

| | | | | | | | | | | |
|-------------------------------------|----------------|--|---------------------------------------|-----------|-------------|-------------------------|---|-------------|------------------------|--|
| CENTER/OFFICE | INTERVIEW DATE | UNIT ID | WORKER ID | CASE TYPE | CASE NUMBER | DISTRICT | CATEGORY | LANG | NUMBER REUSE INDICATOR | |
| CASE NAME | | | | | LIFELINE | EFFECTIVE DATE | DISPOSITION <input type="checkbox"/> RECERTIFICATION <input type="checkbox"/> CLOSE | REASON CODE | | |
| ELIGIBILITY DETERMINED BY (WORKER): | | DATE | ELIGIBILITY APPROVED BY (SUPERVISOR): | | DATE | FORM OF | SIGNATURE OF PERSON WHO OBTAINED ELIGIBILITY INFORMATION | | DATE | |
| DATE RECEIVED BY AGENCY | | EMPLOYED BY: SOCIAL SERVICES DISTRICT PROVIDER AGENCY SPECIFY: _____ | | | | | | | | |
| TA AUTHORIZATION PERIOD | | | MA AUTHORIZATION PERIOD | | | FS AUTHORIZATION PERIOD | | | | |
| FROM | | TO | FROM | | TO | FROM | | TO | | |

NEW YORK STATE

RECERTIFICATION FORM FOR: TEMPORARY ASSISTANCE (TA) - MEDICAL ASSISTANCE (MA) - MEDICARE SAVINGS PROGRAM (MSP) - FOOD STAMP BENEFITS (FS)

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 for Temporary Assistance and Food Stamp Benefits where required. Whenever you see "Temporary Assistance" or "TA" on the recertification form, it means "Family Assistance" and "Safety Net Assistance". We call both Public Assistance Programs "Temporary Assistance". These TA Programs are meant to assist you only until you can fully support yourself and your family.

Please refer to the "How to Complete" instruction book (Pub-1313 Statewide) when completing this recertification form.

| | | | | | | |
|--|---|-----------|--|--|--|----------------|
| CHECK EACH PROGRAM YOU OR ANY HOUSEHOLD MEMBER WANTS TO RECERTIFY FOR | <input type="checkbox"/> Temporary Assistance <u>and</u> Medical Assistance | | <input type="checkbox"/> Temporary Assistance <u>1</u> | | <input type="checkbox"/> Medical Assistance | |
| | <input type="checkbox"/> Medicare Savings Program | | <input type="checkbox"/> Food Stamp Benefits | | | |
| DO YOU WANT TO RECEIVE NOTICES IN: | <input type="checkbox"/> SPANISH AND ENGLISH | | <input type="checkbox"/> ENGLISH ONLY | | WHAT IS YOUR PRIMARY LANGUAGE? <input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> OTHER (specify) <u>2</u> | |
| RECIPIENT INFORMATION | | | | PLEASE PRINT CLEARLY | | |
| FIRST NAME | M.I. | LAST NAME | | MARITAL STATUS | PHONE NUMBER | |
| HOUSE NO. | STREET ADDRESS | | APT. NO. | CITY | COUNTY | STATE ZIP CODE |
| CARE OF NAME (Complete if you receive your mail in care of another person) | | | | | | |
| MAILING ADDRESS (IF DIFFERENT FROM ABOVE) | | | | APT. NO. | CITY | STATE ZIP CODE |
| AGENCY HELPING RECIPIENT/CONTACT PERSON | | | | | PHONE NUMBER | |
| HOW LONG HAVE YOU LIVED AT YOUR PRESENT ADDRESS? | YEARS | MONTHS | IS THIS A SHELTER? | ANOTHER PHONE WHERE YOU CAN BE REACHED | NAME | |
| | | | <input type="checkbox"/> YES <input type="checkbox"/> NO | | PHONE NUMBER | |
| DIRECTIONS TO HOME | | | | | | |
| FORMER ADDRESS | | | | APT. NO. | CITY | STATE ZIP CODE |
| List the things that have changed since your application or last recertification (such as moved, had a baby, income, etc.) _____ | | | | | | |
| If You Are Reapplying For Food Stamp Benefits (FS), you have the right to turn in (file) this form the same day you get it. It must have at least your Name, Address (if you have one) and Signature below when you turn it in. If you are eligible, you will get FS back to the date you filed. You may be able to get FS quicker if you have little or no income or liquid resources, or if your rent and utility expenses are more than your income and liquid resources. Talk to your worker if you have questions about this. | | | | | | |
| FS RECIPIENT/REPRESENTATIVE SIGNATURE | | | | | DATE SIGNED | |

DO ANY OF THESE APPLY TO YOU?

- Pregnant 1
- Victim Of Domestic Violence 2
- Need To Establish Paternity 3
- Need Child Support 4
- Drug/Alcohol Problem 5
- Fuel Or Utility Shutoff 6
- No Place To Stay/Homeless 7
- Urgent Personal Or Family Problem 8
- Fire Or Other Disaster 9
- Have No Job 10
- Serious Medical Problem 11
- Recently Lost Income 12
- Pending Eviction 13
- No Food 14
- Need Foster Care 15
- Need Child Care 16
- Other _____ 17

4

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

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

HIGHEST SCHOOL GRADE COMPLETED

| RI | LN | (Middle Initial) | | THIS PERSON IS RECERTIFYING FOR: | | | | DATE OF BIRTH | | | SEX M OR F | RELATIONSHIP TO YOU | SOCIAL SECURITY NUMBER OF RECERTIFYING MEMBERS <i>(See "How to Complete" instruction book Pub-1313 Statewide, or talk to your worker)</i> | | | |
|----|----|------------------|------|----------------------------------|----|----|-----|---------------|-----|------|---------------------|---------------------|--|-----|----|--|
| | | FIRST NAME | M.I. | TA | FS | MA | MSP | Month | Day | Year | | | | YES | NO | |
| | 01 | | | | | | | | | | | SELF | | | | |
| | 02 | | | | | | | | | | | | | | | |
| | 03 | | 6 | | | | | | | | | | | | | |
| | 04 | | | | | | | | | | | | | | | |
| | 05 | | | | | | | | | | | | | | | |
| | 06 | | | | | | | | | | | | | | | |
| | 07 | | | | | | | | | | | | | | | |
| | 08 | | | | | | | | | | | | | | | |

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 |
| | | 7 | | |
| Line No. | ONC | FIRST NAME | M.I. | LAST NAME |
| | | | | |

HAS ANYONE MOVED INTO THE HOUSEHOLD IN THE PAST YEAR? YES NO

HAS ANYONE MOVED OUT OF THE HOUSEHOLD IN THE LAST YEAR? YES NO

IF YES, INDICATE BELOW.

| | | | |
|------|--|------|-------|
| NAME | <input type="checkbox"/> YES <input type="checkbox"/> NO | NAME | WHEN? |
| 8 | | | |
| NAME | <input type="checkbox"/> YES <input type="checkbox"/> NO | NAME | WHEN? |
| | | | |

IS ANYONE SANCTIONED? YES NO

IF YES, WHO

REASON

END DATE

DO NOT WRITE IN SHADED AREAS

NON-APPLICANT INFORMATION

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

INDIVIDUAL EDUCATION

| LN | DEGREE RECEIVED |
|----|-----------------|----|-----------------|----|-----------------|----|-----------------|
| 01 | | 03 | | 05 | | 07 | |
| 02 | | 04 | | 06 | | 08 | |

CITIZENSHIP/IMMIGRATION STATUS INFORMATION

Please read the entire page carefully before completing. If you have questions, see the "How to Complete" instruction book or talk to your worker.

SECTION 9

LIST EVERYONE WHO IS RECERTIFYING OR WHO IS REQUIRED TO RECERTIFY. IF YOU HAVE QUESTIONS, SEE THE "HOW TO COMPLETE" INSTRUCTION BOOK (PUB-1313 Statewide) OR TALK TO YOUR WORKER.

You **do not** have to fill out Section 9 or 10 if you are recertifying for MA **only** and:

- you are pregnant
- you are not a U. S. citizen, Native American or national of the United States or an immigrant with satisfactory immigration status. The term "satisfactory immigration status" means an immigration status which does not make the individual ineligible for benefits under the applicable program.

You **do** have to fill out Section 9 or 10 if you are:

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

SECTION 10 - CERTIFICATION

Some social services programs require that you certify that you are a U.S. citizen, Native American or national of the United States, or an immigrant with satisfactory immigration status. Other programs do not. If you are an immigrant and do not know if you have 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, Native American or national of the United States, or an immigrant with satisfactory immigration status, **and** you are recertifying 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 recipient is pregnant), or
- Medicare Savings Program

An adult household member or authorized representative may sign for all household members.

Example: A parent without satisfactory status may sign for his/her child who has satisfactory status.

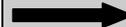
A recertification for FS must list all persons living in the FS household. A recertification for TA must list all children for whom you are recertifying, their brothers and sisters and all parents of those children who live together. If you do not check whether a listed person is a U. S. citizen or national, or an immigrant, or provide an alien number for an immigrant, that person will not be given assistance, and the remaining members of the household will receive reduced benefits. If you are a Native American, check "CITIZEN/NATIONAL".

SIGN* AND DATE THE BOX BELOW FOR EACH RECIPIENT.

IN THE CASE OF A RECERTIFYING IMMIGRANT, CHECK (✓) THE PROGRAM(S) FOR WHICH EACH RECERTIFYING IMMIGRANT HAS SATISFACTORY IMMIGRATION STATUS. (SEE "HOW TO COMPLETE" INSTRUCTION BOOK, PUB-1313 STATEWIDE.)

| LN | FIRST NAME | MI | LAST NAME | Check either "CITIZEN/NATIONAL" or "IMMIGRANT" for each person. | | Alien Number (If Applicable) | CERTIFICATION | Date | T A | F S | M A | MS P |
|----|------------|----|-----------|---|------------------------------------|------------------------------|----------------|------|--------|--------|--------|---------|
| | | | | <input type="checkbox"/> CITIZEN/NATIONAL | <input type="checkbox"/> IMMIGRANT | | | | | | | |
| 01 | | | | <input type="checkbox"/> CITIZEN/NATIONAL | <input type="checkbox"/> IMMIGRANT | A | Sign Name X | | | | | |
| 02 | | | | <input type="checkbox"/> CITIZEN/NATIONAL | <input type="checkbox"/> IMMIGRANT | A | Sign Name X | | | | | |
| 03 | | | 9 | <input type="checkbox"/> CITIZEN/NATIONAL | <input type="checkbox"/> IMMIGRANT | A | Sign Name X | 10 | | | | |
| 04 | | | | <input type="checkbox"/> CITIZEN/NATIONAL | <input type="checkbox"/> IMMIGRANT | A | Sign Name X | | | | | |
| 05 | | | | <input type="checkbox"/> CITIZEN/NATIONAL | <input type="checkbox"/> IMMIGRANT | A | Sign Name X | | | | | |
| 06 | | | | <input type="checkbox"/> CITIZEN/NATIONAL | <input type="checkbox"/> IMMIGRANT | A | Sign Name X | | | | | |
| 07 | | | | <input type="checkbox"/> CITIZEN/NATIONAL | <input type="checkbox"/> IMMIGRANT | A | Sign Name X | | | | | |
| 08 | | | | <input type="checkbox"/> CITIZEN/NATIONAL | <input type="checkbox"/> IMMIGRANT | A | Sign Name X | | | | | |

By checking a box above and by signing the certification in Section 10, I hereby certify, under penalty of perjury, that I, and/or the persons for whom I am signing, am a United States citizen, Native American or national of the United States, or an immigrant with satisfactory immigration status.



I understand that signing the above Certification may result in information about recertifying members of my household being submitted to the United States Citizenship and Immigration Services (USCIS) 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 Temporary Assistance (TA), Food Stamp Benefits (FS), Medical Assistance (MA) Programs and the Medicare Savings Program (MSP).

* 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: _____ Date Signed: _____

NON-CUSTODIAL PARENT/CHILD SUPPORT/MEDICAL SUPPORT INFORMATION

DO NOT WRITE IN SHADED AREAS

If you are recertifying for Temporary Assistance, you must help us obtain child support/medical support for you and your children. If you are recertifying for Medical Assistance **only**, you may have to help us obtain medical support for yourself and your recertifying children. If you have questions, see the "How to Complete" instruction book (PUB-1313 Statewide). 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 non-custodial parent. If **you** are under 21, write down the information about **your** non-custodial parent who is not in the household.

| NAME OF PERSON UNDER 21 | NON-CUSTODIAL PARENT'S NAME AND ADDRESS | NON-CUSTODIAL PARENT'S DATE OF BIRTH | | |
|-------------------------|---|--------------------------------------|-----|------|
| | | MONTH | DAY | YEAR |
| A. | | | | |
| B. | | | | |
| C. | 11 | | | |
| D. | | | | |
| E. | | | | |

| SOCIAL SECURITY NUMBER |
|------------------------|
| |
| |
| |
| |
| |

Do you or does anyone who lives with you get money from child support payments? Yes No
 If yes, list below:

Circle whichever arrangement applies:
 Is there JOINT/SHARED/SPLIT custody? Yes No
 If Yes, how was it determined? court order agreement of the parties

| WHO | AMOUNT RECEIVED | HOW OFTEN | FROM WHOM |
|-----|-----------------|-----------|-----------|
| | \$ | | |
| | \$ | | |
| | \$ | | |
| | \$ | | |

| REQUESTED | DOCUMENTATION | IN FILE |
|-------------------------------------|--|---|
| | Paternity Acknowledgement | |
| | Child Support Order | |
| | Good Cause Form (LDSS-4279) | |
| | IV-D Attestation (LDSS-4281) | |
| | LRR Letter/Questionnaire | |
| | Other Support | |
| | Death Certificate | |
| | Divorce Decree | |
| | VA Benefits | |
| | Order of Filiation/Paternity | |
| NEEDED | REFERRALS | COMPLETED |
| | CTHP | |
| | CAP | |
| | CSS Application (LDSS-2521) | |
| | IV-D (LDSS-2860) | |
| | Paternity | |
| CONSIDER | | |
| <input checked="" type="checkbox"/> | Health Insurance of Non-Custodial Parent/Absent Spouse | <input checked="" type="checkbox"/> Child Health Plus |
| <input checked="" type="checkbox"/> | Petition to Family Court | <input checked="" type="checkbox"/> TASA |
| | | <input checked="" type="checkbox"/> SSI/SSA |

ABSENT/DECEASED SPOUSE INFORMATION - If the husband or wife of anyone recertifying lives someplace else or is deceased, please indicate below.

| FIRST NAME | M.I. | LAST NAME | DATE OF BIRTH | DATE OF DEATH | SOCIAL SECURITY NUMBER |
|------------|------|-----------|---------------|---------------|------------------------|
| | | 12 | | | |

ADDRESS _____ CITY _____ COUNTY _____ STATE _____ ZIP CODE _____

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

| NAME OF PERSON RECERTIFYING | NAME OF ABSENT CHILD | DATE OF BIRTH | ADDRESS (Street, City, County, State and Zip Code) | PATERNITY ESTABLISHED? | | DO YOU PAY CHILD SUPPORT? | |
|-----------------------------|----------------------|---------------|---|------------------------|----|---------------------------|----|
| | | | | Yes | No | Yes | No |
| | | 13 | | | | | |

TEEN PARENT INFORMATION

TEEN PARENT:

TEEN PARENT CHILDREN

Is there a teen parent under age 18 in the household? Yes No **14**
 Who _____
 Does the teen parent's child live in the household? Yes No
 Name of teen parent's child _____

LN NO. _____ Marital Status _____
 High School Diploma? _____
 LN NO. _____ Marital Status _____
 High School Diploma? _____

LN NO. _____ LN NO. _____

EDUCATION/TRAINING

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

Has a High School diploma or G.E.D.? Yes No
 Who _____ 1
 Dates attended _____
 Dates completed _____

Is or has been in any training program **in the last 12 months?** Yes No
 Who _____
 Where _____ 2
 Program _____
 Dates attended _____
 Dates completed _____

Is 16 years of age or older and is attending school or college? Yes No
 Who _____ 3
 Where _____

Is getting a Training Allowance? Yes No 4
 Who _____ Amt. \$ _____

Is getting Educational Grants or Loans? Yes No 5
 Who _____ Amt. \$ _____

Is under 16 years of age and is attending school? Yes No
 Who _____
 School _____
 Who _____
 School _____
 Who _____
 School _____ 6
 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 | |
| | | |

| | 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 RECERTIFYING: | YES | NO | WHO | IF YES, GIVE AMOUNT/VALUE | WHO | IF YES, GIVE AMOUNT/VALUE |
| Has cash on hand | 1 | | | \$ | | \$ |
| Has a checking account(s) | 2 | | | | | |
| Has a savings account(s) or certificate of deposit(s) | 3 | | | | | |
| Has a credit union account(s) | 4 | | | | | |
| Has life insurance | 5 | | | | | |
| Has title or registration to a motor vehicle(s) or other vehicle(s) (Specify) Year _____ Make/Model _____ Year _____ Make/Model _____ | 6 | | | | | |
| Has stocks, bonds, certificates or mutual funds | 7 | | | | | |
| Has savings bonds | 8 | | | | | |
| Has an IRA, Keogh, 401-(k) or deferred compensation account(s) | 9 | | | | | |
| Has an irrevocable burial trust | 10 | | | | | |
| Has a burial fund | 11 | | | | | |
| Has a burial space | 12 | | | | | |
| Has own home | 13 | | | | | |
| Has real estate including income-producing and non-income-producing property | 14 | | 19 | | | |
| Is eligible for an income tax refund | 15 | | | | | |
| Has an annuity | 16 | | | | | |
| Is named the beneficiary of a trust | 17 | | | | | |
| Expects to receive a trust fund, lawsuit settlement, inheritance or income from any other sources | 18 | | | | | |
| Has an "in trust" account(s) | 19 | | | | | |
| Has a safe deposit box | 20 | | | | | |
| Has resources other than those listed above | 21 | | | | | |
| Has anyone (including your spouse, even if not recertifying or living with you) given away any cash, or sold/transferred any real estate, income or personal property in the past 36 months? | 22 | | | | | |
| Has anyone (including your spouse, even if not recertifying 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? _____ | 23 | | | | | |

| DO NOT WRITE IN SHADED AREAS | | |
|------------------------------|----------|----------|
| NEEDED | REFERRAL | COMPETED |
| | Legal | |
| | Resource | |
| | | |

| LIFE INSURANCE | |
|----------------|------------|
| FACE AMOUNT | CASH VALUE |
| | |
| | |
| | |
| | |

| REQUESTED | DOCUMENTATION | IN FILE |
|-----------|---|---------|
| | Resource Checklist | |
| | Market Value | |
| | DMV Clearance | |
| | Bank Statement | |
| | Assignment of Proceeds | |
| | Car/Vehicle Title | |
| | Car/Vehicle Registration (older models) | |
| | 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
 - ✓ EIC
 - ✓ Change in Resources from Last Budget

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

*IF EXEMPT, WHY?

| MEDICAL INFORMATION | | | | DO NOT WRITE IN SHADED AREAS | | | CONSIDER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|-----------|-------------|--|--|--|---|--|--|-----------|---------------|-----------|--|---------------------|--|--|----------------------------------|--|--|------------------------------------|--|--|------------------------|--|--|------------------------------|--|--|---|--|--|-------|--|--|------|--|--|------|--|--|-----------------|--|--|------|--|--|------------|--|--|--------------------|--|--|----------------------|--|--|-------------------|--|--|-------------------|--|--|----------------------|--|--|-----------|--|
| INDICATE IF YOU OR ANYONE WHO LIVES WITH YOU WHO IS RECERTIFYING: | YES | NO | IF YES, WHO | | | | <ul style="list-style-type: none"> ✓ AD/SSI Related ✓ FS Aged/Disabled Indicator ✓ FS Medical Deduction ✓ TPHI Reimbursement ✓ Buy-In Eligibility ✓ Kreiger (LDSS-3664) ✓ Domestic Violence ✓ SSI Referral ✓ Earned Income Credit ✓ Change in Resources <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 33%;">NEEDED</th> <th style="width: 33%;">REFERRALS</th> <th style="width: 33%;">COMPLETED</th> </tr> </thead> <tbody> <tr><td></td><td>SSI (D-CAP)</td><td></td></tr> <tr><td></td><td>Disability Interview (LDSS-1151)</td><td></td></tr> <tr><td></td><td>Medical Report (LDSS-486, 486t)</td><td></td></tr> <tr><td></td><td>Disability Report</td><td></td></tr> <tr><td></td><td>AD</td><td></td></tr> <tr><td></td><td>TPHI</td><td></td></tr> <tr><td></td><td>VESID</td><td></td></tr> <tr><td></td><td>CTHP</td><td></td></tr> <tr><td></td><td>PCAP</td><td></td></tr> <tr><td></td><td>Family Planning</td><td></td></tr> <tr><td></td><td>TASA</td><td></td></tr> <tr><td></td><td>SSA (RSDI)</td><td></td></tr> <tr><td></td><td>Veteran's Benefits</td><td></td></tr> <tr><td></td><td>Veteran's Counseling</td><td></td></tr> <tr><td></td><td>Child Health Plus</td><td></td></tr> <tr><td></td><td>COBRA Eligibility</td><td></td></tr> <tr><td></td><td>Nurse's Aide Service</td><td></td></tr> <tr><td></td><td>Home Care</td><td></td></tr> </tbody> </table> | | | 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 | |
| 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Has any medical bills or medically-related expenses 1 | | | | 20 | | | <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">REQUESTED</th> <th style="width: 50%;">DOCUMENTATION</th> <th style="width: 25%;">IN FILE</th> </tr> </thead> <tbody> <tr><td></td><td>Pregnancy Statement</td><td></td></tr> <tr><td></td><td>Med/Psych Statement</td><td></td></tr> <tr><td></td><td>Drug/Alcohol Screening (LDSS-4571)</td><td></td></tr> <tr><td></td><td>Drug/Alcohol Statement</td><td></td></tr> <tr><td></td><td>Paid or Unpaid Medical Bills</td><td></td></tr> <tr><td></td><td>SSI Application Verification TA ONLY</td><td></td></tr> </tbody> </table> | | | 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is on Medicaid with a spenddown 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Has health or hospital/accident insurance (including insurance from employer) 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Has health insurance available through your employer 4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Has Medicare (red, white, and blue card) 5 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Has a health attendant 6 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is blind, sick or disabled 7 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is a handicapped child 8 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is in a hospital, nursing home or other medical institution 9 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Has paid or unpaid medical bills within 3 months preceding the month of this application 10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is or was drug or alcohol dependent 11 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Needs home care 12 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is on SSI or has ever applied for SSI 13 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is pregnant 14 | | | | IF PREGNANT, PLEASE GIVE DUE DATE: _____ 15 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Receives treatment from a drug abuse or alcohol treatment program 16 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Has not been able to work for at least 12 months because of a disability or illness 17 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Has daily activity limited because of a disability or illness that has lasted or will last at least 12 months 18 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Has been in a car accident or work-related accident in the past two years 19 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Has any government agency (public program) besides Medical Assistance or Medicare paid any of your medical bills? 20 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

HEALTH PLAN SELECTION

Persons eligible for Family Health Plus must join a health plan to receive their health services. Some people enrolled in Medicaid may be required to join a health plan now and others may be required to join one soon. Use this section to choose a health plan. If you do not know what health plans are available, ask your worker.

NOTE: If you are in a county that does not require Medicaid recipients to join a health plan, you will still be enrolled in the health plan(s) you choose, unless you check this box.

| Check (✓) Program | Name of Plan you are enrolling in (Adults age 19 to 64 must pick a FHPlus Plan) | Last Name | First Name | Date Of Birth mm/dd/yy | SEX M/F | ID# (from Medicaid Card if you have one) | Social Security # (optional if pregnant) | Primary Care Provider (PCP) or Health Center (check box if current provider) | Name and ID# of OB/GYN (check box if current provider) |
|--|---|-----------|------------|------------------------|---------|--|--|--|--|
| <input type="checkbox"/> MA <input type="checkbox"/> FHPLUS | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> MA <input type="checkbox"/> FHPLUS | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> MA <input type="checkbox"/> FHPLUS | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> MA <input type="checkbox"/> FHPLUS | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> |

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 the following expenses separate from your rent or shelter expense? | YES | NO |
| • Heat 1 | | |
| • Electricity (for lights, cooking, hot water) 2 | | |
| • Gas (for cooking, hot water) 3 | | |
| • Other utilities (water, etc.) 4 | | |
| • Air conditioning (monthly fee, or pay own electric) 5 | | |
| • Utility installation fees 6 | | |
| Does any person, group or organization outside the household pay any of the household expenses? 7 | | |
| Do you live in public housing? | | |
| Do you live in Section 8 or other subsidized housing? | | |
| Do you live in a drug/alcohol rehab. facility? | | |
| Do you live in a 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 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
 - ✓ Lifeline
 - ✓ AIDS/HIV Emergency Shelter Allowance
 - ✓ Property Lien
 - ✓ If Shelter Expenses/Living Quarters are Shared by More Than One Household

| MONTHLY EXPENSES | MONTHLY ACTUAL COST | NAME OF DEALER | ACCOUNT NUMBER | IN WHOSE NAME IS THE BILL? (CUSTOMER OF RECORD) | WHO IS THE TENANT OF RECORD? |
|---|---------------------|----------------|----------------|---|------------------------------|
| A. Heat* | | | | | |
| B. Electricity (for cooking, lights, hot water) | | | | | |
| C. Gas (for cooking, hot water) | | | | | |
| D. Liquid Propane Gas | | | | | |
| E. Other Utilities (Water, etc.) | | | | | |
| F. Air Conditioning | | | | | |
| G. Utility Installation Fees | | | | | |
| H. Sewer | | | | | |
| I. Garbage | | | | | |
| J. Trash | | | | | |
| K. Other Expenses | | | | | |

***Check Primary Heat Type:**

- Natural Gas
 Oil
 PSC Electric
 Coal
 Other _____
 Kerosene
 Propane
 Municipal Electric
 Wood

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

\$

Does Client Receive Contribution Towards Difference?

YES NO

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

I REQUEST THAT MY CASE BE CLOSED FOR:

- Temporary Assistance
- Food Stamp Benefits
- Medical Assistance
- Medicare Savings Program

I understand that I may reapply at any time.

Give reason: _____

Signature **x** _____ Date _____

NOTES/COMMENTS

Large empty area for notes and comments.

READ THE IMPORTANT INFORMATION BELOW.**NOTICES**

PRIVACY ACT STATEMENT - COLLECTION AND USE OF SOCIAL SECURITY NUMBERS (SSNs) - The collection of SSNs 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 this recertification form requires a SSN, the collection of SSNs is also mandatory and is authorized under one or more of the following sections of law: 205(c) of the Social Security Act (42 U.S. Code 405), Section 1137 of the Social Security Act (42 U.S. Code 1320b-7) and Section 7(a)(2) of the Privacy Act of 1974. See the "How To Complete" instruction book Sections 6 and 24 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.

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 SSNs, may be used to assist in the formation of jury pools.

If a FS claim arises against your household, the information on this recertification, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action. Providing the requested information, including the SSN of each household member, is voluntary for Food Stamp Benefits. However, anyone applying who fails to give a SSN will be denied FS. SSNs of ineligible members will also be used and disclosed in the manner above.

REIMBURSEMENT OF MEDICAL EXPENSES

MEDICAID - You have a right as part of your Medical Assistance application, or within two years from the date of your application, 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.

FAMILY HEALTH PLUS - If you are determined eligible for Family Health Plus, your enrollment will be effective no later than 90 days from the date of submission of your completed application. If there is an error or delay in enrollment, reimbursement may be available for expenses you pay as a result of the error or delay. Unpaid expenses can be paid only if the provider is a Medicaid enrolled provider.

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 recertification contain additional assignments.

NON-DISCRIMINATION NOTICE - In accordance with Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs.

To file a complaint of discrimination, contact USDA or HHS. Write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). USDA and HHS are equal opportunity providers and employers.

FOOD STAMP BENEFITS AUTHORIZED REPRESENTATIVE - You can authorize someone who knows your household circumstances to **apply** for Food Stamp Benefits (FS) for you. 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.

When an Authorized Representative is applying on behalf of a Food Stamp Benefits Household that does not reside in an institution, **both** the Authorized Representative and the Food Stamp Benefits Head of Household must sign and date the signature sections at the bottom of page 16.

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

PENALTIES - Your recertification 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 recertification 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 waived 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.

NOTICES (cont.)**FOOD STAMP BENEFITS (FS) PENALTY WARNING**

Any information you provide in connection with your application for Food Stamp Benefits will be subject to verification by Federal, State and local officials. If any information is incorrect, you may be denied FS. You may be subject to criminal prosecution for knowingly providing incorrect information.

You will **never** be able to get FS again if you are:

- Found guilty in a court of law for the second time of buying or selling controlled substances (illegal drugs or certain drugs for which a doctor's prescription is required) in exchange for FS; **or**
- Found guilty in a court of law of selling or getting firearms, ammunition or explosives in exchange for FS; **or**
- Found guilty in a court of law of trafficking in FS worth \$500 or more. Trafficking includes the illegal use, transfer, acquisition, alteration or possession of FS, authorization cards or access devices; **or**
- Found guilty of committing a third Intentional Program Violation (IPV).

You will not be able to get FS for two years if you are found guilty in a court of law for the first time of buying or selling controlled substances (illegal drugs or certain drugs for which a doctor's prescription is required) in exchange for FS.

If you have committed your:

- First IPV, you will not be able to get FS for one year.
- Second IPV, you will not be able to get FS for two years.

A court could also bar you from receiving Food Stamp Benefits for an additional 18 months.

If you make a false statement about who you are or where you live in order to get multiple FS, you will not be able to get FS for ten years (or **permanently** if this is the third IPV).

You may be found guilty of an Intentional Program Violation if you:

- Make a false or misleading statement, or misrepresent, conceal or withhold facts; **or**
- Commit any act that constitutes a violation of Federal or State law for the purpose of using, presenting, transferring, acquiring, receiving, possessing or trafficking of coupons, authorization cards or reusable documents used as part of the Electronic Benefit Transfer (EBT) system.

You could also be fined up to \$250,000, sent to jail for up to 20 years, or both.

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ASSIGNMENTS. AUTHORIZATIONS & CONSENTS

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 recertification is made. In addition, I will assist in making any assigned benefits available to the social services official to whom this recertification is made.

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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.

MEDICAL ASSISTANCE (MA) RECOVERIES - Upon receipt of MA, a lien may be filed and a recovery may be made against your real property under certain circumstances if you are in a medical institution and not expected to return home. MA paid on your behalf may be recovered from persons who had legal responsibility for your support at the time medical services were obtained. MA may also recover the cost of services and premiums incorrectly paid.

CHILD/TEEN HEALTH PROGRAM - I understand that if my child is on Child Health Plus A (Medicaid), he or she can get comprehensive primary and preventive care, including all necessary treatment through the Child/Teen Health Program. I can get more information on this program from the Department of Social Services.

REQUIREMENT TO REPORT/VERIFY HOUSEHOLD EXPENSES - Your household must report child care and utility expenses in order to get a FS deduction for these expenses. Your 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.

Failure to report/verify the above expenses will be seen as a statement by your household that you 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. You 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.

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.

CHANGES - I agree to inform the agency **promptly** of any changes, to the best of my knowledge and belief, including, but not limited to, any change in my needs, residency/address, living arrangements, household size, income, employment, property/resources, dependent care costs, health insurance, immigration/citizenship status or pregnancy.

If I am applying for child care assistance, I agree to inform the agency **immediately** of any change in family income, who lives in my house, employment, child care arrangements or other changes which may affect my continued eligibility or amount of my benefit.

CONSENT FOR INVESTIGATION - I agree to any investigation to verify or confirm the information I have given 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.

READ THE IMPORTANT INFORMATION BELOW AND SIGN AT THE BOTTOM.

ASSIGNMENTS, AUTHORIZATIONS & CONSENTS (cont.)

STANDARD UTILITY ALLOWANCE (SUA) - 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 HEAP 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. I understand that FS recipients are eligible for a telephone allowance if they pay for a home phone, cell phone, phone calling card or coin-operated pay phone. If I do not have to pay for phone calls, 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.

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

- Obtain any information regarding the educational records of myself and/or my minor child(ren), herein named, including information 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.

RELEASE OF INFORMATION FOR THE EARLY INTERVENTION PROGRAM - If my child is evaluated for or participates in the New York State Early Intervention Program, I give permission to the local department of social services and New York State to share my child's Medical Assistance eligibility information with my county or municipal Early Intervention Program for the purpose of billing Medical Assistance.

RELEASE OF MEDICAL INFORMATION - I consent to the release of any medical information about me and any members of my family for whom I can give consent: by my Primary Care Provider, any other health care provider or the New York State Department of Health (SDOH) to my health plan and any health care providers involved in caring for me or my family, as reasonably necessary for my health plan or my providers to carry out treatment, payment, or health care operations; by my health plan and any health care providers to SDOH and other authorized federal, state, and local agencies for purposes of administration of the Medicaid, Child Health Plus and Family Health Plus programs; and, by my health plan to other persons or organizations, as reasonably necessary for my health plan to carry out treatment, payment, or health care operations. I also agree that the information released may include HIV, mental health or alcohol and substance abuse information about me and members of my family, to the extent permitted by law. If more than one adult in the family is joining a Family Health Plus or Medicaid health plan, the signature of each adult applying is necessary for consent to release information.

LIFELINE - For applicants/recipients of Temporary Assistance and/or Food Stamp Benefits: The Office of Temporary and Disability Assistance may or may not release your name and address to your telephone service provider. Your telephone service provider may or may not use this information to enroll you in their Lifeline Service for a discounted telephone rate.

If you **do not** want this information released, check this box .
 You may contact your telephone service provider directly for enrollment in the discounted rate Lifeline Service.

Medicaid-**only** applicants/recipients must contact their telephone service provider directly for enrollment in the discounted rate Lifeline Service.

AUTHORIZATION FOR REIMBURSEMENT OF PUBLIC 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 that is 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 my SSI benefits are terminated or suspended and are later reinstated.

I understand that the local social services district may take from my retroactive SSI payment the amount of Public Assistance (except assistance paid wholly or partly with federal funds) that it paid to me during the period that begins (1) with the first day I became eligible for payment of SSI benefits or (2) the first day to which SSI benefits were reinstated after a period of suspension or termination and ends 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 resume).

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. It will not have any effect on cases that have been completely decided or if the SSA has already made an initial payment of SSI either on my application or after a period of suspension or termination or if the State and I have mutually agreed to terminate the authorization.

This authorization will terminate one (1) year after it is received by the local social services district and will not have any effect upon new SSI applications made after that date.

I have read and understand the notices above. I understand and agree to the assignments, authorizations and consents above. 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 SIGNATURE X 29 | DATE SIGNED | HUSBAND/WIFE OR PROTECTIVE REPRESENTATIVE SIGNATURE X | DATE SIGNED |
| AUTHORIZED REPRESENTATIVE SIGNATURE X | DATE SIGNED | | |

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 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.

_____/____/____
(Date)

(Signature)

(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：如果你有興趣索取本中文資料表格，請電 1 - 800 - 367-8683

한국어: 한국어 양식을 원하시면 1-800-367-8683 으로 전화하십시오.

VOTER REGISTRATION APPLICATION (instructions on back)

NVRA-05 (01/2011)

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 <input type="checkbox"/> No <input type="checkbox"/> | | 2 | Will you be 18 years old on or before election day? Yes <input type="checkbox"/> No <input type="checkbox"/> | | For Board use only! |
| | If you answered NO, do not complete this form. | | | If you answered NO, do not complete this form unless you will be 18 by the end of the year. | | |
| 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 route, etc. | Post Office | Zip Code | |
| 6 | Date of Birth | 7 | Sex (circle) M <input type="checkbox"/> F <input type="checkbox"/> | 8 | Home Tel. Number (optional) | |
| 10 | The last year you voted | Your Address was (give house number, street and city) | | | 9 | ID Number—Check the applicable box and provide your number: <input type="checkbox"/> New York DMV number _____ If you do not have a New York DMV number, please provide: <input type="checkbox"/> Last four digits of your Social Security Number _____ <input type="checkbox"/> I do not have a New York Driver's license number |
| | In county/state | Under the Name (if different from your name now) | | | | |
| 11 | Choose a party -- Check one box only <input type="checkbox"/> Democratic Party <input type="checkbox"/> Republican Party <input type="checkbox"/> Conservative Party <input type="checkbox"/> Working Families Party <input type="checkbox"/> Independence Party <input type="checkbox"/> Green Party <input type="checkbox"/> Other (write in) _____ <input type="checkbox"/> I do not wish to enroll in a party | | | 12 | AFFIDAVIT: I swear or affirm that <ul style="list-style-type: none"> • 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 _____ Zip Code _____
 City _____
 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.

Sign

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:

New York State Board of Elections, 40 Steuben Street,
Albany, New York 12207-2109
Telephone: 1-800-469-6872;
TDD/TTY users contact the New York State Relay at 711;
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.

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, pay-check, 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. To vote in a primary election, you must be enrolled in one of these listed parties — Except the Independence Party, which permits non-enrolled voters to participate in certain primary elections.
