INSTRUCTIONS FOR COMPLETING THE NEW YORK STATE APPLICATION FOR:

- PUBLIC ASSISTANCE
- CHILD CARE IN LIEU OF PUBLIC ASSISTANCE
- SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM
- MEDICAID AND SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM
- MEDICAID AND PUBLIC ASSISTANCE
- SERVICES, INCLUDING FOSTER CARE
- CHILD CARE ASSISTANCE
- EMERGENCY ASSISTANCE ONLY

If you are blind or seriously visually impaired and need an application or these instructions in an alternative format, you may request them from your social services district ("district"). The following alternative formats are available:

- Large print
- Data format (a screen reader-accessible electronic file)
- Audio format (an audio transcription of the instructions or application questions)
- Braille, if you assert that none of the alternative formats above will be equally effective for you

Applications and instructions are also available for download in large print, data format and audio format from www.otda.ny.gov or www.health.ny.gov. Please note that applications are available in audio format and Braille solely for informational purposes. In order to apply, you must submit an application in written, non-alternative format.

If you have any disabilities that prevent you from completing this application and/or from waiting to be interviewed, please notify your district. The district will make every effort to provide a reasonable accommodation to address your needs.

If you require another accommodation or need other help completing this application, please contact your district. We are committed to assisting and supporting you in a professional and respectful manner.

TIPS FOR COMPLETING THE APPLICATION

Whenever you see “Public Assistance” or “PA” on the application, it means “Family Assistance” and/or “Safety Net Assistance.” We call both programs “Public Assistance.” PA and the other programs for which you can apply using this application were created to give temporary help to those in need. Certain programs limit how long you can get help, so it is important for you to achieve self-sufficiency as soon as you can. The district is there to help you with achieving self-sufficiency. In order to do so, we must know who you are and what you need. This is why you must fill out an application.

As a part of the application process, the district will ask you to provide and verify information about yourself and other individuals for whom you are applying. A listing of documentation requirements, which can be found at the end of these instructions, shows the kinds of information you may need to provide and the kinds of documents that can verify this information. For instance, to prove who you are, you can supply photograph identification, a driver license, a United States passport, a naturalization certificate, hospital or doctor’s records, or adoption papers. In addition, the district will interview you as part of the application process. The district will combine interviews for multiple programs where possible.

The application and these instructions are numbered by section to help you. Please keep the following in mind when filling out the application:

- **PLEASE PRINT CLEARLY.**
- **DO NOT WRITE IN THE SHADED AREAS.**
- **BE SURE TO COMPLETE EACH SECTION RELEVANT TO THE PERSON(S) FOR WHOM YOU ARE APPLYING.**
- **ALWAYS USE LEGAL NAMES, UNLESS OTHERWISE INSTRUCTED.**
- **IF YOU ARE APPLYING AS SOMEONE’S REPRESENTATIVE, PLEASE PROVIDE INFORMATION ABOUT THAT PERSON, NOT YOURSELF. MAKE SURE THAT BOTH YOU AND THE PERSON YOU ARE REPRESENTING SIGN THE LAST PAGE OF THE APPLICATION.**
- **IF YOU ARE UNSURE ABOUT HOW TO COMPLETE ANY PART OF THIS APPLICATION, ASK YOUR DISTRICT FOR HELP.**

In addition to the LDSS-2921, "New York State Application for Certain Benefits and Services," make sure you have copies of the following informational booklets, available from the district or www.otda.ny.gov:

- **LDSS-4148A: "Book 1: What You Should Know About Your Rights and Responsibilities"**
- **LDSS-4148B: "Book 2: What You Should Know About Social Services Programs"**
- **Supplement to Book 1, LDSS-4148A and Book 2, LDSS-4148B: “Important Changes in the Medicaid Program”**
- **LDSS-4148C: "Book 3: What You Should Know if You Have an Emergency"**

COVER PAGE FOR THE APPLICATION

If you are blind or seriously visually impaired, you may choose to receive notices regarding the program(s) for which you apply/enroll in an alternative format. Alternative formats are available in large print, data CD, audio CD, or Braille, if you assert that none of the other alternative formats will be equally effective for you.

IF YOU ARE BLIND OR SERIOUSLY VISUALLY IMPAIRED, WOULD YOU LIKE TO RECEIVE WRITTEN NOTICES IN AN ALTERNATIVE FORMAT? If you are blind or seriously visually impaired, check (✓) "Yes" or "No" to indicate whether you would like to receive written notices regarding the program(s) for which you apply/enroll in an alternative format.

IF YES, CHECK THE TYPE OF FORMAT YOU WOULD LIKE: If you are blind or seriously visually impaired and would like to receive notices regarding the program(s) for which you apply/enroll in an alternative format, check (✓) the type of format you prefer: large print, data CD, audio CD, or Braille. Braille is available as an alternative format if you assert that none of the other alternative formats will be as effective for you as Braille.
If you require another accommodation or need other help completing this application, please contact your district.

PAGE 1 OF THE APPLICATION

SECTION 1: CHECK EACH PROGRAM YOU OR ANY HOUSEHOLD MEMBER ARE APPLYING FOR

Check (✓) the box for each program that you or any household member wants to apply for.

Medicaid includes the Medicaid Program, Medicaid Buy-In for Working People with Disabilities, and Family Planning Benefit programs. When you see "MA" on the application, it means "Medicaid," which was previously called "Medical Assistance." You may apply for MA using this application only if you are also applying for Public Assistance (PA) or the Supplemental Nutrition Assistance Program (SNAP) at the same time. If you want to apply for Medicaid and SNAP, check (✓) the "Medicaid (MA) and SNAP" box. If you want to apply for Medicaid and PA, check (✓) the "Medicaid (MA) and PA" box.

If you wish to only apply for MA, you can go online at https://nystateofhealth.ny.gov/ and/or call 1-855-355-5777 for more information or to apply, or you may use the MA-only paper application, Form DOH-4220, which your worker can give you, or call MA help line at 1-800-541-2831. If you want to apply only for the Medicare Savings Program (MSP), you must apply with Form DOH-4328, which your worker can provide to you. If you have an immediate need for personal care services, you should apply for MA separately using the DOH-4220 MA application form.

If you are eligible for Public Assistance, but decide you only need Child Care Assistance, check (✓) the "Child Care in lieu of PA" box. If you change your mind and decide you need Public Assistance, you can apply for this program at any time.

If you check (✓) the "Emergency Assistance Only (EMRG)" box, you are indicating that you are applying for a one-time-only emergency payment and an eligibility determination will not be made for any other programs.

SECTION 2

WHAT IS YOUR PRIMARY LANGUAGE? Check (✓) the "English," "Spanish," or "Other" box to indicate the language you use most often. If you check (✓) the "Other" box, print your preferred language.

DO YOU WANT TO RECEIVE NOTICES IN: You will receive notices regarding the programs for which you apply/enroll. Check (✓) the "English Only" or "English and Spanish" box to indicate the language(s) in which you would like to receive these notices.

SECTION 3: APPLICANT INFORMATION

NAME: Print your name, including your first name, middle initial (M.I.), and last name.

MARITAL STATUS: Print whether you are now single, married, widowed, legally separated or divorced. If you have ever been married, print the appropriate status, do not print "single."

PHONE NUMBER: Print your phone number, if you have one.

MOBILE NUMBER?: Indicate whether this is a mobile phone number by checking (✓) "YES" or "NO."

RESIDENTIAL ADDRESS: **Street Address:** Print the house or building number, street, avenue, road, etc., where you live.
Apt. No.: Print the number of your apartment, if applicable.
City: Print the name of the city you live in.
County: Print the name of the county you live in.
State: Print the name of the state you live in.
Zip Code: Print the zip code for your address.

IN CARE OF NAME: If someone else receives your mail for you, print that person's name.

MAILING ADDRESS: If you get your mail somewhere other than where you live, print the street address (and apartment number, if applicable) or post office box, city, county, state, and zip code of this location.

HOW LONG HAVE YOU LIVED AT YOUR PRESENT ADDRESS?: Print the number of years and/or months that you have lived at your current address.

IS THIS A SHELTER?: Check (✓) "YES" or "NO" to indicate whether the place you are living is a shelter.

ANOTHER PHONE WHERE YOU CAN BE REACHED: Print another phone number where you can be reached, if you have one.

EMAIL ADDRESS (OPTIONAL): Print your email address to give the district permission to contact you by email. **Providing an email address is not required to apply.**

DIRECTIONS TO CURRENT ADDRESS: Print directions on how to find your home. Use commonly known landmarks.

FORMER ADDRESS: Print the address where you lived before you moved to your present address.

IF YOU ARE CURRENTLY WITHOUT A HOME, CHECK HERE: If you do not have anywhere to live/do not have an address, check (✓) this box.

AGENCY HELPING APPLICANT/CONTACT PERSON: If someone is helping you to apply, print the name of that person, their agency, if any, and the person's phone number.

DO YOU NEED THE MEDICAID PORTION OF THIS APPLICATION AND THE POTENTIAL RECEIPT OF ANY MEDICAID COVERAGE TO BE KEPT CONFIDENTIAL?: Check (✓) "YES" or "NO" to indicate on the application and/or tell your worker whether you need your application and/or correspondence related to the receipt of any Medicaid coverage to be kept confidential.

SECTION 4: IF YOU ARE APPLYING FOR SNAP

Read the statement in Section 4 of the application, and sign and date underneath the statement if it applies to you or anyone for whom you are applying. Please contact the district if you have questions about this section.

SECTION 5: DO ANY OF THESE APPLY TO YOU?

Check (✓) each situation that applies to you or someone for whom you are applying

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SECTION 6: HOUSEHOLD INFORMATION

NAME: Print the first name, middle initial (M.I.), and last name of everyone who lives with you, *even if they are not applying*. List yourself first.

THIS PERSON IS APPLYING FOR: Check (✓) the type(s) of assistance each person is applying for: PA for Public Assistance, SNAP for the Supplemental Nutrition Assistance Program, MA for Medicaid, CC for Child Care Assistance, FC for Foster Care, S for Services (such as child or adult preventive/protective services), or EMRG for an Emergency Assistance Only.

DATE OF BIRTH: Print the date of birth of each person *who is applying*.

SEX and GENDER IDENTITY: New York State ensures your right to access State benefits and/or services regardless of sex, gender identity, or expression. You must report your sex and the sex of all household members as male, female, or "X." Please indicate "M" for male, "F" for female, or "X" for non-binary or another identity. The sex you report is needed to process your application. It will not appear on any benefit card you may receive or any other public-facing document.

Gender identity is how you perceive yourself and what you call yourself. Your gender identity can be the same as or different from your sex or gender assigned at birth. Gender identity is not required for this application. If your gender identity, or the gender identity of anyone in your household, is different than the sex you report for that person and you would like to provide that person's gender identity, print "Male," "Female," "Non-Binary," "X," "Transgender," or "Different Identity" in the space provided. If you print "Different Identity," you may choose to describe that person's gender identity further in the space provided. Providing this information is voluntary. It will not affect the eligibility of the person(s) applying or the level of benefits received.

RELATIONSHIP TO YOU: For each person, print their relationship to you (for example: spouse, son, foster child, friend, roommate, boarder, etc.).

SOCIAL SECURITY NUMBER OF APPLYING HOUSEHOLD MEMBERS: Print the Social Security number of each person who is applying *unless that person is*:

- A pregnant woman who is applying only for Medicaid;
- A non-citizen who is applying only for Medicaid or benefits as a result of an emergency medical condition;
- An adult who is applying only for adult protective services; or
- Applying only for Child Care Assistance. If the person is applying for Child Care Assistance and preventive services *or in lieu of* Public Assistance, print that person's Social Security number.

Other Services, such as foster care, child protective services, child preventive services, and counseling, are funded by a variety of sources, many of which require that a Social Security number be provided. While applicants for some Services are not required to provide a Social Security number, these Services may be unavailable if you do not furnish a Social Security number. We are, therefore, requesting a Social Security number for all applicants for these Services, in order to help them get all the benefits for which they may qualify.

HIGHEST SCHOOL GRADE COMPLETED: Enter the highest school grade (1 through 12) completed for each person *who is applying*. If more than 12 years, enter 13. If no formal schooling, enter 0. If you are applying only for Services, you do not have to answer this question.

DOES THIS PERSON (INCLUDING MINOR CHILDREN) BUY FOOD OR PREPARE MEALS WITH

YOU?: It is important to check (✓) "YES" or "NO" to this question for every person who *lives* with you, whether or not they are applying. Sometimes, people who buy food and prepare meals separately may get more SNAP benefits.

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

HAVE BEEN KNOWN: Print any maiden names, names from a previous marriage, or other names used by anyone listed in this section. Include first name, middle initial (M.I.), and last name.

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SECTION 7: RACE/ETHNICITY

Providing this information is voluntary. It will not affect the eligibility of the persons applying or the level of benefits received. The reason for requesting this information is to ensure that benefits are distributed without regard to race, color, or national origin. If you complete this section, please enter "Y" for "YES" for each person applying in the column labeled "H" to indicate whether the person is Hispanic and/or Latino. Enter "Y**"** for "YES" in the applicable race column(s) to indicate each person's racial background:

- 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
- U = Unknown

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SECTION 8: CITIZENSHIP/ NON-CITIZEN WITH SATISFACTORY IMMIGRATION STATUS

Complete this section for each person who is applying for any of the following programs:

- Child Care Assistance;
- Foster Care; or
- Other Services.

In addition, if you or anyone in your household is applying for the Supplemental Nutrition Assistance Program (SNAP), you must list *everyone* in the household, even if they are not applying for SNAP. You must also list any siblings and parents who live with any children applying for Public Assistance (PA). If applying for Child Care Assistance or Foster Care only, complete this section only for the children who need child care or foster care. If you do not complete this section for a person who is applying, that person may not receive assistance.

NAME: Print the first name, middle initial (MI), and last name of each person who is applying or who must be listed.

CHECK EITHER "CITIZEN/NATIONAL" OR "NON-CITIZEN" FOR EACH PERSON: Next to each person's name, check (✓) *either* the **"**CITIZEN/NATIONAL**"** box to indicate that the person is a U.S. citizen, Native American, or national, or **"**NON-CITIZEN**"** box to indicate that the person is *not* a U.S. citizen, Native American, or national.

USCIS NUMBER (ALIEN REGISTRATION NUMBER) OR NON-CITIZEN NUMBER: Enter the person's U.S. Citizenship and Immigration Services (USCIS) number or non-citizen number, if applicable.

SECTION 9: CERTIFICATION

Read carefully the statements at the bottom of this section, then sign and date the certification attesting to the citizenship or non-citizen-with-satisfactory-immigration status of each person *who is applying* for any of

the following programs. (If applying for Child Care Assistance or Foster Care only, complete this section only for the children who need child care or foster care.) If anyone applying is not a U.S. citizen, Native American, or national, check (✓) the programs for which that person is applying and has non-citizen-with-satisfactory-immigration status:

- Public Assistance (PA);
- Supplemental Nutrition Assistance Program (SNAP);
- Medicaid (MA);
- Child Care Assistance (CC);
- Foster Care (FC);
- Other Services (S); and/or
- Emergency Assistance (EMRG).

"Satisfactory non-citizen status" means a non-citizen status that does not make the person ineligible for benefits from a given program. Please note that different programs have different non-citizen status requirements. LDSS-4148B, "Book 2: What You Should Know About Social Services Programs," and the Insert for LDSS-4148B, "What You Should Know About Social Services Programs (LDSS-4148B.1)," contain more information about satisfactory non-citizen statuses. You may also contact your district for more information.

Any adult household member or authorized representative may sign the certification for all applying household members. For example, a parent *without* citizenship or satisfactory non-citizen status may sign the certification for a child *with* citizenship or satisfactory non-citizen status. If an applying household member is under age 18 (or is age 18 or older but unable to sign their own name due to a medical impairment or disability), a household member who is age 18 or older *must* sign for them. When signing for another household member, sign your own name. For example, Mary Doe, when signing for infant Johnny Doe, should sign "Mary Doe."

Checking a box and signing the certification means that you certify, under penalty of perjury, that you and/or the person(s) for whom you are signing is/are a U.S. citizen(s), Native American(s), national(s), or non-citizen(s) with satisfactory immigration status, for each program for which you/they are applying. If you do not check one of the boxes or provide a U.S. Citizenship and Immigration Services (USCIS) number for a non-citizen who is applying, that person may not receive assistance.

You should not sign the certification for yourself or any other person who is not a U.S. citizen, Native American, or national, or who does not have non-citizen-with-satisfactory-immigration status. Non-citizens without satisfactory immigration status are not eligible for PA, SNAP benefits, or Medicaid (except Medicaid for treatment of an emergency medical condition). Such persons also may be ineligible for certain Services.

We may confirm the non-citizen status of any or all household members applying for PA, SNAP benefits, Medicaid, or Services by submitting the information you give us to the USCIS. Information received from USCIS may affect your household's eligibility and level of benefits.

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SECTION 10: INFORMATION REGARDING REFERRAL TO THE CHILD SUPPORT ENFORCEMENT UNIT

You do not need to fill out this section if you are applying only for Medicaid and you are pregnant, gave birth within the past 60 days, or are applying for children under 21 only, or if you are applying for child care assistance only.

1. Check (✓) "Yes" or "No" to indicate whether you are applying for any person, *including yourself*, who is under the age of 21, who was born to unmarried parents, and/or for whom legal parentage has not been established.

2. Check (✓) "Yes" or "No" to indicate whether you are applying for any person, *including yourself*, who is under the age of 21 and at least one of this person's parents lives outside of the home.

If you checked (✓) "No" for both of these questions, skip to Section 11. You do not have to complete the rest of Section 10. If you checked (✓) "Yes" for either or both of these questions, you must complete the rest of Section 10.

3. Check (✓) "Yes" or "No" to indicate whether you are under the age of 21.

NAME OF INDIVIDUAL UNDER AGE 21: Print the first, middle, and last name of each person for whom you checked "Yes" for Questions 1, 2, and/or 3.

NONCUSTODIAL, ALLEGED, OR INTENDED PARENT'S NAME AND ADDRESS, DATE OF BIRTH, and SOCIAL SECURITY NUMBER: If known, print the first, middle, and last name, address, date of birth, and Social Security number of the noncustodial, alleged, or intended parent of each person for whom you checked **(✓)** "Yes" for Questions 1, 2, and/or 3. The "noncustodial parent" includes the genetic/biological parent, legal parent, stepparent, or adoptive parent of any child where such parent is reported to be absent from the child's household. With respect to a child in foster care, a noncustodial parent or "absent parent" also includes a genetic/biological parent, legal parent, stepparent, or adoptive parent of any child where such parent was present in the child's household when the child entered foster care.The "alleged parent" is a person who may be the child's genetic/biological parent, but who has not yet been legally declared to be the parent. The "intended parent" is the person who intends to be legally bound as the parent of a child resulting from assisted reproduction. The intended parent may be married to the birth parent.

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SECTION 11: TAX FILING/DEPENDENT STATUS

Print the following information for each individual living in the household:

FIRST NAME, MIDDLE INITIAL, and LAST NAME: Print the first name, middle initial, and last name of each individual who lives in the household.

TAX STATUS: Check (✓) the appropriate tax filing status for each individual who lives in the household. Please list any tax dependents who do not live with you and are claimed by you or anyone in your household. If you do not file taxes, you can skip these questions.

NAME OF TAX DEPENDENT: Print the first name, middle initial, and last name of any individual who does not live with you, but who you or anyone who lives with you claims as a tax dependent.

NAME OF TAX FILER: For each tax dependent listed, print the first name, middle initial, and last name of the individual living in the household who claims the tax dependent.

SECTION 12: ABSENT/DECEASED SPOUSE INFORMATION

NAME OF PERSON APPLYING: Print the name of any person applying who is/was married, but whose spouse does not live with them or is deceased.

NAME OF SPOUSE: Print the name of the spouse of any married/formerly married person applying whose spouse does not live with them or is deceased.

DATE OF SPOUSE'S BIRTH and DATE OF SPOUSE'S DEATH, IF APPLICABLE: Print the month, day, and year of birth, and death (if applicable), of the spouse of any married/formerly married person applying whose spouse does not live with them or is deceased.

SPOUSE'S SOCIAL SECURITY NUMBER: Print the Social Security number of the spouse of any married/formerly married person applying whose spouse does not live with them or is deceased.

SPOUSE'S ADDRESS, IF APPLICABLE: Print the street address, city, county, state, and zip code of the spouse of any married person applying whose spouse does not live with them. If unknown, print the spouse's last known address.

SECTION 13: ABSENT CHILD INFORMATION

NAME OF PERSON APPLYING: Print the name of any person applying who has a child under the age of 21 who does not live with them.

NAME OF ABSENT CHILD and DATE OF BIRTH: Print the name and month, day, and year of birth of any child under the age of 21 who does not live with a person applying.

ADDRESS OF CHILD: Print the street address, city, county, state, and zip code of any living child under the age of 21 who does not live with a person applying.

LEGAL PARENTAGE ESTABLISHED?: Check (✓) "Yes" or "No" to indicate whether legal parentage has been established for any child under the age of 21 who does not live with a person applying.

DO YOU PAY CHILD SUPPORT?: Check (✓) "Yes" or "No" to indicate whether any person applying pays child support for a child under the age of 21 who does not live with them.

SECTION 14: TEEN PARENT INFORMATION

Only complete this section if you are applying for Public Assistance.

IS THERE A PARENT UNDER THE AGE OF 18 ("TEEN PARENT") IN THE HOUSEHOLD?: Check (✓) "Yes" or "No" to indicate whether any person applying is a parent under the age of 18.

NAME: Print the name of any person applying who is a parent under the age of 18.

DOES THE TEEN PARENT'S CHILD LIVE IN THE HOUSEHOLD?: Check (✓) "Yes" or "No" to indicate whether the child of any person under the age of 18 who is applying lives with you.

NAME OF TEEN PARENT'S CHILD: Print the name of the child of any person under the age of 18 who is applying.

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SECTION 15: INCOME INFORMATION

INDICATE IF YOU OR ANYONE WHO LIVES WITH YOU RECEIVES MONEY FROM and WHO: Check

(✓) "YES" or "NO" for lines 1 through 27 to indicate whether you or anyone who lives with you receives money from any of the kinds of income listed, and for each "YES" answer, print the name(s) of the person(s) who receive(s) the money.

AMOUNT/VALUE & FREQUENCY: For each "YES" answer, print the dollar ($) amount or value and how often this kind of income is received by each person who receives it. For instance, if you receive $100 in unemployment insurance benefits every week, print "$100 per week" or "$100/wk."

SUPPLEMENTAL SECURITY INCOME (SSI) BENEFITS (STATE AND FEDERAL TOTAL): If you or

anyone who lives with you gets New York State Supplement Program (SSP) benefits in addition to Supplemental Security Income (SSI) benefits, add these amounts together and enter them in the AMOUNT/VALUE & FREQUENCY column for SSI Benefits on line 2. If you or anyone who lives with you gets SSP benefits only, enter this amount in the AMOUNT/VALUE & FREQUENCY column for SSI Benefits on line 2.

FOSTER CARE MAINTENANCE PAYMENTS (RECEIVED): If you or anyone who lives with you gets foster care maintenance payments, enter this amount into the AMOUNT/VALUE & FREQUENCY column for Foster Care Maintenance Payments on line 17. If you or anyone who lives with you gets foster care maintenance payments for the care of a child in foster care and you are applying for Supplemental Nutrition Assistance Program (SNAP) benefits, you have two choices: You can choose to include the child in foster care and the foster care maintenance payments in your SNAP benefits household or you can choose *not* to include the child in foster care and the foster care maintenance payments in your SNAP benefits household. Ask your district which choice would give you more SNAP benefits.

CHILD SUPPORT PAYMENTS (RECEIVED): If you or anyone who lives with you gets child support payments, print the name of the person who pays the child support after "Received From" on line 18.

OTHER INCOME: Describe any other money received by you or anyone who lives with you, including who receives the money, how much they receive, and how often they receive it.

DEDUCTIONS, WHO, and AMOUNT/VALUE & FREQUENCY: If you are applying for Medicaid, check (✓) "YES" or "NO" for lines 1 through 15 to indicate whether you or anyone who lives with you will claim any of the federal tax deductions listed on the current year's income tax return. For each "YES" answer, print the name(s) of the person(s) who will claim the deduction(s), and the amount or value and frequency of the expense(s) that will be claimed on the income tax return.

OTHER ADJUSTMENT: Describe any other federal tax deductions that you or anyone who lives with you will claim on the current year's income tax return, including who will claim the deduction(s), and the amount or value and frequency of the expense(s) that will be claimed on the income tax return.

SECTION 16: STEPPARENT/NON-CITIZEN WITH SATISFACTORY IMMIGRATION STATUS SPONSOR INFORMATION

DOES THE STEPPARENT OF ANY CHILDREN WHO LIVE WITH YOU HAVE ANY RESOURCES OR

RECEIVE INCOME OF ANY KIND? and WHO: Check (✓) "YES" or "NO" to indicate whether anyone applying, including yourself, has a stepparent who does not live with you and who has financial resources or receives money from any source. (If the stepparent lives with you, the stepparent's resources/income should be included in Section 15, Income Information.) If "YES," print the name of the stepparent.

IS ANYONE IN YOUR HOUSEHOLD A NON-CITIZEN WITH SATISFACTORY IMMIGRATION STATUS WHO WAS SPONSORED FOR ADMISSION INTO THE U.S. and WHO?: Check (✓) "YES" or "NO" to indicate whether you or anyone in your household is a non-citizen with satisfactory immigration status who was sponsored by someone in order to be admitted to the U.S. If "YES," print the name of the individual who was sponsored.

NAME OF SPONSOR, ADDRESS, and PHONE NO.: If "YES," print the name of the person who sponsored you or anyone in your household for admission to the U.S., the sponsor's address, and the sponsor's phone number.

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SECTION 17: EMPLOYMENT INFORMATION

Complete this section for yourself and for everyone who lives with you. If you are employed, you may still be eligible for assistance. For the purposes of this section, "working age" means 18 years of age or older, or 16 years of age or older for anyone who does not attend school.

I AM CURRENTLY: Check (✓) "employed," "self-employed," or "unemployed" to indicate whether you are working, and if so, whether you work for yourself or someone else.

GROSS INCOME: Print the amount you get paid before taxes on a weekly, biweekly, or monthly (not yearly)

basis, if applicable. Include all wages, salary, overtime pay, commissions, and tips.

HOURS WORKED MONTHLY: Print the number of hours you work each month, if applicable.

PAID: Check (✓) "Weekly," "Biweekly," or "Monthly" to indicate how often you get paid, if applicable.

DAY OF THE WEEK PAID: Print the day of the week that you get paid, if applicable.

EMPLOYER'S NAME AND ADDRESS and PHONE NO.: Print your employer's name, address, and phone number, if applicable. Print "self," and your business address and phone number, if you are self-employed.

IS ANYONE ELSE WHO LIVES WITH YOU CURRENTLY EMPLOYED OR SELF-EMPLOYED and

WHO: Check (✓) "employed" or "self-employed" if anyone who lives with you is working, and print their name.

GROSS INCOME, HOURS WORKED MONTHLY, PAID, DAY OF THE WEEK PAID,

EMPLOYER'S NAME AND ADDRESS, and PHONE NO.: Complete for any person who lives with you and works, according to the directions above.

IS HEALTH INSURANCE AVAILABLE THROUGH YOUR EMPLOYER?: If you are employed, check (✓)

"Yes" or "No" to indicate whether you have medical coverage available through your employer.

DOES ANYONE WHO LIVES WITH YOU HAVE HEALTH INSURANCE WITH AN EMPLOYER? and

WHO: Check (✓) "Yes" or "No" to indicate whether anyone who lives with you has medical coverage through an employer, and if "Yes," print their name.

NAME OF INSURANCE COMPANY: Print the name of your health insurance company and/or the health insurance company of any person who lives with you, if applicable.

DO YOU OR ANYONE WHO LIVES WITH YOU HAVE CHILD OR DEPENDENT CARE EXPENSES DUE

TO EMPLOYMENT? and WHO: Check (✓) "Yes" or "No" to indicate whether you or anyone who lives with you has child care or dependent care (e.g., for an elderly parent) expenses as a result of being employed and print the name of the person with these expenses.

DO YOU OR ANYONE WHO LIVES WITH YOU HAVE OTHER EMPLOYMENT-RELATED EXPENSES?

and WHO: Check (✓) "Yes" or "No" to indicate whether you or anyone who lives with you has any employment-related expenses (e.g., transportation, uniforms), and if "Yes," print your/their name.

IF NOT EMPLOYED, WHEN WAS THE LAST TIME YOU OR ANYONE WHO LIVES WITH YOU

WORKED?, WHO, WHEN, and WHERE: If you or anyone of working age who lives with you is unemployed, print your/their name(s), the date(s) you/they were last employed, and where you/they were last employed.

WHY DID YOU (OR THEY) STOP WORKING?: Print the reason(s) that you or anyone of working age who lives with you is unemployed.

DID YOU OR ANYONE LIVING WITH YOU FILE FOR UNEMPLOYMENT?, WHO, WHEN, and STATUS

OF FILING: If you or anyone of working age who lives with you is unemployed, check (✓) "Yes" or "No" to indicate whether you/they have filed for unemployment. If "Yes," print your/their name, when you/they filed for unemployment, and the status of the filing.

ARE YOU OR IS ANYONE WHO LIVES WITH YOU PARTICIPATING IN A STRIKE? and WHO: Check

(✓) "Yes" or "No" to indicate whether you or anyone who lives with you is on strike (i.e., has stopped working in protest to an employer's decision or practices), and if "Yes," print your/their name.

WHEN THE STRIKE BEGAN: If you or anyone who lives with you is on strike, print the date that you/they went on strike.

ARE YOU OR IS ANYONE WHO LIVES WITH YOU A MIGRANT OR SEASONAL FARM WORKER?

and WHO: Check (✓) "Yes" or "No" to indicate whether you or anyone who lives with you travels to different farms for work or works on a farm only during the growing season, and if "Yes," print your/their name.

DO YOU OR ANY OTHER ADULT WHO LIVES WITH YOU HAVE ANY MEDICAL CONDITIONS THAT LIMIT THE ABILITY TO WORK OR THE TYPE OF WORK THAT CAN BE PERFORMED? and WHO:

Check (✓) "Yes" or "No" to indicate whether you or anyone of working age who lives with you has any condition that keeps you/them from working full-time or from doing certain kinds of work, and if "Yes," print your/their name.

DESCRIBE LIMITATIONS: If you or anyone of working age who lives with you has any condition that keeps you/them from working full-time or from doing certain kinds of work, explain the ways in which you/they are limited.

COULD YOU ACCEPT A JOB TODAY? and IF NOT, WHY?: Check (✓) "Yes" or "No" to indicate whether you could take a job today if it was available, and if "No," explain why.

WHAT TYPE OF WORK WOULD YOU LIKE TO DO?: Indicate what kind of job would you enjoy doing.

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SECTION 18: EDUCATION/TRAINING

WHAT IS YOUR HIGHEST LEVEL OF EDUCATION COMPLETED?: Check (✓) the description that best matches how much education you have completed.

IF SO, LAST GRADE COMPLETED?: If you did not finish high school, print the last grade that you completed.

DOES ANYONE ELSE IN THE HOUSEHOLD HAVE A HIGH SCHOOL DIPLOMA, GENERAL EQUIVALENCY DIPLOMA (GED) OR TEST ASSESSING SECONDARY COMPLETION (TASC™), OR HIGHER LEVEL OF EDUCATION?, WHO, DEGREE ATTAINED, and DATE COMPLETED: Check (✓)

"Yes" or "No" to indicate whether anyone who lives with you has a high school diploma, General Equivalency Diploma (GED) or Test Assessing Secondary Completion (TASC™), or higher level of education. If "Yes," print the name of that person, the degree received, and the date it was received.

Complete the following questions for yourself and anyone who lives with you who is applying for or getting assistance:

IS OR HAS BEEN IN ANY TRAINING PROGRAM?, WHO, WHERE, PROGRAM, DATES ATTENDED,

and DATES COMPLETED: Check (✓) "Yes" or "No" to indicate whether you or anyone who lives with you who is applying for or getting assistance has participated in a job training program, and if "Yes," print the name of that person, where that person attended the training program, the name of the program or what kind of program it was, and the dates that person attended and completed the program.

IS 16 YEARS OF AGE OR OLDER AND IS ATTENDING SCHOOL OR COLLEGE?, WHO, and WHERE:

Check (✓) "Yes" or "No" to indicate whether you or anyone who lives with you who is applying for or getting

assistance is *16 years of age or older* and going to school or college, and if "Yes," print the name of that person and their school or college.

IS UNDER 16 YEARS OF AGE AND IS ATTENDING SCHOOL?, WHO, and SCHOOL: Check (✓) "Yes"

or "No" to indicate whether you or anyone who lives with you who is applying for or getting assistance is under 16 years of age, and if "Yes," print the name(s) of any such person(s) and /their school(s).

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SECTION 19: RESOURCES INFORMATION

You do not have to fill out this section if you are applying only for Services, other than Foster Care and/or Child Care Assistance.

If you are applying only for Supplemental Nutrition Assistance Program benefits, you do not have to indicate whether you have life insurance.

INDICATE IF YOU OR ANYONE WHO LIVES WITH YOU WHO IS APPLYING: For lines 1 through 23, check (✓) "YES" or "NO" to indicate whether you or anyone who lives with you who is applying for assistance has any of the financial resources listed.

WHO: For each "YES" answer, print the names(s) of the person(s) with the resources.

IF YES, AMOUNT/VALUE: For each "YES" answer, print the dollar ($) amount or value of the resource. Be sure to list any joint holdings (i.e. resources belonging to two or more people, e.g., joint bank accounts). Anyone applying for Public Assistance or Medicaid must include the resources of any legally responsible relatives. These are people who are required by law to financially support you or anyone applying, such as a spouse or, if you are under the age of 21, any parents or stepparents who live with you or anyone applying.

HAS TITLE OR REGISTRATION TO A MOTOR VEHICLE(S) OR OTHER VEHICLE(S), YEAR,

MAKE/MODEL, and OTHER: If your name or the name of anyone who lives with you who is applying is listed on the title for a car or other vehicle, print the year, make, and model for each vehicle on line 6. List resources, such as campers, snowmobiles, and boats, after "Other" on line 6.

HAS RESOURCES OTHER THAN THOSE LISTED ABOVE: It is very important to let your district know right away if you get or are expecting to get money from a lump sum. A lump sum is a one-time payment, such as an insurance settlement, inheritance, or award from a lawsuit or lottery winning. See LDSS-4148A, "Book 1: What You Should Know About Your Rights and Responsibilities," for more information about lump sums.

HAS ANYONE . . . EVER CREATED A TRUST IN THE PAST OR TRANSFERRED ANY ASSETS INTO

A TRUST WITHIN THE PAST 60 MONTHS?: If you or your spouse transfer or give away any assets within the 36 months (60 months for transfers to a trust) prior to the first day of the month in which you receive nursing facility services and you have submitted an application for Medicaid, you may not be eligible to receive nursing facility services or home and community-based waivered services under the Medicaid Program.

If you or anyone applying, or a spouse of you or anyone applying (even if the spouse is not applying or living in the household), has created a trust or put any money into a trust in the past five years, print when the trust was created or money was put into it on line 23.

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SECTION 20: MEDICAL INFORMATION

INDICATE IF YOU OR ANYONE WHO LIVES WITH YOU WHO IS APPLYING and IF YES, WHO: Check

(✓) "YES" or "NO" to indicate whether any of the situations listed apply to you or anyone who lives with you who is applying for assistance, and if "YES," print the name of the person to whom each situation applies. Be sure to list all health and hospital/accident insurance that you have or that is available to anyone applying.

HAS PAID OR UNPAID MEDICAL BILLS WITHIN 3 MONTHS PRECEDING THE MONTH OF THIS

APPLICATION: Medicaid may be able to pay for medical bills for care you were given during the three months before the month you apply for help. If you have already paid the bill, we may be able to pay you for the bill if we determine that you would have been eligible for Medicaid at the time. We may be able to pay you even if the doctor or other provider does not accept Medicaid, but we can only pay you the amount Medicaid would have paid and only if the bill was for services that Medicaid would have covered.

IS PREGNANT: If you or anyone who lives with you who is applying is pregnant, print the due date and the expected number of births on line 14.

HEALTH PLAN SELECTION: Complete this section for anyone applying for Medicaid. Most people enrolled in Medicaid are required to join a managed care health plan unless they are in an exempt category. Use this section to choose a health plan. If you do not know what health plans are available, ask your worker or call the Managed Care Medicaid Choice Help Line at 1-800-505-5678.

NAME OF PLAN YOU ARE ENROLLING IN: Print the name of the health plan(s) in which anyone applying for Medicaid wishes to enroll. If you do not know which health plans are available to you, ask the district.

LAST NAME and FIRST NAME: Print the last name and first name of each person applying for Medicaid.

DATE OF BIRTH: Print the two-digit month, two-digit day, and two-digit year of the date of birth of each person applying for Medicaid.

SEX: Print "M" for male, "F" for female, or "X" for non-binary or another identity to indicate the sex of each person applying for Medicaid.

ID# (FROM MEDICAID CARD IF YOU HAVE ONE): If anyone applying for Medicaid has a Medicaid card, print the Medicaid card identification number here.

SOCIAL SECURITY #: Print the Social Security number of each person applying for Medicaid.

PRIMARY CARE PROVIDER (PCP) OR HEALTH CENTER (CHECK BOX IF CURRENT PROVIDER): Print

the name of the primary care provider (i.e., general practitioner or family doctor) or the health center anyone applying for Medicaid wishes to use. If this is the provider or center used by this person already, check (✓) the box. You must make sure that the provider or center accepts Medicaid before receiving medical care.

NAME AND ID # OF OB/GYN (CHECK BOX IF CURRENT PROVIDER): If anyone applying for

Medicaid needs obstetrician/gynecologist (OB/GYN) care and services, print the name of the OB/GYN the applicant wishes to use. If the applicant already uses this OB/GYN, check (✓) the box. You must make sure that the provider or center accepts Medicaid before receiving medical care.

You must make sure that any doctor or medical provider you see accepts Medicaid ***before*** you get medical care.

SECTION 21: SHELTER

You do not have to fill out this section if you are applying only for Services other than Foster Care and/or Child Care Assistance.

WHAT IS YOUR LANDLORD'S NAME, ADDRESS, and PHONE NUMBER?: If you have a landlord, print your landlord's name, address, and phone number.

DO YOU OR ANYONE WHO LIVES WITH YOU HAVE A RENT, MORTGAGE OR OTHER SHELTER

EXPENSE?: Check (✓) "YES" or "NO" to indicate whether you or anyone who lives with you pays rent, a mortgage, or other shelter (e.g., room and board) expense, and if "YES," print the amount you/they pay per month. If you have a mortgage payment, include the amount of property taxes and homeowner's insurance (including fire insurance).

DO YOU OR ANYONE WHO LIVES WITH YOU HAVE A HEAT BILL SEPARATE FROM YOUR RENT

OR OTHER SHELTER EXPENSE?: Check (✓) "YES" or "NO" to indicate whether you or anyone who lives with you pays for heat separately from your rent, mortgage, or other shelter expense, and if "YES," print the amount you/they pay per month.

DO YOU OR ANYONE WHO LIVES WITH YOU HAVE THE FOLLOWING EXPENSES SEPARATE

FROM YOUR RENT OR OTHER SHELTER EXPENSE?: For lines 1 through 8, check (✓) "YES" or "NO" to indicate whether you or anyone who lives with you pays for any of the expenses listed separately from your rent, mortgage, or other shelter expense, and if "YES," print the amount you/they pay per month. For the questions on lines 9 through 11, check (✓) "YES" or "NO" to indicate whether you or anyone applying lives in any of these arrangements.

SECTION 22: OTHER EXPENSES

INDICATE IF YOU OR ANYONE WHO LIVES WITH YOU WHO IS APPLYING and IF YES, AMOUNT:

Check (✓) "YES" or "NO" to indicate whether you or anyone who lives with you who is applying makes any of the payments listedon lines 1 through 5. Identify on line 6 any expenses not listed. For each "YES" answer, print the amount of the payment or expense and how often it is paid (e.g., $100 per week or $100/wk.)

DO YOU OR ANYONE WHO LIVES WITH YOU WHO IS APPLYING OWE AT LEAST FOUR MONTHS OF SUPPORT FOR A CHILD UNDER AGE 21: Check (✓) "YES" or "NO" to indicate whether you or anyone who lives with you who is applying owes four months or more of child support.

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SECTION 23: OTHER INFORMATION

DO YOU BUY OR PLAN TO BUY MEALS FROM A HOME DELIVERY OR COMMUNAL DINING

SERVICE?: Check (✓) "YES" or "NO" to indicate whether you or anyone applying currently buys or plans to buy meals from a home delivery (e.g., Meals on Wheels) or communal dining (e.g., a cafeteria in the building where you live) service.

ARE YOU ABLE TO COOK OR PREPARE MEALS AT HOME?: Check (✓) "YES" or "NO" to indicate whether you have a place at home where you can cook.

For purposes of the questions on lines 10 through 12, "U.S. military" means the:

- U.S. Army
- U.S. Navy

- U.S. Coast Guard
- U.S. Marine Corps
- U.S. Air Force
- U.S. Merchant Marine during World War II

HAVE YOU OR ANYONE IN YOUR HOUSEHOLD EVER BEEN IN THE U.S. MILITARY? and WHO:

Check (✓) "YES" or "NO" to indicate whether you or anyone who lives with you has ever been in any of the military branches listed above, and if "YES," print their name.

HAS YOUR SPOUSE EVER BEEN IN THE U.S. MILITARY? Check (✓) "YES" or "NO" to indicate whether your spouse has ever been in any of the military branches listed above.

IS ANYONE IN YOUR HOUSEHOLD A DEPENDENT OF SOMEONE WHO IS OR WAS IN THE U.S.

MILITARY? and WHO: Check (✓) "YES" or "NO" to indicate whether you or anyone who lives with you is financially dependent on someone who is or ever has been in any of the military branches listed above, and if "YES," print the name of the dependent.

DO YOU OR DOES ANYONE WHO LIVES WITH YOU RECEIVE ASSISTANCE OR SERVICES

NOW?; IF YES, WHO; and TYPE OF ASSISTANCE: Check (✓) "YES" or "NO" to indicate if you or anyone who lives with you now receives Public Assistance, Medicaid, Supplemental Nutrition Assistance Program (SNAP; formerly, "Food Stamp") benefits, Child Care Assistance, or Services. If "YES," print this person's name and the type of assistance received.

HAVE YOU OR ANYONE WHO LIVES WITH YOU RECEIVED ASSISTANCE OR SERVICES IN THE

PAST?; IF YES, WHO; and TYPE OF ASSISTANCE: Check (✓) "YES" or "NO" to indicate if you or anyone who lives with you has ever received Public Assistance, Medicaid, SNAP benefits, Child Care Assistance, or Services in the past. If "YES," print this person's name and the type of assistance received.

OTHER INFORMATION (CONT.): Check (✓) "YES" or "NO" to indicate whether the situations described in the next nine questions apply to you or anyone who lives with you, and if "YES," print the name of the person to whom the situation applies. If you do not understand these questions, ask your district to explain. Please note that New York State law provides for a fine or jail, or both, for a person found guilty of obtaining Public Assistance, Medicaid, SNAP benefits, Child Care Assistance, or Services by hiding the facts or not telling the truth.

PROPERTY TRANSFER STATUS: Check (✓) the "I have" box or "I have not" box to indicate whether you or anyone applying has sold, transferred, or given away any property in order to receive Public Assistance or SNAP benefits. Please note that New York State law provides for a fine or jail, or both, for a person found guilty of obtaining Public Assistance, Medicaid, SNAP benefits, Child Care Assistance, or Services by hiding the facts or not telling the truth.

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NOTICES, ASSIGNMENTS, AUTHORIZATIONS, AND CONSENTS

Read <u>ALL</u> of the information in this section carefully or have someone read it to you. This section contains important information about your rights and responsibilities relative to receiving assistance, as well as penalties you may incur (e.g., a fine and/or jail) if you do not fulfill your responsibilities under this section. By signing and submitting an application, you indicate that you understand and agree to the statements in this section.

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM AUTHORIZED REPRESENTATIVE: If you

want someone to apply for Supplemental Nutrition Assistance Program (SNAP) benefits for you and/or you

want someone who does not live with you to get the SNAP benefits for you and/or use them to buy food for you, print that person's name, address, and phone number in the box. This person is your "Authorized Representative." The Authorized Representative must sign and date the signature section at the end of the application. If your household does not live in an institution, a responsible adult member of your household must sign and date the application also, unless your household has otherwise designated the Authorized Representative to do so in writing.

RELEASE OF MEDICAL INFORMATION: Check (✓) "Do not disclose HIV/AIDS information," "Do not disclose mental health information," and/or "Do not disclose drug and alcohol information" if you do not agree to have this medical information about you and/or applying family members disclosed as permitted by law.

SIGNATURE SECTION: Read this section carefully or have someone read it to you. New York State law provides for a fine or jail, or both, for a person found guilty of obtaining Public Assistance, Medicaid, Supplemental Nutrition Assistance Program benefits, Child Care Assistance, or Services by hiding the facts or not telling the truth. **By signing and submitting an application, you indicate that you understand and agree to the statements in this section, and that all of the information you have provided on this application or will provide to the district in the future is complete and correct to the best of your knowledge.**

APPLICANT SIGNATURE and DATE SIGNED: Sign your name and print the date you signed the application, unless you have designated a Supplemental Nutrition Assistance Program (SNAP) Authorized Representative on the application and you live in an institution, in which case the Authorized Representative may sign and date the application. If you do not reside in an institution, both you and the Authorized Representative must sign and date the application, unless you have previously designated the SNAP Authorized Representative to do so in writing. If you have filled out the application for someone else, sign *your* name, not the name of the person for whom you applied, and print the date you signed.

SPOUSE OR PROTECTIVE REPRESENTATIVE SIGNATURE and DATE SIGNED: If you are married and applying for Public Assistance, Medicaid, Child Care Assistance, or Services, your spouse must sign and date the application. If you are married and applying just for Supplemental Nutrition Assistance Program benefits, only one spouse must sign and date the application. If you have a Protective Representative, that person must sign and date the application.

AUTHORIZED REPRESENTATIVE SIGNATURE: If you have designated a SNAP Authorized Representative on the application, that person must sign and date the application.

I CONSENT TO *WITHDRAW* MY APPLICATION FOR: Do not check any of the boxes, or sign or date this section, if you want to submit an application. Only mark this section if you want to *withdraw* your application for one or more programs. To withdraw your application for a program, check (✓) the box next to that program, and sign and date where indicated. Your application will be withdrawn only for the program(s) you check.

VOTER REGISTRATION FORM: The last two pages of this Application are a voter registration form. Using the form to register or declining to register to vote will not affect the decision made about your application for benefits and/or services, or the amount of assistance that you may receive. If you would like help filling out the voter registration form, ask your district.

Informational Purposes

DOCUMENTATION REQUIREMENTS

This following list of eligibility factors and documentation requirements is solely for informational purposes. Your district will inform you which of the eligibility factors you will be required to prove. You may be asked to prove other eligibility factors not listed below. You may be able to provide documentation not listed below to prove these eligibility requirements. If you have any questions regarding documentation requirements, please contact your district.

Eligibility Factor	To prove this factor, provide: ✓ ONE of the following OR	✓ TWO of the following (If you are applying for SNAP Benefits or Medicaid **only,** you need to bring **only** one form for each eligibility factor checked.)
☐ **Identity** You must prove who you are.	Photo I.D. Driver license U.S. passport Naturalization Certificate Hospital/Doctor's Records Adoption paper	Statement from another person Validated Social Security Number Birth/Baptismal Certificate
☐ **Marital Status** You must prove if you are married, divorced, separated, or widowed.	Marriage/Death certificates Separation agreement Divorce decree Social Security records VA records	Statement from clergy Census records Newspaper notice Statement from another person
☐ **Residence** You must prove where you live.	Statement from landlord Current rent receipt or lease Mortgage records	Statement from another person Current mail School records
☐ **Household Composition/Size** You must prove who is living with you.	Statement from non-relative Landlord School records	Statements from other persons
☐ **Age** You must prove the age of each person applying for assistance, where appropriate.	Birth certificate Baptismal certificate Hospital records Adoption records Naturalization Certificate Driver license	Insurance policy Census records School records Statement from another person Physician statement Official correspondence from SSA
☐ **Absent Parent** If the parent of any child in your home is not living with you, you must prove this.	Death certificate Survivor's benefits Hospital records VA or military records Divorce papers Proof of remarriage	Newspaper notice Insurance company records Institutional records Agency case records and burial payment files Statement from another person
☐ **Absent Parent Information** You must provide any information you have: name, address, Social Security Number, birth date, employment	Pay Stubs Tax returns Social Security or VA records Monetary determination letters ID. cards (health insurance) Driver license or registration	

Eligibility Factor	To prove this factor, provide one of the following:
☐ **Social Security Number** (For Public Assistance, SNAP Benefits and Medicaid- **only**, you do **not** have to provide proof of your Social Security Number (SSN) unless the SSN you give does not match with SSA'S records or cannot be verified by the agency.)	Social Security Card Official correspondence from SSA A Social Security Number is not required for non-citizens who are seeking Medicaid for emergency treatment only or are Medicaid-only applicants who are pregnant.
☐ **Citizenship or Current** Non-Citizen **Status -** US citizens are eligible for Public Assistance, SNAP and Medicaid. Non- citizens must be in satisfactory immigration status in order to be eligible for Public Assistance, SNAP or Medicaid. Immigration status is not an eligibility factor for pregnant women or immigrant children applying for Child Health Plus B. Undocumented immigrants and temporary non-immigrants are eligible only for the treatment of an emergency medical condition.	Birth certificate Baptismal certificate Hospital records U.S. passport Military service records Naturalization certificate USCIS documentation Evidence of continuous U.S. residence since prior to1/1/72.
Earned Income ☐ From employer	Current wage stubs Pay envelopes On letterhead, rate of pay per hour; hours worked per week; date of first pay, if new and employer's phone number Contact with employer Business records Tax records
☐ From self-employment	Records and related materials concerning self-employment earnings and expenses Current income tax return
☐ Income from rent or room/board	Current contribution check Statement from roomer, boarder, tenant Income tax records
Unearned Income ☐ Child support	Statement from Family Court Statement from person paying support Check stubs Current award certificate Current benefit check Official correspondence
☐ Unemployment Insurance benefits (UIB)	with NYS Dept. of Labor Current award certificate Current benefit check Official correspondence from SSA
☐ Social Security benefits (including SSI)	Current award certificate Current benefit check Official correspondence from VA
☐ Veteran's benefits	

Eligibility Factor	To prove this factor, provide one of the following:
Unearned Income (con't)	
☐ Workers' Compensation	Award Letter Check stub
☐ Education grants and loans	Statement from school Statement from bank Award letter
☐ Interest/dividends/royalties	Statement from bank or credit union Statement from broker/agent
☐ Private pension/annuity	Current award letter Current benefit check Official correspondence from source of income
☐ Other	
☐ **Resources**	Statement from household Statement from nursing home
☐ Bank accounts: checking, savings, retirement (IRA and Keogh)	Current bank records Current credit union records
☐ Stocks, bonds, certificates	Stock certificate Bonds Statement from financial institution
☐ Life Insurance	Insurance policy Statement from insurance company
☐ Burial trust or fund burial plot or funeral agreement	Bank records Burial agreement Burial plot deed Statement from funeral director
☐ Income tax refund or earned income tax credit (EITC)	Tax Refund Statement from tax office
☐ Real estate other than Residence	Deed Statement from real estate broker Appraisal/estimate of current value by broker
☐ Motor Vehicle	Registration (older models) Title of ownership Appraisal of current value by dealer Financing data
☐ Lump sum payment	Statement from source of payment

Eligibility Factor	To prove this factor, provide one of the following:
☐ Other	
☐ **Shelter Expenses** You must prove how much it costs you to live where you do (You may need to provide separate documentation for **each** item of shelter expense.) Medicaid **does not require documentation of shelter expenses.**	Current rent receipt Current lease Mortgage book/records Property and school tax records Landlord statement Sewer and water bills Homeowner's insurance records Fuel bills Non-heating utility bills Telephone bills
☐ **Medical Bills**	Copies of medical bills (paid and unpaid)
☐ **Health Insurance** If you or anyone applying has health insurance coverage (even if paid for by someone else), you must prove this.	Insurance policy Insurance card Statement from provider of coverage **Medicare** card
☐ **Disabled/Incapacitated /Pregnant** If you or anyone living with you is sick or pregnant, you must provide proof.	Statement from medical professional verifying pregnancy and expected date of birth Statement from medical professional Proof of SSA or SSI benefits for disability or blindness
☐ **Unpaid Bills** Rent, utility	Copy of each bill showing amount owed, period of services and provider
☐ **Referral** Drug/Alcohol Treatment Program ☐ Employment Service	Statement from provider of Treatment Statement from employment service
☐ **Other Expenses/ Dependent Care Cost** You must provide proof if you **pay** court-ordered support, child care, recurring loans, or for services of a home health aide or attendant.	Court order Statement from day care center or other child care provider Statement from aide or attendant Cancelled checks or receipts
☐ **School Attendance** You must prove who is in school	School records (current report card) Statement from school/ or Higher Education Institution
☐ **Other:**	