Dist Cd:	Ofc:	Unit:	Worker:	Case Name:	Case #:

MAIL-IN RECERT/ELIGIBILITY QUESTIONNAIRE

To determine your continued eligibility for Temporary Assistance (TA) and Supplemental Nutrition Assistance Program (SNAP) you must complete this form, sign, date it and return it to us at the address on the first page of the notice by:

RETURN DATE

- For TA this form is considered a mail-in recertification form. For SNAP it is an Eligibility Questionnaire.
- You must enclose copies of letters or documents that verify the changes you report. In addition, if you or a family member has a job (earned income) you must submit the last four pay-stubs even if the wages have not changed.
- Failure to return the form or returning it without the required verification may result in the closing of your case or reduction of benefits.

1. Do you still need:	Temporary Assistance? Yes ☐ No ☐	SNAP? Yes ☐ No ☐	Medical Assistance? Yes ☐ No ☐

2. Did anyone **move into** or **out of** your household since the last time you reported the number of persons in your household (including births)?

If yes, provide the information requested below.
If they want to apply for assistance an application must be filed.
If you are reporting a newborn enclose a copy of a birth certificate for verification.

Yes ☐ No ☐

SOCIAL SECURITY #	NAME	RELATIONSHIP TO YOU	MOVED IN	MOVED OUT	DATE

3. Other than Temporary Assistance, did you or anyone in your household, have a change in income? Has anyone begun receiving any new or increased income or lost income from any of the following sources since the last time you reported your income? If you check "YES", indicate the amount you receive and whether this amount is new, more or less. <u>You must submit photocopies of pay-stubs (if working) to verify the last four weeks of pay, or other proof of how much you or your family member earned/received in the last four weeks</u>.

SOURCE OF INCOME	YES	NO	AMOUNT	NEW	MORE	LESS
A. Contributions			$			
B. Employment Please indicate the number of hours working per week _____.			$			
C. Unemployment Insurance Benefits (UIB)			$			
D. Supplemental Security Income (SSI)			$			
E. Child Support (Including Legally Obligated Payments)			$			
F. Veterans Or Other Military Benefits			$			
G. Other income			$			

4. Have there been any changes in the following since you last reported to us:

YES	NO	
		A. Rent cost: ☐ Increase ☐ Decrease ☐ New Amount $ _____ (Enclose rent receipt copy if your rent changed)
		B. Do you now pay separately from your rent for: ☐ Heat or Air Conditioning ☐ Other Utilities (electricity, cooking gas, water, sewer, trash, etc.)
		C. Is someone pregnant, disabled or 60 years of age or older? Name: _____ (Enclose copy of Medical Proof)
		D. Resources (examples: motor vehicle, bank account, etc.)
		E. Other changes (including hours employed or in work activities), please explain:
		F. Have any medical conditions that limit their ability to work or the type of work they can perform? Name: _____

Able Bodied Adult Without Dependents (ABAWDs) - If anyone in your SNAP household is an Able-Bodied Adult Without Dependents ("ABAWD"), you must report when the individual's, who is an ABAWD, monthly participation in employment or other work activities falls below 80 hours.

NOTE: The last part of this form is an application to register to vote. If you would like help filling out the voter registration application form, ask your TA examiner. Applying to register or declining to register to vote will not affect the amount of assistance that you will be given by this agency. Return this form to the agency whether it has been completed or not.

MAIL-IN RECERT/ELIGIBILITY QUESTIONNAIRE

SNAP

In order to determine if you can still get SNAP, you must complete this eligibility questionnaire and return it by the date on the front of this questionnaire. If you do not complete and return the eligibility questionnaire by the due date, your SNAP benefits will be reduced or stopped. We will send you another notice if this happens. This decision is based on Regulation 18 NYCRR 387.17.

List of changes you must report for SNAP at this time:

- Changes in any **source of income** for anyone in your household.
- Changes in your household's total **earned income** when it goes up or down by more than $100 a month.
- Changes in your household's total **unearned income** from a **public source** such as Social Security Benefits or Unemployment Insurance benefits when it goes up or down by more than $100 a month.
- Changes in your household's total **unearned income from a private source** such as Child Support Payments or Private Disability Insurance when it goes up or down by more than $100 a month.
- Changes in the amount of legally obligated **child support you pay** to a child outside of your SNAP household.
- Changes in **who lives with you**.
- **If you move**, your new address and your new rent or mortgage costs, heat/air conditioning costs and utility costs.
- Increases in your household's **cash, stocks, bonds, money in the bank** or savings institution if the total cash and savings of all household members now amounts to more than $2250 for a household without an elderly or permanently disabled household member or $3500 for a household with an elderly or permanently disabled household member.
- If anyone in your SNAP household is an Able-Bodied Adult Without dependents (ABAWD), he/she MUST tell the district if their hours go below 80 hours each month within 10 days after the end of that month. The ABAWD can request a qualifying work activity from the district to help him/her meet the federal ABAWD requirement. If anyone in your SNAP household is an ABAWD, he/she should also report if your household has moved to an area with a federally approved ABAWD waiver or if the ABAWD believes he/she should be exempt from the ABAWD requirement.

MEDICAL ASSISTANCE - You must immediately report any changes in your address, income, resources or household size to this agency. You will be notified if your Medical Assistance coverage changes.

Authorization To Repay Public Assistance Benefits From Retroactive SSI

I authorize the Commissioner of the Social Security Administration (SSA) to use my first payment of SSI (i.e. my retroactive SSI payment) to reimburse the local Social Services District (SSD) for Public Assistance (PA) the SSD pays me from State or local funds while SSA decides if I am eligible for Supplemental Security Income (SSI). SSA will not reimburse the SSD for PA that was paid using any federal funds.

I will be bound by this authorization only if the State gives notice to SSA that I and an SSD representative have signed it. The State must give notice within 30 calendar days of matching my SSI record with my State record. SSA will not accept it after 30 calendar days. Instead, SSA will send me my retroactive SSI payment under SSA rules.

Only my first payment of SSI can be used. If my first payment is larger than the amount owed to the SSD, SSA will send the rest to me under its rules.

SSA can reimburse the SSD in two situations:

(1) It will repay the SSD if I apply for SSI and SSA finds me eligible.
(2) It will repay the SSD if my SSI benefits are reinstated after termination or suspension.

SSA will only reimburse the SSD for PA it paid me during the time I am waiting for an SSA determination of eligibility. This is called "interim assistance". The period begins (1) with the first month I become eligible for payment of SSI benefits, or (2) on the first day I am reinstated after my SSI was suspended or terminated. The period includes the month SSI payments actually begin. If the SSD cannot stop my last PA payment, the period ends the next month.

No later than 10 days after SSA reimburses the SSD, the SSD must send me a notice telling me the amount of interim assistance paid. The notice will also tell me that SSA will send me a letter telling me how any remaining SSI money owed to me will be sent by SSA and, that if I do not agree with a state decision, how I can appeal the decision to the state.

Under its rules, SSA may use the date I sign this authorization as the date I first become eligible for SSI. It will do this only if I apply for SSI within the next 60 days.

This authorization applies to any SSI application or appeal I now have pending before SSA.

This authorization terminates if my SSI case is completely decided. It terminates when SSA first pays me. The State and I can also agree to terminate the authorization. I must sign a new authorization consistent with NYS rules if I reapply for SSI after this authorization terminates, or if I file a new SSI claim while I have an SSI application or appeal pending.

I will be given an opportunity for a fair hearing if I disagree with a decision the SSD made about reimbursement.

I received a copy of the pamphlet called "What You Should Know About Social Services Programs'. I understand what it says about interim assistance.

SIGNATURE SECTION	
I swear (or) affirm that the information I have provided on this form is true and correct.	
Sign here: X	Date:
Spouse or Authorized Representative Signature: X	Date:
Worker Signature: X	Date:

WARNING: Federal and State law provides for penalties of fine, imprisonment or both if you do not tell the truth or if you conceal or fail to disclose facts regarding your continuing eligibility for assistance. Regulations require that you immediately notify this agency of any changes in needs, income, resources, living arrangements or address.

NYS Agency-Based Voter Registration Form

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

- ☐ **YES** If you checked **YES**, please complete the **VOTER REGISTRATION APPLICATION** below
- ☐ **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 _____

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.

Información en español: si le interesa obtener este formulario en español, llame al 1-800-367-8683

中文資料:若您有興趣索取中文資料表格, 請電: 1-800-367-8683

한국어: 한국어 한국어 양식을 원하시면 1-800-367-8683 으로 전화 하십시오.

যদি আপনি এই ফর্মটি ইংরেজীতে পেতে চান তাহলে 1-800-367-8683 নম্বরে ফোন করুন

Rev. 2/2015

VOTER REGISTRATION APPLICATION (instructions on back)

☐ 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	**Will you be 18 years old on or before election day?** ☐ **YES** ☐ **NO** If you answered **NO**, do not complete this form unless you will be 18 by the end of the year	**For Board Use Only**
3	Last Name / First Name / Middle Initial / Suffix			
4	Address where you live (do not give P.O. box) / Apt. No. / City/Town/Village / Zip Code / County			
5	Address where you get your mail (if different than above) / P.O. Box, Star Route, etc. / Post Office / Zip Code			
6	Date of Birth	7	Sex ☐ **M** ☐ **F**	8 Telephone (optional) / Email (optional)
10	The last year you voted / In county/state		Your address was (give house number, street and city) / Under the name (if different from your name now)	
9	**ID Number** (Check the applicable box and provide your number) ☐ New York State DMV number — — — — — — — — — ☐ Last four digits of your Social Security number — — — — ☐ I do not have a New York State DMV or Social Security number			
11	**Political Party** **I wish to enroll in a political party** ☐ Democratic party ☐ Republican party ☐ Conservative party ☐ Green party ☐ Working Families party ☐ Independence party ☐ Women's Equality party ☐ Reform party ☐ Other _____ **I do not wish to enroll in a political party** ☐ No party			
12	**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. • I will meet all requirements to register to vote in New York State. • 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 in ink _____ Date / /			

(Optional) Register to donate your organs and tissues

Last Name		
First Name	Middle Initial	Suffix
Address		
Apt Number / City/Town/Village		Zip Code
Birth Date	Sex ☐ M ☐ F	
Eye Color	Height Ft. In.	

By signing below, you certify that you are:

- 18 years of age or older
- Consent to donate all of your organs and tissues for transplantation, research, or both;
- Authorizing the Board of Elections to provide your name and identifying information to DOH for enrollment in the Registry;
- And authorizing DOH to allow access to this information to federally regulated organ procurement organizations and NYS-licensed tissue and eye banks and hospitals upon your death.

DONATE LIFE New York State

Signature _____ Date / /

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; and
- not claim the right to vote elsewhere.

Important!

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:

NYS Board of Elections
40 North Pearl St, Suite 5
Albany, NY 12207-2729
Telephone: 1-800-469-6872;
TDD/TTY users contact the New York State Relay at 711;
or visit our web site - www.elections.ny.gov

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.

Verifying your identity

We will try to check your identity before Election Day, through the DMV number (driver's license number or non-driver ID number), or the last four digits of your social security number, which you will fill in Box 9.

If you do not have a DMV or Social Security number, you may use a valid photo ID, a current utility bill, bank statement, paycheck, government check or some other government document that shows your name and address. You may include a copy of one of those types of ID with this form.

If we are unable to verify your identity before Election Day, you will be asked for ID when you vote for the first time.

To complete this form:

It is a crime to procure a false registration or to furnish false information to the Board of Elections.

Box 9: You must make one selection. For questions refer to Verifying your identity above.

Box 10: If you have never voted before, write "None". If you can't remember when you last voted, put a question mark (?). If you voted before under a different name, put down that name. If not, write "Same".

Box 11: Check one box only. Political party enrollment is optional but that, in order to vote in a primary election of a political party, a voter must enroll in that political party, unless state party rules allow otherwise.