George E. Pataki
Governor

NEW YORK STATE
OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE
40 NORTH PEARL STREET
ALBANY, NY 12243-0001

Robert Doar
Commissioner

Informational Letter

Section 1

Transmittal:	05-INF-09
To:	Local District Commissioners
Issuing Division/Office:	Division of Program Support & Quality Improvement
Date:	March 28, 2005
Subject:	New Statewide "Common Application", LDSS - 2921 Statewide (Rev. 1/05) New Statewide "How to Complete" publication, PUB - 1301 Statewide (Rev. 1/05).
Suggested Distribution:	Temporary Assistance Food Stamp Directors Medical Assistance Directors Directors of Services CAP Coordinators Staff Development Coordinators Child Support Enforcement Coordinators Employment Coordinators Forms Coordinators WMS Coordinators
Contact Person(s):	Jackie Brace, Document Services (518) 474-9522
Attachments:	Attachment 1 - LDSS-2921 Statewide (Rev. 1/05) Attachment 2 - PUB-1301 Statewide (Rev. 1/05)
Attachment Available On – Line:	☒

Filing References

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
85 ADM-38 89 INF-53 95 INF-8 95 INF-29 01 INF-22 02 INF-20 03 INF 39	95 INF-29 95 INF-8	350.4 351.21 360.1 369.1 369.4 387.6 387.17 404.1		PSAB III-E, III-H, V-B-1, V-C FSSB IV-E-2, IV-F IV-E-5, VI-A MARG p. 364	95-ADM-1

Section 2

I. Purpose

This INF introduces revisions made to the following mandated forms:

LDSS-2921 Statewide Common Application Form
PUB-1301 Statewide "How to Complete" Publication

This INF releases the (Rev. 1/05) versions of this form and publication.

II. Background

This release includes specific changes that are outlined in the following section, which are **bolded**.

III. Form and Publication Implications:

GENERAL – The Revision Date was changed to 1/05 on all pages.

TEMPORARY ASSISTANCE CHANGES:

PAGE 1

1. **Lifeline Indicator – shaded area**

   A one-character field has been **added** after the "Case Name" field in the shaded worker data entry section at the top of the page. This field should be labeled **"lifeline"** and will be driven by the answer given to the question that will be asked on **Page 16.**

2. **Consent To Withdraw Statement – shaded area**

   The "**Consent to Withdraw**" section was **removed** from the shaded worker data entry section at the top of Page 1, expanded and placed on **Page 13.**

3. **Self- Sufficiency Statement - shaded area**

   The second sentence in the first paragraph was **changed** to include program names. It now reads:

   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.

4. **Check Each Program – shaded area**

   A "Child Care In Lieu Of TA" box was **added.**

   The box reads as follows:

- □ **Child Care In Lieu Of TA**

5. **Check Each Program area – shaded area**

   An "Emergency Payment Only (EMRG)" box was **added** to allow the applicant to indicate that they are applying only for a one-time emergency need.

   The box reads as follows:

   - □ **Emergency Payment Only**

(The worker should detail the determination/action regarding the emergency assistance request on page 13.)

PAGE 2

1. **EMRG column - Section 6**

An additional choice column, titled "**EMRG**", was **added** to the right of the "S" column where the applicant can check the type(s) of Assistance each person is applying for. "EMRG" is an abbreviation for the "Emergency Payment Only".

2. **Alien Information Section –** All "Alien" references in this section were **changed** to **"Immigration".**

PAGE 3

1. **Race/Ethnic Affiliation Codes - Section 6**

2. The Ethnic Code definition, **H** Hispanic or Latino (a)" was **changed** to "**H** Hispanic or Latino".

3. **Race/Ethnic Affiliation Codes - Section 6**

   An additional Race/Ethnic code definition and new column for this definition has been **added**. The new definition is "**U Unknown (MA ONLY)**" and the new column will be titled "**U**" for unknown and was **added** to the right of the "**W**" column. This new column allows for 8 entries.

   Documentation Cue section – The "Alien Status" reference was **changed** to "**Immigration Status".**

PAGE 4

Citizenship/Immigration Status Information – Sections 8 and 9

1. All "Alien" references were **changed** to "Immigrant".

2. The reference to the "Immigration and Naturalization Service (INS)" was **changed** to **"United States Citizenship and Immigration Services (USCIS)".**

3. The example, after the sentence about an authorized representative signing the Certification, was **changed** to read:

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

4. **EMRG column** - An additional choice column, titled **"EMRG",** was **added** to the right of the "S" column in section 9 where the applicant certifies that they are a U.S. Citizen or national, or an alien with satisfactory immigration and the where they check the type(s) of Assistance each person is applying for. **"EMRG"** is an **abbreviation** for the **"Emergency Payment Only".**

5. The "Immigration and Naturalization Service (INS)" reference was **changed** to **"United States Citizenship and Immigration Services (USCIS)".**

PAGE 6

Step- Parent/Alien Sponsor Information – Section 15

1. The title for the "Step-Parent/Alien Sponsor Information" section was **changed** to **"Step-Parent/Immigrant Sponsor Information"**
2. The "alien" reference in the 2nd question was **changed** to **"immigrant".**

PAGE 7

Employment Information – Section 16

1. The sentence that asks about health insurance was **changed** to read:

   Does anyone **else** have health insurance with their employer?

3. A new question was **added** that reads:

   Is health insurance available through your employer?

PAGE 8

Education/Training - Section 17

A new question was **added** that reads:

Is under 16 years of age is attending school

PAGE 9

Documentation Cues – shaded area

Car/Vehicle Registration" was changed to read

Car/Vehicle Registration (older models)

PAGE 10

Medical Information - Section 19

1. A new 2nd question was **added** that asks:

   Is on Medicaid with a Spendown

2. A new 4th question was **added** that reads:

Has health insurance available through your employer

PAGE 11

Shelter – Section 20

1. The telephone related information on this page was **eliminated** because the new language in the "SUA statement" on page 16, now addresses Food Stamp Benefits Recipients' eligibility for a phone allowance.

2. An additional column was **added** in the shaded gray "Monthly Expenses" chart. That column should appear directly after "Name of Dealer" and be titled "Account Number". The addition of this column will help in identifying and recording account numbers for the purpose of vendor payments and payment accuracy.

PAGE 13

1. **Consent To Withdraw Statement – shaded area**

   The **"Consent To Withdraw"** section, originally in the shaded area on page 1, was **moved** to the shaded area on this page. The original section only offered the applicant/recipient the choice of withdrawing their application for all the assistance programs. This question has been expanded to offer the applicant/recipient the opportunity to indicate which program or programs they do not wish to apply for.

   The revised **"Consent To Withdraw"** statement will continues to be located in a shaded area and was **revised** to read:

   I consent to withdraw my application for:

   □ Temporary Assistance □ Food Stamp Benefits □ Medical Assistance □ Services
   □ One-Time/Emergency Payment Only

   I understand that I may reapply at any time.

   Signature **x** _____ Date: _____

2. **Emergency Cash Assistance – shaded area**

3. An "**Emergency Cash Assistance**" area has been **added** to the shaded worker area to document the action/determination criteria.

PAGES 14, 15 and 16

1. **GENERAL**– The Notices Section was **revised** and reformatted into 2 separate sections:

   - Notices
   - Assignments, Authorizations & Consents

2. **CHANGES - section 26 on Page 15**

The **Changes** section was **changed** to read:
CHANGES - I agree to inform the agency **promptly** of any change in my needs, income, property, living arrangements or address to the best of my knowledge or belief.

If I am applying for child care assistance, I agree to inform the agency **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.

3. **SUA STATEMENT – Section 26 on Page 16**

   An additional statement regarding a telephone allowance was **added** to the "SUA" section. The statement reads:

   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."

4. **LIFELINE – Section 26 on Page 16**

5. The Lifeline language was **revised** to read:

   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."

LAST PAGE

Voter Registration Form - The most current version of the "Voter Registration" form has been attached to this version.

MEDICAID CHANGES:

Publication 1301

1. **Section 1** includes an explanation that Medical Assistance includes the Medicaid, Family Health Plus, Child Health Plus A, Medicaid Buy-In for Working People With Disabilities and Family Planning Benefit programs.

2. All references to “alien” were **changed** to “immigrant” or “immigration”. To clarify the status of Native Americans, “Native American” was **added** to these sections.

3. **In Section 9,** the name of the "Immigration Naturalization Service (INS)" has been **changed** to "United States Citizenship and Immigration Services (USCIS)".

4. **In Section 10,** "Non-Custodial Parent/Child Support/Medical Support Information", the following statement was **added**, "If you want to pursue medical support from a non-custodial parent, you must complete this section." This statement informs applicants who are not required to pursue medical support that they may choose to pursue medical support.

5. **In Section 18,** the instructions as to who is required to provide resource information have been **changed**. The words," or guardians", were **deleted.** Guardians are not legally responsible relatives.

6. **Section 19** was **reformatted** and the "Health Plan Selection" was **added** to provide information about the need to select a health plan for some people eligible for Medicaid and for all people eligible for Family Health Plus.

7. **In Section 28**, "Signatures", the following statement was **deleted**, "All persons 18 years of age or older must sign."

8. **In Section 28**, under the "Notice" regarding fair hearing rights, "Medicare Savings Program" was **added.**

LDSS-2921

1. In **Sections 8 and 9**, all references to "alien" were **changed** to "immigrant" or "immigration". References to "alien number" were inadvertently **changed** to "immigrant number" and will be corrected in the next revision of the LDSS-2921. To clarify the status of Native Americans, "Native American" was **added** to these sections.

2. **In Section 9,** the name of the "Immigration Naturalization Service (INS)" has been **changed** to "United States Citizenship and Immigration Services (USCIS)".

3. **In Section 16**, the question, "Is health insurance available through your employer?", was added.

4. **Section 19** was reformatted and the "Health Plan Selection" was **added** to allow applicants to select a health plan for some people eligible for Medicaid and for all people eligible for Family Health Plus.

5. "I consent to withdraw my application..." was **moved** from the shaded area of page one to page thirteen. The applicant is now requested to check the box indicating for which program(s) the application is being withdrawn. A new box for "Medicare Savings Program" was **added**.

6. **In Section 23**, under "Reimbursement of Medical Expenses", the first sentence was **changed** to, "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."

7. **In Section 26,** under "Release of Educational Records", "State and local department of social services" was **changed** to "State Department of Health and local department of social services".

CHILD CARE CHANGES:

Changes to Common Application for child care

Section One Child Care in lieu of TA has been **added** as program area that an applicant may select.

Changes Page 15

Notification of changes in child care arrangements has been **changed** from promptly to immediately.

Pub 1301 changes for child care

Applicants may select child care in lieu of Temporary Assistance if they are eligible for Temporary Assistance and decide all they need is child care.

IV. Forms Implications

Districts were sent supplies of the LDSS-2921 Statewide (Rev. 1/05) and PUB-1301 Statewide (Rev 7/03) “How to Complete”. Upon receipt of this version, any supply of the previously issued (Rev. 7/03) should be destroyed.

Any future requests for printed copies of the (Rev. 01/05) versions of the LDSS-2921 Statewide Common Application and the PUB-1301 Statewide “How to Complete” should be submitted on an OTDA-876 (Rev. 6/98): “Requests For Forms or Publications” form, and should be sent to:

Office of Temporary and Disability Assistance
Document Services
P.O. Box 1990
Albany, New York 12201

Questions concerning ordering forms should be directed to Document Services at 1-800-343-8859, Ext. 4-9522.

In addition, electronic PDF versions of the (Rev 01/05) LDSS-2921 Statewide and the PUB-1301 Statewide are posted on the OTDA Intranet Home Page, LDSS E-Forms link. http://sdssnet5/otda/ldss_eforms/default.htm

V. Additional Information

Because these documents provide current program and policy information as well as mandated legal information, comments on the format and content of these forms and publications are always welcomed. Comments received will be pended and considered at the next printing of these forms.

Comments may be forwarded to:

Ms. Jacqueline Brace
Document Services
93 Broadway
Menands, New York 12204
Jacqueline.Brace@otda.state.ny.us

Issued By
Name: Mary Meister
Title: Deputy Commissioner
Division/Office: Division of Program Support & Quality Improvement

DO NOT WRITE IN THE SHADED AREAS OF THIS APPLICATION

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

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

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

DATE RECEIVED BY AGENCY | EMPLOYED BY: ☐ SOCIAL SERVICES DISTRICT ☐ PROVIDER AGENCY SPECIFY: _____

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

NEW YORK STATE

APPLICATION FOR: TEMPORARY ASSISTANCE (TA) - MEDICAL ASSISTANCE (MA) - MEDICARE SAVINGS PROGRAM (MSP) - FOOD STAMP BENEFITS (FS) - SERVICES (S), including Foster Care (FC) - CHILD CARE ASSISTANCE (CC)

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 application, 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-1301 Statewide) when completing this application.

CHECK EACH PROGRAM YOU OR ANY HOUSEHOLD MEMBER ARE APPLYING FOR

1

☐ Temporary Assistance and Medical Assistance ☐ Temporary Assistance ☐ Child Care in lieu of TA ☐ Medical Assistance
☐ Medicare Savings Program ☐ Food Stamp Benefits ☐ Services, including Foster Care ☐ Child Care Assistance ☐ Emergency Payment Only (EMRG)

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

WHAT IS YOUR PRIMARY LANGUAGE? ☐ ENGLISH ☐ SPANISH ☐ OTHER (specify) _____

2

APPLICANT INFORMATION — PLEASE PRINT CLEARLY

3

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

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	COUNTY	STATE	ZIP CODE

AGENCY HELPING APPLICANT/CONTACT PERSON	PHONE NUMBER ( ) AREA CODE

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

DIRECTIONS TO HOME

FORMER ADDRESS	APT. NO.	CITY	COUNTY	STATE	ZIP CODE

If You Are Applying For Food Stamp Benefits (FS), you have the right to turn in (file) this application 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.

4

FS APPLICANT/REPRESENTATIVE SIGNATURE	DATE SIGNED
x	

DO ANY OF THESE APPLY TO YOU?

5

- ☐ 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

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

RI	LN	FIRST NAME	M.I. (Middle Initial)	LAST NAME	TA	FS	MA	MSP	CC	FC	S	EMRG	DATE OF BIRTH Month	Day	Year	SEX M OR F	RELATIONSHIP TO YOU	SOCIAL SECURITY NUMBER OF APPLYING MEMBERS (*See "How to Complete" instruction book Pub-1301 Statewide, **or** talk to your worker*)	HIGHEST SCHOOL GRADE COMPLETED	DOES THIS PERSON (INCLUDING YOUR MINOR CHILDREN) BUY FOOD OR PREPARE MEALS WITH YOU? YES	NO
	01																**SELF**				
	02																				
	03																				
	04																				
	05																				
	06																				
	07																				
	08																				

6

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

7

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 YES	LEGALLY RESPONSIBLE NO	FOR WHOM?	CONTRIBUTION/ DEEMED INCOME	CHECK IF MEMBER OF FS HOUSEHOLD

IMMIGRATION INFORMATION

LN	IMMIGRATION STATUS	STATUS ADJUSTED YES	STATUS ADJUSTED NO	DATE OF ENTRY/STATUS MONTH	DATE OF ENTRY/STATUS DAY	DATE OF ENTRY/STATUS YEAR	APPLIED FOR CITIZENSHIP YES	APPLIED FOR CITIZENSHIP NO	SPONSORED YES	SPONSORED NO

INDIVIDUAL EDUCATION

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

RACE/ETHNIC AFFILIATION CODES

- **H** Hispanic or Latino
- **I** Native American or Alaskan Native
- **A** Asian
- **B** Black or African American
- **P** Native Hawaiian **or** Pacific Islander
- **W** White
- **U** Unknown **(MA Only)**

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

ANTICIPATED FUTURE ACTION

LINE NO.	CODE	DATE

SERVICE ELIGIBILITY PROCESS CODE

SFUI	CODE	SFUI	CODE
SFUI	CODE	SFUI	CODE

CASE TYPE	RELATED CASE NUMBERS

NEEDED	REFERRALS	COMPLETED
	CAP	
	Services	
	SSA	
	Legal	

CONSIDER

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

REQUESTED	DOCUMENTATION	IN FILE
	Photo I.D.	
	Birth Verification	
	Marriage License	
	Social Security Card	
	Code 9 Resolution	
	Immigration Status	
	Multi-Suffix/Co-op Case Notice (Single Economic Unit Questionnaire)	

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 8

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

IF YOU HAVE QUESTIONS, SEE THE "HOW TO COMPLETE" INSTRUCTION BOOK (PUB-1301 Statewide) OR TALK TO YOUR WORKER.

You **do not** have to fill out Section 8 or 9 if you are applying for MA **only** and:

- You are pregnant, or
- You are applying **only** for coverage for the treatment of an **emergency** medical condition.

You **do** have to fill out Sections 8 and 9 if you are:

- Applying for MA **only,** but you do not have to include people who do not want MA.
- Applying for Child Care Assistance **only**, but you need to fill out the information only for the children who would be receiving Child Care Assistance.
- Applying for Foster Care **only**, but you need to fill out the information only for children who would be receiving Foster Care.
- Applying for other Services under certain circumstances.

SECTION 9 - 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 applying for:

- Temporary Assistance (where there are children in the household or a member of the household is pregnant), or
- Food Stamp Benefits, or
- Medical Assistance (except if the applicant is pregnant), or
- Medicare Savings Program, or
- Child Care Assistance (certification is needed for the children **only**), or
- Foster Care (certification is needed for the children **only)**, or
- Other services under certain circumstances.

An adult household member or authorized representative may sign for all household members. Example: A *parent* without satisfactory immigrant status may sign for his/her *child* who has satisfactory immigrant status.

An application for FS must list all persons living in the FS household. An application for TA must list all children for whom you are applying, their brothers and sisters and all parents of those children who live together. If you do not check whether a listed person is a U. S. citizen, Native American or national of the United States, or an immigrant, or provide an immigrant 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 APPLICANT.

IN THE CASE OF AN APPLYING IMMIGRANT, CHECK (✓) THE PROGRAM(S) FOR WHICH EACH APPLYING IMMIGRANT HAS SATISFACTORY IMMIGRATION STATUS. (SEE "HOW TO COMPLETE" INSTRUCTION BOOK, PUB-1301 STATEWIDE.)

LN	FIRST NAME	MI	LAST NAME	Check **either "CITIZEN / NATIONAL" or "IMMIGRANT" for** each person.		***IMMIGRANT Number (If Applicable)***	**CERTIFICATION**	Date	TA	FS	MA	MSP	CC	FC	S	EMRG
01				☐ CITIZEN/ NATIONAL	☐ **IMMIGRANT**	A	Sign Name X									
02				☐ CITIZEN/ NATIONAL	☐ **IMMIGRANT**	A	Sign Name X									
03				☐ CITIZEN/ NATIONAL	☐ **IMMIGRANT**	A	Sign Name X									
04				☐ CITIZEN/ NATIONAL	☐ **IMMIGRANT**	A	Sign Name X									
05				☐ CITIZEN/ NATIONAL	☐ **IMMIGRANT**	A	Sign Name X									
06				☐ CITIZEN/ NATIONAL	☐ **IMMIGRANT**	A	Sign Name X									
07				☐ CITIZEN/ NATIONAL	☐ **IMMIGRANT**	A	Sign Name X									
08				☐ CITIZEN/ NATIONAL	☐ **IMMIGRANT**	A	Sign Name X									

8

9

By checking a box above and by signing the certification in Section 9, 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 this Certification may result in information about applying 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), Medicare Savings Program (MSP), Child Care Assistance (CC), Foster Care (FC) and Services (S) Programs.

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

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

NON-CUSTODIAL PARENT/CHILD SUPPORT/MEDICAL SUPPORT INFORMATION

DO NOT WRITE IN SHADED AREAS

If you are applying for Temporary Assistance, you must help us obtain child support/medical support for you and your children. If you are applying for Medical Assistance **only**, you may have to help us obtain medical support for yourself and your applying children. If you are applying for Child Care Assistance and/or Foster Care, you may have to help us obtain child support for the children for whom you are applying. If you have questions, see the "How to Complete" instruction book (PUB-1301 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			SOCIAL SECURITY NUMBER
		MONTH	DAY	YEAR	
A.					
B.					
C.					
D.					
E.					

10

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

WHO	AMOUNT RECEIVED	HOW OFTEN	FROM WHOM
	$		
	$		
	$		
	$		

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

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

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

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

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

ADDRESS	CITY	COUNTY	STATE	ZIP CODE

11

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

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

12

TEEN PARENT INFORMATION

Is there a teen parent under age 18 in the household?
☐ Yes ☐ No

13

Who _____

Does the teen parent's child live in the household?
☐ Yes ☐ No

Name of teen parent's child _____

TEEN PARENT:

LN NO. _____ Marital Status _____

High School Diploma? _____

LN NO. _____ Marital Status _____

High School Diploma? _____

TEEN PARENT CHILDREN

LN NO. _____ LN NO. _____

INCOME INFORMATION:

Indicate if you or anyone who lives with you receives money from:	YES	NO	WHO	AMOUNT/VALUE	WHO	AMOUNT/VALUE
Wages, Salary, Including Overtime, Commissions, Training Programs, Tips 1						
Self-Employment 2						
Unemployment Insurance Benefits 3						
Supplemental Security Income (SSI) Benefits 4						
Social Security Disability Benefits 5						
Social Security Dependent Benefits 6						
Social Security Survivor's Benefits 7						
Social Security Retirement Benefits 8						
Railroad Retirement Benefits 9						
Retirement Benefits (Pensions) 10						
Dividends/Interest from Stocks, Bonds, Savings, etc. 11						
Workers' Compensation 12						
NYS Disability Benefits 13						
Veteran's Pensions/Benefits/Aid and Attendance 14						
Public Assistance Grant 15						
GI Dependency Allotments 16						
Education Grants **or** Loans 17						
Contributions/Gifts (Received) 18						
Foster Care Payments (Received) 19						
Child Support Payments (Received) 20						
Alimony/Support (Received) 21						
Private Disability Insurance-Health/Accident Insurance Policy Income 22						
No Fault Insurance Benefits 23						
Union Benefits (Including Strike Benefits) 24						
Loans (Received) 25						
Income from a Trust (Including income you are currently entitled to receive, or were entitled to receive in the past, that has not been distributed.) 26						
Training Allotments 27						
Rental Income (Received) 28						
Boarders/Lodgers Income (Received) 29						
OTHER INCOME *(Please Specify)*						

DO NOT WRITE IN SHADED AREAS

CD	INCOME			
01	LN No.	SOURCE CODE	AMOUNT	PERIOD
20				
49				
45				
42				
43				
44				
38				
39				
03				
59				
33				
55				
37				
10				
06				
02				
50				
31				
14				

CONSIDER

- ✓ Child Support Pass-Through
  - ☐ Explained ☐ Budgeted
- ✓ FS Aged/Disabled Indicator
- ✓ Disability Review
- ✓ Refugee Matched Grants

STEP- PARENT/IMMIGRANT SPONSOR INFORMATION

Answer all Questions listed below

	YES	NO	WHO?
Does the step-parent of any children who live with you have any resources or receive any income of any kind? 15			
Is anyone in your household an immigrant who was sponsored for admission into the U.S.?			

NAME OF SPONSOR: TELEPHONE NO.:

ADDRESS:

NEEDED	REFERRAL	COMPLETED
	UIB	

EMPLOYMENT INFORMATION

I am currently: ☐ employed ☐ self-employed ☐ unemployed

Gross Income $ _____ Current hours worked Monthly _____

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

Employer's Name and Address: 1

_____ Phone No. _____

_____

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

Who: _____

Gross Income $ _____ Current hours worked Monthly _____

Paid: ☐ Weekly ☐ Bi-Weekly ☐ Monthly Day of the week paid _____ 2

Employer's Name and Address:

_____ Phone No. _____

_____

Is health insurance available through your employer? ☐ Yes ☐ No

Does anyone else have health insurance with their employer? ☐ Yes ☐ No

Who: _____ 3

Name of Insurance Company: _____

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

Who: _____ 4

Does anyone have other employment-related expenses? ☐ Yes ☐ No

Who: _____ 5

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

Who: _____ When: _____

Where: _____ 6

Why did you (or they) stop working? _____

_____

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

Who: _____ When: _____ 7

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

Who: _____ 8

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

_____ 9

_____

Could you accept a job today? ☐ Yes ☐ No 10

If not, why? _____

DO NOT WRITE IN THE SHADED AREAS

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

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

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

CHILD/DEPENDENT CARE EXPENSES

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

EDUCATION/TRAINING

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

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

Who _____ 1

Dates attended _____

Dates completed _____

Is or has been in any training program? ☐ 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 under 16 years of age and is attending school? ☐ Yes ☐ No

Who _____

School _____

Who _____

School _____

Who _____

School _____ 4

Who _____

School _____

Who _____

School _____

Who _____

School _____

DO NOT WRITE IN SHADED AREAS

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

NEEDED	REFERRALS	COMPLETED
	Supportive Services	

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

RESOURCES INFORMATION

INDICATE IF YOU OR ANYONE WHO LIVES WITH YOU WHO IS APPLYING:		YES	NO	WHO	IF YES, GIVE AMOUNT/VALUE	WHO	IF YES, GIVE AMOUNT/VALUE
Has cash on hand	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						
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 applying 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 applying or living with you) ever created a trust in the past or transferred any assets into a trust within the past 60 months? If yes, when? _____	23						

VEHICLE INFORMATION

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

***IF EXEMPT, WHY?**

DO NOT WRITE IN SHADED AREAS

NEEDED	REFERRAL	COMPETED
	Legal	
	Resource	

LIFE INSURANCE

FACE 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

MEDICAL INFORMATION

INDICATE IF **YOU OR ANYONE WHO LIVES WITH YOU** WHO IS APPLYING:	YES	NO	IF YES, WHO
Has any medical bills or medically-related expenses 1			
Is on Medicaid with a spendown 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			
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			

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DO NOT WRITE IN SHADED AREAS

POLICY NO.:

INSURANCE COMPANY NAME:

If Pregnant, Please Give Due Date: _____ 15

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

CONSIDER

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

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	

RETROACTIVE MEDICAID	WHO	DATE

RECURRING MEDICAL EXPENSES	WHO	AMOUNT $	AMOUNT $

MEDICAL BILLS: ☐ YES ☐ NO

TPHI: ☐ YES ☐ NO

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 plans 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)
☐ MA ☐ FHPLUS								☐	☐
☐ MA ☐ FHPLUS								☐	☐
☐ MA ☐ FHPLUS								☐	☐
☐ MA ☐ FHPLUS								☐	☐

SHELTER

WHAT IS YOUR LANDLORD'S NAME?

_____

WHAT IS YOUR LANDLORD'S ADDRESS?

_____

_____

_____

WHAT IS YOUR LANDLORD'S PHONE NUMBER?

( ) _____

	YES	NO	IF YES, GIVE AMOUNT
Do **you (or anyone who lives with you)** have a rent, mortgage or other shelter expense?			$
Do **you (or anyone who lives with you)** have a heat bill separate from your rent or shelter expense?			$
Do **you (or anyone who lives with you)** have the following expenses separate from your rent or shelter expense?	YES	NO	IF YES, GIVE AMOUNT
• Electricity 1			$
• Gas 2			$
• Other utilities (water, etc.) 3			$
• Air conditioning 4			$
• Utility installation fees 5			$
Does any person, group or organization outside the household pay any of the household expenses? 6			$
Do you live in public housing? 7			
Do you live in Section 8 or other subsidized housing? 8			
Do you live in a drug/alcohol rehab. facility? 9			
Do you live in a domestic violence shelter? 10			

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DO NOT WRITE IN SHADED AREAS

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

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

CONSIDER

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

ADDITIONAL INFORMATION

OTHER EXPENSES

INDICATE IF **YOU OR ANYONE WHO LIVES WITH YOU** WHO IS APPLYING:		YES	NO	IF YES, GIVE AMOUNT
Pays child support	1			$
Pays alimony	2			$
Pays child care	3			$
Pays dependent care	4			$
Pays tuition and fees	5			$
Has additional expenses Specify _____	6			$

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Do you or anyone who lives with you who is applying owe at least four months' court-ordered support for a child under age 18?	7	☐ YES	☐ NO

OTHER INFORMATION

Do you buy or plan to buy meals from a home delivery or communal dining service?	8	☐ YES	☐ NO
Are you able to prepare meals at home?	9	☐ YES	☐ NO
Have you or anyone in your household ever been in the U.S. military? Who? _____	10	☐ YES	☐ NO
Has your spouse ever been in the U.S. military?	11	☐ YES	☐ NO
Is anyone in your household a dependent of someone who is or was in the U.S. military? Who? _____	12	☐ YES	☐ NO

22

Do you or does anyone who lives with you receive assistance or services **now?** ☐ YES ☐ NO

IF YES, WHO 13	TYPE OF ASSISTANCE	LOCATION RECEIVED	DATES RECEIVED

Have you or anyone who lives with you received assistance or services **in the past?** ☐ YES ☐ NO

IF YES, WHO 14	TYPE OF ASSISTANCE	LOCATION RECEIVED	DATES RECEIVED

NEEDED	REFERRALS	COMPLETED	CONSIDER
	Services		✓ FS Dependent Care Deductions
	UIB		

DO NOT WRITE IN SHADED AREAS

HOW OFTEN PAID	LEGALLY OBLIGATED		CHILD IN FS HH	
	Yes	No	Yes	No

VETERAN STATUS	VETERAN CODE

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

PROPERTY TRANSFER STATUS

I have ☐ **I have not** ☐ sold, transferred or given away any of my property to anyone to get Temporary Assistance or Food Stamp Benefits.

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

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

Actual Expenses	$
- Actual Income	$
= Difference	$

	YES	NO
Does Client Receive Contribution Towards Difference	☐	☐

If Yes, From Whom? _____

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

I CONSENT TO WITHDRAW MY APPLICATION FOR:

☐ Temporary Assistance ☐ Food Stamp Benefits ☐ Medical Assistance

☐ Medicare Savings Program ☐ Services

☐ One-Time/Emergency Payment **Only**

I UNDERSTAND THAT I MAY REAPPLY AT ANYTIME.

SIGNATURE: **x** _____ DATE: _____

EMERGENCY CASH ASSISTANCE

Is there an immediate need?
If Not, Why Not? _____

_____

_____

_____

NOTES/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 application 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 23 or talk to your worker.

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

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

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

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

If a FS claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action. Providing the requested information, 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 application 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 STAMPS AUTHORIZED REPRESENTATIVE - You can authorize someone who knows your household circumstances to **apply** for FS for you. If you do, have them **sign** in the Signature section at the bottom of page 16. You can also authorize someone outside your household to get FS for you or to use them to buy food for you. If you would like to authorize someone, print the person's name, address and phone number directly below.

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

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

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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.

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

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 change in my needs, income, property, living arrangements or address to the best of my knowledge or belief.

If I am applying for child care assistance, I agree to inform the agency **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.

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

READ THE IMPORTANT INFORMATION BELOW AND SIGN AT THE BOTTOM.

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 due to me at the time of my first payment of (1) retroactive Supplemental Security Income (SSI) benefits that I may receive upon an application for SSI or (2) retroactive SSI benefits I may receive if I am terminated or suspended from receiving SSI benefits and am later reinstated.

I understand that the local social services district may take from my SSI payment the amount of Public Assistance (except assistance paid wholly or partly with federal funds) that was paid to me during the period beginning with my first day of eligibility for SSI or the first day to which SSI benefits were reinstated after a period of suspension or termination and ending with the month that SSI payments actually began (or the following month if the local social services district cannot stop delivery of my last public assistance payment during the month that SSI payments began).

After taking this money from my SSI check(s), the local social services district will pay me the balance; if there is any, no later than 10 working days from the date it receives my SSI payment. I also understand that if the district takes more money than I believe was paid to me as Public Assistance, I will be given an opportunity for a hearing.

I understand that:

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

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

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

NYS Agency-Based Voter Registration Form

ESTE FORMULARIO ESTÁ DISPONIBLE EN ESPAÑOL

本表格有中文文本

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

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

☐ NO because I choose not to register OR

☐ I am already registered at my current address OR

☐ I asked for and received a mail registration form.

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

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

_____ (Please Print Name)

Qualifications for Registration

You Can Use This Form To:

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

To Register You Must:

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

IMPORTANT!

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

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

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with *New York State Board of Elections, 40 Steuben Street, Albany, New York 12207-2109.*
Tele: 1-800-469-6872, TTY 1-800-533-8683; or visit our web site - www.elections.state.ny.us

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

Vote New York

VOTER REGISTRATION FORM

VOTER REGISTRATION APPLICATION (instructions on back)

NVRA-05 (10/03)

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

1 Are you a U.S. citizen? Yes ☐ No ☐
If you answered NO, do not complete this form.

2 I will be 18 years old on or before election day: Yes ☐ No ☐
If you answered NO, do not complete this form, unless you will be 18 by the end of the year.

For Board use only!

3 Last Name | First Name | Middle Initial | Suffix

4 Address Where You Live (do not give P.O. address) | Apt. No. | City/Town/Village | Zip Code | County

5 Address Where You Get Your Mail (if different from above) | P.O. box, star rte., etc. | Post Office | Zip Code

6 Date of Birth

7 Sex (circle) M F

8 Home Tel. Number (optional)

9 ID Number - Check the applicable box and provide your number
☐ New York Driver's License Number ☐ Last four digits of your Social Security number
➜
☐ I do not have a New York driver's license number or a Social Security number.

10 The last year you voted | Your Address was (give house number, street, and city)
In county/state | Under the name (if different from your name now)

11 **Choose a Party** — Check one box only
☐ REPUBLICAN PARTY
☐ DEMOCRATIC PARTY
☐ INDEPENDENCE PARTY
☐ CONSERVATIVE PARTY
☐ WORKING FAMILIES PARTY
☐ OTHER (write in)_____
☐ I DO NOT WISH TO ENROLL IN A PARTY

Please note: In order to vote in a **primary election,** you must be enrolled in one of these parties.

12 **AFFIDAVIT**: I swear or affirm that
- I am a citizen of the United States.
- I will have lived in the county, city, or village for at least 30 days before the election.
- I 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↓

X _____ Date

Please do not write in this space

TO COMPLETE THIS FORM:

***Box 1*:** Must be completed. If you answer NO, do not complete this form.

Box 2: Must be completed, however if you check NO, do not complete this form UNLESS you are a New York resident who will be 18 by the end of this year.

Box 4: Give your home address.

Box 5: Give your mailing address if it is different from your home address (post office box no., star route or rural route no., etc.)

Box 8: The completion of this box is optional.

Box 9: Must be completed. If you have a current New York driver's license, you must provide that number. If you do not have a current New York driver's license, you must provide the last four digits of your social security number.

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: In order to vote in a party primary, you must be enrolled in one of New York's 5 constituted parties. Check one box only.

Box 12: This application must be signed and dated in ink.

NEW YORK STATE
HOW TO COMPLETE THE
TEMPORARY ASSISTANCE (TA) - MEDICAL ASSISTANCE (MA) - MEDICARE SAVINGS PROGRAM (MSP) - FOOD STAMP BENEFITS (FS) - SERVICES (S), including Foster Care (FC) - CHILD CARE ASSISTANCE (CC) APPLICATION

Whenever you see "Temporary Assistance" or "TA" on the application, it means "Family Assistance" and "Safety Net Assistance". We call both of these Public Assistance Programs "Temporary Assistance". Social Services programs were created to give temporary help to those in need. Certain programs now have time limits on how long you can get help. It is important for you to achieve self-sufficiency as soon as you can. The local Department of Social Services is here to help you with your goal of self-sufficiency. In order to help you, we must know who you are and what you need. This is why you have been asked to fill out this Application. The things this application will tell us about you are:

- **Who you are**
- **Where you live**
- **How you have been living**
- **How we can help you**

The directions and application are numbered by Section to help you. You may write over these numbers when appropriate.

- PLEASE PRINT CLEARLY
- DO NOT WRITE IN THE SHADED AREAS
- BE SURE TO COMPLETE EACH SECTION THAT APPLIES TO YOU
- IF YOU ARE APPLYING AS SOMEONE'S REPRESENTATIVE, PLEASE PRINT INFORMATION ABOUT THAT PERSON, NOT YOURSELF.
- IF YOU HAVE ANY DISABILITIES, WHICH PREVENT YOU FROM COMPLETING THIS APPLICATION AND/OR WAITING TO BE INTERVIEWED, PLEASE NOTIFY THE RECEPTIONIST. THE AGENCY WILL MAKE EVERY EFFORT TO PROVIDE REASONABLE ACCOMMODATION TO ADDRESS YOUR NEEDS.

WITHDRAWAL: IF YOU WANT TO WITHDRAW YOUR APPLICATION, TALK TO YOUR ELIGIBILITY EXAMINER.

In addition to the LDSS-2921: "Application", make sure you have been given copies of:

- **LDSS-4148A**: "What You Should Know About Your Rights and Responsibilities"
- **LDSS-4148B**: "What You Should Know About Social Services Programs"
- **LDSS-4148C**: "What You Should Know If You Have An Emergency"

PAGE 1 OF THE APPLICATION

1

PROGRAMS:

Check (✓) the box for EACH program that you or any household member wants to apply for. Because of welfare reform, an application for Temporary Assistance is no longer automatically an application for Medical Assistance. **If you want to apply for both Temporary Assistance and Medical Assistance check (✓) the Temporary Assistance and Medical Assistance box. If you want to apply for the Medicare Savings Program check (✓) the Medicare Savings Program box. Medical Assistance includes the Medicaid, Family Health Plus, Child Health Plus A, Medicaid Buy-In for Working People With Disabilities and Family Planning Benefit programs. If you want to apply for any of these programs, check (✓) the Medical Assistance box. If you are eligible for Temporary Assistance but decide you only need Child Care Assistance check (✓) Child Care in lieu of Temporary Assistance. If you change your mind and decide you need Temporary Assistance you can apply at any time.** If you check (✓) the "Emergency Payment Only" box, you are indicating that you are only applying for a one-time only emergency payment and an eligibility determination **will not** be made for any other programs such as Temporary Assistance, Food Stamp Benefits or Medical Assistance.

If you are applying for Temporary Assistance and Food Stamp Benefits, and/or Medical Assistance, usually you will be required to have only a single interview for all programs.

2

DO YOU WANT TO RECEIVE NOTICES IN: Check (✓) the "Spanish and English" **or** "English Only" box.

WHAT IS YOUR PRIMARY LANGUAGE: Check (✓) the English or Spanish or Other box and enter your primary language.

3

APPLICANT INFORMATION

NAME: PRINT your legal name including your first name, middle initial, and last name.

MARITAL STATUS: PRINT whether you are **now** single, married, widowed, legally separated or divorced.

PHONE NO: PRINT your home phone number. Include your area code.

RESIDENCE ADDRESS: PRINT the house number, street, avenue, road, etc., where you now live.
Apt No: PRINT the number of your apartment.
City: PRINT the city you live in.
County: PRINT the county you live in.
State: PRINT the state you live in.
Zip Code: PRINT the zip code for your address.

CARE OF NAME: If you receive your mail in care of someone else, PRINT that person's name.

MAILING ADDRESS: If you get your mail somewhere other than where you live, PRINT that address in this space.

If an agency is helping you apply, PRINT the name of the agency, the person helping you from the agency and the person's telephone number.

HOW LONG HAVE YOU LIVED AT PRESENT ADDRESS: PRINT the number of years and/or months that you have lived where you are now living.

PAGE 1 OF THE APPLICATION

APPLICANT INFORMATION (cont'd)

3

ANOTHER PHONE: If you can be reached at someone else's phone, PRINT that person's name and telephone number. If you are working, PRINT your employer's name and telephone number.

DIRECTIONS TO HOME: 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.

4

FOOD STAMP BENEFITS APPLICANTS: You have the right to turn in your Food Stamp Benefits application during office hours on the same day you get the form. It must be accepted if it has at least your name, address (if you have one) and signature. To figure out if you can get Food Stamp Benefits, however, you will have to fill out the whole form.

5

DO ANY OF THESE APPLY TO YOU? Check (✓) EACH item that applies to you.

PAGES 2 AND 3 OF THE APPLICATION

HOUSEHOLD MEMBERS INFORMATION

6

LIST THE NAMES OF EVERYONE WHO LIVES WITH YOU, EVEN IF THEY ARE NOT APPLYING WITH YOU. PRINT your full name first. Then PRINT the names of the other people who live with you:

- Check (✓) the type(s) of Assistance each person is applying for: Temporary Assistance (TA), Food Stamp Benefits (FS), Medical Assistance (MA), Medicare Savings Program (MSP), Child Care Assistance (CC), Foster Care (FC), and/or Services (S), or Emergency Payment **Only** (EMRG).

  NOTE: Applicants for MSP complete all sections required for MA.

- PRINT the date of birth and sex for **each** person who is applying.
- For each person who is applying, PRINT their relationship to you (For example: wife, son, foster child, friend, roomer, boarder, etc.).
- PRINT each person's Social Security Number **unless that person is:**
  - Not applying for assistance or services of any kind; or
  - A pregnant woman who is applying **only** for Medical Assistance; or
  - An immigrant who is applying **only** for Medical Assistance or benefits as a result of an emergency medical condition; or
  - An adult applying **only** for adult protective services; or
  - Applying only for child care assistance. (You do not have to list the social security numbers if you are applying only for child care assistance unless you are applying for child care as part of a preventive services case or in lieu of receiving temporary assistance.)

NOTE: Other Services, such as foster care, child protective, child preventive, and counseling, are funded by a variety of funding 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 to you if you do not furnish a Social Security Number. We are therefore requesting a Social Security Number of 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 (1-12) completed for each person applying for assistance. If more than 12 years, enter 13. If no formal schooling, enter 0. If you are applying **only** for Medical Assistance or **only** for Services, you do not have to answer this question.

PAGES 2 AND 3 OF THE APPLICATION

HOUSEHOLD MEMBERS INFORMATION (cont'd)

6

- Purchasing or Preparing Meals: It is important to check (✓) YES or NO to the Question "Does this person (including your minor children) buy food or prepare meals with you?" for every person who lives with you. Sometimes, people who buy food and prepare meals separately may get more Food Stamp Benefits.
- Race/Ethnic Affiliation: You must fill out this section for each person applying for assistance, including Child Care Assistance. Enter **Yes** or **No** if your ethnicity is Hispanic or Latino, also enter the letter that best tells your racial background. This information is required by the Federal government. If you do not fill out this section, an interviewer in the agency must fill it out based on observation.

  If you are applying for Medical Assistance **only** you may fill out this section if you want to. If you do not fill out this section, an interviewer in the agency may fill it out based on observation.

  If you are applying for Foster Care, fill out this section only for the children for whom you are seeking foster care. If you do not fill out this section, an interviewer from the agency may fill it out based on observation.

NOTE: If you are applying for Services and do not fill out this section, it may not be possible to provide you with certain services. This depends upon the source of funds we use to pay for those services.

PAGE 2 OF THE APPLICATION

OTHER NAMES INFORMATION

7

PRINT any maiden names, names from a previous marriage, or other names which any person listed above has used or now uses.

PAGE 4 OF THE APPLICATION

CITIZENSHIP/IMMIGRATION STATUS INFORMATION

Complete this section if you are applying for **Medical Assistance, Temporary Assistance, Food Stamp Benefits, Child Care Assistance or Foster Care**.

NOTE: You **DO NOT** have to complete this certification if you are applying for **Medical Assistance only** and

- You are pregnant, or
- You are applying **only** for coverage for the treatment of an **emergency** medical condition, or
- 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.** If you have any questions about your immigration status, please see LDSS-4148B: "What You Should Know About Social Services Programs" or talk to your worker.

8

NOTE: You **DO** have to fill out this section if you are:

- Applying for Medical Assistance **only,** but you do not have to include people who do not want Medical Assistance.
- Applying for Child Care Assistance **only,** but you need to fill out the information only for the children who would be receiving Child Care Assistance.
- Applying for Foster Care **only**, but you need to fill out the information only for the children who would be receiving Foster Care.
- Applying for other Services under certain circumstances.

NOTE: If you are applying for other **Services** and do not provide the information, it may not be possible to provide you with certain services. This depends upon the source of funds we use to pay for those Services.

PAGE 4 OF THE APPLICATION

CERTIFICATION OF CITIZENSHIP/IMMIGRATION STATUS INFORMATION (cont'd)

If you are applying for **Medical Assistance, Temporary Assistance, Food Stamp Benefits, Child Care Assistance or Foster Care,** you **must complete and sign** this written certification of citizenship or satisfactory immigration status.

NOTE: The term "satisfactory immigration status" means an immigration status which does not make the individual ineligible for benefits under the applicable program. If you have any questions about your immigration status, please see LDSS-4148B: "What You Should Know About Social Services Programs" or talk to your worker.

NOTE: You **DO NOT** have to sign this certification if you are applying for **Medical Assistance only** and:

- You are pregnant, or
- You are applying **only** for coverage for the treatment of an **emergency** medical condition, or
- You are *not* a **U. S. citizen, Native American or a national of the United States** *or* **an immigrant with satisfactory immigration status**.

NOTE: You **MUST** sign this certification 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 applying for:

- Temporary Assistance (where there are children in the household or a member of the household is pregnant); or
- Food Stamp Benefits; or
- Medical Assistance (except if the applicant is pregnant); or
- Medicare Savings Program; or
- Child Care Assistance (certification is needed for the children **only**); or
- Foster Care (Certification is needed for the children **only**); or
- Other Services under certain circumstances; or
- Emergency Payment **Only.**

NOTE: If you are applying for other **Services** and do not sign the certification, it may not be possible to provide you with certain Services. This depends upon the source of funds we use to pay for those Services.

A signature and date of signing must be given for all persons applying for these benefits, except as noted above.

- An adult household member or authorized representative may sign for all applying household members.
- If an applying household member is under 18 (or is 18 or older but is unable to sign their own name due to a medical impairment or disability), a household member who is 18 or older must sign for them.

NOTE: When signing for another individual, sign *your* own name. **For example**, Mary Doe, when signing for infant Johnny Doe, must sign Mary Doe.

A *parent* without satisfactory status may sign for his/her *child* who has satisfactory status. **For example,** a mother who does not have satisfactory immigration status may still sign the certification for her children who are U. S. citizens.

PAGE 4 OF THE APPLICATION

CERTIFICATION OF CITIZENSHIP/IMMIGRATION STATUS INFORMATION (cont'd)

NOTICE

You should not sign this declaration for yourself or for another person who is not a citizen, Native American or national of the United States or an immigrant with satisfactory immigration status. Noncitizens without satisfactory immigration status are not eligible for any Temporary Assistance, Food Stamp Benefits or Medical Assistance benefits (except Medical Assistance for a pregnant person or Medical Assistance coverage ONLY for treatment of an emergency medical condition). Such persons may also be ineligible for certain Services.

We may confirm the immigration status of any or all household members applying for Temporary Assistance, Medical Assistance benefits, Food Stamp Benefits or Services by submitting the information you give us to the United States Citizenship and Immigration Services (USCIS). Information received from the USCIS may affect your household's eligibility and level of benefits.

PAGE 5 OF THE APPLICATION

NON-CUSTODIAL PARENT/CHILD SUPPORT/MEDICAL SUPPORT INFORMATION

10 **TEMPORARY ASSISTANCE, MEDICAL ASSISTANCE, MEDICARE SAVINGS PROGRAM, CHILD CARE ASSISTANCE AND SERVICES APPLICANTS ONLY:**
Fill out this section if any of the following apply:

1. You or anyone who lives with you is pregnant and the father of the unborn child lives someplace else.
2. You are applying for any person under 21 and this person's parent(s) lives outside of the household.
3. You are under 21 and your parent(s) do not live with you.

NOTE: You do not need to fill out this section if you are applying only for Medical Assistance and you are pregnant, gave birth within the past two months, or are applying for children under 21 only. If you want to pursue medical support from a non-custodial parent, you must complete this section.

ABSENT/DECEASED SPOUSE INFORMATION

11 **TEMPORARY ASSISTANCE, MEDICAL ASSISTANCE, MEDICARE SAVINGS PROGRAM, CHILD CARE ASSISTANCE AND SERVICES APPLICANTS ONLY**: If anyone who is applying is married and their husband or wife does *not* live with them, fill out this section as best you can. If you don't know where this person lives now, PRINT their last known address.

ABSENT CHILD INFORMATION

12 **TEMPORARY ASSISTANCE, MEDICAL ASSISTANCE, MEDICARE SAVINGS PROGRAM, CHILD CARE ASSISTANCE AND SERVICES APPLICANTS ONLY.** If anyone applying has a child under 18 living someplace else, please list the parent and child.

TEEN PARENT INFORMATION

13 Only applicants for Temporary Assistance must complete this section. If there are teen parents under the age of 21 in your household who are applying for assistance, list their names. If the teen parent's child lives in the household, list the child's name.

PAGE 6 OF THE APPLICATION

INCOME INFORMATION

14 Check (✓) YES or NO for yourself or anyone who lives with you. For each "Yes" answer, PRINT the dollar ($) amount or value and the name of the person who gets the income.

NOTE: Foster Care Payments and Food Stamp Benefits - If you get foster care payments for the care of a foster child or adult, you have two choices. You can choose to include the foster care child or adult and the foster care payments in your Food Stamp Benefits household, or you can choose **not** to include the foster care child or adult and the payments. Ask your worker which way would give you more Food Stamp Benefits.

STEP-PARENT/IMMIGRANT SPONSOR INFORMATION

15 Check (✓) YES or NO for yourself, spouse and everyone who is applying for assistance. For each "YES" answer, PRINT the name of the person that the answer refers to.

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EMPLOYMENT INFORMATION

Complete this page for yourself and for everyone who is applying for assistance.

16 **NOTE:** If you are employed, you may still be eligible for Temporary Assistance, Medical Assistance or other health care programs, Services and/or Food Stamp Benefits and help with paying your child care costs.

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EDUCATION/TRAINING INFORMATION

17 Complete this page for yourself and for everyone who is applying for assistance, including Child Care Assistance and/or Foster Care or other services. Be sure to answer the question about where your children go to school.

NOTE: If you are applying **only** for Medical Assistance, you do not need to fill out this page.

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RESOURCES INFORMATION

18 Check (✓) YES or NO for each question for yourself and everyone who is applying for assistance. For each "Yes" answer, PRINT the dollar ($) amount or value and the name of the person who has the resource. **Be sure to list any joint holdings.** Temporary Assistance and Medical Assistance applicants must also answer these questions about **legally responsible relatives. These are people who are required by law to support you financially, such as** your spouse, and if you are under 21, your parents or stepparents that live with you.

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RESOURCES INFORMATION (cont'd)

NOTE: You **do no**t have to fill out this section:

- If you are applying **only** for Medical Assistance for children under **19,** or are a pregnant woman.
- If you are applying **only** for Services *(other than Foster Care)*, and/or Child Care Assistance**.**
- If you are applying **only** for Food Stamp Benefits, you **do not** have to answer the question on life insurance.

NOTE: If you are applying for Foster Care, you must fill out this section.

Has Resources Other Than Those Listed Above: Include items such as vacation homes, campers, snowmobiles, boats, etc.

NOTE: It is very important to let your worker know right away if you get or are expecting to get 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 the LDSS-4148A: "What You Should Know About Your Rights and Responsibilities" for more information about lump sums.

NOTE: 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 of the month in which you are in receipt of nursing facility services and have submitted an application for Medical Assistance, you may not be eligible to receive nursing facility services or home and community-based waivered services under the Medical Assistance Program.

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MEDICAL INFORMATION

19

Check (✓) YES or NO for yourself and everyone who is applying for assistance. For each "YES" answer, PRINT the requested information. Be sure to list all health and hospital/accident insurance that you have or that is available to anyone applying. Medical Assistance 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 Medical Assistance at the time. We can pay you even if the doctor or other provider does not accept Medical Assistance, but we can only pay you the amount Medical Assistance pays and only if the bill was for services that Medical Assistance covers.

HEALTH PLAN SELECTION

If you are determined eligible for Family Health Plus, you must select a health plan in order to receive medical care. If you want to keep the doctor you have now, you need to join a health plan that your doctor belongs to. If you want to pick a new doctor or health center, call the plan you want for help. Once enrolled in a health plan, you must use the doctors and hospitals under that plan.

Some people enrolled in Medicaid are required to join a health plan. Others are not. If you or family members are determined eligible for Medicaid and you are in a county that requires people to join a health plan, we will enroll you in the plan you chose, if that plan participates in Medicaid. If you are in a county that does not require people to be in a health plan, we will still enroll you in the plan you chose, unless you tell us that you do not want to be in this plan by checking the box in this section. Your interviewer will discuss this with you.

After the day you apply for Medical Assistance, you must make sure the doctor or other provider accepts Medical Assistance before you get medical care.

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SHELTER INFORMATION

20 PRINT the amount you pay for rent, mortgage, room and board or other housing. If you have a mortgage payment, include property taxes, homeowner's insurance (including fire insurance), and assessments in the Shelter Expenses Amount. Check (✓) YES or NO if you or anyone who lives with you pay for heat or other utilities. Be sure to answer the last question at the end of the section.

NOTE: If you are applying for Foster Care, you must fill out this section.

NOTE: 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.

NOTE: If you are unsure about how to answer any questions about your type of housing or the amount of your shelter expenses, ask your worker.

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OTHER EXPENSES INFORMATION

21 Check (✓) YES or NO for yourself and everyone who is applying for assistance. For each "YES" answer, PRINT a dollar ($) amount.

OTHER INFORMATION

Check (✓) YES or NO for yourself and everyone who is applying for assistance.

NOTE: "U.S. Military" means the:

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- U.S. Army
- U.S. Navy
- U.S. Coast Guard
- U.S. Marines
- U.S. Air Force
- U.S. Merchant Marine during World War II

ASSISTANCE: If you or anyone who lives with you now receives or has ever received Temporary Assistance, Medical Assistance, Food Stamp Benefits, Child Care Assistance or Services, check (✓) the YES box(es). PRINT this person's name, type of assistance, where it was received, and the last date that assistance was received.

PROPERTY TRANSFER STATUS: Check (✓) the **I have** box or **I have not** box.

NOTE: New York State Law provides for fine or jail, or both, for a person found guilty of obtaining Temporary Assistance, Medical Assistance, Food Stamp Benefits, Services or Child Care Assistance by hiding the facts or not telling the truth.

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DO NOT WRITE ON THIS PAGE UNLESS you want to withdraw your application for one or more of the programs listed in the top right hand corner of Page 13 of the Application. To withdraw your application for a program, put a checkmark (✓) in the box next to that program and sign where indicated. Your application will only be withdrawn for the program(s) you check.

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23 PRIVACY ACT STATEMENT/REIMBURSEMENT OF MEDICAL EXPENSES/SUPPORT/NON-DISCRIMINATION NOTICE: Read this section carefully or have someone read it to you.

PAGE 14 OF THE APPLICATION

24 **FOOD STAMP BENEFITS AUTHORIZED REPRESENTATIVE:** If you are applying for Food Stamp Benefits and you want someone from outside your household to get the Food Stamp Benefits for you or to buy the food for you, PRINT their name, address and telephone number.

25 **PENALTIES/FOOD STAMP BENEFITS (FS) PENALTY WARNING:** Read this section carefully or have someone read it to you.

NOTE: New York State Law provides for fine or jail, or both, for a person found guilty of obtaining Temporary Assistance, Medical Assistance, Medicare Savings Program, Food Stamp Benefits, Services or Child Care Assistance by hiding the facts or not telling the truth.

PAGE 15 AND 16 OF THE APPLICATION

26 **ASSIGNMENTS, AUTHORIZATIONS & CONSENTS:** Read this section carefully or have someone read it to you.

NOTE: For **Lifeline**, Temporary Assistance and/or Food Stamp applicants/recipients must check (✓) the box if you ***do not*** authorize the NYS Office of Temporary and Disability Assistance to possibly disclose 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. Lifeline is the lowest rate available for basic telephone service from telephone service providers.

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

27 **AUTHORIZATION FOR REIMBURSEMENT FROM SSI:** Read this section carefully or have someone read it to you. If this is an application for Temporary Assistance and both husband and wife who live together are applying for Temporary Assistance, both must sign the Signature section at the bottom of the page.

NOTE: The Social Security Administration may treat the date you submit this signed authorization to the local department of social services as the date you first become eligible for SSI if you submit an application for initial SSI benefits within the next 60 days.

28 **SIGNATURES:** Read this section carefully or have someone read it to you. New York State Law provides for fine or jail, or both, for a person found guilty of obtaining Temporary Assistance, Medicare Savings Program, Medical Assistance, Food Stamp Benefits, Child Care Assistance or Services by hiding the facts or not telling the truth.

Sign your name. Date the application. When **both** husband and wife who live together are applying for Temporary Assistance, Medical Assistance, Child Care Assistance or Services, **both** must sign. If you are applying **just** for Food Stamp Benefits, only one signature is needed. If you have filled out the application for someone else, sign **your name** here and PRINT the date you signed.

NOTICE:	Applicants for Temporary Assistance, Medical Assistance, Medicare Savings Program, Child Care Assistance, Services and Food Stamp Benefits, who are not satisfied with the action taken on their application, have a right to request a fair hearing by contacting the Office of Administrative Hearings, New York State Office of Temporary & Disability Assistance, PO Box 1930, Albany, New York 12201.

Information from your application will be entered and stored in the Welfare Management System (WMS), a statewide computer system. This system is used to improve the management of Social Services programs and to deter fraud.

NOTE: The last page of this Application is an application to register to vote. If you would like help filling out the voter registration application form, ask your eligibility examiner. Applying to register or declining to register to vote will not affect the amount of assistance that you will be given by this agency.