by insurance *(SNAP, EAD)*

- ✓ Summary of provided services such as doctor or hospital visits
- ✓ Receipts showing unreimbursed medical expenses
- ✓ Health insurance policy showing premium amount
- ✓ Prescription pill bottles showing cost on label or printout
- ✓ Invoices or receipts for medical equipment (including the rental cost)

9. To verify relationships among household members *(RIW, CCAP, ACC)*

- ✓ Adoption papers or records
- ✓ Hospital or public health records of birth or parentage
- ✓ Child support paternity records
- ✓ Marriage license/tribal marriage certificates
- ✓ Divorce/custody papers
- ✓ Guardianship papers or records

10. To verify your disability or blindness *(RIW, SNAP, CCAP, GPA, EAD, LTSS)*

- ✓ Proof of receipt of Retirement, Survivors, and Disability Insurance (RSDI) or Supplemental Security Income (SSI); copy of the award letter or similar documentation from the Social Security Administration and/or current finding of eligibility for RSDI or SSI based on blindness
- ✓ Copy of medical examination report on file at the Office of Rehabilitation Services (ORS), Services for the Blind and Visually Impaired
- ✓ Statement from a medical professional

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

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

You will be sent a written request for any verification missing from your application. Your application will be denied if the missing verification is not received within ten (10) days of the written request.

FINANCIAL ASSISTANCE (RIW) (GPA) (CCAP) (SSP)

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

MEDICAID (LTSS) (EAD)

Retroactive Medicaid coverage for certain health expenses may be provided to applicants eligible through the LTSS and EAD pathways for up to three (3) months prior to the date we receive a signed application, provided all factors of eligibility are met for each month. There is no retroactive coverage available for ACC Medicaid beneficiaries.

Applicants may qualify for Medicaid through more than one eligibility pathway. If you are uncertain which pathway best suits the needs of the applicants in your household, contact 1-855-MYRIDHS (1-855-697-4347).

ABOUT THE PROGRAMS

Again, the letter boxes next to each program below are used through this application to identify questions you need to answer to be considered for specific programs. Answer only those questions for the programs you want to apply for. For example, if you want to apply for all programs, answer all the questions. If you are applying for only RIW and ACC, you must answer a question with a RIW or ACC box above it, and can leave the other questions blank.

RIW RI Works (RIW) Cash Assistance: The RIW Program gives cash assistance for a limited number of months to families in need of support, as well as those who are unable to work, or in training or looking for a job. Applicants for RIW must be responsible for the support and care of a child under age 18, or between ages 18 and 19 if enrolled full-time in and expected to complete secondary school prior to their 19th birthday. A pregnant woman with no other children can qualify for assistance if she is in her third trimester of pregnancy. RIW requires an interview with an eligibility worker and a meeting with a Social Caseworker to complete an employment plan.

SNAP Supplemental Nutrition Assistance Program (SNAP): SNAP, formerly known as food stamps, helps low income households buy the food needed to stay healthy. Your income minus certain allowable expenses will determine if you are eligible for SNAP benefits. You will need to participate in an interview over the telephone or in the office before you can be granted SNAP benefits.

CCAP Child Care Assistance Program (CCAP): Child Care Assistance is available to families with earnings up to 180% of the federal poverty level and is only available to cover hours of employment or short-term training. Families may be required to pay a co-payment based on their family size, income level and number of children. Families that participate in RIW automatically meet the income requirements for CCAP. Prior to enrollment, RIW applicants or participants who are not employed must discuss child care options with a Social Worker as part of the assessment process and the development of the employment plan. For families not participating in the RIW Program, eligibility for CCAP is based on working at least 20 hours per week at or above Rhode Island's minimum wage.

GPA General Public Assistance (GPA) Program: GPA is available for adults ages 18-64 who have very limited income and resources and have a chronic or disabling illness or condition that keeps them from working. Adults who have a current pending application for Supplemental Security Income (SSI) may be determined eligible for GPA benefits. A determination for ACC Medicaid health care coverage must be completed prior to a determination of eligibility based on a disabling condition. GPA applicants can apply for ACC Medicaid healthcare coverage by completing the ACC questions on this application, or by applying online at www.healthyrhode.ri.gov.

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

ACC Affordable Care Coverage -- Medicaid and Private Health Insurance with Financial Help (ACC): Medicaid is available for parents/caretakers with income up to 136% of the Federal Poverty Level (FPL), children with income up to 261% of the FPL, pregnant women with income up to 253% of the FPL and adults age 19 to 64 with income up to 133% of the FPL who are otherwise ineligible for Medicaid and not eligible for or enrolled in Medicare through this eligibility pathway. Adults who are awaiting a determination of disability by a government agency, have resources above the limits for EAD eligibility, and/or do not meet the criteria for disability determination may apply for Medicaid affordable care coverage through this pathway. Families and individuals not eligible for Medicaid with income below 400% of the FPL may be eligible for a tax credit from the federal government to help pay the costs of coverage through a private a health plan. You can also apply for coverage online at www.healthyrhode.ri.gov or over the phone by calling the HSRI Contact Center at 1-855-840-4774.

LTSS Medicaid Long Term Services and Supports (LTSS): LTSS are available for individuals who meet the necessary level of need and financial requirements, and for individuals with disabilities. You must meet both the financial and clinical "level of care" requirements to qualify for LTSS. For people who qualify, Medicaid LTSS may be provided in a health institution like a nursing home, at home, or in certain pre-approved community settings including some assisted living residences. The range of long-term services Medicaid covers includes, but is not limited to, homemaker/certified nursing assistant (CNA) services, environmental modifications, case management, self-directed care, respite, minor home modifications and shared living/RIte at Home. The range of services and the choice of service settings depends on an individual's care needs.

EAD Medicaid: Health Coverage for Low-Income Elders and Persons with Disabilities and Working Adults with Disabilities/Sherlock Plan (EAD): To qualify for Medicaid for low-income elders and persons with disabilities, an individual or member of a couple must be age 65 years or older or living with a disability. Persons who are blind also qualify for coverage in this category. Income must be at or below 100% of the FPL, and resources cannot exceed $4,000 for a single person and $6,000 for a couple. In addition, a person under age 65 must be determined to have a disability by the Medicaid Review Team (MART) that prevents gainful activity, including work, for a minimum of one year. Some applicants who have income and/or resources above these amounts may qualify for Medicaid through the medically needy pathway if they have high medical expenses each month. You will be given more information about this pathway if you do not meet the EAD income and resource standards. People who receive Supplemental Security Income (SSI) based on age or disability are automatically eligible for Medicaid and do *not* need to complete this application. People who receive Social Security Disability Insurance (SSDI) must apply, but do not have to undergo a disability review by the MART.

Medicaid for Working People with Disabilities Program/Sherlock Plan: People eligible under this category are entitled to the full scope of Medicaid benefits, home and community-based services, and services needed to gain and/or maintain employment. To be found eligible for this program, a person must be at least eighteen (18) years of age, meet the Medicaid requirements for eligibility based on a disability, have proof of active, paid employment, have income at or below 250% of the FPL and meet special resource standards.

MPP Medicare Premium Payment Program (MPP): Eligibility for the MPP is based on income and helps adults over age 65 and adults with disabilities pay all or some of the costs of Medicare Part A and Part B premiums, deductibles and co-payments. Medicare Part A is hospital insurance coverage and Medicare Part B is for physician services, durable medical equipment and outpatient services. People with income up to 135% of the FPL are eligible to participate in MPP.

KB Katie Beckett (KB): Katie Beckett provides Medicaid/health insurance coverage to children under age 19 who are living at home but have complex health needs that typically require the care provided in a health facility like a hospital or nursing home. To determine Katie Beckett eligibility, only the income and resources of the child who needs coverage are considered. A child may qualify for the same services available through this pathway if family income is within the limits for coverage for the ACC groups. Call 1-855-MYRIDHS (1-855-697-4347) if you need more information about which pathway is best for you.

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

Do you need: ❑Help filling out this application? ❑ Free language help?

Preferred language: _____ Preferred language read: _____

I want to apply for:

❑	RIW	CASH ASSISTANCE (RHODE ISLAND WORKS- RIW)	❑	ACC	MEDICAID/PRIVATE HEALTH INSURANCE WITH FINANCIAL HELP (ACC)
❑	SNAP	SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)	❑	LTSS	MEDICAD: LONG-TERM SERVICES AND SUPPORTS (LTSS)
❑	CCAP	CHILD CARE ASSISTANCE PROGRAM (CCAP)	❑	KB	KATIE BECKETT: HEALTH COVERAGE FOR CHILDREN WITH SEVERE DISABILITIES (KB)
❑	GPA	GENERAL PUBLIC ASSISTANCE (GPA)	❑	MPP	MEDICARE PREMIUM PAYMENT PROGRAM (MPP)
❑	SSP	RI SSI STATE SUPPLEMENTAL PAYMENT PROGRAM (SSP)	❑	EAD	MEDICAID HEALTH COVERAGE FOR AGE 65 AND OVER, BLIND OR DISABLED OR PERSONS WITH DISABILITIES AND WORKING ADULTS WITH DISABILITIES/SHERLOCK PLAN (EAD)

First Name, Middle Initial, Last Name Suffix	E-Mail Address	Telephone Number ( ) ❑Cell ❑Home ❑Work
Street Address	Apartment/Unit Number:	City/Town
State	Zip Code	Alternate Telephone Number: ( ) ❑Cell ❑Home ❑Work
Are you homeless? ❑YES ❑NO		
Best time to contact you: ❑morning ❑afternoon ❑evening ❑night ❑weekend ❑anytime		

If your mailing address is different, please fill it in below. If not, please leave blank.

Street or PO Box Address	City	State	Zip Code

FOR SNAP APPLICANTS ONLY: Answer the questions below to see if you can get SNAP benefits faster (within 7 days). If your income, cash and money in the bank add up to less than your monthly housing expense; or your monthly income is less than $150 and your money in the bank and liquid resources are less than $100; or you are a migrant or seasonal farm worker, you may be eligible for expedited service.

How much money do members of your household have in cash or money in the bank? $_____
What is the total amount of income from any source (including unearned income such as Child Support, SSI, TDI, Unemployment, or SSDI, RSDI, etc.) you expect your household to receive this month? $_____
What is your current monthly rent/mortgage payment? $_____ Utilities? $ _____
Do you pay to heat or cool your home? ❑Yes ❑No
Is anyone in your household a migrant or seasonal farm worker? ❑Yes ❑No

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

Signature of Applicant or Recipient	Date	Signature of Authorized Representative	Date

You may tear off this sheet and submit JUST the front and backside of this page with your Name, Address and Signature to allow us to date stamp and start this application. To determine ongoing benefit eligibility, you must sign and complete the remainder of this application and may bring or mail or fax the application to the DHS office.

If you would like someone to apply on your behalf, authorize someone to use your benefits, and/or receive important notices or bills for health insurance, answer the questions below. Selecting an Authorized Representative is optional. You and your Authorized Representative will both have access to your electronic account. If you want to name an Authorized Representative, check "Yes" below and enter his or her details. Your authorized representative must be 18 or older and can be a friend, relative, or anyone else you choose.

Do you want this person to: ❑Apply for benefits on your behalf? ❑Use your benefits? *(SNAP & RIW Cash benefits only)* ❑Receive Notices?

Authorized Representative's Name	Mailing Address	
Primary Phone Number ( ) ❑Cell ❑Work ❑Other	Secondary Phone Number ( ) ❑Cell ❑Work ❑Other	Email Address
Preferred method of contact ❑Email ❑Phone ❑Paper Mail	Preferred time of contact? ❑Morning ❑Afternoon ❑Evening ❑Anytime	
Preferred Language Spoken ❑English ❑Español ❑Português	Preferred Written Language ❑English ❑Español ❑Português	Company/Organization Name and ID (if applicable)

HOUSEHOLD COMPOSITION: Please list the members of your household below.

- SNAP Applicants: list yourself and everyone who lives in your home now, even if they do not want assistance.
- Health Coverage/ACC Applicants: include yourself, other family members, and anyone who is included on your federal tax return, if you file one. Only include your unmarried partner (boyfriend or girlfriend) if you live together AND have a child together. Do not include your roommate. You can complete an application for other people in your family even if you don't need coverage or are not eligible for coverage.

Household members choosing not to seek benefits are not required to answer questions about Social Security Numbers or Citizenship information.

Name *(First, Last, Middle Initial, Suffix)*	D.O.B. *(mm/dd/yyyy)*	Gender M: Male F: Female	Social Security Number *(Required only if applying for benefits)*	Is this person's name different on his/her Social Security Card? *If yes, write the name on the card below*	U.S. Citizen? *(Required only if applying for benefits)*
					❑Yes ❑No
					❑Yes ❑No
					❑Yes ❑No
					❑Yes ❑No
					❑Yes ❑No
					❑Yes ❑No
					❑Yes ❑No

If there are more people in your household, please list them on page 27 marked, "for applicant/recipient use only".

If you are applying for SNAP benefits, how would you like to be interviewed? ❑Telephone Interview (OR) ❑In-Office Interview
(Note: an in-office interview is required for RIW cash assistance. Your SNAP and RIW interview can be combined.)
Telephone#: Day_____ Evening:_____

We may need to contact you regarding the status of your application and/or to request additional information. What is your preferred method of contact? ❑Email ❑Paper Mail

Note: If you are applying for SNAP and you select "email", you will continue to receive notices in the mail at this time.

I live in a (check one):

❑Elderly/Disabled Housing	❑Homeless: lobby, street, car	❑Own Home/Trailer	❑Shelter/Halfway House	❑Rent home/apt/trailer
❑Living in another's home/apartment	❑Drug/Alcohol rehab center			❑No permanent address
❑Nursing Home/Facility: Name of Facility:	❑Residential care/Assisted Living: Name of Facility:		❑Other (describe):	

Is anyone in the household applying for dental coverage? ❑Yes ❑No If yes, please write their names below:

1._____ 4._____
2._____ 5._____
3._____ 6._____

1 **RIW** **SNAP** **CCAP** **GPA** **SSP** **ACC** **LTSS** **EAD** **MPP** **KB**

Please fill out some additional information below about each member of your household.

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

Name	Relationship to Primary Applicant	Lives with Primary Applicant? Yes or No If no, enter address	Ethnicity *Enter a number (see below)*	Race *Enter a number (see below)*	Marital Status	Applying for Benefits?
	Self	❑Yes ❑No, Address:				❑Yes ❑No
		❑Yes ❑No, Address:				❑Yes ❑No
		❑Yes ❑No, Address:				❑Yes ❑No
		❑Yes ❑No, Address:				❑Yes ❑No
		❑Yes ❑No, Address:				❑Yes ❑No
		❑Yes ❑No, Address:				❑Yes ❑No
		❑Yes ❑No, Address:				❑Yes ❑No

Ethnicity: 1-Hispanic 2-Non-Hispanic 3-Mexican 4-Puerto Rican 5-Cuban 6-Other Hispanic

Race: 1-White 2-Black or African American 3- American Indian or Alaskan Native 4-Asian 5-Asian Indian 6-Chinese 7-Filipino 8-Japanese 9-Korean 10-Vietnamese 11-Other Asian 12-Guamanian 13-Chamorro 14-Samoan 15-Native Hawaiian 16-Other Pacific Islander 17-Other

2 **RIW** **SNAP** **CCAP** **GPA** **SSP** **ACC** **LTSS** **EAD** **MPP** **KB**

Is any applicant getting benefits/receiving assistance in another state? ❑YES ❑NO

If, YES, Who?_____ Which State?_____

3 **SNAP**

Before now, has any applicant ever applied for, or received any type of assistance payments, benefits or SNAP/Food Stamp benefits in Rhode Island or in another state? ❑YES ❑NO

If, YES, Who?_____ Which State?_____

Under what name?_____ When?_____

What type(s) of benefits were received?_____

4 **RIW** **SNAP**

The Rhode Island Department of Human Services (DHS) uses an automatic phone system to make "appointment reminder calls" to remind you of a scheduled phone or office interview appointment. The reminders are for SNAP and Rhode Island Works certification and recertification appointments. Two days before your scheduled appointment, you will automatically be contacted at the number you write on this application, unless you choose to opt out below.

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

5 **RIW** **SNAP** **CCAP** **GPA** **SSP** **ACC** **LTSS** **EAD** **MPP** **KB**

Is any applicant imprisoned (detained or jailed)? ❑YES ❑NO

If, YES, Who?_____ Which facility?_____

Date of imprisonment:_____ Date of release_____

6 **ACC**

Was any applicant in the care and custody of the RI Department of Children, Youth and Families on his/her 18th birthday? ❑YES ❑NO

If, YES, Who?_____

7 **RIW** **CCAP** **GPA** **SSP** **ACC** **LTSS** **EAD** **MPP** **KB**

Is any applicant pregnant? ❑Yes ❑No

If Yes, please fill in the boxes below for each person who is pregnant.

Last Name First Name Middle Initial	Pregnancy Due Date	Number of Babies Expected

8 **RIW** **SNAP** **ACC** **LTSS** **EAD** **MPP** **KB**

Is any applicant a honorably discharged veteran or active duty member of the military? ❑Yes ❑No

If, YES, Who?_____

9 **RIW** **SNAP** **ACC** **LTSS** **EAD** **MPP** **KB**

Is any applicant a military veteran, a dependent of a veteran, or a survivor of a veteran? ❑Yes ❑No

If, YES, Who?_____ Check one: ❑veteran ❑child ❑spouse

10 **ACC**

Is any applicant an American Indian or Alaskan Native? ❑YES ❑NO

If yes, you may be eligible for Rhode Island Medicaid protections and for special benefits. Fill in the information below.

Is any applicant a member of a Federally Recognized Tribe? ❑Yes ❑No If yes, who?_____

Tribe Name:_____ Tribe State:_____

Has this person ever received services from the Indian Health Service, Tribal Program or Urban Indian Health Program? ❑Yes ❑No

Is this person eligible to get services from the Indian Health Service, Tribal Health Program, or Urban Indian Health Programs through a referral from one of these programs? ❑Yes ❑No

11 **SNAP**

If you are applying for SNAP, you will need to select a head of household. A head of household is typically an adult parent of the children in the home or a person who is working and providing financial support for the household. If there is no parent or working individual, you can select any adult to be the head of household. Please select a head of household below.

Last Name	First Name	Middle Initial

12 **SNAP**

Is there anyone who lives with you who purchases and prepares food separately? ❑YES ❑NO

If yes, list the people who purchase and prepare food separately.

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

13 **RIW** **SNAP** **CCAP** **GPA** **SSP** **ACC** **LTSS** **EAD** **MPP** **KB**

Are you or anyone in your household *not* a U.S. citizen? ❑YES ❑NO

If yes, fill in the information in the boxes below for each individual who is requesting benefits and is not a U.S. citizen.
If you are applying for Child Care or Katie Beckett, answer this question for the child only.

**If you are a non-citizen applying for benefits, the information you provide below will be subject to verification by the United States Citizenship and Immigration Services (USCIS- formerly known as INS) through submission of information from this application to USCIS. Submitted information received from USCIS may affect your household's eligibility and level of benefits. Household members choosing not to seek benefits are not required to provide citizenship/immigration information. Household members who are seeking benefits must supply information about citizenship or immigration status. The amount of benefits will depend on the number of people requesting benefits, but eligible household members who apply will be able to get benefits even though some people in the household are not seeking benefits. Household members who are not seeking benefits will be required to provide their financial information if it is needed to determine eligibility and benefit amount for persons who are applying.

*Non-Citizen Status: 1- Lawful Permanent Resident (LPR/Green Card) 2-Asylee 3-Refugee 4- Cuban/Haitian Entrant 5-Paroled into the U.S. 6-Conditional Entrant 7-Battered Spouse/Child/Parent 8-Victim of Trafficking 9-Granted Withholding of Deportation/Removal 10-Work Visa 11-Student Visa 12-Temporary Protected Status 13-Lawful Temporary Resident 14-Other (please describe)

Person 1

Last Name	First Name	Middle Initial	*Non-Citizen Status *(enter a number from above)*:

Please provide information on your documentation below:

Alien Registration #_____

Permanent Resident Card (Green Card, I-551):

Alien #_____

Card #_____

Machine Readable Immigrant Visa (with temporary I-551 language)

Visa #_____ Country of Issuance_____

Alien #_____

Refugee Travel Document (I-571)#_____

Foreign Passport Number_____

Reentry Permit (I-327)#:_____

Naturalization Certificate #_____

Employment Authorization Card (I-766):

Alien #_____

Arrival/Departure Record (I-94, I-94A) issued by USCIS:

SEVIS ID_____

Student and Exchange Visitor Information System (SEVIS) ID:

_____

Certificate of Eligibility for Nonimmigrant (F-1) Student Status

(I-20): SEVIS ID_____

Country of Issuance:_____

Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019) Temporary I-551 Stamp (on passport or I-94, I-94A)

SEVIS ID_____ Country of Issuance: _____

Country of Issuance_____ Alien Number:_____

Other documents or status types:

Document Description_____ Alien #_____SEVIS ID_____

If your name is different on your immigration document, please provide the name on the document:

Document Expiration Date:_____/_____/_____ Date of Entry into U.S.: _____/_____/_____

Country of Origin:_____ Lived in the U.S. before 08/22/1996? ❑ Yes ❑ No

If this individual has applied for or received permanent residence status, please provide the USCIS/INS Status Date/Permanent Residence Date: _____/_____/_____

Does this individual have a Sponsor? ❑Yes ❑No If yes, what is the type of sponsor? ❑Individual ❑Agency/Organization

Is the sponsor a member of the household? ❑Yes ❑No If yes, name of household member:_____

If the sponsor is a person/organization outside of the household, please provide the following information:

Organization Name:_____ Sponsor Name:_____

Address:_____ Primary Phone Number:_____

Secondary Phone Number:_____ Email Address:_____

Person 2

Last Name	First Name	Middle Initial	*Non-Citizen Status *(enter a number from above)*:

Please provide information on your documentation below:

Alien Registration #_____ Naturalization Certificate #_____

Permanent Resident Card (Green Card, I-551): Employment Authorization Card (I-766):

Alien #_____ Alien #_____

Card #_____ Arrival/Departure Record (I-94, I-94A) issued by USCIS:

Machine Readable Immigrant Visa (with temporary I-551 language) SEVIS ID_____

Visa #_____Country of Issuance_____ Student and Exchange Visitor Information System (SEVIS) ID:

Alien #_____ _____

Refugee Travel Document (I-571)#_____ Certificate of Eligibility for Nonimmigrant (F-1) Student Status

Foreign Passport Number_____ (I-20): SEVIS ID_____

Reentry Permit (I-327)#:_____ Country of Issuance:_____

Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019) Temporary I-551 Stamp (on passport or I-94, I-94A)

SEVIS ID_____ Country of Issuance: _____

Country of Issuance_____ Alien Number:_____

Other documents or status types:

Document Description_____ Alien #_____SEVIS ID_____

If your name is different on your immigration document, please provide the name on the document:

Document Expiration Date:_____/_____/_____ Date of Entry into U.S.: _____/_____/_____

Country of Origin:_____ Lived in the U.S. before 08/22/1996? ❑ Yes ❑ No

If this individual has applied for or received permanent residence status, please provide the USCIS/INS Status Date/Permanent Residence Date: _____/_____/_____

Does this individual have a Sponsor? ❑Yes ❑No If yes, what is the type of sponsor? ❑Individual ❑Agency/Organization

Is the sponsor a member of the household? ❑Yes ❑No If yes, name of household member:_____

If the sponsor is a person/organization outside of the household, please provide the following information:

Organization Name:_____ Sponsor Name:_____

Address:_____ Primary Phone Number:_____

Secondary Phone Number:_____ Email Address:_____

14 RIW SNAP CCAP GPA SSP ACC LTSS EAD MPP KB

Are you or anyone in the household living with a mental, emotional or physical disability or illness, or blind? ❑YES ❑NO

If yes, complete the boxes below for each person.

Person 1:

Last Name First Name Middle Initial	Medical problem (describe)	Caused by an accident? ❑Yes ❑No

Has this person applied for SSI or Social Security Benefits (SSDI)? ❑Yes ❑No If yes, date applied:_____/_____/_____

Has the Social Security Administration made an official decision that this person is living with a disability or blind? ❑Yes ❑No

Is this person receiving services for with the RI Office of Rehabilitation Services or Services for the Blind? ❑Yes ❑No

If this person is a parent who is not working, does this person's disability make him/her unable to care for the child(ren)? ❑Yes ❑No

Is this disability expected to last at least 12 months and will it prevent this person from working or going to school? ❑Yes ❑No

Does this person need help with activities of daily living such as bathing, dressing, getting into bed, daily chores, etc.? ❑Yes ❑No

Does this person need long-term care services at home or in a community or health facility setting like a nursing home to help with the condition? ❑Yes ❑No

Person 2:

Last Name First Name Middle Initial	Medical problem (describe)	Caused by an accident? ❑Yes ❑No

Has this person applied for SSI or Social Security Benefits (SSDI)? ❑Yes ❑No If yes, date applied:_____/_____/_____

Has the Social Security Administration made an official decision that this person is living with a disability or blind? ❑Yes ❑No

Is this person active with the Office of Rehabilitation Services or Services for the Blind? ❑Yes ❑No

If this person is a parent who is not working, does this person's disability make him/her unable to care for the child(ren)? ❑Yes ❑No

Is this disability expected to last at least 12 months and will it prevent this person from working or going to school? ❑Yes ❑No

Does this person need help with activities of daily living such as bathing, dressing, getting into bed, daily chores, etc.? ❑Yes ❑No

Does this person need long-term care services at home or in a community or health facility setting like a nursing home to help with the condition? ❑Yes ❑No

15 RIW SNAP CCAP GPA SSP ACC LTSS EAD MPP KB

Do you or anyone in the household expect income from a job this month? ❑YES ❑NO

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

EXAMPLES: Salaries/Wages, Commissions, National Guard, Army Reserve, Work Study, Job Training, Sheltered Workshop, U.S. Military, Jury Duty, Foreign Earned Income

If yes, complete the boxes below for each person who is employed and each job.

Person 1/Job 1:

Last Name First Name Middle Initial	Employer Name, Address and/or Employer Identification Number, if available

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

How Often Paid: ❑Hourly ❑Weekly ❑Every two weeks ❑Twice a month ❑Monthly ❑Yearly ❑Other_____
Average hours worked each week_____

List below the gross amount paid on each pay day over the last 30 days.

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

Did you receive earned income tax credit in your paycheck? ❑Yes ❑No

Is this job part of a work study program? ❑Yes ❑No

Is this an On the Job training program? ❑Yes ❑No

Will this income be received in the following month? ❑Yes ❑No

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

Number of Hours:_____Expected Gross Earnings:$_____Tips/Commissions: $_____

Does this person have work related expenses required by the employer or due to being blind or disabled? ❑Yes ❑No

If yes, expense type: _____

Expense amount: $_____

Did this person receive unemployment compensation in the last 12 months? ❑Yes ❑No

If yes, dates received: From_____to_____

Did this person refuse a job or training program offer in the last 30 days? ❑Yes ❑No

If this person's income is not the same from month to month, how much do you think this person will make next year? $_____

Person 2/Job 2:

Last Name First Name Middle Initial	Employer Name, Address and/or Employer Identification Number, if available

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

How Often Paid: ❑Hourly ❑Weekly ❑Every two weeks ❑Twice a month ❑Monthly ❑Yearly ❑Other_____
Average hours worked each week_____

List below the gross amount paid on each pay day over the last 30 days.

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

Did you receive earned income tax credit in your paycheck? ❑Yes ❑No

Is this job part of a work study program? ❑Yes ❑No

Is this an On the Job training program? ❑Yes ❑No

Will this income be received in the following month? ❑Yes ❑No

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

Number of Hours:_____Expected Gross Earnings:$_____Tips/Commissions: $_____

Does this person have work related expenses required by the employer or due to being blind or disabled? ❑Yes ❑No

If yes, expense type: _____

Expense amount: $_____

Did this person receive unemployment compensation in the last 12 months? ❑Yes ❑No

If yes, dates received: From_____to_____

Did this person refuse a job or training program offer in the last 30 days? ❑Yes ❑No

If this person's income is not the same from month to month, how much do you think this person will make next year? $_____

Person 3/Job 3:

Last Name	First Name	Middle Initial	Employer Name, Address and/or Employer Identification Number, if available

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

How Often Paid: ❑Hourly ❑Weekly ❑Every two weeks ❑Twice a month ❑Monthly ❑Yearly ❑Other_____

Average hours worked each week_____

List below the gross amount paid on each pay day over the last 30 days.

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

Did you receive earned income tax credit in your paycheck? ❑Yes ❑No

Is this job part of a work study program? ❑Yes ❑No

Is this an On the Job training program? ❑Yes ❑No

Will this income be received in the following month? ❑Yes ❑No

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

Number of Hours:_____Expected Gross Earnings:$_____Tips/Commissions: $_____

Does this person have work related expenses required by the employer or due to being blind or disabled? ❑Yes ❑No	If yes, expense type: _____	Expense amount: $_____
Did this person receive unemployment compensation in the last 12 months? ❑Yes ❑No	If yes, dates received: From_____to_____	Did this person refuse a job or training program offer in the last 30 days? ❑Yes ❑No

If this person's income is not the same from month to month, how much do you think this person will make next year? $_____

16 **RIW** **SNAP** **CCAP** **GPA** **SSP** **ACC** **LTSS** **EAD** **MPP** **KB**

Do you, your spouse, or anyone in the household receive income from self-employment? ❑YES ❑NO

EXAMPLES: Home Business, Online Sales *(ex. EBay, Craigslist*), Farming, Fishing, Babysitting/Child Care, Door-to-door Sales, Home Sales, House Cleaning

If yes, complete the boxes below about each person. Attach documentation of expenses.

Person 1/Job 1:

Last Name First Name Middle Initial	Gross Income/How Often $_____per_____	Average number of hours worked per week

Type of Business	Name of Business	Will this income be received in the following months? ❑YES ❑NO

Total Monthly Business Related Expenses: $_____	How much net income (income minus expenses) will you get from this self-employment this month? $_____ Check one: ❑Profit ❑Loss

If caring for children in your home, number of children cared for:	Number of weeks worked:

Person 2/Job 2:

Last Name First Name Middle Initial	Gross Income/How Often $_____per_____	Average number of hours worked per week

Type of Business	Name of Business	Will this income be received in the following months? ❑YES ❑NO
Total Monthly Business Related Expenses: $_____	How much net income (income minus expenses) will you get from this self-employment this month? $_____	Check one: ❑Profit ❑Loss
If caring for children in your home, number of children cared for:	Number of weeks worked:	

17 **RIW** **SNAP** **CCAP** **GPA** **SSP** **ACC** **LTSS** **EAD** **MPP** **KB**

Do you, or your spouse, or anyone in the household receive or expect to receive, income other than from a job or self-employment, such as the types below? (This includes money given to you by a friend or relative.) ❑YES ❑NO

If yes, complete the boxes below for each person.

If you are applying for **ACC** only, do not report Supplemental Security Income (SSI), Veterans Disability Benefits, child support, gifts, proceeds from loans (such as student loans, home equity loans, or bank loans) or scholarships for classes. Provide more information about your dividend payments, interest payments, capital gains or losses, or income from partnership corporations not included in your self-employment income. For *all other programs*, list the portion of student loans, scholarships, awards or fellowship grants used for living expenses.

EXAMPLES:

Adoption Subsidy	401(k)	Railroad Retirement	Unemployment Compensation
Court Award	Gifts, Prizes, Inheritance, Lottery	Royalties	Cash Support
Alien Sponsorship	In-kind Shelter	Retirement Pensions	VA Aid and Attendance
Alimony	Income Tax Refund	Social Security (RSDI)	VA Compensation
Annuities	Other in-kind	Section 8 Utility Payment	VA Basic Benefits
Net Capital Gains/Investment Income	Gambling winnings	Interest Income	Income from Partnership Corporations
Child Support	Royalty Income	SSI, SSDI	VA Improved Pension
Dividends, Interest	Insurance and Lawsuit Claim	Workers' Compensation	IRA Distributions
Earned Income Tax Credit Refund	Strike Benefits	TDI	Promissory Note
Foster Care	Military Allotment	Trust Funds	Student Income (Loans, Grants, Scholarships)
	Out of State Assistance		

Person 1:

Last Name First Name Middle Initial	Amount/How Often	Date Income Received
	$_____per_____	_____/_____/_____
Claim Number *(if applicable)*	Type of Income	Will this income be received in the following months? ❑YES ❑NO
Do you have any expenses withheld from or related to this income? ❑YES ❑NO	If yes, please describe the expense(s):	Amount of expense(s): _____

Person 2:

Last Name First Name Middle Initial	Amount/How Often	Date Income Received
	$_____per_____	_____/_____/_____
Claim Number *(if applicable)*	Type of Income	Will this income be received in the following months? ❑YES ❑NO
Do you have any expenses withheld from or related to this income? ❑YES ❑NO	If yes, please describe the expense(s):	Amount of expense(s): _____

Person 3:

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

Do you have any expenses withheld from or related to this income? ❑YES ❑NO	If yes, please describe the expense(s):	Amount of expense(s): _____

Person 4:

Last Name First Name Middle Initial	Amount/How Often	Date Income Received
	$_____per_____	_____/_____/_____
Claim Number *(if applicable)*	Type of Income	Will this income be received in the following months? ❑YES ❑NO
Do you have any expenses withheld from or related to this income? ❑YES ❑NO	If yes, please describe the expense(s):	Amount of expense(s): _____

If anyone in the household expects income within the next 12 months, fill in the box below for that person.		
Last Name First Name Middle Initial	Type of income Expected	Expected Date income will be received ____/____/____

18 ACC

Please report any additional allowable tax deductions not previously reported on this application.

The purpose of a tax reduction is to reduce your taxable income. If you pay any of the expenses listed below, that means your income is lower and it may lower the cost of your health insurance. ***If you have previously reported expenses in questions 15 - 17, you do not have to report them again here.***

Examples of allowable deductions:

Health Savings Account (HSA) Contributions
Self-Employment Retirement Plans and Self-Employment Health Insurance
Penalties Paid for Early Withdrawal from Savings
Moving Costs Related to a job change
Interest Paid on Student Loans
Educator Expenses
Tuition and School Fees
IRA/401K Deductions
Domestic Product Activities
Business expenses of performing artists, reservists, and fee-basis government officials

❑Alimony Paid	❑Student Loan Interest	❑Tuition and School Fees
Who?_____	Who?_____	Who?_____
How much?_____	How much?_____	How much?_____
How Often?_____	How Often?_____	How Often?_____
❑Other_____	❑ Other_____	❑ Other_____
Who?_____	Who?_____	Who?_____
How much?_____	How much?_____	How much?_____
How Often?_____	How Often?_____	How Often?_____

19 ACC

Please complete the boxes below for every household member even if the tax payer or tax dependent is not in your home.

Name	Does this person plan to file a federal income tax return next year?	Will this person file jointly with a spouse/partner? *(If married, you have to file jointly to qualify for a tax credit)*	Does this person have any tax dependents? *(A dependent can be claimed by only one tax filer. For joint filers, you need to list dependents for the tax filer who will sign the tax form.)*	Is this person claimed as a tax dependent on someone else's tax return?	How is this person related to the tax filer?
	❑YES ❑NO	❑YES ❑NO If yes, name of spouse or partner:	❑YES ❑NO If yes, name of tax dependents:	❑YES ❑NO If yes, name of the tax filer:	

	❑YES ❑NO	❑YES ❑NO If yes, name of spouse or partner:	❑YES ❑NO If yes, name of tax dependents:	❑YES ❑NO If yes, name of the tax filer:	
	❑YES ❑NO	❑YES ❑NO If yes, name of spouse or partner:	❑YES ❑NO If yes, name of tax dependents:	❑YES ❑NO If yes, name of the tax filer:	
	❑YES ❑NO	❑YES ❑NO If yes, name of spouse or partner:	❑YES ❑NO If yes, name of tax dependents:	❑YES ❑NO If yes, name of the tax filer:	

20 **ACC** **LTSS** **EAD** **MPP**

Is anyone in the household enrolled in or does anyone in the household *have access to* health coverage now? ❑YES ❑NO
If yes, complete the boxes below for each person/type of insurance.

*Examples of Insurance Types: Tricare, Veteran's Health Insurance, Peace Corps, Medicare, Employer Insurance, Private Insurance, Cobra, Dental Insurance, Retiree Plan, Other

Name	Insurance Company Name	Insurance Policy # or Medicare Claim #	*Insurance Type *(see examples above)*	Currently Enrolled?
		_____ Monthly Premium:_____	_____ Check one: ❑Individual ❑Family	❑YES ❑NO If no, plans to enroll? ❑YES ❑NO Start Date:
		_____ Monthly Premium:_____	_____ Check one: ❑Individual ❑Family	❑YES ❑NO If no, plans to enroll? ❑YES ❑NO Start Date:
		_____ Monthly Premium:_____	_____ Check one: ❑Individual ❑Family	❑YES ❑NO If no, plans to enroll? ❑YES ❑NO Start Date:
		_____ Monthly Premium:_____	_____ Check one: ❑Individual ❑Family	❑YES ❑NO If no, plans to enroll? ❑YES ❑NO Start Date:
		_____ Monthly Premium:_____	_____ Check one: ❑Individual ❑Family	❑YES ❑NO If no, plans to enroll? ❑YES ❑NO Start Date:
		_____ Monthly Premium:_____	_____ Check one: ❑Individual ❑Family	❑YES ❑NO If no, plans to enroll? ❑YES ❑NO Start Date:

Please fill in the information below if there are any upcoming changes to any of the employer insurance listed above.

Name of person with employer coverage:_____
❑Employer plans to drop plan on (MM/DD/YYYY):_____ ❑Will become eligible on (MM/DD/YYYY):_____

Name of person with employer coverage:_____
❑Employer plans to drop plan on (MM/DD/YYYY):_____ ❑Will become eligible on (MM/DD/YYYY):_____

Fill in the information below for all family members applying for health coverage.

Name:	Last covered by health insurance: ❑Within the last year:_____/_____/_____ ❑1-3 years ago ❑More than 3 years ago ❑Never ❑Other/Uninsured
Name:	Last covered by health insurance: ❑Within the last year:_____/_____/_____ ❑1-3 years ago ❑More than 3 years ago ❑Never ❑Other/Uninsured

21 **RIW** **SNAP** **CCAP** **ACC**

Please fill in the boxes below about the educational background of each member of your household.

Person 1:

Name	Highest Grade Completed	High School Graduation Date (if graduated):_____/_____/_____	Received GED? ❑Yes ❑No	In School Now? ❑Yes ❑No
If in school, name of school:		Attending: ❑Full Time ❑Half Time ❑Less than Half Time		
Type: ❑K-12 ❑GED ❑Vocational ❑College/University ❑Trade School ❑Other		Expected Graduation Date: _____/_____/_____		
Participating in a work study program? ❑Yes ❑No		Participating in a training program? ❑Yes ❑No		
If yes, name of training program:				

Person 2:

Name	Highest Grade Completed	High School Graduation Date (if graduated):_____/_____/_____	Received GED? ❑Yes ❑No	In School Now? ❑Yes ❑No
If in school, name of school:		Attending: ❑Full Time ❑Half Time ❑Less than Half Time		
Type: ❑K-12 ❑GED ❑Vocational ❑College/University ❑Trade School ❑Other		Expected Graduation Date: _____/_____/_____		
Participating in a work study program? ❑Yes ❑No		Participating in a training program? ❑Yes ❑No		
If yes, name of training program:				

Person 3:

Name	Highest Grade Completed	High School Graduation Date (if graduated):_____/_____/_____	Received GED? ❑Yes ❑No	In School Now? ❑Yes ❑No
If in school, name of school:		Attending: ❑Full Time ❑Half Time ❑Less than Half Time		
Type: ❑K-12 ❑GED ❑Vocational ❑College/University ❑Trade School ❑Other		Expected Graduation Date: _____/_____/_____		
Participating in a work study program? ❑Yes ❑No		Participating in a training program? ❑Yes ❑No		
If yes, name of training program:				

Person 4:

Name	Highest Grade Completed	High School Graduation Date (if graduated):_____/_____/_____	Received GED? ❑Yes ❑No	In School Now? ❑Yes ❑No
If in school, name of school:		Attending: ❑Full Time ❑Half Time ❑Less than Half Time		
Type: ❑K-12 ❑GED ❑Vocational ❑College/University ❑Trade School ❑Other		Expected Graduation Date: _____/_____/_____		
Participating in a work study program? ❑Yes ❑No		Participating in a training program? ❑Yes ❑No		
If yes, name of training program:				

22 **RIW** **SNAP** **LTSS**

Are you, your spouse, or anyone in the household in a group living arrangement such as the types listed below? ❑YES ❑NO

Shelter for Homeless | Drug Treatment Center | Hospital | Group Home
Alcohol Treatment Center | Domestic Violence Shelter | Assisted Living Facility | Dormitory

If yes, complete the boxes below.

Last Name	First Name	Middle Initial	Name of Facility	Type of Facility	Number of meals provided per day?

23 **SNAP**

Are you or any member of your household hiding or running from the law to avoid prosecution, being taken into custody, or going to jail, for a felony crime or attempted felony crime, or violating a condition or parole or probation? ❑YES ❑NO

If yes, complete the boxes below for each household member.

Last Name	First Name	Middle Initial	Date of Finding	State

24 **CCAP**

If you are applying for child care assistance, please tell us about your schedule regarding your need for child care. Fill in the table below with the reason you need child care and enter the time for child care on each day.

Person 1:

Parent's Name:		Child's Name:	
Day	Need Reason (*check the appropriate boxes*)	Start Time	End Time
Monday	❑Work ❑High School/GED Completion ❑Special Needs due to Health Condition		
Tuesday	❑Work ❑High School/GED Completion ❑Special Needs due to Health Condition		
Wednesday	❑Work ❑High School/GED Completion ❑Special Needs due to Health Condition		
Thursday	❑Work ❑High School/GED Completion ❑Special Needs due to Health Condition		
Friday	❑Work ❑High School/GED Completion ❑Special Needs due to Health Condition		
Saturday	❑Work ❑High School/GED Completion ❑Special Needs due to Health Condition		
Sunday	❑Work ❑High School/GED Completion ❑Special Needs due to Health Condition		
If your schedule varies, please explain how (you may send additional documentation to verify).			

Person 2:

Parent's Name:		Child's Name:	
Day	Need Reason (*check the appropriate boxes*)	Start Time	End Time
Monday	❑Work ❑High School/GED Completion ❑Special Needs due to Health Condition		
Tuesday	❑Work ❑High School/GED Completion ❑Special Needs due to Health Condition		
Wednesday	❑Work ❑High School/GED Completion ❑Special Needs due to Health Condition		

Thursday	❑Work ❑High School/GED Completion ❑Special Needs due to Health Condition		
Friday	❑Work ❑High School/GED Completion ❑Special Needs due to Health Condition		
Saturday	❑Work ❑High School/GED Completion ❑Special Needs due to Health Condition		
Sunday	❑Work ❑High School/GED Completion ❑Special Needs due to Health Condition		
If your schedule varies, please explain how (you may send additional documentation to verify).			

25 **RIW** **SNAP**

Do you, your spouse or anyone in the household pay for room and/or board? ❑YES ❑NO
If yes, complete the box below for the household member who pays for room and/or board.

Last Name First Name Middle Initial	Amount Paid/How Often	What does the room/board cover?
	$_____ per_____	❑Room only ❑Board (1-2 meals) ❑Board (3 meals)
Who is the room/board payment paid to?		

26 **RIW** **CCAP** **GPA** **SSP** **LTSS** **EAD** **MPP** **KB**

Does anyone in your household, including you, have a legal claim or lawsuit for illnesses or injuries resulting from a car or workplace accident or other matter in which you may receive money? ❑YES ❑NO

If yes, complete the boxes below for each person.

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

27a **RIW** **CCAP** **ACC**

Are there children in the household who have a parent (natural or adoptive) living outside the home or deceased? ❑YES ❑NO
If applying for ACC, answering this question is optional. If YES, I know I'll be asked to cooperate with the Office of Child Support Services that collects medical support from a non-custodial parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency and I may not have to cooperate.

27b **RIW** **CCAP**

If you answered yes to question #27a and are applying for RIW and/or CCAP, please fill in the boxes below for each parent living outside the home (non-custodial parent) or deceased.

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

Parent 1:

Non-custodial/Deceased Parent's Last Name First Name MI	Gender	Non-custodial/Deceased Parent's SSN	Birth Date
	❑M ❑F	____/____/____	____/____/____

Non-custodial Parent's Address		Non-custodial Parent's Telephone Number
Employer Name	Employer Address	Is this parent disabled and/or a veteran? ❑Yes ❑No
Was the child born during the marriage or within 300 days after the marriage ended due to death or divorce? ❑Yes ❑No If yes, date married____/____/____	Are the parents of the child(ren) *currently* married to each other? ❑Yes ❑No If no, date divorced____/____/____	Non-custodial Parent's Marital Status ❑Never Married ❑Divorced ❑Widowed ❑Married ❑Separated ❑Unknown
Non-custodial Parent's Race: Ethnicity: Hair Color: Height: Weight: Birth City: Birth State:		
Has the non-custodial parent ever been in jail? ❑Yes ❑No	If yes, incarceration begin date: ____/____/____	Incarceration end date: ____/____/____
Is a parent of the child(ren) deceased? ❑Yes ❑No	If yes, deceased parent's date of death: / /	

Child(ren) of this non-custodial parent living in the applicant's household. Child's Last Name First Middle Initial	State of Birth	Is child support, health coverage or paternity court ordered? (If yes, check off type of coverage and list date.)			
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 ____/____/____

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

Parent 2:

Non-custodial/Deceased Parent's Last Name First Name MI	Gender	Non-custodial/Deceased Parent's SSN	Birth Date
	❑M ❑F	____/___/____	____/____/____

Non-custodial Parent's Address		Non-custodial Parent's Telephone Number
Employer Name	Employer Address	Is this parent disabled and/or a veteran? ❑Yes ❑No
Was the child born during the marriage or within 300 days after the marriage ended due to death or divorce? ❑Yes ❑No If yes, date married____/____/____	Are the parents of the child(ren) *currently* married to each other? ❑Yes ❑No If no, date divorced____/____/____	Non-custodial Parent's Marital Status ❑Never Married ❑Divorced ❑Widowed ❑Married ❑Separated ❑Unknown
Non-custodial Parent's Race: Ethnicity: Hair Color: Height: Weight: Birth City: Birth State:		
Has the non-custodial parent ever been in jail? ❑Yes ❑No	If yes, incarceration begin date: ____/____/____	Incarceration end date: ____/____/____

Is a parent of the child(ren) deceased? ❑Yes ❑No	If yes, deceased parent's date of death: ____/____/____

Child(ren) of this non-custodial parent living in the applicant's household. Child's Last Name First Middle Initial	State of Birth	Is child support, health coverage or paternity court ordered? (If yes, check off type of coverage and list date.)			
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 ____/____/____

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

Parent 3:

Non-custodial/Deceased Parent's Last Name First Name MI	Gender ❑M ❑F	Non-custodial/Deceased Parent's SSN ____/___/____	Birth Date ____/____/____
Non-custodial Parent's Address		Non-custodial Parent's Telephone Number	
Employer Name	Employer Address		Is this parent disabled and/or a veteran? ❑Yes ❑No
Was the child born during the marriage or within 300 days after the marriage ended due to death or divorce? ❑Yes ❑No If yes, date married____/____/____	Are the parents of the child(ren) *currently* married to each other? ❑Yes ❑No If no, date divorced____/____/____	Non-custodial Parent's Marital Status ❑Never Married ❑Divorced ❑Widowed ❑Married ❑Separated ❑Unknown	
Non-custodial Parent's Race: Ethnicity: Hair Color: Height: Weight: Birth City: Birth State:			
Has the non-custodial parent ever been in jail? ❑Yes ❑No	If yes, incarceration begin date: ____/____/____	Incarceration end date: ____/____/____	
Is a parent of the child(ren) deceased? ❑Yes ❑No	If yes, deceased parent's date of death: ____/____/____		

Child(ren) of this non-custodial parent living in the applicant's household. Child's Last Name First Middle Initial	State of Birth	Is child support, health coverage or paternity court ordered? (If yes, check off type of coverage and list date.)			
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 ____/____/____

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

Person 4:

Non-custodial/Deceased Parent's Last Name First Name MI	Gender ❑M ❑F	Non-custodial/Deceased Parent's SSN ___/___/___	Birth Date ___/___/___
Non-custodial Parent's Address		Non-custodial Parent's Telephone Number	
Employer Name	Employer Address		Is this parent disabled and/or a veteran? ❑Yes ❑No
Was the child born during the marriage or within 300 days after the marriage ended due to death or divorce? ❑Yes ❑No If yes, date married___/___/___	Are the parents of the child(ren) *currently* married to each other? ❑Yes ❑No If no, date divorced___/___/___	Non-custodial Parent's Marital Status ❑Never Married ❑Divorced ❑Widowed ❑Married ❑Separated ❑Unknown	
Non-custodial Parent's Race: Ethnicity: Hair Color: Height: Weight: Birth City: Birth State:			
Has the non-custodial parent ever been in jail? ❑Yes ❑No	If yes, incarceration begin date: ___/___/___	Incarceration end date: ___/___/___	
Is a parent of the child(ren) deceased? ❑Yes ❑No	If yes, deceased parent's date of death: ___/___/___		

Child(ren) of this non-custodial parent living in the applicant's household. Child's Last Name First Middle Initial	State of Birth	Is child support, health coverage or paternity court ordered? (If yes, check off type of coverage and list date.)			
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 ___/___/___

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

28 SNAP

Have you or has any member of your household been convicted of any of the offenses listed below? ❑YES ❑NO

If yes, please fill in the boxes below for each household member who has been convicted of an offense and check the box for the applicable offense on the right.

Last Name First Name Middle Initial	Check the box(es) below that apply.
	❑Trading SNAP benefits for drugs after September 22, 1996? ❑Buying or selling SNAP benefits over $500 after September 22, 1996? ❑Fraudulently receiving duplicate SNAP benefits in any state after September 22, 1996? ❑Trading SNAP benefits for guns, ammunitions or explosives after September 22, 1996?

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

If yes, complete the boxes below for each household member.

Last Name First Name Middle Initial	Date	State

30 **RIW** **CCAP** **GPA** **SSP** **LTSS** **EAD** **MPP** **KB**

Do you, your spouse, or anyone in the household own, and/or have registered in his/her name any vehicle? ❑YES ❑NO

If yes, complete the boxes below for each vehicle. Examples: car, boat, camper, snowmobile, truck, motorcycle

Vehicle 1:

Owner's Last Name First Name Middle Initial	Vehicle Type	Make	Model	Year

What is the vehicle used for? *(ex: work, everyday use, transportation for disabled household member)*	Amount owed $	License Plate Number	Vehicle ID Number (VIN)

Insurance Company Name:

Is vehicle registered? ❑Yes ❑No	Is vehicle income producing? ❑Yes ❑No	Do you currently have possession of the vehicle? ❑Yes ❑No

Do you own the vehicle with someone else? ❑Yes ❑No	If yes, name of person who co-owns the vehicle:

Vehicle 2

Owner's Last Name First Name Middle Initial	Vehicle Type	Make	Model	Year

What is the vehicle used for? *(ex: work, everyday use, transportation for disabled household member)*	Amount owed $	License Plate Number	Vehicle ID Number (VIN)

Insurance Company Name:

Is vehicle registered? ❑Yes ❑No	Is vehicle income producing? ❑Yes ❑No	Do you currently have possession of the vehicle? ❑Yes ❑No

Do you own the vehicle with someone else? ❑Yes ❑No	If yes, name of person who co-owns the vehicle:

31 **RIW** **CCAP** **GPA** **SSP** **LTSS** **EAD** **MPP** **KB**

Certain resources/assets such as bank accounts may count toward your eligibility depending on which program you are applying for. Certain resources/assets may not count, such as a home and lot where you live and the resources of people who receive Supplemental Security Income. Examples of things you own include, but are not limited to: Cash on hand, checking account, savings account, trust(s), CD –Certificate of Deposit, royalties, life or burial insurance, stocks or bonds, retirement account, livestock, house/land - not occupying, life estate, mutual funds

Do you, your spouse, or anyone in the household have any resources/assets? ❑YES ❑NO

If yes, complete the boxes below for each resource/asset owned by your and anyone in your household.

Resource or Asset	Who owns it?	Value	Bank or Company Name, if Applicable
		$_____ Income producing? ❑Yes ❑No	
		$_____ Income producing? ❑Yes ❑No	
		$_____ Income producing? ❑Yes ❑No	
		$_____ Income producing? ❑Yes ❑No	

32 **RIW** **CCAP** **GPA** **SSP** **LTSS** **EAD** **MPP** **KB**

Did you, your spouse, or anyone in the household receive a lump sum payment such as Social Security, Retirement, Survivors and Disability (RSDI) in the past 6 months? ❑YES ❑NO

If yes, complete the boxes below for each lump sum payment.

Person 1

Last Name	First Name	Middle Initial	Type of payment	Date received _____/____/_____

Lump sum amount: $_____	Is lump sum jointly owned? ❑Yes ❑No	If yes, who is the co-owner?

Person 2

Last Name	First Name	Middle Initial	Type of payment	Date received _____/____/_____

Lump sum amount: $_____	Is lump sum jointly owned? ❑Yes ❑No	If yes, who is the co-owner?

33 **RIW** **CCAP** **GPA** **SSP** **LTSS** **MPP** **KB**

Have you, your spouse or anyone acting on your behalf (including a court) established a trust or put any money or other resource into a trust within the last sixty (60) months? ❑YES ❑NO

Has any property come out of a trust within the last sixty (60) months? ❑YES ❑NO

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

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

34 **RIW** **EAD** **LTSS** **MPP**

Have you, your spouse, or anyone in the household given away, sold, deeded, or transferred to anyone or any entity, any items of value in the past sixty (60) months? ❑YES ❑NO

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

If yes, complete the boxes below.

Item Transferred	Transferred to Whom?	$ Value	Date of Transfer

35 **SNAP**

Did you or anyone in the household leave a job in the last sixty (60) days or is anyone on strike? ❑YES ❑NO

If yes, fill in the boxes below.

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

36 **RIW** **SNAP** **CCAP** **GPA** **SSP** **ACC** **LTSS** **EAD** **MPP** **KB**

Do you, your spouse or anyone in your household receive income from rent? ❑YES ❑NO

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

Last Name First Name Middle Initial	Number of Units	Does the person live here? ❑YES ❑NO
Hours per week maintaining property:_____	Total rent received $_____ per_____	Will this income continue in the next months? ❑YES ❑NO

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

37 **RIW** **SNAP** **CCAP** **GPA** **SSP** **ACC** **LTSS** **EAD** **MPP** **KB**

Do you, your spouse or anyone in your household receive payment from roomers and/or boarders? ❑YES ❑NO

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

Name of person receiving payment: Last Name First Name Middle Initial				Number of hours worked per week:
				Will this income be received in the following months? ❑YES ❑NO
Names of Roomer/Boarders	Amount Received/How Often	Includes *(check boxes)*		Date Received
	$_____ per_____	Room only Board (1-2 meals) Board (3 meals)	❑ ❑ ❑	____/____/____
	$_____ per_____	Room only Board (1-2 meals) Board (3 meals)	❑ ❑ ❑	____/____/____
	$_____ per_____	Room only Board (1-2 meals) Board (3 meals)	❑ ❑ ❑	____/____/____
Expenses: $_____ per _____		Type(s) of expenses:		

**(If you report and provide proof of your expenses you list for questions 38-42, it can help you get more benefits from SNAP and may affect your eligibility. If you do not report an expense or provide proof, then we will assume that you do not want this expense to be counted.)*

38 **RIW** **SNAP**

Do you, your spouse, or anyone in the household pay for someone to care for children, elderly, or disabled adults due to work, training, looking for work or schooling? ❑YES ❑NO

EXAMPLES: Payments made to child or adult care providers for day care; Payments made for before and after school programs; Summer camp fees; Cost of transportation to and from child/adult care providers

If yes, complete the boxes below for each person who paid for care.

Person 1:

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

Person 2:

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

39 **SNAP** **LTSS** **EAD**

Is there anyone in the household who is age sixty (60) or older (age 65 or older if applying for EAD/LTSS) or disabled, who incurs or has any unpaid medical expenses not covered by health insurance? ❑**YES** ❑**NO**

EXAMPLES: Health Insurance Premiums Hearing Aids Dental Care Prescription Drugs Medicare Premiums Eyeglasses Hospital Bills Medical Equipment/Supplies Transportation to and from Medical Treatment or Services

If yes, complete the boxes below for each person who has medical expenses or each medical expense.

Person 1/Expense 1:

Last Name First Name Middle Initial		Type of Medical Expense	Amount Incurred $_____ How often? _____
Is the medical expense overdue? ❑YES ❑NO	Expense is paid to:	Date of Service _____/_____/_____	When do you expect this to end? _____/_____/_____

Person 2/Expense 2:

Last Name First Name Middle Initial		Type of Medical Expense	Amount Incurred $_____ How often? _____
Is the medical expense overdue? ❑YES ❑NO	Expense is paid to:	Date of Service ____/____/____	When do you expect this to end? ____/____/____

Person 3/Expense 3:

Last Name First Name Middle Initial		Type of Medical Expense	Amount Incurred $_____ How often? _____
Is the medical expense overdue? ❑YES ❑NO	Expense is paid to:	Date of Service ____/____/____	When do you expect this to end? ____/____/____

40 **SNAP** **ACC**

Do you, your spouse, or anyone in the household pay child support or alimony/spousal support for any person not living in this household? ❑**YES** ❑**NO**

If you are applying for **ACC** *only, you need to answer this question only if you pay alimony/spousal support.*

If yes, complete the boxes below about each person who pays child support or alimony/spousal support.

Person 1:

Last Name First Name Middle Initial	Who is the person claiming/Who is the support paid for?	
Amount Paid $_____per_____	Type of claim/support: ❑Child Support ❑ Medical Support ❑Alimony/Spousal Support	Is this expense court ordered? ❑YES ❑NO

Person 2:

Last Name First Name Middle Initial	Who is the person claiming/Who is the support paid for?	
Amount Paid $_____per_____	Type of claim/support: ❑Child Support ❑ Medical Support ❑Alimony/Spousal Support	Is this expense court ordered? ❑YES ❑NO

41 **RIW** **SNAP** **LTSS**

Do you, your spouse, or anyone in the household have housing bills? ❑**YES** ❑**NO**

EXAMPLES: Rent or a share of the rent for the apartment, house, mobile home or shelter where you live homeowner's insurance mortgage land contract property taxes assessment fees mobile home payments condo/association fees

If yes, complete the boxes below for each person who pays housing bills.

Last Name First Name Middle Initial	Total Rent or Mortgage Amount/How Often	Amount Paid by you	Shelter Type
	$_____/_____	$_____	
Does anyone share a cost of the housing expense? ❑YES ❑NO	If yes, Name:_____ Amount $_____		

If renting, included in rent: ❑Heat ❑Utilities	If renting, is the rent subsidized? ❑YES ❑NO	If yes, the amount of subsidy is $_____	Subsidy Type
If renting, Landlord's Name:		Landlord's Telephone Number	
Landlord's Address:			

Monthly Homeowner's Expenses: First Mortgage	Monthly Homeowner's Expenses: Second Mortgage
Principal $_____ Interest $_____ Includes: ❑Taxes ❑Insurance Taxes $_____ Insurance $_____ Lot Rental $_____ Other $_____	Principal $_____ Interest $_____ Includes: ❑Taxes ❑Insurance Taxes $_____ Insurance $_____ Lot Rental $_____ Other $_____

42 **SNAP** **LTSS**

Have you or anyone in the household received low-income heating assistance within the last 12 months? ❑**YES** ❑**NO**
Do you, or anyone in the household pay all or a share of the fuel or utilities listed below? ❑**YES** ❑**NO**

If yes, complete the boxes below indicating which fuel/utilities are paid for and how much.

Heating or Cooling? ❑YES ❑NO Included in Rent? ❑YES ❑NO	Telephone? ❑YES ❑NO If Yes, amount: $_____per_____	Electric? ❑YES ❑NO If Yes, amount: $_____per_____
Water? ❑YES ❑NO If Yes, amount: $_____per_____	Sewer? ❑YES ❑NO If Yes, amount: $_____per_____	Trash? ❑YES ❑NO If Yes, amount: $_____per_____

43 **EAD**

After April 1977, did you ever get an SSI check at the same time that you got social security, or did you get SSI in the month just before social security started? ❑YES ❑NO

If yes, fill in the boxes below.

Last Name	First Name	Middle Initial	Year Received

44 **ACC**

CONSENT FOR USE OF INCOME DATA

IN ORDER TO DETERMINE YOUR ELIGIBILITY FOR HELP PAYING FOR YOUR HEALTH COVERAGE, WE WILL USE INCOME DATA, INCLUDING INFORMATION FROM TAX RETURNS. YOU WILL RECEIVE A NOTICE WITH YOUR ELIGIBILITY DETERMINATION AND MAY MAKE CHANGES TO UPDATE THE INCOME INFORMATION USED AT ANY TIME BY CONTACTING HEALTHSOURCE RI. CHECK ONE OF THE BOXES BELOW:

❑**I AGREE TO GIVE MY CONSENT FOR USE OF INCOME DATA**

❑**I DO NOT GIVE MY CONSENT AND I UNDERSTAND THAT THIS WILL IMPACT MY ELIGIBILITY FOR HELPING TO PAY FOR HEALTH COVERAGE.**

YOU CAN CHOOSE TO HAVE THIS CONSENT RENEWED AUTOMATICALLY FOR ONE, TWO, THREE, FOUR OR FIVE YEARS. SELECTING A LONGER PERIOD OF TIME MAY MAKE IT EASIER FOR US TO DETERMINE YOUR ELIGIBILITY IN FUTURE YEARS. PLEASE RENEW MY ELIGIBILITY AUTOMATICALLY FOR THE NEXT (CHECK ONE):

❑**5 YEARS (THIS IS THE MAXIMUM AUTOMATIC RENEWAL PERIOD)** ❑**4 YEARS** ❑**3 YEARS** ❑**2 YEARS** ❑**1 YEAR**

I UNDERSTAND THAT IF RECEIVE FINANCIAL HELP TO REDUCE THE COST OF HEALTH COVERAGE FOR MYSELF AND/OR MY DEPENDENTS:

- ✓ **I MUST FILE A FEDERAL INCOME TAX RETURN THE YEAR AFTER MY COVERAGE YEAR FOR THE TAX YEAR IN WHICH I RECEIVED COVERAGE.**
- ✓ **IF I'M MARRIED AT THE END OF THE COVERAGE YEAR, I MUST FILE A JOINT INCOME TAX RETURN WITH MY SPOUSE.**

I ALSO EXPECT THAT:

- ✓ **NO ONE ELSE WILL BE ABLE TO CLAIM ME AS A DEPENDENT ON THEIR COVERAGE YEAR FEDERAL INCOME TAX RETURN.**

- ✓ I'll claim a personal exemption deduction on my coverage year federal income tax return for any individual listed on this application as a dependent who is enrolled in coverage and who receives financial help for this coverage.

If any of the above changes, I understand that it may impact my ability to get an advance premium tax credit.
I also understand that when I file my coverage year federal income tax return, the Internal Revenue Service (IRS) will compare the income on my tax return with the income on my application. I understand that if the income on my tax return is lower than the amount of income on my application, I may be eligible to get an additional tax credit amount. On the other hand, if the income on my tax return is higher than the amount of income on my application, I may owe additional federal income tax.

CONSENT TO IDENTITY VERIFICATION

To protect your privacy, you will need to successfully complete Identity Verification before establishing an online account with us and obtaining access to certain information that will be contained within your account. By clicking on the "I Agree" box you are providing your consent to Experian to access your personal information to conduct ID Verification on behalf of CMS and the state of Rhode Island.

- ❑ I Agree to give my Consent to Experian to conduct ID Verification
- ❑ I do not give my Consent and I understand that this will impact my eligibility for helping to pay for health coverage.

Ensure that you have written your legal name, current home address, primary phone number, date of birth, and email address correctly. For online account access, we will only collect personal information to verify your identity with Experian, an external identity verification provider. Identity Verification involves Experian using information from your consumer report profile to help confirm your identity. As a result, you may see an entry called a "soft inquiry" on your Experian consumer report. Soft inquiries are only visible to you, will never be presented to third parties, and do not affect your credit score. The soft inquiry will be titled "CMS Proofing Services" and will be removed from your Experian consumer report after 25 months. You may need to have access to your personal and consumer report information, as the Experian application will pose questions to you, based on data in their files.

YOUR CONSENT TO SHARE DATA FOR ELIGIBILITY DECISIONS

We can help you better if we are able to work with other agencies and professionals that know you and your family. By checking the I Agree box you are giving permission for us to obtain, use and share confidential information about you from a variety of sources including the R.I. Department of Labor and Training, the R.I. Department of Human Services, the R.I. Executive Office of Health and Human Services, the R.I. Department of Health, the R.I. Department of Corrections, and Experian on behalf of Centers for Medicaid and Medicare Services and Social Security Administration.

We will not refuse you any benefits or access to any programs that you are eligible simply because you do not give us permission to obtain, use and share confidential information, however, we are unable to assist you in accessing certain programs and supports that you may be eligible for if we do not have your consent to obtain and share information. Your consent is required in order to determine your eligibility.

You can proceed to shop for and purchase health insurance coverage without completing this consent by contacting our Contact Center at 1-855-840-HSRI (4774), but if you would like to know whether you are eligible for any financial help for the purchase of coverage, whether you are eligible for Medicaid, it will be necessary for you to complete this consent.

All information sharing and use that you are authorizing by checking the "I Agree" box will be done in compliance with all relevant federal and state laws and regulations protecting your privacy, including but not limited to: The Health Insurance Portability and Accounting Act of 1996 (Pub. L. 104-191 known as HIPAA); The R.I. Confidentiality of Health Care Communications and Information (R.I.G.L. 5-37.3-1 et seq.); R.I.G.L. 28-32-5, 28-36-12, 28-42-38, 28-39-19, 28-39-22, 40.1-5-26, 23-3-23, 42-12-22, 40-6-12 and all other applicable laws and regulations. Information will be shared by computer data transfer.

By checking on the I Agree box "I consent to the obtaining and use of confidential information about me to determine my eligibility for enrollment in publicly funded health insurance coverage or other publicly funded programs administered through this site, plan, provide, and coordinate benefits and payments".

- ❑ I Agree to give my Consent to Share Data for Eligibility Decisions
- ❑ I do not agree to this Consent and understand that my eligibility for certain programs and supports

WILL BE IMPACTED BY THIS DECISION **I HAVE READ OR HAD EXPLAINED TO ME MY RIGHTS AND RESPONSIBILITIES AND UNDERSTAND THAT I MAY KEEP A COPY OF THE RIGHTS AND RESPONSIBILITIES (LISTED ON PAGES 28-32).** ❑**YES** ❑**NO**

For Certified Application Counselors, Navigators, Agents and Brokers Only Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for someone else.	
Application Start Date: _____/_____/_____	
Last Name First Name Middle Initial	
Organization name	ID Number (if applicable)

Please read the Rights and Responsibilities on the following pages **and SIGN Rights and Responsibilities page 32. Your application must be signed to be a valid application.**

For Applicant/Recipient Use Only

Use this page to add information about questions 1 through 44. Be sure to include the question number.

Question #_____ Page #_____
Question #_____ Page #_____
Question #_____ Page #_____
Question #_____ Page #_____
Question #_____ Page #_____
Question #_____ Page #_____

RIGHTS AND RESPONSIBILITIES

Of Applicants/Recipients of RI Works Program (RIW), Supplemental Nutrition Assistance Program (SNAP), Medicaid and Private Health Insurance with Financial Help, Child Care Assistance, General Public Assistance (GPA), RI SSI State Supplemental Payment Program (SSP)

RIGHTS

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

You have a RIGHT to appeal and to receive an administrative fair hearing if you disagree with any agency actions or if there are delays in the process of your application. Hearings are the responsibility of the Executive Office of Health and Human Services Hearing Office, which has been designated to serve as the appeal entity for all public-funded health and human services programs included in this application. If you request an appeal, your hearing must be held promptly. You may be represented by a lawyer or any other person you select to appear on your behalf. For some programs, your benefits or services may be continued until a hearing decision is made if you appeal by certain deadlines. See the chart below for details.

Program	You must file an appeal in:	Will benefits continue if the appeal is made within 10 days of the notice?
Medicaid/Private Health Insurance with Financial Help	35 days after the notice date	Yes
SNAP	90 days from the notice mail date	Yes
CCAP	30 days from the notice mail date	Benefits may be reduced until a hearing decision is made.
GPA	10 days from the notice mail date	Yes, but request must be made in writing
All other programs	30 days from the notice mail date	Yes

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

In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794), Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), and Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Food and Nutrition Act of 2008 (formerly the Food Stamp Act), the Age Discrimination Act of 1975, the U.S. Department of Health and Human Services implementing regulations (45 C.F.R. Parts 80 and 84) and the U.S. Department of Education implementing regulations (34 C.F.R. Parts 104 and 106), and the U.S. Department of Agriculture, Food and Nutrition Services (7 C.F.R. 272.6); the EOHHS and the Department of Human Services (DHS), does not discriminate on the basis of race, color, national origin, disability, religion, political beliefs, age, religion or gender in acceptance for or provision of services, employment or treatment, in its education and other program activities. Under other provisions of applicable law, EOHHS/DHS does not discriminate on the basis of sexual orientation, gender identity or expression. For further information about these non-discrimination laws, regulations and complaint procedures for resolution of complaints of discrimination, contact DHS at 206 Elmwood Avenue, Providence, RI 02907 telephone number 415-8500 (for deaf/hearing impaired 1-800-745-6575 Voice; 1-800-745-5555 TTY, or 711). The Community Relations Liaison Officer is the coordinator for implementation of Title VI, the Office of Rehabilitation Services (ORS) Administrator or his/her designee is the coordinator for implementation of the Title IX, Section 504, and ADA. The Director of DHS or his/her designee has the overall responsibility for civil rights compliance for all agency programs. The Secretary of EOHHS is responsible for Medicaid related discrimination issues and any such complaints will be referred accordingly.

You have a RIGHT to confidentiality. Under state law, all agencies administrating programs included as part of this application are bound by state and federal laws and regulations to use 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. HIPAA restrictions prevent us

from discussing the health information of you or any member of your household with anyone, including unauthorized representative, unless that individual has power of attorney or you have signed a consent form authorizing the disclosure of this information. This includes disclosure of mental health information, HIV, AIDS, STD test results or treatment and chemical dependency services.

I understand that by signing this application, I am giving the EOHHS and the DHS my consent to use or disclose protected health information for the purposes of treatment, payment and health care operations in accordance with applicable agency notices of privacy practices. The EOHHS and DHS do 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, 40-6-12.1, and 42-7.2-5(13), regulations set forth in the DHS Administrative Code and Medicaid Codes of Administrative Rules. Any person found guilty of violating the provisions of Rhode Island General Laws 40-6-12 shall be deemed guilty of a misdemeanor. Violators are subject to a maximum fine of two hundred dollars ($200), or imprisonment of up to six (6) months, or both.

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

You have a RIGHT to apply for support enforcement services through the Office of Child Support Services. To get an application for these services, go to http://www.cse.ri.gov/ or visit your local Office of Child Support Services at 77 Dorrance St., Providence, RI 02903.

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

If you are applying for Medicaid affordable health care coverage, the EOHHS requires that the Department must:

- Provide you with thirty (30) days to give us the information we need to review your eligibility. If you don't give us the information or ask for more time we may deny, close, or change your health care coverage.
- Notify you, in most cases, at least ten (10) days before we stop your health care coverage.
- Give you a written decision, in most cases, within thirty (30) days. Health care coverage and some disability cases may take forty-five (45) to ninety (90) days.
- Continue Rhode Island Medicaid coverage while we decide if you are eligible under another program.

RESPONSIBILITIES

You have a RESPONSIBILITY to supply accurate information about your income, resources and living arrangements on this application.

You have a RESPONSIBILITY within ten (10) days for most programs and within thirty (30) days for Private Health Insurance with Financial Help of any changes in your income, resources, family composition, or any other changes that affect your household. For Medicaid, the ten (10) days begins five (5) days after the date the request for information was sent via email (transmittal date) or U.S. mail (postmark date). If you don't give us the information or ask for more time, we may deny, terminate suspend or change your health care coverage or benefits. For RIW Cash and CCAP, you must tell us within five (5) days when a child leaves your household for any reason. For SNAP, if you are a simplified reporter, you must report changes in income which bring the household's gross monthly income over the allowable amount for your household size. If you are unsure about your reporting requirements, contact DHS for assistance.

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

You have a RESPONSIBILITY to provide Social Security numbers (or proof that you have applied for one) for yourself and your household, or to apply, if you are required to, for them as a condition of eligibility. The collection of information on the application, as well as the Social Security numbers of all members of your household for whom you receive assistance, is authorized under the Food and Nutrition Act of 2008 (formerly the Food Stamp Act), as amended, 7 U.S.C. 2011-2036 and under Federal Law (45 CFR 155.305 and 42 CFR 435.910). This information will be used to determine whether your household is eligible or continues to be eligible to participate in SNAP, Medicaid, RIW, GPA, CCAP, Private Health Insurance with Financial Help. The Department will verify this information through computer matching with the Department of Labor and Training, the Social Security

Administration, the Internal Revenue Service, the Food and Nutrition Service, and other governmental and non-governmental entities authorized by law, regulation or contract, and they will be subject to verification by Federal, State, and local officials. The income and eligibility information obtained from these agencies will be used to make sure your household is eligible for and receiving the correct amount of SNAP benefits, GPA, Child Care, RIW, Medicaid, and Private Health Insurance with Financial Help. This information will also be used to monitor compliance with program regulations, for program management as well as to prevent fraud and verify health care claims.

This information may be disclosed to other federal and state agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law. If a claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies as well as private claims collection agencies for claims collection action. Providing the requested information is voluntary. However, failure to provide a SSN will result in the denial of benefits to any individual applying for benefits. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible household members.

You have a RESPONSIBILITY to report and provide proof of your expenses shown in questions 38 through 42 in order to get the maximum amount of SNAP benefits allowed. Failure to report or provide proof of your expenses will be regarded as your statement that you do not want to receive a deduction for the unreported or unproven expense.

You have a RESPONSIBILITY to cooperate fully with state and federal personnel conducting quality control reviews.

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

You have a RESPONSIBILITY to cooperate with the Office of Child Support Services if you receive RI Works, Child Care Assistance or Medicaid. You must help establish, modify, or enforce child support for the child(ren) in your care, and establish paternity (if necessary). If you can show that you have a good reason to believe that cooperating with the Office of Child Support Services puts you, your children, or the children in your care at risk of harm from the non-custodial parent, you may claim good cause not to cooperate.

You have a RESPONSIBILITY to apply for and make a reasonable effort to get potential income from other sources when you ask for or receive RI Medicaid coverage.

Information about Private Health Insurance with Financial Help
If you have questions about the terms of your health insurance plan, including what benefits you are eligible for, out of pocket expenses under your plan, and making a benefit claim or appealing a denial of benefits, you should contact your health insurance carrier. If you are eligible for COBRA following the termination of any health insurance coverage, administering COBRA and providing you the required COBRA notices and election periods is your former employer's or issuer's responsibility. Do not cancel any current insurance coverage or decline any COBRA benefits until you receive an approval letter and insurance policy, also known as insurance contract or certificate, from the insurance carrier you select. Make sure you understand and agree with the terms of the policy, pay special attention to the effective date, waiting periods, premium amount, benefits, limitations, exclusions, and riders.

If you enroll in a private health insurance through HealthSource RI and you do not provide enough information for HealthSource RI to verify your eligibility to purchase a plan or receive a reduced-cost plan, or if any information you provide is not verifiable, you will have ninety (90) days to provide further information to satisfy HealthSource RI's eligibility requirements. During this time, you should work with HealthSource RI staff to try to provide any missing information or resolve any inconsistencies so that you may obtain coverage as soon as possible, or, if you are provided conditional eligibility, you may avoid a disruption in coverage. If you enroll in private health insurance through HealthSource RI and you have a change in income, you must notify HealthSource RI within thirty (30) days of that change. A change in income could change the tax credits or cost-sharing reductions for which you are eligible to help you pay for insurance. We base your tax credit on the income you put on this application. If your income goes up, you will qualify for less of a tax credit on your health coverage. If you don't tell us about your income changing, we will continue to offer the same discount every month but you may have to pay that money back at tax time.
Premium rates are subject to change based on the health insurance carrier's underwriting practices and your selection of available optional benefits, if any. Final rates are always determined by the health insurance carrier. Premium rates are for your requested effective date ONLY. If the actual effective date of your policy is different from your requested effective date, the actual cost of your policy may differ from the rates listed on healthsourceri.com, due to rate increases or policy changes from the insurance company and/or one or more family members having a birthday. (Rates are highly dependent on age.) The carrier you selected may not guarantee their rates for any period of time until a contract is signed.

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

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

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

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

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

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

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

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

I understand that pursuant to Rhode Island General Law, Sections 40-6-9, 40-6-10, or 40-8-15, without the necessity of signing any document:
a.) Regarding Child Support and Establishment of Paternity
I have assigned any and all rights that I may have for and on behalf of myself, and for and on behalf of my child or children, to the Department of Human Services (DHS) and/or Executive Office of Health and Human Services (EOHHS), against any person failing to provide for support, maintenance, and medical care for myself and my minor child or children for whom assistance is paid by the DHS/EOHHS. The DHS/EOHHS is authorized to perform the act of instituting suit to establish paternity and/or to collect support for myself or my child or children who receive or received assistance from the DHS/EOHHS. If you stop getting cash or Medicaid, you must tell the Office of Child Support Services about any changes that affect child/medical support such as if your child has moved or your address has changed.
b.) Regarding Amounts Recoverable from a Third Party
I have assigned any and all rights to the DHS/EOHHS, for and on behalf of myself and any person for whom I may legally act, for amounts recoverable from a third party equal to the amount of financial assistance and Medicaid provided as a result of accident, injury, or illness.
c.) Regarding Amounts Recoverable from Workers' Compensation
The Department of Human Services and/or Executive Office of Health and Human Services may place a lien upon any pending award, order, or settlement, which I may be entitled to under the provisions of the Rhode Island Workers Compensation Act, Chapters 28-29 through 28-38 of the Rhode Island General Laws. The purpose of the lien is to secure reimbursement to the Department for financial and Medicaid payments made to me or on my behalf for the period of time for which my workers' compensation award, order, or settlement is made.
d.) Regarding Lien on Deceased Recipient's Estate for Medicaid Reimbursement
The DHS/EOHHS may place a lien upon the estate of a Medicaid recipient who was fifty-five (55) years of age or older at the time of death. **For purposes of this section the term "estate" with respect to a deceased individual shall include all real and personal property and other assets included or includable within the individual's probate estate.**
R.I.G.L. 40-8-15 provides that the total sum of Medicaid paid on behalf of a Medicaid recipient who was fifty-five (55) years of age or older at the time of receipt of such assistance shall be a debt to the state and shall constitute a lien upon the estate of the recipient in favor of the DHS. However, the lien shall not be effective and shall not apply to the estate of a recipient who is survived by a spouse, or a child who is under the age of twenty-one (21) or a child who is blind or permanently and totally disabled as defined in Title XVI (SSI) of the Social Security Act. Tribal lands and certain properties belonging to American Indians and Alaskan Natives may be exempt from recovery.

I understand that as a condition of receiving RIW benefits, all persons from whom I am requesting RIW, unless exempt by law, are required to comply with the RIW Program requirements.
I understand that this application will serve as authorization to the Department of Human Services to obtain from Medical providers information that is pertinent to me or any person included in this application for as long as the case remains open.
I understand and agree that the DHS office may contact other persons or organizations to obtain the necessary proof of my eligibility and level of benefits.

SNAP PENALTY WARNINGS

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

- **For a period of one (1) year for the first violation, with the exceptions in numbers 1. through 5. below;**
- **For a period of two (2) years after the second violation, with the exceptions in numbers 1. through 5. below; and,**
- **Permanently for the third occasion of any intentional program violation.**

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

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

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

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

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

Trafficking as defined in 7 CFR 271.2 means:

1) Buying, selling, stealing or attempting to buy, sell, steal, or otherwise effect an exchange of SNAP benefits issued and accessed via Electronic Benefit Transfer (EBT) cards, card numbers and personal identification numbers (PINs), or by manual voucher and signature, for cash or consideration other than eligible food, either directly, indirectly, in complicity or collusion with others, or acting alone;
2) The exchange of firearms, ammunition, explosives, or controlled substances for SNAP benefits;
3) Purchasing a product with SNAP benefits that has a container requiring a return deposit with the intent of obtaining cash by discarding the product and returning the container for the deposit amount, intentionally discarding the product, and intentionally returning the container for the deposit amount;
4) Purchasing a product with SNAP benefits with the intent of obtaining cash or consideration other than eligible food by reselling the product, and subsequently intentionally reselling the product purchased with SNAP benefits in exchange for cash or consideration other than eligible food; or
5) Intentionally purchasing products originally purchased with SNAP benefits in exchange for cash or consideration other than eligible food.

DO NOT lie or hide information to get or continue to get SNAP benefits that your household should not get.
DO NOT use SNAP benefits to buy non-food items, such as alcoholic drinks and cigarettes or to pay on credit accounts.
DO NOT trade or sell (or attempt to trade or sell) EBT cards or 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. I certify under penalty of perjury that my answers are correct, including information about citizenship and alien status, and complete to the best of my knowledge and belief. I know that under the state of Rhode Island General Laws, Section 40-6-15, a maximum fine of $1,000, or imprisonment of up to five (5) years, or both, may be imposed for a person who obtains or attempts to obtain, or aids or abets any person to obtain, public assistance to which s/he is not entitled, or who willfully fails to report income, resources or personal circumstances or increases therein which exceed the amount previously reported. I attest to the identity of the minor children identified herein and that all of the information contained in this application is true. I understand that I am breaking the law if I give wrong information and can be punished under federal law, state law or both.

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

FOR AGENCY USE ONLY

Withdrawal of Application

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

______________________________ ______________________

Applicant's signature Date

Agency Representative Name:______________________________ Signature:______________________________

COMMENTS	INITIALS	DATE

Notice to Applicant
Registering to Vote in Rhode Island

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

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

Register to vote

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

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

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

- If you believe that someone has interfered with your right to register or decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Voter Registration Coordinator, 50 Branch Avenue, Providence, RI 02904 or (401)222-2345.

RHODE ISLAND

VOTER REGISTRATION FORM

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

YOU MAY USE THIS FORM TO:

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

TO REGISTER TO VOTE IN RI YOU MUST BE:

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

INSTRUCTIONS

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

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

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

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

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

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

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

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

(This form may be reproduced)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Official Use For Barcode

PLEASE SIGN FULL NAME OR PLACE MARK BELOW

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

Are you interested in working at the polls? ☐

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

11. **PREVIOUS NAME** (if different from Box 4)

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

02/2012 Regs
Form Revised 12/2012

Return Address

_____

_____

_____

Postage Required Post Office will not deliver without proper postage.

Mail To: **BOARD OF CANVASSERS**

_____

_____

_____

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

INSTRUCTIONS FOR MAILING THE VOTER REGISTRATION FORM

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

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

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

LOCAL BOARDS OF CANVASSERS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Newport City Hall, 43 Broadway, Newport, RI 02840

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Voter Registration Questions May Be Addressed To:

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