CENTER/ OFFICE	APPLICATION DATE	UNIT ID	WORKER ID	CASE TYPE	SERV. IND	CASE NUMBER	REGISTRY NUMBER	VERS	DISTRICT	NUMBER REUSE INDICATOR

CASE NAME	EFFECTIVE DATE	DISPOSITION	SERVICES TRANSACTION TYPE
		☐ DENIAL ☐☐☐ REASON CODE ☐ WITHDRAWAL	☐ NEW OPENING 02 ☐ REOPEN 10 ☐ RECERTIFICATION 06

ELIGIBILITY DETERMINED BY (WORKER):	DATE	ELIGIBILITY APPROVED BY (SUPERVISOR):	DATE	FORM _____ 0F _____	SIGNATURE OF PERSON WHO OBTAINED ELIGIBILITY INFORMATION	DATE
					X _____	

I CONSENT TO WITHDRAW MY APPLICATION	DATE	DATE RECEIVED BY AGENCY		EMPLOYED BY: ☐ SOCIAL SERVICES DISTRICT
SIGNATURE X_____	DATE_____			PROVIDER AGENCY SPECIFY: _____

TA AUTHORIZATION PERIOD		MA AUTHORIZATION PERIOD		FS AUTHORIZATION PERIOD		SERVICES AUTHORIZATION PERIOD	
FROM	TO	FROM	TO	FROM	TO	FROM	TO

NEW YORK STATE

APPLICATION FOR: TEMPORARY ASSISTANCE (TA) - MEDICAL ASSISTANCE (MA) - FOOD STAMP BENEFITS (FS) – SERVICES – CHILD CARE ASSISTANCE

We are committed to assisting and supporting you in a professional and respectful manner with your goal of achieving self-sufficiency. You, in turn, must be committed to becoming self-sufficient and must be responsible for participating in activities to reach self-sufficiency including work activities. Whenever you see "Temporary Assistance" or "TA" on the application, it means "Family Assistance" and "Safety Net Assistance". We call both of these Public Assistance Programs "Temporary Assistance". Social Services programs were created to give temporary help to those in need. These TA Programs are meant to assist you only until you can fully support yourself and your family.

CHECK EACH PROGRAM YOU ARE APPLYING FOR

1

☐ **Temporary Assistance And Medical Assistance** ☐ **Temporary Assistance** ☐ **Medical Assistance**

☐ **Qualified Beneficiary Program** ☐ **Food Stamp Benefits** ☐ **Services** ☐ **Child Care Assistance**

DO YOU WANT TO RECEIVE NOTICES IN: ☐ **SPANISH AND ENGLISH** ☐ **ENGLISH ONLY**

2

APPLICANT INFORMATION **PLEASE PRINT CLEARLY**

FIRST NAME	M.I.	LAST NAME	MARITAL STATUS	PHONE NUMBER ( ) AREA CODE

3

RESIDENCE ADDRESS	APT. NO.	CITY	COUNTY	STATE	ZIP CODE
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	APT. NO.	CITY	COUNTY	STATE	ZIP CODE

HOW LONG HAVE YOU LIVED AT YOUR PRESENT ADDRESS?	YEARS	MONTHS	IS THIS A SHELTER? YES NO	ANOTHER PHONE WHERE YOU CAN BE REACHED	NAME	PHONE NUMBER ( ) AREA CODE

DIRECTIONS TO HOME

FORMER ADDRESS	APT. NO.	CITY	COUNTY	STATE	ZIP CODE

DO ANY OF THESE APPLY TO YOU?

4

Pregnant	Drug/Alcohol Problem	Urgent Personal Or Family Problem	Pending Eviction
Victim Of Domestic Violence	Fuel Or Utility Shutoff	Have No Job	No Food
Need To Establish Paternity	No Place To Stay/Homeless	Serious Medical Problem	Need Child Care
Need Child Support	Fire Or Other Disaster	Recently Lost Income	Other _____
Foster Care			

DO NOT WRITE IN SHADED AREAS

LIST EVERYBODY WHO LIVES WITH YOU, EVEN IF THEY ARE NOT APPLYING WITH YOU. LIST YOURSELF ON THE FIRST LINE. *PLEASE PRINT.*

DOES THIS PERSON (INCLUDING YOUR MINOR CHILDREN) BUY FOOD AND/OR PREPARE MEALS WITH YOU?

HIGHEST SCHOOL GRADE COMPLETED

R I	L N	FIRST NAME	(Middle Initial) M.I.	LAST NAME	IS THIS PERSON APPLYING? YES	NO	DATE OF BIRTH MONTH	DAY	YEAR	SEX M OR F	RELATIONSHIP TO YOU	SOCIAL SECURITY NUMBERS OF APPLYING MEMBERS		DOES THIS PERSON BUY FOOD AND/OR PREPARE MEALS WITH YOU? YES	NO
	01										**SELF**				
	02														
	03														
	04														
	05														
	06														
	07														
	08														

5

PLEASE LIST MAIDEN OR OTHER NAMES BY WHICH YOU OR ANYONE IN YOUR HOUSEHOLD HAS BEEN KNOWN

Line No.	ONC	FIRST NAME	M.I.	LAST NAME
		6		

IS ANYONE SANCTIONED? YES NO

IF YES, WHO

REASON

END DATE

DO NOT WRITE IN SHADED AREAS

NON-APPLYING INFORMATION

L N	FIRST NAME	LAST NAME	LEGALLY RESPONSIBLE YES	NO	FOR WHOM?	CONTRIBUTION/ DEEMED INCOME	CHECK IF MEMBER OF FS HOUSEHOLD

ALIEN INFORMATION

L N	ALIEN STATUS	STATUS ADJUSTED YES	NO	DATE OF ENTRY/STATUS MONTH	DAY	YEAR	APPLIED FOR CITIZENSHIP YES	NO	SPONSORED YES	NO

INDIVIDUAL EDUCATION

L N	DEGREE RECEIVED	L N	DEGREE RECEIVED
01		05	
02		06	
03		07	
04		08	

RACE/ETHNIC AFFILIATION CODES

- **H** Hispanic or Latino
- **I** Native American or Alaskan Native
- **A** Asian
- **B** Black or African American
- **P** Native Hawaiian **or** Pacific Islander
- **W** White

LN	ENTER Y (YES) OR N (NO) IF HISPANIC OR LATINO	ENTER Y (YES) OR N (NO) FOR EACH RACE AFFILIATION					CLIENT IDENTIFICATION NUMBER	REL CODE	SSN	SFUI	MC CODE	SI CODE	LA CODE	EM CODE	CI CODE	EL CODE
	H	**I**	**A**	**B**	**P**	**W**										
01																
02																
03																
04																
05																
06																
07																
08																

ANTICIPATED FUTURE ACTION

LINE NO.	CODE	DATE

SERVICE ELIGIBILITY PROCESS CODE

	SFUI	CODE	SFUI	CODE
	SFUI	CODE	SFUI	CODE

RELATED CASE NUMBERS

CASE TYPE	
CASE TYPE	
CASE TYPE	

CONSIDER

- ✓ Relationship
- ✓ Filing Unit
- ✓ Legally Responsible Relative
- ✓ Single Economic Unit
- ✓ FS Household Composition
- ✓ FS Aged/Disabled Individual
- ✓ Photo ID/AFIS
- ✓ CBIC/PIN
- ✓ RFI/OCA
- ✓ Health Insurance

NEEDED	REFERRALS	COMPLETED
	CAP	
	Services	
	SSA	
	Legal	

REQUESTED	DOCUMENTATION	IN FILE
	Photo I.D.	
	Birth Verification	
	Marriage License	
	Social Security Card	
	SS-5/LDSS-4000	
	Code 9 Resolution	
	Alien Status	
	Co-Op Case Notice (Single Economic Unit Quest	

CITIZENSHIP/ALIEN STATUS INFORMATION

Please read the entire page carefully before completing. If you have questions, talk to your worker

SECTION A

LIST EVERYONE WHO IS APPLYING OR WHO IS REQUIRED TO APPLY.

SEE THE "HOW TO COMPLETE" INSTRUCTION BOOK OR TALK TO YOUR WORKER.

You **do not** have to fill out Section A or Section B if you:

- Are pregnant and applying only for MA, or
- Have an medical emergency

You **do** have to fill out Section A or B if you are:

- Applying for MA **only** but you do not have to include people who do not want MA.

SECTION B - CERTIFICATION

Some social services programs require that you certify that you are a U.S. citizen or national or an alien with satisfactory immigration status. Other programs do not. If you are an alien and do not know if you are in satisfactory immigration status, see the "How To Complete" instruction book or talk to your worker.

You MUST sign the Certification below only if you are a U.S. citizen, national or alien with satisfactory immigration status **and** you are applying for:

- Temporary Assistance (where there are children in the household or a member of the household is pregnant) or
- Food Stamp Benefits or
- Medical Assistance (except if the applicant is pregnant)
- Services and Child Care Assistance under certain circumstances.

An adult household member or authorized representative may sign for all household members. Example: a mother who is not in satisfactory immigration status may still sign the Certification for her children who are citizens

If you are applying for FS, you must list all persons living in the FS household. If you are applying for TA, you must list all children for whom you are applying, their brothers and sisters and all parents of those children who live together. If you do not check whether a listed person is a citizen or alien or provide an alien number for an alien, that person will not be given assistance, and the remaining members of the household will receive reduced benefits.

SIGN* AND DATE THE BOX BELOW AND CHECK (✓) THE PROGRAM(S) FOR WHICH YOU HAVE SATISFACTORY IMMIGRATION STATUS

LN	FIRST NAME	MI	LAST NAME	Check **either "CITIZEN/ NATIONAL" or "ALIEN" for** Each Person.		*Alien Number (If Applicable)*	**CERTIFICATION**		**TA**	**MA**	**FS**
01				CITIZEN/ NATIONAL	ALIEN	A	Sign Name X	Date			
02				CITIZEN/ NATIONAL	ALIEN	A	Sign Name X	Date			
03				CITIZEN/ NATIONAL	ALIEN	A	Sign Name X	Date			
04				CITIZEN/ NATIONAL	ALIEN	A	Sign Name X	Date			
05				CITIZEN/ NATIONAL	ALIEN	A	Sign Name X	Date			
06				CITIZEN/ NATIONAL	ALIEN	A	Sign Name X	Date			
07				CITIZEN/ NATIONAL	ALIEN	A	Sign Name X	Date			
08				CITIZEN/ NATIONAL	ALIEN	A	Sign Name X	Date			

By checking a box above and by signing the certification in Section B, I hereby certify, under penalty of perjury, that I, and/or the persons for whom I am signing, am a United States citizen or national or an alien with a satisfactory immigration status.

By signing the Certification, I understand that information about my household may be submitted to the Immigration and Naturalization Service (INS) for verification of Immigration Status, if applicable.
The use or disclosure of the information above is restricted to persons and organizations directly connected with the verification of immigration status and the administration or enforcement of the provisions of the TA, MA, FS, Services and Child Care Assistance Programs.

*** A person who wishes to sign the Certification but cannot write may make an "X" on the line in front of a witness. The witness must sign below.**

I witnessed the marks made in lines: _____,_____,_____,_____,_____,_____ Signature of witness: _____

ABSENT PARENT/CHILD SUPPORT/MEDICAL SUPPORT INFORMATION

DO NOT WRITE IN SHADED AREAS

Please help us obtain child support/medical support for you and your children. List the names of everyone under 21 whose parent is not in the household, and write down any information you currently have about that person's absent parent. If **you** are under 21, write down information about **your** absent parent who is not in the household.

NAME OF PERSON UNDER 21	ABSENT PARENT'S NAME AND ADDRESS	ABSENT PARENT'S DATE OF BIRTH MONTH	DAY	YEAR	SOCIAL SECURITY NUMBER
A.					
B.					
C.					
D.					
E.					

9

Do you or does anyone who lives with you get money from child support payments? Yes No

If yes, list below:

WHO	AMOUNT RECEIVED	HOW OFTEN	FROM WHOM
	$		
	$		
	$		
	$		

IS THERE JOINT CUSTODY? Yes No If Yes, How Determined?

ABSENT SPOUSE INFORMATION - If the husband or wife of anyone applying lives someplace else, please indicate below. (Include name and date of birth even if deceased)

FIRST NAME	M.I.	LAST NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

10

ADDRESS	CITY	COUNTY	STATE	ZIP CODE

ABSENT CHILD INFORMATION - If anyone applying has a child under 18 living someplace else, please indicate below.

NAME OF PERSON APPLYING	NAME OF ABSENT CHILD	DATE OF BIRTH	ADDRESS *(Street, City, County, State and Zip Code)*	PATERNITY ESTABLISHED? Yes	No	DO YOU PAY CHILD SUPPORT? Yes	No

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REQUESTED	DOCUMENTATION	IN FILE
	Assignment of Child Support	
	Child Support Order	
	Good Cause Form (LDSS-4279)	
	IV-D Attestation (LDSS-4281)	
	LRR Letter/Questionnaire	
	Other Support	
	Death Certificate	
	Divorce Decree	
	VA Benefits	

NEEDED	REFERRALS	COMPLETED
	CTHP	
	CAP	
	CSS Application (LDSS-2521)	
	IV-D (LDSS-2860)	
	Paternity	

CONSIDER

- ✓ Health Insurance of Absent Parent/Spouse
- ✓ Petition to Family Court
- ✓ Child Health Plus
- ✓ TASA
- ✓ SSI/SSA

TEEN PARENT INFORMATION

Name of teen parent's child. Is there a teen parent under age 18 in the household?

Yes No

Who _____

12

Does the teen parent's child live in the household?

Yes No

Name of teen parent's child _____

TEEN PARENT:

LN NO. _____ Marital Status _____

High School Diploma? _____

LN NO. _____ Marital Status _____

High School Diploma? _____

TEEN PARENT CHILDREN

LN NO. _____ LN NO. _____

Getting child support, when possible, is a critical step in becoming self-sufficient.

INCOME INFORMATION:

DO NOT WRITE IN SHADED AREAS

INDICATE IF YOU OR ANYONE WHO LIVES WITH YOU RECEIVES MONEY FROM:	YES	NO	WHO	AMOUNT/VALUE	WHO	AMOUNT/VALUE	CD
Wages, Salary, Including Overtime, Commissions, Training Programs, Tips							01
Self-Employment							20
Unemployment Insurance Benefits							49
Supplemental Security Income (SSI) Benefits							45
Social Security Disability Benefits							42
Social Security Dependent Benefits							
Social Security Survivor's Benefits							43
Social Security Retirement Benefits							44
Railroad Retirement Benefits							38
Retirement Benefits (Pensions)							39
Dividends/Interest from Stocks, Bonds, Savings, etc.							03
Workers' Compensation							59
NYS Disability Benefits							33
Veteran's Pensions/Benefits/Aid and Attendance							55
Education Grants **or** Loans							
Contributions/Gifts (Received)							
Child Support Payments (Received)							06
Alimony/Support (Received)							02
Private Disability Insurance-Health/Accident Insurance Policy Income							
No Fault Insurance Benefits							
Union Benefits (Including Strike Benefits)							50
Loans (Received)							
Income from a Trust (Including income you are entitled to receive but is not being distributed)							
Training Allotments							
Rental Income (received)							31
Boarders/Lodgers Income (received)							14
OTHER INCOME *(Please Specify)*							

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Ln No.	SOURCE CODE	AMOUNT	PERIOD

CONSIDER

- ✓ Child Support Pass-Through Explained Budgeted
- ✓ FS Aged/Disabled Indicator
- ✓ Disability Review

ANSWER ALL QUESTIONS LISTED BELOW

	YES	NO	WHO?
Does the step-parent of any children who live with you have any resources or receive any income of any kind?			
Is anyone in your household an alien who was sponsored for admission into the U.S.?			

14

NAME OF SPONSOR: TELEPHONE NO.:

ADDRESS:

NEEDED	REFERRAL	COMPLETED
	UIB	

In order to become self-sufficient, you should try to get all of the benefits to which you are entitled.

EMPLOYMENT INFORMATION

I am currently: employed self-employed unemployed

Gross Income $ _____ Current hours worked Monthly _____

Paid: Weekly Bi-Weekly Monthly Day of the week paid

Employer's Name and Address:

_____ _____

_____ Phone No. _____

Is anyone else who lives with you currently: employed self-employed

Who: _____

Gross Income $ _____ Current hours worked Monthly _____

Paid: Weekly Bi-Weekly Monthly Day of the week paid

Employer's Name and Address:

_____ _____

_____ Phone No. _____

Does anyone have health insurance with their employer? Yes No

Who: _____

Name of Insurance Company: _____

Does anyone have child or dependent care **expenses** due to **employment**? Yes No

Who: _____

Does anyone have other employment-related expenses? Yes No

Who: _____

If not employed, when was the last time you or anyone who lives with you worked?

Who: _____ When: _____

Where: _____

Why did you (or they) stop working? _____

_____

Are you or is anyone who lives with you participating in a strike? Yes No

Who: _____ When: _____

Are you or is anyone who lives with you a migrant or seasonal farm worker? Yes No

Who: _____

What type of work would you like to do? (specify) _____

_____

_____

Could you accept a job today? Yes No

If not, why? _____

DO NOT WRITE IN THE SHADED AREAS

REQUESTED	DOCUMENTATION	IN FILE
	CINTRAK/RFI/1099/IRCS	
	Employment Verification	
	Income Tax Return	
	Self-Employment Worksheet	
	Wage Stubs	
	Work Registration Form	
	Dependent/Child Care Form/Statement	
	Approval of Informal Child Care Provider	

NEEDED	REFERRALS	COMPLETED
	CAP	
	Disability	
	Employment	
	TPHI/COBRA	
	UIB	
	Worker's Compensation	
	Drug/Alcohol	
	Domestic Violence	

CONSIDER
✓ Earned Income Tax Credit (Flyer)
✓ Explaining Quarterly Reporting Requirements
✓ Net Loss of Cash Income
✓ P.A.S.S. Income Amount and Sources
✓ Employment Sanctions
✓ Temporary Employment
✓ Disability Review
✓ Individual Development Account (IDA)
✓ Voluntary Quit

CHILD/DEPENDENT CARE EXPENSES

Who Pays	Amount	Name(s)	Age(s)	Care Provider
	$			
	$			
	$			
	$			
	$			
	$			
	$			
	$			

Have you tried to find a job on your own? Have you identified all your needs and barriers to employment?

EDUCATION/TRAINING

INDICATE IF YOU OR ANYONE WHO LIVES WITH YOU WHO IS APPLYING FOR OR GETTING ASSISTANCE:

Has a High School diploma or G.E.D.? Yes No

Who _____

Dates attended _____

Dates completed _____

Is or has been in any training program? Yes No

Who _____

Where _____

Program _____

Dates attended _____

Dates completed _____

Is 16 years of age or older attending school or college? Yes No

Who _____

Where _____

For your children under 16, list their names and what schools they attend:

Who _____

School _____

Who _____

School _____

Who _____

School _____

Who _____

School _____

Who _____

School _____

Who _____

School _____

DO NOT WRITE IN SHADED AREAS

REQUESTED	DOCUMENTATION	IN FILE
	School Attendance Verification (LDSS- 3708)	
	Educational Grant Worksheet	
	Child Care Statement	

NEEDED	REFERRALS	COMPLETED
	Supportive Services	

FS STUDENT ELIGIBILITY CRITERIA	YES	NO
Does anyone 18 through 49 who is attending college half-time or more meet the FS student eligibility requirement?		
Does anyone pay for child or dependent care to attend school or training?		
Is there a 16-19 year old parent who does not have a high school diploma or G.E.D., and who is not attending school?		
Is anyone in training?		
Are any other supportive services appropriate?		
Are there any training related expenses?		

RESOURCES INFORMATION

INDICATE IF YOU OR ANYONE WHO LIVES WITH YOU WHO IS APPLYING:	YES	NO	WHO	IF YES, GIVE AMOUNT/VALUE	WHO	IF YES, GIVE AMOUNT/VALUE
Has cash on hand				$		$
Has a checking account (s)						
Has a savings account(s) or c.d. (cert. of deposit)						
Has a credit union account(s)						
Has life insurance						
Has title or registration to a motor vehicle(s) or other vehicle(s) (Specify) Year _____ Make/Model _____ Year _____ Make/Model _____						
Has stocks, bonds, certificates or mutual funds						
Has savings bonds						
Has an IRA, Keogh, 401-k or deferred compensation account(s)						
Has an irrevocable burial trust						
Has a burial fund						
Has a burial space						
Has own home						
Has real estate including income-producing and non-income-producing property						
Is eligible for an income tax refund						
Has an annuity						
Is named the beneficiary of a trust						
Expects to receive a trust fund, lawsuit settlement, inheritance or income from any other sources						
Has an "in trust" account(s)						
Has a safe deposit box						
Has resources other than those listed above						
Has anyone (including your spouse, even if not applying or living with you) given away any cash, or sold/transferred any real estate, income or personal property in the past 36 months?						
Has anyone (including your spouse, even if not applying or living with you) ever created a trust in the past or transferred any assets into a trust within the past 60 months? If yes, when? _____						

VEHICLE INFORMATION

YR.	MAKE	MODEL	OWNER'S NAME	AMOUNT OWED	NADA VALUE	EXEMPT YES*	EXEMPT NO	LIEN HOLDER	ACCOUNT NO.
				$					
				$					

***IF EXEMPT, WHY?**

DO NOT WRITE IN SHADED AREAS

NEEDED	REFERRAL	COMPETED
	Legal	
	Resource	

LIFE INSURANCE

FACE	CASH VALUE

REQUESTED	DOCUMENTATION	IN FILE
	Resource Checklist	
	Market Value	
	DMV Clearance	
	Bank Statement	
	Assignment of Proceeds	
	Car/Vehicle Title	
	Car/Vehicle Registration	
	Bank Clearance	
	RFI/OCA/1099	

CONSIDER

- ✓ "In Trust" Accounts
- ✓ Children's Resources
- ✓ Lump Sum
- ✓ Boats, Campers, Snowmobiles
- ✓ Income Tax Refund
- ✓ Individual Development Account (IDA)
- ✓ Exempt Vehicles

MEDICAL INFORMATION

INDICATE IF **YOU OR ANYONE WHO LIVES WITH YOU** WHO IS APPLYING:	YES	NO	IF YES, WHO
Has any medical bills or medically-related expenses			
Has health or hospital/accident insurance (including insurance from employer)			
Has Medicare (red, white, and blue card)			
Has a health attendant			
Is blind, sick or disabled			
Is a handicapped child			
Is in a hospital, nursing home or other medical institution			
Has paid or unpaid medical bills for 3 months preceding the month of this application			
Is or was drug or alcohol dependent			
Needs home care			
Is pregnant			

IF PREGNANT PLEASE GIVE DUE DATE: _____

INDICATE IF **YOU OR ANYONE WHO LIVES WITH YOU** WHO IS APPLYING:	YES	NO	IF YES, WHO
Receives treatment from a drug abuse or alcohol treatment program			
Has not been able to work for at least 12 months because of a disability or illness			
Has daily activity limited because of a disability or illness that has lasted or will last at least 12 months			
Has been in a car accident or work-related accident in the past two years			
Has any government agency (public program) besides Medical Assistance or Medicare paid any of your medical bills?			

RETROACTIVE MEDICAID	WHO	DATE

RECURRING MEDICAL EXPENSES	WHO	AMOUNT $	AMOUNT $

MEDICAL BILLS: YES NO **TPHI:** YES NO

DO NOT WRITE IN SHADED AREAS

POLICY NO.:

INSURANCE COMPANY NAME:

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REQUESTED	DOCUMENTATION	IN FILE
	Pregnancy Statement	
	Med/Psych Statement	
	Drug/Alcohol Screening (LDSS-4571)	
	Drug/Alcohol Statement	
	Paid or Unpaid Medical Bills	
	SSI Application Verification **TA ONLY**	

CONSIDER

- ✓ AD/SSI Related
- ✓ FS Aged/Disabled Indicator
- ✓ FS Medical Deduction
- ✓ TPHI Reimbursement
- ✓ Buy-In Eligibility
- ✓ Kreiger (LDSS-3664)
- ✓ Domestic Violence
- ✓ SSI Referral

NEEDED	REFERRALS	COMPLETED
	SSI (D-CAP)	
	Disability Interview (LDSS-1151)	
	Medical Report (LDSS-486, 486t)	
	Disability Report	
	AD	
	TPHI	
	VESID	
	CTHP	
	PCAP	
	Family Planning	
	TASA	
	SSA (RSDI)	
	Veteran's Benefits	
	Veteran's Counseling	
	Child Health Plus	
	COBRA Eligibility	
	Nurse's Aide Service	
	Home Care	

SHELTER

WHAT IS YOUR LANDLORD'S NAME?

_____

WHAT IS YOUR LANDLORD'S ADDRESS?

_____

_____

_____

WHAT IS YOUR LANDLORD'S PHONE NUMBER?

( )_____

	YES	NO	IF YES, GIVE AMOUNT
Do **you (or anyone who lives with you)** have a rent, mortgage or other shelter expense?			$
Do **you (or anyone who lives with you)** have a heat bill separate from your rent or shelter expense?			
Do **you (or anyone who lives with you)** have the following expenses separate from your rent or shelter expense?	**YES**	**NO**	**IF YES, GIVE AMOUNT**
• Electricity			$
• Gas			
• Other utilities (water, etc.)			
• Telephone			
• Air conditioning			
• Utility/telephone installation fees			
Does any person, group or organization outside the household pay any of the household expenses?			
Do you live in section 8 or other subsidized housing?			
If yes, are you in the certificate program?			
Do you live in public housing?			
Do you live in a drug/alcohol rehab or domestic violence shelter?			

DO NOT WRITE IN SHADED AREAS

SHELTER COSTS	MONTHLY ACTUAL COST
A. Room and Board	
B. Rent	
C. Trailer Lot Rent	
D. Mortgage Payment	
1. Principal	
2. Interest	
3. Property Tax (Including School Tax)	
4. Homeowner's Insurance on Structure (Incl. Fire Insurance)	
5. Taxes Included in Mortgage (Escrow Payment)	
6. Assessments (Sewer, etc.)	
D. Total Mortgage Payment (Line 1-6)	
E. Utility/Phone Installation Fees	
TOTAL *(Lines A - E)*	

REQUESTED	DOCUMENTATION	IN FILE
	Landlord Statement	
	Rent Receipt	
	Tenant of Record	
	Customer of Record	
	Voluntary Restrict	
	Mandatory Restrict	
	Subsidized Housing	
	Mortgage/Title Search	
	Section 8 Lease or Statement from Section 8 Office	
	Property Lien	
	Shelter/Utility Repayment Agreement	

CONSIDER

- ✓ Utility and/or Fuel Restrict
- ✓ Utility Guarantee
- ✓ HEAP
- ✓ Subsidized Housing May Show Total Rent, NOT Client Amount
- ✓ Foster Care Related Additional Allowances
- ✓ FS Household Comp. Rules
- ✓ FS Aged/Disabled Indicator
- ✓ Real Property Tax Credit
- ✓ Life Line
- ✓ AIDS/HIV Emergency Shelter Allowance
- ✓ Property Lien

MONTHLY EXPENSES	MONTHLY ACTUAL COST	NAME OF DEALER	IN WHOSE NAME IS THE BILL? (CUSTOMER OF RECORD)	WHO IS THE TENANT OF RECORD?
A. Fuel for Heat(ing) *				
B. Electricity				
C. Gas				
D. Liquid Propane Gas				
E. Other Utilities* (Water, etc.)				
F. Telephone*				
G. Air Conditioning				
H. Utility/Telephone Installation Fees				
I. Sewer				
J. Garbage				
K. Trash				
L. Other Expenses				
TOTAL				

*CONSIDER CUSTOMER OF RECORD FOR SUA

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Your goal should be to become self-sufficient so that you will be able to pay all of your shelter expenses.

ADDITIONAL INFORMATION

OTHER EXPENSES

INDICATE IF **YOU OR ANYONE WHO LIVES WITH YOU** WHO IS APPLYING:	YES	NO	IF YES, GIVE AMOUNT
Pays child support			**$**
Pays alimony			**$**
Pays child care			**$**
Pays dependent care			**$**
Pays tuition and fees			**$**
Has additional expenses Specify _____			

20

Do you or anyone who lives with you who is applying owe at least four months' court-ordered support for a child under age 18?	YES	NO

OTHER INFORMATION REQUIRED

Do you buy or plan to buy meals from a home delivery or communal dining service?	YES	NO
Are you able to prepare meals at home?	YES	NO
Have you or anyone in your household ever been in the U.S. military? Who? _____	YES	NO
Has your spouse ever been in the U.S.military?	YES	NO
Is anyone in your household a dependent of someone who was in the U.S. military? Who? _____	YES	NO

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Have you or anyone who lives with you who is applying moved into New York State within the past twelve months? YES NO

- If yes, who? _____
- When? _____
- From what country/state? _____
- Has this person ever lived in New York State before? YES NO
- If yes, when _____

NEEDED	REFERRALS	COMPLETED	CONSIDER
	Services		✓ FS Dependent Care Deductions
	State Charge		✓ District of Fiscal Responsibility (SSL 62.5)
	UIB		

DO NOT WRITE IN SHADED AREAS

VETERAN STATUS	VETERAN CODE

OTHER INFORMATION REQUIRED	YES	NO	WHO
Have you or anyone who lives with you who is applying moved into **this** county from another **New York State** county within the past two months?			
Have you or anyone who lives with you ever been found guilty of and/or been disqualified for Temporary Assistance and/or Food Stamp because of fraud/intentional program violation?			
Have you or anyone who lives with you received benefits for which they were not entitled, which have not been fully repaid to this or another agency?			
Do you or does anyone who lives with you **now** receive any type of assistance or services in **New York City**?			
Do you or does anyone who lives with you **now** receive any type of assistance or services in another county within **New York State**?			
Do you or does anyone who lives with you **now** receive any type of assistance or services outside of **New York State**?			
Have you or anyone who lives with you **applied for** or received any type of assistance or services outside of **New York State**?			
Have you or any member of your household been convicted of making a fraudulent statement or representation of residence in order to receive temporary assistance in two or more states?			
Are you or any member of your household fleeing prosecution, confinement or conviction for a felony?			
Are you or any member of your household violating probation or parole?			

- If yes to any of the above, who? _____
- Type of assistance? _____
- Where? _____
- Date of last assistance? _____

I have **have not** sold, transferred or given away any of my property to anyone to get temporary assistance or food stamp benefits.

REQUESTED	DOCUMENTATION	IN FILE
	School Attendance Verification (LDSS-3708)	
	Educational Grant Worksheet	
	Child/Dependent Care Statement	
	Recoupments	
	Outstanding Overpayment	
	Pending Disqualification	

IF TOTAL EXPENSES (INCLUDING EXPENSES NOT USED IN THE BUDGET DETERMINATION) EXCEED INCOME (INCLUDING TA GRANT), EXPLORE HOW THE HOUSEHOLD IS MEETING ITS OBLIGATIONS.

Actual Expenses $

- Actual Income $

= Difference $

YES NO

Does Client Receive Contribution Towards Difference

If Yes, From Whom?

_____

CONSIDER

- ✓ Actual Expenses
- ✓ Actual Shelter
- ✓ Actual Fuel/Utility Costs
- ✓ Telephone Expenses
- ✓ Car Expenses
- ✓ Furniture/Appliance Rental
- ✓ Cable TV
- ✓ Private School Tuition
- ✓ Out-of-Pocket Medical Expenses

NOTES/COMMENTS

READ THE IMPORTANT INFORMATION BELOW.

PRIVACY ACT STATEMENT -- COLLECTION AND USE OF SOCIAL SECURITY NUMBERS (SSN) - The collection of SSN's is authorized for each household member with respect to Food Stamp Benefits pursuant to the Food Stamp Act of 1977 (as amended, 7 US Code 2011-2036).

With respect to all other programs for which application is made on this form, the collection of SSN's is also mandatory and is authorized under Section 205(c) of the Social Security Act (42 U.S. Code 405) for Temporary Assistance, Section 1137 of the Social Security Act (42 U.S. Code 1320b-7) for Temporary Assistance, Medical Assistance and Food Stamp Benefits and Section 7(a)(2) of the Privacy Act of 1974 for all programs covered by this application, including services and foster care maintenance. See the "How To Complete" instruction book or talk to your worker.

The information we collect will be used to determine whether your household is eligible or continues to be eligible for assistance or benefits. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management.

This information may be disclosed to other State and Federal agencies for official examination and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law.

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The information will be used to check identity, to verify earned and unearned income, to determine if absent parents can receive health insurance coverage for applicants or recipients, to determine if applicants or recipients can obtain child or spousal support and to determine if applicants or recipients can receive money or other help.

Information collected with respect to applicants for and recipients of Family Assistance and Safety Net Assistance, including SSN's, may be used to assist in the formation of jury pools.

If you do not have a SSN and need to get one, the information you give to the social services districts may be used to get one for you.

REIMBURSEMENT OF MEDICAL EXPENSES - You have a right as part of your Medical Assistance application, or later, to request reimbursement of expenses you paid for covered medical care, services and supplies received during the three month period prior to the month of your application. After the date of your application, reimbursement of covered medical care, services and supplies will only be available if obtained from Medicaid-enrolled providers.

SUPPORT - Applying for or receiving Family Assistance (FA), Safety Net Assistance (SNA) or foster care services operates as an assignment to the State and the social services district of any rights to support from any other person that the applicant or recipient may have in his or her own right or on behalf of any other family member for whom the applicant or recipient is applying or receiving assistance (Social Services Law, 158 and 348). Other sections of this application contain additional assignments.

FOOD STAMPS AUTHORIZED REPRESENTATIVE - You can authorize someone who knows your household circumstances to **apply** for FS for you. If you do, have them **sign** in the Signature section at the bottom of page 16. You can also authorize someone outside your household to get FS for you or to use them to buy food for you. If you would like to authorize someone, print the person's name, address and phone number directly below.

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NAME, ADDRESS AND PHONE NUMBER OF AUTHORIZED REPRESENTATIVE *(PLEASE PRINT)*

NON-DISCRIMINATION NOTICE - This application will be considered without regard to race, color, sex, disability, religious creed, national origin or political belief.

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PENALTIES – Your application may be investigated. By signing this agreement you are consenting to cooperate in such an investigation. Federal and State laws provide for penalties of fine, imprisonment or both if you do not tell the truth when you apply for Temporary Assistance, Medical Assistance, Food Stamp Benefits, Services or Child Care Assistance (Assistance, Benefits or Services) or at any time when you are questioned about your eligibility, or cause someone else not to tell the truth regarding your application or your continuing eligibility. Penalties also apply if you conceal or fail to disclose facts regarding your initial and continuing eligibility for Assistance, Benefits or Services, or if you conceal or fail to disclose facts that would affect the right of someone for whom you have applied to obtain or continue to receive Assistance, Benefits or Services; and such Assistance, Benefits or Services must be used for the other person and not for yourself. Federal and State laws provide that any transfer of assets for less than fair market value made by an individual or an individual's spouse, within 36 months (or 60 months in the case of trust-related transfers) prior to the first of the month in which the individual is both in receipt of nursing facility services and has submitted an application for Medical Assistance, **may** render the individual ineligible for nursing facility services or home and community based waivered services for a period of time. It is unlawful to obtain Assistance, Benefits or Services by concealing information or providing false information.

READ THE IMPORTANT INFORMATION BELOW.

FOOD STAMP (FS) PENALTY WARNING - The information provided on this form will be subject to verification by Federal, State and local officials. If any is found inaccurate, you may be denied FS and/or be subject to criminal prosecution for knowingly providing false information.

Any member of your household who is found guilty in a court of law of buying or selling firearms, ammunition or explosives in exchange for FS will never be able to get FS again.

Any member of your household who is found guilty in a court of law of buying or selling controlled substances (illegal drugs or certain drugs for which a doctor's prescription is required) in exchange for FS will not be able to get FS for 24 months for the first offense and permanently for the second offense.

Any member of your household who intentionally breaks any of the following rules can be barred from the FS program for 12 months after the third violation. The individual can be fined up to $250,000, sent to jail for up to 20 years, or both. A court can also bar an individual for an additional 18 months from the FS program. The individual may also be subject to further prosecution under other applicable State and Federal laws.

Any member of your household who is convicted of an offense for knowingly using, transferring, acquiring, altering or possessing Food Stamp coupons, authorization to participate cards or access devices in any unauthorized manner is permanently ineligible for Food Stamps if such Food Stamp coupons, authorization to participate cards or electronic devices have a value of $500 or more.

Any member of your household who is found to have made a false statement or representation about their identity or place of residence in order to receive multiple Food Stamp Benefits at the same time is ineligible to receive Food Stamps for 10 years.

Any member of your household who is fleeing to avoid prosecution, custody or confinement after conviction, for a crime, or attempt to commit a crime, that is a felony under the law of the place from which the member is fleeing (in the case of the sate of New Jersey, is a high misdemeanor under the law of New Jersey) is ineligible to receive Food Stamps.

DO NOT give false information, or hide information to get or continue to get FS.
DO NOT trade or sell FS or Food Stamp identification/benefit cards for your household.
DO NOT alter Food Stamp identification/benefit cards to get FS you're not entitled to receive.
DO NOT use FS to buy ineligible items, such as alcoholic drinks and tobacco.
DO NOT use someone else's FS or Food Stamp identification/benefit cards for your household.

MEDICAL ASSISTANCE (MA) RECOVERIES - I understand that upon receipt of MA, a lien may be filed and a recovery may be made against my real property under certain circumstances if I am in a medical institution and not expected to return home. I understand that MA paid on my behalf may be recovered from persons who had legal responsibility for my support at the time medical services were obtained.

TEMPORARY ASSISTANCE (TA) RECOVERIES - TA you receive for yourself and for persons for whom you are legally responsible to support is recoverable from property or money you possess or may acquire. You may be required, as a condition of receiving TA, to execute a deed or mortgage of real property you own. Your tax refunds and portions of lottery winnings may be taken to repay your debt for TA.

ASSIGNMENT OF INSURANCE AND OTHER BENEFITS - For Temporary Assistance and Medical Assistance, I agree to file any claims for health or accident insurance benefits and to pursue any personal injury claims or any other resources to which I may be entitled, and do hereby assign any such resources to the social services official to whom this application is made. In addition, I will assist in making any assigned benefits available to the social services official to whom this application is made."

DIRECT PAYMENT - I authorize payments owed to me or members of my household for health or accident insurance benefits to be made directly to the appropriate social services official for medical and other health services furnished while we are eligible for Medical Assistance.

MEDICARE - I Authorize payments under "Medicare" (Part B of Title XVIII, Supplementary Medical Insurance Program) to be made directly to physicians and medical suppliers on any future unpaid bills for medical and other health services furnished to me while I am eligible for Medical Assistance.

RELEASE OF EDUCATIONAL RECORDS - I give permission to the State and local department of social services to:

- Obtain any information regarding the educational records of my child(ren), herein named, necessary for claiming MA reimbursement for health-related educational services.
- Provide the appropriate federal government agency access to this information for the sole purpose of audit.

CHANGES - I agree to inform the agency **promptly** of any change in my needs, income, property, living arrangements or address to the best of my knowledge or belief.

If I am applying for child care assistance, I agree to inform the agency promptly of any change in child care arrangements, including where care is provided, who is providing child care, provider fees, and hours for which child care is needed.

REQUIREMENT TO REPORT/VERIFY HOUSEHOLD EXPENSES – I understand that my household must report child care and utility expenses in order to get a FS deduction for these expenses. I further understand that my household must report and verify rent/mortgage payments, property taxes, insurance, medical expenses and child support paid to a non-household member in order to get a FS deduction for these expenses.

I understand that failure to report/verify the above expenses will be seen as a statement by my household that I/we do not want to receive a deduction for those unreported/unverified expenses. A deduction for these expenses may make you eligible for FS or may increase your FS benefits. I understand that I may report/verify these expenses at any time in the future. This deduction would then be applied to the calculation of FS benefits in future months in accordance with the rules for change reporting.

TURN TO THE BACK PAGE (PAGE 16) AND READ AND SIGN AT THE BOTTOM OF PAGE 16 ➡

READ THE IMPORTANT INFORMATION BELOW AND SIGN AT THE BOTTOM.

CONSENT - I understand that by signing this application/certification form I agree to any investigation made by the Department of Social Services to verify or confirm the information I have given or any other investigation made by them in connection with my request for TA, MA, FS, Services or Child Care Assistance. If additional information is requested, I will provide it. I will also cooperate fully with State and Federal personnel in a Temporary Assistance and/or Food Stamp Quality Control Review.

SUA INFORMATION - I understand that Temporary Assistance (TA) and Food Stamp Benefits (FS) recipients are categorically income eligible for the Home Energy Assistance Programs (HEAP). If I am not included in the annual automatic HEAP payment process for certain TA and FS recipients, I intend to apply for a benefit within the next 12 months. If I decide not to apply for HEAP within the next 12 months I will let my worker know.

ASSIGNMENT OF SUPPORT RIGHTS – I assign to the State and social services district any rights I have to support from persons having legal responsibility for my support and any rights I have to support on behalf of any family member.

AUTHORIZATION FOR REIMBURSEMENT OF TEMPORARY ASSISTANCE BENEFITS FROM SSI RETROACTIVE PAYMENT - I authorize the Commissioner of the Social Security Administration (SSA), to send to the local social services district the amount due to me at the time of my first payment of (1) retroactive Supplemental Security Income (SSI) benefits that I may receive upon an application for SSI or (2) retroactive SSI benefits I may receive if I am terminated or suspended from receiving SSI benefits and am later reinstated.

I understand that the local social services district may take from my SSI payment the amount of Temporary Assistance (except assistance paid wholly or partly with federal funds) that was paid to me during the period beginning with my first day of eligibility for SSI or the first day to which SSI benefits were reinstated after a period of suspension or termination and ending with the month that SSI payments actually began (or the following month if the local social services district cannot stop delivery of my last public assistance payment during the month that SSI payments began).
After taking this money from my SSI check(s), the local social services district will pay me the balance, if there is any, no later than 10 working days from the date it receives my SSI payment. I also understand that if the district takes more money than I believe was paid to me as Public Assistance, I will be given an opportunity for a hearing.

I understand that:

- the SSA may treat the date that I submit this signed authorization to the local social services district as the date I first become eligible for SSI if I submit an application for initial SSI benefits within the next 60 days.
- this authorization will apply to any SSI application or appeal which is presently pending before the SSA with respect to me and to any SSI application I make or appeal I request with respect to the period ending one year after I sign this agreement.

This authorization will terminate one (1) year after it is received by the local social services district and will not have any effect upon future SSI applications, appeals or reviews if my case is completely decided, if the SSA makes an initial payment of SSI either on my application or after a period of suspension or termination or if the State and I mutually agree to terminate the authorization.

CERTIFICATION – I swear and/or affirm under the penalties of perjury that the information I have given or will give to the local social services district is correct.

APPLICANT/REPRESENTATIVE SIGNATURE	DATE SIGNED	HUSBAND/WIFE OR PROTECTIVE REPRESENTATIVE SIGNATURE	DATE SIGNED
X		X	

NYS Agency-Based Voter Registration Form

ESTE FORMULARIO ESTÁ DISPONIBLE EN ESPAÑOL

本表格有中文文本

"If you are not registered to vote where you live now, would you like to apply to register here today?"

☐ **YES** **(If you check yes, please complete VOTER REGISTRATION APPLICATION at bottom of page)**

☐ NO because I choose not to register **OR**

☐ I am already registered at my current address **OR**

☐ I asked for and received a mail registration form.

If you do not check any box, you will be considered to have decided not to register to vote at this time.

_____ ___/___/___
(Signature) (Date)

_____
(Please Print Name)

Qualifications for Registration

You Can Use This Form To:

- **register to vote in New York State**
- **change your name and/or address, if there is a change since you last voted**
- **enroll in a political party or change your enrollment**

To Register You Must:

- **be a U.S. citizen**
- **be 18 years old by December 31 of the year in which you file this form (note: you must be 18 years old by the date of the general, primary, or other election in which you want to vote.)**
- **be a resident of the County, or of the City of New York at least 30 days before an election.**
- **not be in jail or on parole for a felony conviction**
- **not claim the right to vote elsewhere**

IMPORTANT!

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

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

If you believe that someone has interfered with your right to register or to 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 *New York State Board of Elections, 40 Steuben Street, Albany, New York 12207-2109.*
Tele: 1-800-469-6872, TTY 1-800-533-8683; or visit our web site - www.elections.state.ny.us

Your decision to register will remain confidential and will be used only for voter registration purposes. Anyone not choosing to register to vote and/or information regarding the office to which the application was submitted will remain confidential, to be used only for voter registration purposes.

Vote New York

VOTER REGISTRATION FORM

VOTER REGISTRATION APPLICATION

NVRA-05 (4/01)

☐ Yes, I need an application for an Absentee Ballot **Please print or type in blue or black ink** ☐ Yes, I would like to be an Election Day Worker

1	Are you a U.S. citizen? ☐ Yes ☐ No If you answered NO, do not complete this form.	2	Check boxes that apply: ☐ new registration and enrollment ☐ address change ☐ party enrollment change ☐ name change	**For Board Use Only**
3	Last Name First Name Middle Initial Suffix			
4	Address Where You Live (do not give P.O. address) Apt. No. City/Town/Village Zip Code County			
5	Address Where You Get Your Mail (if different from above) P.O. box, star rte., etc. Post Office Zip Code			
6	Date of Birth	7	Sex (circle) M F	8 Home Tel. Number (optional)
9	The last year you voted / Your Address was (give house number, street, and city) / In county/state / Under the name (if different from your name now)			

10 **Choose a Party** — Check one box only

- ☐ REPUBLICAN PARTY
- ☐ DEMOCRATIC PARTY
- ☐ INDEPENDENCE PARTY
- ☐ CONSERVATIVE PARTY
- ☐ LIBERAL PARTY
- ☐ RIGHT TO LIFE PARTY
- ☐ GREEN PARTY
- ☐ WORKING FAMILIES PARTY
- ☐ I DO NOT WISH TO ENROLL IN A PARTY

Please note: In order to vote in a **primary election,** you must be enrolled in a party.

11 **AFFIDAVIT**: I swear or affirm that
- I am a citizen of the United States.
- I will have lived in the county, city, or village for at least 30 days before the election.
- This is my signature or mark on the line below.
- The above information is true. I understand that if it is not true I can be convicted and fined up to $5,000 and/or jailed for up to four years.

⬇ Signature or mark ⬇

X _____ Date _____

Please do not write in this space