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**LDSS-3174 Statewide LP (Rev. 7/20)**

This document is being provided in an alternate format (large print, audio or data CD, or Braille) for informational purposes only. Any documents that need to be completed and returned must be completed and returned in written, non-alternative format.

## **NEW YORK STATE RECERTIFICATION FORM FOR CERTAIN BENEFITS AND SERVICES**

If you are blind or seriously visually impaired and need this recertification form in an alternative format, you may request one from your social services district. For additional information regarding the types of formats available and how you can request a recertification form in an alternative format, see the instruction book (PUB-1313 Statewide), available at [www.otda.ny.gov](http://www.otda.ny.gov) or <https://www.health.ny.gov/>.

If you are blind or seriously visually impaired, would you like to receive written notices in an alternative format?

Yes

No

If yes, check the type of format you would like:

Large Print

Data CD

Audio CD

Braille, if you assert that none of the other alternative formats will be equally effective for you

If you require another accommodation, please contact your social services district.

We are committed to assisting and supporting you in a professional and respectful manner. You are responsible for participating in activities, including work activities for Public Assistance and the Supplemental Nutrition Assistance Program, where required, so you can become self-sufficient. Whenever you see “Public Assistance” or “PA” on the recertification form, it means “Family Assistance” and/or “Safety Net Assistance.” We call both programs “Public Assistance.” These PA programs are meant to assist you only until you can fully support yourself and your family. **Please refer to the instruction book (PUB-1313 Statewide) and “What You Should**

**Know” Books 1, 2 and 3 (LDSS-4148A, LDSS-4148B, and LDSS-4148C) when completing this recertification form, and contact your social services district with any questions.**

When you see “MA” on the recertification form, it means “Medicaid.” You may apply for MA using this recertification form only if you are also recertifying for Public Assistance or the Supplemental Nutrition Assistance Program at the same time. If you wish to only recertify for MA, you can go online at <https://nystateofhealth.ny.gov/> and/or call 1-855-355-5777 for more information or to recertify, or you may use the MA-only paper application - Form DOH-4220, which your worker can give you, or call MA help line at 1-800-541-2831. If you want to recertify only for the Medicare Savings Program (MSP), you must apply with Form DOH-4328, which your worker can provide to you. If you have an immediate need for personal care services, you should apply for MA separately using the DOH- 4220 MA application form.

**SECTION 1 CHECK EACH PROGRAM YOU OR ANY HOUSEHOLD MEMBER ARE RECERTIFYING FOR**

- Public Assistance (PA)
- Supplemental Nutrition Assistance Program (SNAP)
- Medicaid (MA) and SNAP
- Medicaid (MA) and PA

**SECTION 2**

**WHAT IS YOUR PRIMARY LANGUAGE?**

- ENGLISH
- SPANISH
- OTHER (specify) \_\_\_\_\_

**DO YOU WANT TO RECEIVE NOTICES IN:**

ENGLISH ONLY

ENGLISH AND SPANISH

**SECTION 3 RECIPIENT INFORMATION**

**PLEASE PRINT CLEARLY**

FIRST NAME \_\_\_\_\_

M.I. \_\_\_\_\_

LAST NAME \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_

PHONE NUMBER AREA CODE (\_\_\_\_\_) \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

APT. NO. \_\_\_\_\_

CITY \_\_\_\_\_

COUNTY \_\_\_\_\_

STATE \_\_\_\_\_

ZIP CODE \_\_\_\_\_

IN 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 \_\_\_\_\_

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 CURRENT ADDRESS \_\_\_\_\_

FORMER ADDRESS \_\_\_\_\_

APT. NO. \_\_\_\_\_

CITY \_\_\_\_\_

COUNTY \_\_\_\_\_

STATE \_\_\_\_\_

ZIP CODE \_\_\_\_\_

IF YOU ARE CURRENTLY WITHOUT A HOME, CHECK  
HERE  \_\_\_\_\_

AGENCY HELPING APPLICANT/CONTACT PERSON  
\_\_\_\_\_

PHONE NUMBER AREA CODE (\_\_\_\_\_) \_\_\_\_\_

DO YOU NEED THE MEDICAID PORTION OF THIS  
RECERTIFICATION FORM AND THE POTENTIAL  
RECEIPT OF ANY MEDICAID COVERAGE TO BE KEPT  
CONFIDENTIAL?

YES

NO

LIST THE THINGS THAT HAVE CHANGED SINCE YOUR APPLICATION OR LAST RECERTIFICATION (such as moved, had a baby, income, etc.) \_\_\_\_\_

## **SECTION 4 – If You Are Reapplying For SNAP:**

You can file a recertification form the day you get it. In order to file a SNAP recertification, it must have, at minimum, your name, address (if you have one) and signature below. You must complete the recertification process, including signing the last page of the recertification and being interviewed. If eligible, you will get SNAP benefits back to the date you filed the recertification. You must be told, within 30 days of the date you turned in (filed) your recertification for SNAP benefits, if your recertification is approved or denied. If your household has little or no income or liquid resources, or if your rent and utility expenses are more than your income and liquid resources, you may be eligible to get SNAP benefits within five calendar days of the date you file. If you are a resident of an institution and are recertifying for both Supplemental Security Income (SSI) and SNAP benefits prior to leaving the institution, the filing date of the recertification is the date you leave the institution.



SNAP RECIPIENT/REPRESENTATIVE SIGNATURE X

\_\_\_\_\_

DATE SIGNED \_\_\_\_\_

## **SECTION 5**

### **DO ANY OF THESE APPLY TO YOU?**

1.  Pregnant
  
2.  Victim of Domestic Violence
  
3.  Need To Establish Parentage
  
4.  Need Child Support
  
5.  Drug/Alcohol Problem
  
6.  Fuel Or Utility Shutoff
  
7.  No Place To Stay/Homeless
  
8.  Fire Or Other Disaster

- 9.  Have No Income
  
- 10.  Serious Medical Problem
  
- 11.  Pending Eviction
  
- 12.  No Food
  
- 13.  Need Foster Care
  
- 14.  Need Child Care
  
- 15.  Problems with English
  
- 16.  Reasonable Accommodations
  
- 17.  Other \_\_\_\_\_

**LDSS-3174 Statewide LP (Rev. 7/20)**

**SECTION 6 – HOUSEHOLD INFORMATION –**

List everybody who lives with you, even if they are not recertifying with you. List yourself on the first line.

LN 01

First Name, Middle Initial, Last Name \_\_\_\_\_

This person is recertifying for:

PA

SNAP

MA

Date of Birth: (mm/dd/yyyy) \_\_\_\_\_

Sex: (M/F) \_\_\_\_\_

Gender Identity (Optional): (Male, Female, Non-Binary, X, Transgender, Different Identity [please describe]) \_\_\_\_\_

Relationship to you **SELF**

Social Security Number of Recertifying Household Members (See instruction book, PUB-1313 Statewide, or talk to your social services district) \_\_\_\_\_

Highest School Grade Completed \_\_\_\_\_

Does This Person (Including Minor Children) Buy Food or Prepare Meals with You?

YES

NO

LN 02

First Name, Middle Initial, Last Name \_\_\_\_\_

This person is recertifying for:

PA

SNAP

MA

Date of Birth: (mm/dd/yyyy) \_\_\_\_\_

Sex: (M/F) \_\_\_\_\_

Gender Identity (Optional): (Male, Female, Non-Binary, X, Transgender, Different Identity [please describe]) \_\_\_\_\_

Relationship to you \_\_\_\_\_

Social Security Number of Recertifying Household Members (See instruction book, PUB-1313 Statewide, or talk to your social services district) \_\_\_\_\_

Highest School Grade Completed \_\_\_\_\_

Does This Person (Including Minor Children) Buy Food or Prepare Meals with You?

YES

NO

LN 03

First Name, Middle Initial, Last Name \_\_\_\_\_

This person is recertifying for:

PA

SNAP

MA

Date of Birth: (mm/dd/yyyy) \_\_\_\_\_

Sex: (M/F) \_\_\_\_\_

Gender Identity (Optional): (Male, Female, Non-Binary, X, Transgender, Different Identity [please describe]) \_\_\_\_\_

Relationship to you \_\_\_\_\_

Social Security Number of Recertifying Household Members (See instruction book, PUB-1313 Statewide, or talk to your social services district) \_\_\_\_\_

Highest School Grade Completed \_\_\_\_\_

Does This Person (Including Minor Children) Buy Food or Prepare Meals with You?

YES

NO

LN 04

First Name, Middle Initial, Last Name \_\_\_\_\_

This person is recertifying for:

PA

SNAP

MA

Date of Birth: (mm/dd/yyyy) \_\_\_\_\_

Sex: (M/F) \_\_\_\_\_

Gender Identity (Optional): (Male, Female, Non-Binary, X, Transgender, Different Identity [please describe]) \_\_\_\_\_

Relationship to you \_\_\_\_\_

Social Security Number of Recertifying Household Members (See instruction book, PUB-1313 Statewide, or talk to your social services district) \_\_\_\_\_

Highest School Grade Completed \_\_\_\_\_

Does This Person (Including Minor Children) Buy Food or Prepare Meals with You?

YES

NO

LN 05

First Name, Middle Initial, Last Name \_\_\_\_\_

This person is recertifying for:

PA

SNAP

MA

Date of Birth: (mm/dd/yyyy) \_\_\_\_\_

Sex: (M/F) \_\_\_\_\_

Gender Identity (Optional): (Male, Female, Non-Binary, X, Transgender, Different Identity [please describe]) \_\_\_\_\_

Relationship to you \_\_\_\_\_

Social Security Number of Recertifying Household Members (See instruction book, PUB-1313 Statewide, or talk to your social services district) \_\_\_\_\_

Highest School Grade Completed \_\_\_\_\_

Does This Person (Including Minor Children) Buy Food or Prepare Meals with You?

YES

NO

LN 06

First Name, Middle Initial, Last Name \_\_\_\_\_

This person is recertifying for:

PA

SNAP

MA

Date of Birth: (mm/dd/yyyy) \_\_\_\_\_

Sex: (M/F) \_\_\_\_

Gender Identity (Optional): (Male, Female, Non-Binary, X, Transgender, Different Identity [please describe]) \_\_\_\_

Relationship to you \_\_\_\_

Social Security Number of Recertifying Household Members (See instruction book, PUB-1313 Statewide, or talk to your social services district) \_\_\_\_

Highest School Grade Completed \_\_\_\_

Does This Person (Including Minor Children) Buy Food or Prepare Meals with You?

YES

NO

LN 07

First Name, Middle Initial, Last Name \_\_\_\_

This person is recertifying for:

PA

SNAP

MA

Date of Birth: (mm/dd/yyyy) \_\_\_\_

Sex: (M/F) \_\_\_\_



Gender Identity (Optional): (Male, Female, Non-Binary, X, Transgender, Different Identity [please describe]) \_\_\_\_\_

Relationship to you \_\_\_\_\_

Social Security Number of Recertifying Household Members (See instruction book, PUB-1313 Statewide, or talk to your social services district) \_\_\_\_\_

Highest School Grade Completed \_\_\_\_\_

Does This Person (Including Minor Children) Buy Food or Prepare Meals with You?

YES

NO

LN 08

First Name, Middle Initial, Last Name \_\_\_\_\_

This person is recertifying for:

PA

SNAP

MA

Date of Birth: (mm/dd/yyyy) \_\_\_\_\_

Sex: (M/F) \_\_\_\_\_

Gender Identity (Optional): (Male, Female, Non-Binary, X, Transgender, Different Identity [please describe]) \_\_\_\_\_

Relationship to you \_\_\_\_\_

Social Security Number of Recertifying Household Members (See instruction book, PUB-1313 Statewide, or talk to your social services district) \_\_\_\_\_

Highest School Grade Completed \_\_\_\_\_

Does This Person (Including Minor Children) Buy Food or Prepare Meals with You?

YES

NO

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

FIRST NAME \_\_\_\_\_

M.I. \_\_\_\_\_

LAST NAME \_\_\_\_\_

FIRST NAME \_\_\_\_\_

M.I. \_\_\_\_\_

LAST NAME \_\_\_\_\_

**SECTION 7**

HAS ANYONE MOVED **INTO** THE HOUSEHOLD IN THE PAST YEAR?

YES

NO

IF YES, INCIDATE BELOW.

NAME \_\_\_\_\_

DID THEY EVER LIVE IN NEW YORK STATE  
BEFORE NOW?

YES

NO

NAME \_\_\_\_\_

DID THEY EVER LIVE IN NEW YORK STATE  
BEFORE NOW?

YES

NO

HAS ANYONE MOVED **OUT** OF THE HOUSEHOLD IN  
THE LAST YEAR?

YES

NO

IF YES, INCIDATE BELOW.

NAME \_\_\_\_\_  
WHEN? \_\_\_\_\_  
NAME \_\_\_\_\_  
WHEN? \_\_\_\_\_

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**LDSS-3174 Statewide LP (Rev. 7/20)**

**SECTION 8 – RACE/ETHNICITY –**

Providing this information is voluntary. It will not affect the eligibility of the persons recertifying or the level of benefits received. The reason for requesting this information is to ensure that program benefits are distributed without regard to race, color, or national origin.

**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)**

**ENTER Y (YES) OR N (NO) FOR HISPANIC OR LATINO**

ENTER Y (YES) OR N (NO) FOR EACH RACE

LN 01

H \_\_\_\_\_

I \_\_\_\_\_

A \_\_\_\_\_

B \_\_\_\_\_

P \_\_\_\_\_

W \_\_\_\_\_

U \_\_\_\_\_

LN 02

H \_\_\_\_\_

I \_\_\_\_\_

A \_\_\_\_\_

B \_\_\_\_\_

P \_\_\_\_\_

W \_\_\_\_\_

U \_\_\_\_\_

LN 03

H \_\_\_\_\_

I \_\_\_\_\_

A \_\_\_\_\_

B \_\_\_\_\_

P \_\_\_\_\_

**W** \_\_\_\_\_

**U** \_\_\_\_\_

LN 04

**H** \_\_\_\_\_

**I** \_\_\_\_\_

**A** \_\_\_\_\_

**B** \_\_\_\_\_

**P** \_\_\_\_\_

**W** \_\_\_\_\_

**U** \_\_\_\_\_

LN 05

**H** \_\_\_\_\_

**I** \_\_\_\_\_

**A** \_\_\_\_\_

**B** \_\_\_\_\_

**P** \_\_\_\_\_

**W** \_\_\_\_\_

**U** \_\_\_\_\_

LN 06

**H** \_\_\_\_\_

**I** \_\_\_\_\_

**A** \_\_\_\_\_

**B** \_\_\_\_\_

**P** \_\_\_\_\_

**W** \_\_\_\_\_

**U** \_\_\_\_\_

LN 07

**H** \_\_\_\_\_

**I** \_\_\_\_\_

**A** \_\_\_\_\_

**B** \_\_\_\_\_

**P** \_\_\_\_\_

**W** \_\_\_\_\_

**U** \_\_\_\_\_

LN 08

**H** \_\_\_\_\_

**I** \_\_\_\_\_

**A** \_\_\_\_\_

**B** \_\_\_\_\_

**P** \_\_\_\_\_

**W** \_\_\_\_\_

**U** \_\_\_\_\_

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**LDSS-3174 Statewide LP (Rev. 7/20)**

**Please read this entire page carefully before completing it. If you have questions, see the instruction book (PUB-1313 Statewide) or talk to your social services district.**

**SECTION 9 – CITIZENSHIP/NON-CITIZEN WITH SATISFACTORY IMMIGRATION STATUS**

**LIST EVERYONE WHO IS RECERTIFYING OR WHO IS REQUIRED TO RECERTIFY. \_\_\_\_\_**

**SECTION 10 – CERTIFICATION**

Some social services programs require that you certify that you are a United States citizen, Native American or national of the U.S., or a non-citizen with satisfactory immigration status. Other programs do not.

You **MUST** sign the Certification below only if you are a United States citizen, Native American or national of the United States, or a non-citizen with satisfactory immigration status, **and** you are recertifying for:



- Public Assistance (where there are children in the household or a member of the household is pregnant), or
- The Supplemental Nutrition Assistance Program, or
- Medicaid (except if the applicant is pregnant)

An adult household member or authorized representative may sign for all household members. Example: A parent without a satisfactory non-citizen status may sign for their child with a satisfactory non-citizen status

A recertification for SNAP must list all persons living in the SNAP household. A recertification for PA must list all children for whom you are recertifying, their siblings, and all parents of those children who live together. If you do not check whether a listed person is a United States citizen, national of the U.S. or a non-citizen with a satisfactory immigration status, or provide a U.S. Citizenship and Immigration Services (USCIS) number (Alien Registration Number) or a non-citizen number (if applicable), 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.

LN 01

FIRST NAME \_\_\_\_\_

MI \_\_\_\_\_

LAST NAME \_\_\_\_\_

Check either "CITIZEN / NATIONAL" or "NON-CITIZEN" for each person.

CITIZEN/ NATIONAL

NON-CITIZEN

USCIS NUMBER (ALIEN REGISTRATION NUMBER)  
OR NON-CITIZEN NUMBER (If Applicable) A \_\_\_\_\_

**SIGN\* AND DATE THE BOX BELOW FOR EACH APPLICANT.**

In the case of a recertifying non-citizen with a satisfactory immigration status, check the program(s) for which each recertifying non-citizen has satisfactory immigration status. (See the instruction book, Pub-1313 Statewide.)

**CERTIFICATION**

Sign Name X \_\_\_\_\_

**DATE** \_\_\_\_\_

PA

SNAP

MA

LN 02

FIRST NAME \_\_\_\_\_

MI \_\_\_\_\_

LAST NAME \_\_\_\_\_

Check either "CITIZEN / NATIONAL" or "NON-CITIZEN" for each person.

CITIZEN/ NATIONAL

NON-CITIZEN

USCIS NUMBER (ALIEN REGISTRATION NUMBER)  
OR NON-CITIZEN NUMBER (If Applicable) A \_\_\_\_\_

**SIGN\* AND DATE THE BOX BELOW FOR EACH APPLICANT.**

In the case of a recertifying non-citizen with a satisfactory immigration status, check the program(s) for which each recertifying non-citizen has satisfactory immigration status. (See the instruction book, Pub-1313 Statewide.)

**CERTIFICATION**

Sign Name X \_\_\_\_\_

**DATE** \_\_\_\_\_

PA

SNAP

MA

LN 03

FIRST NAME \_\_\_\_\_

MI \_\_\_\_\_

LAST NAME \_\_\_\_\_

Check either "CITIZEN / NATIONAL" or "NON-CITIZEN" for each person.

CITIZEN/ NATIONAL

NON-CITIZEN

USCIS NUMBER (ALIEN REGISTRATION NUMBER)  
OR NON-CITIZEN NUMBER (If Applicable) A \_\_\_\_\_

**SIGN\* AND DATE THE BOX BELOW FOR EACH APPLICANT.**

In the case of a recertifying non-citizen with a satisfactory immigration status, check the program(s) for which each recertifying non-citizen has satisfactory immigration status. (See the instruction book, Pub-1313 Statewide.)

**CERTIFICATION**

Sign Name X \_\_\_\_\_

**DATE** \_\_\_\_\_

PA

SNAP

MA

LN 04

FIRST NAME \_\_\_\_\_

MI \_\_\_\_\_

LAST NAME \_\_\_\_\_

Check either "CITIZEN / NATIONAL" or "NON-CITIZEN" for each person.

CITIZEN/ NATIONAL

NON-CITIZEN

USCIS NUMBER (ALIEN REGISTRATION NUMBER)  
OR NON-CITIZEN NUMBER (If Applicable) A \_\_\_\_\_

**SIGN\* AND DATE THE BOX BELOW FOR EACH APPLICANT.**

In the case of a recertifying non-citizen with a satisfactory immigration status, check the program(s) for which each recertifying non-citizen has satisfactory immigration status. (See the instruction book, Pub-1313 Statewide.)

**CERTIFICATION**

Sign Name X \_\_\_\_\_

**DATE** \_\_\_\_\_

PA

SNAP

MA

LN 05

FIRST NAME \_\_\_\_\_

MI \_\_\_\_\_

LAST NAME \_\_\_\_\_

Check either "CITIZEN / NATIONAL" or "NON-CITIZEN" for each person.

CITIZEN/ NATIONAL

NON-CITIZEN

USCIS NUMBER (ALIEN REGISTRATION NUMBER)  
OR NON-CITIZEN NUMBER (If Applicable) A \_\_\_\_\_

**SIGN\* AND DATE THE BOX BELOW FOR EACH APPLICANT.**

In the case of a recertifying non-citizen with a satisfactory immigration status, check the program(s) for which each recertifying non-citizen has satisfactory

immigration status. (See the instruction book, Pub-1313 Statewide.)

**CERTIFICATION**

Sign Name X \_\_\_\_\_

**DATE** \_\_\_\_\_

PA

SNAP

MA

LN 06

FIRST NAME \_\_\_\_\_

MI \_\_\_\_\_

LAST NAME \_\_\_\_\_

Check either "CITIZEN / NATIONAL" or "NON-CITIZEN" for each person.

CITIZEN/ NATIONAL

NON-CITIZEN

USCIS NUMBER (ALIEN REGISTRATION NUMBER)  
OR NON-CITIZEN NUMBER (If Applicable) A \_\_\_\_\_

**SIGN\* AND DATE THE BOX BELOW FOR EACH APPLICANT.**

In the case of a recertifying non-citizen with a satisfactory immigration status, check the program(s) for which each recertifying non-citizen has satisfactory immigration status. (See the instruction book, Pub-1313 Statewide.)

**CERTIFICATION**

Sign Name X \_\_\_\_\_

**DATE** \_\_\_\_\_

PA

SNAP

MA

LN 07

FIRST NAME \_\_\_\_\_

MI \_\_\_\_\_

LAST NAME \_\_\_\_\_

Check either "CITIZEN / NATIONAL" or "NON-CITIZEN" for each person.

CITIZEN/ NATIONAL

NON-CITIZEN

USCIS NUMBER (ALIEN REGISTRATION NUMBER)  
OR NON-CITIZEN NUMBER (If Applicable) A \_\_\_\_\_



**SIGN\* AND DATE THE BOX BELOW FOR EACH APPLICANT.**

In the case of a recertifying non-citizen with a satisfactory immigration status, check the program(s) for which each recertifying non-citizen has satisfactory immigration status. (See the instruction book, Pub-1313 Statewide.)

**CERTIFICATION**

Sign Name X \_\_\_\_\_

**DATE** \_\_\_\_\_

PA

SNAP

MA

LN 08

FIRST NAME \_\_\_\_\_

MI \_\_\_\_\_

LAST NAME \_\_\_\_\_

Check either "CITIZEN / NATIONAL" or "NON-CITIZEN" for each person.

CITIZEN/ NATIONAL

NON-CITIZEN

USCIS NUMBER (ALIEN REGISTRATION NUMBER)  
OR NON-CITIZEN NUMBER (If Applicable) A \_\_\_\_\_  
**SIGN\* AND DATE THE BOX BELOW FOR EACH  
APPLICANT.**

In the case of a recertifying non-citizen with a satisfactory immigration status, check the program(s) for which each recertifying non-citizen has satisfactory immigration status. (See the instruction book, Pub-1313 Statewide.)

**CERTIFICATION**

Sign Name X \_\_\_\_\_

**DATE** \_\_\_\_\_

PA

SNAP

MA

**By checking a box above and by signing the certification form in Section 10, I hereby certify, under penalty of perjury, that I, and/or the person(s) for whom I am signing, am a United States citizen, Native American or national of the United States, or a non-citizen with satisfactory immigration status.**

**I understand that signing the above Certification may result in information about recertifying members of my household being submitted to the United States Citizenship and Immigration Services for verification of non-citizen status, if applicable.**

**The use or disclosure of the information above is restricted to persons and organizations directly connected with the verification of citizenship status, and the administration or enforcement of the provisions of the Public Assistance, Supplemental Nutrition Assistance, and Medicaid.**

**\*A person who wishes to sign the Recertification Form 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: \_\_\_\_\_**

## **SECTION 11 – INFORMATION REGARDING REFERRAL TO THE CHILD SUPPORT ENFORCEMENT UNIT**

If you are recertifying for Medicaid in addition to Public Assistance or the Supplemental Nutrition Assistance Program, you may have to help us obtain medical support for yourself and your recertifying children. Answer the following questions to determine if you need to complete this section. Include yourself, as appropriate:

1. Are you recertifying for an individual under the age of 21 who was born out of wedlock and for whom legal parentage has not been established?

Yes

No

2. Are you recertifying for an individual under the age of 21 who has an absent parent (noncustodial parent)?

Yes

No

**You do not need to complete this section if you answered “No” to both of these questions. Go to the next section.**

**You must complete this section if you answered “Yes” to either or both of these questions.** Provide the names of all individuals under the age of 21 for whom you are recertifying and any information you currently have about those individuals’ noncustodial parents or alleged parents.

3. Are you under the age of 21?

Yes

No

If you answered “Yes” to this question, provide the information for your noncustodial parent(s) or alleged parent(s).

As a condition of obtaining assistance, you are required to assign certain rights related to support, as described in the Notices, Assignments, Authorizations, and Consents section at the end of this recertification. You will be provided with the LDSS-5145 form, “Referral for Child Support Services,” to complete and return to the Child

Support Enforcement Unit. Except in situations of domestic violence or other good cause, as a condition of obtaining assistance, you are required to cooperate with the Child Support Enforcement Unit to locate any noncustodial parent or alleged parent; establish legal parentage for each individual under the age of 21 born out of wedlock; and establish, modify, and/or enforce orders of support. You also will be provided with the LDSS-4279 form, "Notice of Responsibilities and Rights for Support," which explains your responsibilities and your rights if you do not cooperate with the Child Support Enforcement Unit.

A. NAME OF INDIVIDUAL UNDER AGE 21 \_\_\_\_\_

NONCUSTODIAL PARENT OR ALLEGED  
PARENT'S NAME AND ADDRESS \_\_\_\_\_

NONCUSTODIAL PARENT OR ALLEGED  
PARENT'S DATE OF BIRTH

MONTH \_\_\_\_\_

DAY \_\_\_\_\_

YEAR \_\_\_\_\_

NONCUSTODIAL PARENT OR ALLEGED  
PARENT'S SOCIAL SECURITY NUMBER \_\_\_\_\_

B. NAME OF INDIVIDUAL UNDER AGE 21 \_\_\_\_\_

NONCUSTODIAL PARENT OR ALLEGED  
PARENT'S NAME AND ADDRESS \_\_\_\_\_

NONCUSTODIAL PARENT OR ALLEGED  
PARENT'S DATE OF BIRTH

MONTH \_\_\_\_\_

DAY \_\_\_\_\_

YEAR \_\_\_\_\_

NONCUSTODIAL PARENT OR ALLEGED  
PARENT'S SOCIAL SECURITY NUMBER \_\_\_\_\_

C.NAME OF INDIVIDUAL UNDER AGE 21 \_\_\_\_\_

NONCUSTODIAL PARENT OR ALLEGED  
PARENT'S NAME AND ADDRESS \_\_\_\_\_

NONCUSTODIAL PARENT OR ALLEGED  
PARENT'S DATE OF BIRTH

MONTH \_\_\_\_\_

DAY \_\_\_\_\_

YEAR \_\_\_\_\_

NONCUSTODIAL PARENT OR ALLEGED  
PARENT'S SOCIAL SECURITY NUMBER \_\_\_\_\_

D.NAME OF INDIVIDUAL UNDER AGE 21 \_\_\_\_\_

NONCUSTODIAL PARENT OR ALLEGED  
PARENT'S NAME AND ADDRESS \_\_\_\_\_

NONCUSTODIAL PARENT OR ALLEGED  
PARENT'S DATE OF BIRTH

MONTH \_\_\_\_\_

DAY \_\_\_\_\_

YEAR \_\_\_\_\_

NONCUSTODIAL PARENT OR ALLEGED  
PARENT'S SOCIAL SECURITY NUMBER \_\_\_\_\_

E. NAME OF INDIVIDUAL UNDER AGE 21 \_\_\_\_\_

NONCUSTODIAL PARENT OR ALLEGED  
PARENT'S NAME AND ADDRESS \_\_\_\_\_

NONCUSTODIAL PARENT OR ALLEGED  
PARENT'S DATE OF BIRTH

MONTH \_\_\_\_\_

DAY \_\_\_\_\_

YEAR \_\_\_\_\_

NONCUSTODIAL PARENT OR ALLEGED  
PARENT'S SOCIAL SECURITY NUMBER \_\_\_\_\_



**LDSS-3174 Statewide LP (Rev. 7/20)**

**SECTION 12 – TAX FILING/DEPENDENT STATUS –**

Please select the tax status for each individual living in the household.

FIRST NAME \_\_\_\_\_

MIDDLE INITIAL \_\_\_\_\_

LAST NAME \_\_\_\_\_

TAX STATUS

SINGLE \_\_\_\_\_

MARRIED FILING JOINTLY \_\_\_\_\_

MARRIED FILING SINGLE \_\_\_\_\_

HEAD OF HOUSEHOLD (WITH QUALIFYING INDIVIDUAL) \_\_\_\_\_

QUALIFYING WIDOW(ER) WITH DEPENDENT CHILD \_\_\_\_\_

DEPENDENT AND WILL BE FILING TAXES \_\_\_\_\_

WILL NOT BE FILING TAXES \_\_\_\_\_

FIRST NAME \_\_\_\_\_

MIDDLE INITIAL \_\_\_\_\_

LAST NAME \_\_\_\_\_

TAX STATUS

SINGLE \_\_\_\_\_

MARRIED FILING JOINTLY \_\_\_\_\_

MARRIED FILING SINGLE \_\_\_\_\_

HEAD OF HOUSEHOLD (WITH QUALIFYING  
INDIVIDUAL) \_\_\_\_\_

QUALIFYING WIDOW(ER) WITH DEPENDENT  
CHILD \_\_\_\_\_

DEPENDENT AND WILL BE FILING TAXES \_\_\_\_\_

WILL NOT BE FILING TAXES \_\_\_\_\_

FIRST NAME \_\_\_\_\_

MIDDLE INITIAL \_\_\_\_\_

LAST NAME \_\_\_\_\_

TAX STATUS

SINGLE \_\_\_\_\_

MARRIED FILING JOINTLY \_\_\_\_\_

MARRIED FILING SINGLE \_\_\_\_\_

HEAD OF HOUSEHOLD (WITH QUALIFYING  
INDIVIDUAL) \_\_\_\_\_

QUALIFYING WIDOW(ER) WITH DEPENDENT  
CHILD \_\_\_\_\_

DEPENDENT AND WILL BE FILING TAXES \_\_\_\_\_  
WILL NOT BE FILING TAXES \_\_\_\_\_

FIRST NAME \_\_\_\_\_

MIDDLE INITIAL \_\_\_\_\_

LAST NAME \_\_\_\_\_

TAX STATUS

SINGLE \_\_\_\_\_

MARRIED FILING JOINTLY \_\_\_\_\_

MARRIED FILING SINGLE \_\_\_\_\_

HEAD OF HOUSEHOLD (WITH QUALIFYING  
INDIVIDUAL) \_\_\_\_\_

QUALIFYING WIDOW(ER) WITH DEPENDENT  
CHILD \_\_\_\_\_

DEPENDENT AND WILL BE FILING TAXES \_\_\_\_\_  
WILL NOT BE FILING TAXES \_\_\_\_\_

FIRST NAME \_\_\_\_\_

MIDDLE INITIAL \_\_\_\_\_

LAST NAME \_\_\_\_\_

TAX STATUS

SINGLE \_\_\_\_\_

MARRIED FILING JOINTLY \_\_\_\_\_

MARRIED FILING SINGLE \_\_\_\_\_  
HEAD OF HOUSEHOLD (WITH QUALIFYING  
INDIVIDUAL) \_\_\_\_\_  
QUALIFYING WIDOW(ER) WITH DEPENDENT  
CHILD \_\_\_\_\_  
DEPENDENT AND WILL BE FILING TAXES \_\_\_\_\_  
WILL NOT BE FILING TAXES \_\_\_\_\_

FIRST NAME \_\_\_\_\_

MIDDLE INITIAL \_\_\_\_\_

LAST NAME \_\_\_\_\_

TAX STATUS

SINGLE \_\_\_\_\_  
MARRIED FILING JOINTLY \_\_\_\_\_  
MARRIED FILING SINGLE \_\_\_\_\_  
HEAD OF HOUSEHOLD (WITH QUALIFYING  
INDIVIDUAL) \_\_\_\_\_  
QUALIFYING WIDOW(ER) WITH DEPENDENT  
CHILD \_\_\_\_\_  
DEPENDENT AND WILL BE FILING TAXES \_\_\_\_\_  
WILL NOT BE FILING TAXES \_\_\_\_\_

FIRST NAME \_\_\_\_\_

MIDDLE INITIAL \_\_\_\_\_

LAST NAME \_\_\_\_\_

TAX STATUS

SINGLE \_\_\_\_\_

MARRIED FILING JOINTLY \_\_\_\_\_

MARRIED FILING SINGLE \_\_\_\_\_

HEAD OF HOUSEHOLD (WITH QUALIFYING  
INDIVIDUAL) \_\_\_\_\_

QUALIFYING WIDOW(ER) WITH DEPENDENT  
CHILD \_\_\_\_\_

DEPENDENT AND WILL BE FILING TAXES \_\_\_\_\_

WILL NOT BE FILING TAXES \_\_\_\_\_

FIRST NAME \_\_\_\_\_

MIDDLE INITIAL \_\_\_\_\_

LAST NAME \_\_\_\_\_

TAX STATUS

SINGLE \_\_\_\_\_

MARRIED FILING JOINTLY \_\_\_\_\_

MARRIED FILING SINGLE \_\_\_\_\_

HEAD OF HOUSEHOLD (WITH QUALIFYING  
INDIVIDUAL) \_\_\_\_\_

QUALIFYING WIDOW(ER) WITH DEPENDENT  
CHILD \_\_\_\_\_

DEPENDENT AND WILL BE FILING TAXES \_\_\_\_\_  
WILL NOT BE FILING TAXES \_\_\_\_\_

**Tax dependents not living in the household.** Please list any tax dependents who do not live with you and are claimed by you or anyone in your household. If you do not file taxes, you can skip this question.

NAME OF TAX DEPENDENT

FIRST NAME \_\_\_\_\_  
MIDDLE INITIAL \_\_\_\_\_  
LAST NAME \_\_\_\_\_

NAME OF TAX FILER

FIRST NAME \_\_\_\_\_  
MIDDLE INITIAL \_\_\_\_\_  
LAST NAME \_\_\_\_\_

NAME OF TAX DEPENDENT

FIRST NAME \_\_\_\_\_  
MIDDLE INITIAL \_\_\_\_\_  
LAST NAME \_\_\_\_\_

NAME OF TAX FILER

FIRST NAME \_\_\_\_\_  
MIDDLE INITIAL \_\_\_\_\_  
LAST NAME \_\_\_\_\_

NAME OF TAX DEPENDENT

FIRST NAME \_\_\_\_\_

MIDDLE INITIAL \_\_\_\_\_

LAST NAME \_\_\_\_\_

NAME OF TAX FILER

FIRST NAME \_\_\_\_\_

MIDDLE INITIAL \_\_\_\_\_

LAST NAME \_\_\_\_\_

NAME OF TAX DEPENDENT

FIRST NAME \_\_\_\_\_

MIDDLE INITIAL \_\_\_\_\_

LAST NAME \_\_\_\_\_

NAME OF TAX FILER

FIRST NAME \_\_\_\_\_

MIDDLE INITIAL \_\_\_\_\_

LAST NAME \_\_\_\_\_

**SECTION 13 – ABSENT/DECEASED  
SPOUSE INFORMATION –**

If the spouse of anyone recertifying lives someplace else or is deceased, please indicate below

NAME OF PERSON RECERTIFYING \_\_\_\_\_

NAME OF SPOUSE \_\_\_\_\_

DATE OF SPOUSE'S BIRTH \_\_\_\_\_

DATE OF SPOUSE'S DEATH, IF APPLICABLE \_\_\_\_\_

SPOUSE'S SOCIAL SECURITY NUMBER \_\_\_\_\_

SPOUSE'S ADDRESS, IF APPLICABLE \_\_\_\_\_

CITY \_\_\_\_\_

COUNTY \_\_\_\_\_

STATE \_\_\_\_\_

ZIP CODE \_\_\_\_\_

## **SECTION 14 – ABSENT CHILD INFORMATION –**

If anyone recertifying has a child under the age of 21 living  
someplace else, please indicate below.

NAME OF PERSON RECERTIFYING \_\_\_\_\_

NAME OF ABSENT CHILD \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

ADDRESS OF CHILD (STREET, CITY, COUNTY,  
STATE, AND ZIP CODE) \_\_\_\_\_

LEGAL PARENTAGE ESTABLISHED?



Yes

No

DO YOU PAY CHILD SUPPORT?

Yes

No

NAME OF PERSON RECERTIFYING \_\_\_\_\_

NAME OF ABSENT CHILD \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

ADDRESS OF CHILD (STREET, CITY, COUNTY,  
STATE, AND ZIP CODE) \_\_\_\_\_

LEGAL PARENTAGE ESTABLISHED?

Yes

No

DO YOU PAY CHILD SUPPORT?

Yes

No

NAME OF PERSON RECERTIFYING \_\_\_\_\_

NAME OF ABSENT CHILD \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

ADDRESS OF CHILD (STREET, CITY, COUNTY,  
STATE, AND ZIP CODE) \_\_\_\_\_

LEGAL PARENTAGE ESTABLISHED?

Yes

No

DO YOU PAY CHILD SUPPORT?

Yes

No

## **SECTION 15 – TEEN PARENT INFORMATION**

Is there a parent under the age of 18 (“teen parent”) in the household?

Yes

No

Name \_\_\_\_\_

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

Yes

No

Name of teen parent's child \_\_\_\_\_

Original Page 7

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**LDSS-3174 Statewide LP (Rev. 7/20)**

## **SECTION 16 – INCOME INFORMATION:**

Indicate if you or anyone who lives with you receives money from:

### 1. Unemployment Insurance Benefits

YES

NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

### 2. Supplemental Security Income (SSI) Benefits (State and Federal Total)

YES

NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

### 3. Social Security Disability (SSD) Benefits

YES

NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

### 4. Social Security Dependent Benefits

YES

NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

5. Social Security Survivor's Benefits

YES

NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

6. Social Security Retirement Benefits

YES

NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

7. Railroad Retirement Benefits

YES

NO

WHO \_\_\_\_\_  
AMOUNT/VALUE & FREQUENCY \_\_\_\_\_  
WHO \_\_\_\_\_  
AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

8. Retirement Benefits (Pensions)

YES

NO

WHO \_\_\_\_\_  
AMOUNT/VALUE & FREQUENCY \_\_\_\_\_  
WHO \_\_\_\_\_  
AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

9. Dividends/Interest from Stocks, Bonds, Savings, etc.

YES

NO

WHO \_\_\_\_\_  
AMOUNT/VALUE & FREQUENCY \_\_\_\_\_  
WHO \_\_\_\_\_  
AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

10. Workers' Compensation

YES

NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

### 11. NYS Disability Benefits

YES

NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

### 12. Veteran's Pension/Benefits/Aid and Attendance

YES

NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

13. Public Assistance Grant

YES

NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

14. GI Dependency Allotments

YES

NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

15. Education Grants or Loans

YES

NO



WHO \_\_\_\_\_  
AMOUNT/VALUE & FREQUENCY \_\_\_\_\_  
WHO \_\_\_\_\_  
AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

16. Contributions/Gifts (Received)

YES

NO

WHO \_\_\_\_\_  
AMOUNT/VALUE & FREQUENCY \_\_\_\_\_  
WHO \_\_\_\_\_  
AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

17. Foster Care Payments (Received)

YES

NO

WHO \_\_\_\_\_  
AMOUNT/VALUE & FREQUENCY \_\_\_\_\_  
WHO \_\_\_\_\_  
AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

18. Child Support Payments (Received)

Received From: \_\_\_\_\_

YES

NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

#### 19. Spousal Support (Received)

YES

NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

#### 20. Private Disability Insurance - Health/Accident Insurance Policy Income

YES

NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_  
WHO \_\_\_\_\_  
AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

21. No-Fault Insurance Benefits

YES

NO

WHO \_\_\_\_\_  
AMOUNT/VALUE & FREQUENCY \_\_\_\_\_  
WHO \_\_\_\_\_  
AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

22. Union Benefits (including Strike Benefits)

YES

NO

WHO \_\_\_\_\_  
AMOUNT/VALUE & FREQUENCY \_\_\_\_\_  
WHO \_\_\_\_\_  
AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

23. Loans, Other than Education (Received)

YES

NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

24. 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)

YES

NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

25. Training Allotments/Stipends

YES

NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

26. Rental Income (Received)

YES

NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

27. Boarders/Lodgers Income (Received)

YES

NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

**Other Income** (Please Specify) \_\_\_\_\_

YES

NO

WHO \_\_\_\_\_  
AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_  
AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

**Other Income** (Please Specify) \_\_\_\_\_

YES

NO

WHO \_\_\_\_\_  
AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_  
AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

Original Page 8

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**LDSS-3174 Statewide LP** (Rev. 7/20)

**Deductions:** Certain types of Medicaid budgeting allow applicants/recipients to reduce their countable income with deductions that they take on their federal taxes. These are specific expenses that the Internal Revenue Service (IRS) allows people to deduct to reduce their taxable income. Only record deductions here if you will claim them on the current year's tax return.

1. Educator expenses

YES

NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

## 2. Individual Retirement Account (IRA) deduction

YES

NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

## 3. Student loan interest deduction

YES

NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

4. Tuition and fees

YES

NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

5. Certain business expenses (reservists, artists, fee-based government officials)

YES

NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

6. Health savings account deduction

YES



NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

### 7. Job-related moving expenses

YES

NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

### 8. Deductible part of self-employment (S/E) tax

YES

NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

9. S/E, SIMPLE & qualified plans

YES

NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

10. S/E health insurance deduction

YES

NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

11. Penalty on early withdrawal of savings

YES

NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_  
AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

12. Alimony paid

YES

NO

WHO \_\_\_\_\_  
AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_  
AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

13. Domestic production activities deduction

YES

NO

WHO \_\_\_\_\_  
AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_  
AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

14. Additional adjustments added on line 36 (IRS Form 1040 only)

YES

NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

15. Archer MSA deduction

YES

NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

**Other Adjustment** (Please Specify) \_\_\_\_\_

YES

NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

**Other Adjustment** (Please Specify) \_\_\_\_\_

YES

NO

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

WHO \_\_\_\_\_

AMOUNT/VALUE & FREQUENCY \_\_\_\_\_

## **SECTION 17 – STEPPARENT/NON-CITIZEN WITH SATISFACTORY IMMIGRATION STATUS SPONSOR INFORMATION**

Answer all questions listed below.

Does the stepparent of any children who live with you have any resources or receive income of any kind?

YES

NO

WHO? \_\_\_\_\_

Is anyone in your household a non-citizen with satisfactory immigration status who was sponsored for admission into the U.S.?

YES

NO

WHO? \_\_\_\_\_

NAME OF SPONSOR: \_\_\_\_\_

PHONE NO.: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

Original Page 9

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**LDSS-3174 Statewide LP (Rev. 7/20)**

## **SECTION 18 – EMPLOYMENT INFORMATION**

1. I am currently:

employed

self-employed

unemployed

Gross Income \$ \_\_\_\_\_

Hours Worked Monthly \_\_\_\_\_

(Include wages, salary, overtime pay, commissions,  
and tips)

Paid:

Weekly

Biweekly

Monthly

Day of the week paid: \_\_\_\_\_

Employer's Name and Address: \_\_\_\_\_

Phone No. \_\_\_\_\_

2. Is anyone else who lives with you currently:

employed

self-employed

Who: \_\_\_\_\_

Gross Income \$ \_\_\_\_\_

Hours Worked Monthly \_\_\_\_\_

Paid:

Weekly

Biweekly

Monthly

Day of the week paid: \_\_\_\_\_

Employer's Name and Address: \_\_\_\_\_

Phone No. \_\_\_\_\_

3. Is health insurance available through your employer?

Yes

No

Does anyone who lives with you have health insurance with an employer?

Yes

No

Who: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

4. Do you or anyone who lives with you have a child or dependent care expenses due to employment?

Yes

No

Who: \_\_\_\_\_

5. Do you or anyone who lives with you have other employment-related expenses?

Yes

No



Who: \_\_\_\_\_

---

**LDSS-3174 Statewide LP (Rev. 7/20)**

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

Who: \_\_\_\_\_

When: \_\_\_\_\_

Where: \_\_\_\_\_

Why did you (or they) stop working? \_\_\_\_\_

Did you or anyone living with you file for unemployment?

Yes

No

If yes, who? \_\_\_\_\_

When?: \_\_\_\_\_

Status of filing:

Approved

Denied

Pending

7. Are you or is anyone who lives with you participating in a strike?

Yes

No

Who: \_\_\_\_\_

When the strike began: \_\_\_\_\_

8. Are you or is anyone who lives with you a migrant or seasonal farm worker?

Yes

No

Who: \_\_\_\_\_

9. Do you or any other adult who lives with you have any medical conditions that limit the ability to work or the type of work that can be performed?

Yes

No

Who: \_\_\_\_\_

Describe Limitations: \_\_\_\_\_

10. Could you accept a job today?

Yes

No

If not, why? \_\_\_\_\_

11. What type of work would you like to do? \_\_\_\_\_

Original Page 11

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**LDSS-3174 Statewide LP (Rev. 7/20)**

## **SECTION 19 – EDUCATION/TRAINING**

1. What is your highest level of education completed?

Less than high school diploma

If so, last grade completed? \_\_\_\_\_

Completion of an Individualized Education Plan  
(IEP)

High school diploma or General Equivalency  
Diploma (GED) or Test Assessing Secondary  
Completion (TASC™)

Associate's Degree (2-year college degree)

Bachelor's Degree (4-year college degree) or higher

2. Does anyone else in the household have a high school diploma, General Equivalency Diploma (GED) or Test Assessing Secondary Completion (TASC™), or higher level of education?

Yes

No

If yes, who: \_\_\_\_\_

Degree attained: \_\_\_\_\_

Date completed: \_\_\_\_\_

Indicate if you or anyone who lives with you who is recertifying for or getting assistance:

3. Is or has been in any training program **in the last 12 months?**

Yes

No

Who \_\_\_\_\_

Where \_\_\_\_\_

Program \_\_\_\_\_  
Dates attended \_\_\_\_\_  
Dates completed \_\_\_\_\_

4. Is 16 years of age or older and is attending school or college?

Yes

No

Who \_\_\_\_\_

Where \_\_\_\_\_

5. Is getting a Training Allowance?

Yes

No

Who \_\_\_\_\_

Amt. \$ \_\_\_\_\_

6. Is getting Educational Grants or Loans?

Yes

No

Who \_\_\_\_\_

Amt. \$ \_\_\_\_\_

7. Is under 16 years of age and is attending school?

Yes

No

Who \_\_\_\_\_

School \_\_\_\_\_

Who \_\_\_\_\_

School \_\_\_\_\_

Who \_\_\_\_\_

School \_\_\_\_\_

Who \_\_\_\_\_

School \_\_\_\_\_

Original Page 12

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**LDSS-3174 Statewide LP (Rev. 7/20)**

## **SECTION 20 – RESOURCES INFORMATION**

Indicate if you or anyone who lives with you who is recertifying:

1. Has cash available

YES

NO

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

2. Has a checking account(s)

YES

NO

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

3. Has a savings account(s) or certificate(s) of deposit

YES

NO

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

4. Has a credit union account(s)

YES

NO

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

5. Has life insurance

YES

NO

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

6. Has title or registration to a motor vehicle(s) or other vehicle(s):

Year \_\_\_\_\_

Make/Model \_\_\_\_\_

Year \_\_\_\_\_

Make/Model \_\_\_\_\_



Other \_\_\_\_\_

YES

NO

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

7. Has stocks, bonds, certificates or mutual funds

YES

NO

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

8. Has savings bonds

YES

NO

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

9. Has an IRA, Keogh, 401(k) or deferred compensation account(s)

YES

NO

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

10. Has an irrevocable burial trust

YES

NO

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

11. Has a burial fund

YES

NO

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

12. Has a burial space

YES

NO

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

13. Has their own home

YES

NO

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

14. Has real estate, including income-producing and non-income-producing property

YES

NO

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

15. Is eligible for an income tax refund

YES

NO

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

16. Has an annuity

YES

NO

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

17. Is the beneficiary of a trust

YES

NO

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

18. Expects to receive a trust fund, lawsuit settlement,  
inheritance or income from any other sources

YES

NO

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

19. Has an "in trust" account(s)

YES

NO

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

20. Has a safe deposit box(es)

YES

NO

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

21. Has resources other than those listed above

YES

NO

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

22. Has anyone (including your spouse, even if not recertifying or living with you) given away any cash, or sold/transferred any real estate, income or personal property in the past 36 months?

YES

NO

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

23. Has anyone (including your spouse, even if not recertifying or living with you) ever created a trust in the past or transferred any assets to a trust within the past 60 months?

If yes, when \_\_\_\_\_

YES

NO

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

WHO \_\_\_\_\_

IF YES, AMOUNT/VALUE \$ \_\_\_\_\_

Original Page 13

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**LDSS-3174 Statewide LP (Rev. 7/20)**

## **SECTION 21 – MEDICAL INFORMATION**

Indicate if you or anyone who lives with you who is recertifying:

1. Has any medical bills or medically-related expenses

YES

NO

IF YES, WHO \_\_\_\_\_

2. Is on Medicaid with a spend-down

YES

NO

IF YES, WHO \_\_\_\_\_

3. Has health or hospital/accident insurance (including insurance from employer)



YES

NO

IF YES, WHO \_\_\_\_\_

**POLICY NO.:** \_\_\_\_\_

**AMOUNT:** \_\_\_\_\_

**FREQUENCY OF PAYMENT:** \_\_\_\_\_

4. Has health insurance available through an employer

YES

NO

IF YES, WHO \_\_\_\_\_

**INSURANCE COMPANY NAME:** \_\_\_\_\_

**WHO IS COVERED:** \_\_\_\_\_

**EFFECTIVE DATE:** \_\_\_\_\_

5. Has Medicare (red, white, and blue card)

YES

NO

IF YES, WHO \_\_\_\_\_

**INSURANCE COMPANY NAME:** \_\_\_\_\_

**WHO IS COVERED:** \_\_\_\_\_

**EFFECTIVE DATE: \_\_\_\_\_**

6. Has a health attendant/home health aide

YES

NO

IF YES, WHO \_\_\_\_\_

**INSURANCE COMPANY NAME: \_\_\_\_\_**

**WHO IS COVERED: \_\_\_\_\_**

**EFFECTIVE DATE: \_\_\_\_\_**

7. Is blind, sick or disabled

YES

NO

IF YES, WHO \_\_\_\_\_

**Is the answer to question 7 in this section consistent with Section 18 asking if the applicant or any other adult who lives in the household have any medical conditions that limit their ability to work or the type of work that they can perform?**

8. Is a child with a developmental disability

YES

NO

IF YES, WHO \_\_\_\_\_

**Is the answer to question 7 in this section consistent with Section 18 asking if the applicant or any other adult who lives in the household have any medical conditions that limit their ability to work or the type of work that they can perform?**

9. Is in a hospital, nursing home or other medical institution

YES

NO

IF YES, WHO \_\_\_\_\_

10. Has paid or unpaid medical bills within 3 months preceding the month of this recertification

YES

NO

IF YES, WHO \_\_\_\_\_

11. Is or was drug or alcohol dependent

YES

NO

IF YES, WHO \_\_\_\_\_

12. Needs home care/personal care

YES

NO

IF YES, WHO \_\_\_\_\_

13. Is on SSI or has ever applied for SSI

YES

NO

IF YES, WHO \_\_\_\_\_

14. Is pregnant

If pregnant, due date: \_\_\_\_\_

Expected number of births: \_\_\_\_\_

YES

NO

IF YES, WHO \_\_\_\_\_

15. Receives treatment from a drug abuse or alcohol treatment program

YES

NO

IF YES, WHO \_\_\_\_\_

16. Has not been able to work for at least 12 months because of a disability or illness

YES

NO

IF YES, WHO \_\_\_\_\_

17. Has daily activity limited because of a disability or illness that has lasted or will last at least 12 months

YES

NO

IF YES, WHO \_\_\_\_\_

18. Has been in a car accident or work-related accident in the past two years

YES

NO

IF YES, WHO \_\_\_\_\_

19. Has had a government agency (public program) besides Medicaid or Medicare pay any of your medical bills

If yes, what agency \_\_\_\_\_

YES

NO

IF YES, WHO \_\_\_\_\_

20. Will billing any other health insurance cause harm to your physical or emotional health or safety, and/or will it interfere with the privacy and confidentiality of your application for or receipt of Medicaid?

YES

NO

IF YES, WHO \_\_\_\_\_

**LDSS-3174 Statewide LP (Rev. 7/20)**

## **HEALTH PLAN SELECTION**

Most people enrolled in Medicaid are required to join a managed care health plan unless they are in an exempt category. Use this section to choose a health plan. If you do not know what health plans are available, ask your worker or call 1-800-505-5678.

Name of Plan You Are Enrolling In \_\_\_\_\_

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)

\_\_\_\_\_

Name of Plan You Are Enrolling In \_\_\_\_\_

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)

\_\_\_\_\_

Name of Plan You Are Enrolling In \_\_\_\_\_

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) \_\_\_\_\_

Name of Plan You Are Enrolling In \_\_\_\_\_

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) \_\_\_\_\_

## SECTION 22 – SHELTER

WHAT IS YOUR LANDLORD'S NAME? \_\_\_\_\_

WHAT IS YOUR LANDLORD'S ADDRESS? \_\_\_\_\_

WHAT IS YOUR LANDLORD'S PHONE NUMBER?  
(\_\_\_\_) \_\_\_\_\_

Do you or anyone who lives with you have a rent,  
mortgage or other shelter expense?

YES

NO

IF YES, AMOUNT \$ \_\_\_\_\_

Do you or anyone who lives with you have a heat bill  
separate from your rent or other shelter expense?

YES

NO

IF YES, AMOUNT \$ \_\_\_\_\_

**LDSS-3174 Statewide LP (Rev. 7/20)**

**SECTION 22 – SHELTER (CONT.)**

Do you or anyone who lives with you have the following expenses separate from your rent or other shelter expense?

1. Electricity (for needs other than heat; example: lights, cooking, hot water, etc.)

YES

NO

IF YES, AMOUNT \$ \_\_\_\_\_

2. Natural Gas (for needs other than heat; example: cooking, hot water, etc.)

YES

NO

IF YES, AMOUNT \$ \_\_\_\_\_

3. Water

YES

NO

IF YES, AMOUNT \$ \_\_\_\_\_

#### 4. Air Conditioning

YES

NO

IF YES, AMOUNT \$ \_\_\_\_\_

#### 5. Propane (for needs other than heat)

YES

NO

IF YES, AMOUNT \$ \_\_\_\_\_

#### 6. Sewer

YES

NO

IF YES, AMOUNT \$ \_\_\_\_\_

#### 7. Trash

YES

NO

IF YES, AMOUNT \$ \_\_\_\_\_

8. Other Utilities and Expenses

Specify \_\_\_\_\_

YES

NO

IF YES, AMOUNT \$ \_\_\_\_\_

9. Do you live in public housing?

YES

NO

10. Do you live in Section 8, HUD, or other subsidized housing?

YES

NO

11. Do you live in a drug/alcohol treatment facility?

YES

NO

## **ADDITIONAL INFORMATION**

### **SECTION 23 – OTHER EXPENSES**

Indicate if you or anyone who lives with you who is recertifying:

1. Pays child support

YES

NO

IF YES, AMOUNT \$ \_\_\_\_\_

2. Pays spousal support

YES

NO

IF YES, AMOUNT \$ \_\_\_\_\_

3. Pays for child care

YES

NO

IF YES, AMOUNT \$ \_\_\_\_\_

4. Pays for dependent care

YES

NO

IF YES, AMOUNT \$ \_\_\_\_\_

5. Pays tuition, fees, or other educational expenses

YES

NO

IF YES, AMOUNT \$ \_\_\_\_\_

6. Has additional expenses (Example: car payment, car insurance payment, credit card payments, other loan payments, etc.)

Specify: \_\_\_\_\_

YES

NO

IF YES, AMOUNT \$ \_\_\_\_\_

7. Do you or anyone who lives with you who is recertifying owe at least four months of support for a child under the age of 21?

YES

NO

Original Page 16

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**LDSS-3174 Statewide LP (Rev. 7/20)**

## **SECTION 24 – OTHER INFORMATION**

8. Do you buy or plan to buy meals from a home delivery or communal dining service?

YES

NO

9. Are you able to cook or prepare meals at home?

YES

NO



10. Have you or anyone in your household ever been in the U.S. military?

Who? \_\_\_\_\_

YES

NO

11. Has your spouse ever been in the U.S. military?

YES

NO

12. Is anyone in your household a dependent of someone who is or was in the U.S. military?

Who? \_\_\_\_\_

YES

NO

Indicate if you or anyone who lives with you who is recertifying:

Have you or anyone who lives with you who is recertifying moved into this county from another New York State county within the past two months?

YES

NO

WHO \_\_\_\_\_

Have you or anyone who lives with you ever been found guilty of and/or been disqualified for Public Assistance and/or the Supplemental Nutrition Assistance Program (SNAP) because of fraud/an Intentional Program Violation?

YES

NO

WHO \_\_\_\_\_

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?

YES

NO

WHO \_\_\_\_\_

Have you or any member of your household been convicted of making a fraudulent statement or

representation of residence in order to receive Public Assistance in two or more states?

YES

NO

WHO \_\_\_\_\_

Have you or any member of your household been convicted of fraudulently receiving duplicate SNAP Benefits in any state after September 22, 1996?

YES

NO

WHO \_\_\_\_\_

Have you or any member of your household been convicted of buying or selling SNAP Benefits for a combined amount of over \$500 or more after September 22, 1996?

YES

NO

WHO \_\_\_\_\_

Have you or any member of your household been convicted of trading SNAP benefits for firearms, ammunition or explosives, or drugs?

YES

NO

WHO \_\_\_\_\_

Are you or any member of your household fleeing to avoid prosecution, custody or confinement after conviction of a felony or attempted felony and actively being pursued by law enforcement?

YES

NO

WHO \_\_\_\_\_

Are you or any member of your household violating probation or parole according to a court order?

YES

NO

WHO \_\_\_\_\_

# PROPERTY TRANSFER STATUS

I have

I have not

sold, transferred or given away any of my property to anyone to get Public Assistance or SNAP Benefits.

Original Page 17

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**LDSS-3174 Statewide LP (Rev. 7/20)**

## **NOTICES, ASSIGNMENTS, AUTHORIZATIONS, and CONSENTS**

### **COLLECTION AND USE OF SOCIAL SECURITY**

**NUMBERS** – The collection of Social Security Numbers (SSNs) is authorized for each household member with respect to the Supplemental Nutrition Assistance Program (SNAP), pursuant to the Food and Nutrition Act of 2008 (as amended). Anyone applying for SNAP must provide an SSN in order to receive benefits. If you or anyone applying does not have an SSN, that person must apply for an SSN with the Social Security Administration (visit [www.SSA.gov](http://www.SSA.gov) or call 1-800-772-1213).

With respect to all other programs for which this recertification form requires an SSN, the collection of SSNs is also mandatory and is authorized under one or more of the following sections of law: Section 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 instruction book (PUB-1313 Statewide) or talk to your social services district if you have questions.

The information we collect will be used to determine whether your household is eligible or continues to be eligible for assistance or benefits. 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. 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. Besides using the information you give us in this way, the state will use the information to prepare statistics about all

of the people receiving benefits from the Home Energy Assistance Program (HEAP) (see below).

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. 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 SNAP claim arises against your household, the information on this recertification, including all SSNs, may be referred to federal and state agencies, as well as private claims collection agencies, for claims collection action.

SSNs of ineligible household members will also be used and disclosed in the manner above.

Besides using the information you give us in this way, the State also uses the information to prepare statistics about all the people receiving benefits from HEAP. The information is used for quality control by the State to make sure social services districts are doing the best job they can. It is used to verify your energy supplier and to make certain payments to such vendors.

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**LDSS-3174 Statewide LP (Rev. 7/20)**

**NONDISCRIMINATION NOTICE** – This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and, in some cases, religion or political beliefs.

The United States Department of Agriculture (USDA) also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a Supplemental Nutrition Assistance Program (SNAP) complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027),



found online at:

[http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1. Mail: U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW  
Washington, D.C. 20250-9410
2. Fax: (202) 690-7442; or
3. Email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish, or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at:

[http://www.fns.usda.gov/snap/contact\\_info/hotlines.htm](http://www.fns.usda.gov/snap/contact_info/hotlines.htm).

To file a complaint of discrimination regarding a program receiving federal financial assistance through the U.S.

Department of Health and Human Services (HHS), write HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201, or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

New York State additionally prohibits discrimination based on gender identity, transgender status, gender dysphoria, sexual orientation, marital status, military status, domestic violence victim status, pregnancy-related conditions, predisposing genetic characteristics, prior arrest or conviction record, familial status, and retaliation for opposing unlawful discriminatory practices.

**CONSENT FOR INVESTIGATION** – I agree to any investigation to verify or confirm the information I have given in connection with my request for Public Assistance (PA), Medicaid, Supplemental Nutrition Assistance Program (SNAP) Benefits, Home Energy Assistance Program Benefits, 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 any PA and/or SNAP Quality Control Review.

If I am recertifying for SNAP, I understand that the social services district will request and use information available

through the Income and Eligibility Verification System to investigate my recertification, and may verify this information through collateral contacts if discrepancies are found. I also understand that such information may affect my eligibility for SNAP and/or the level of SNAP Benefits I receive.

**CONSENT FOR RELEASE OF CONFIDENTIAL  
UNEMPLOYMENT INSURANCE INFORMATION – I**

authorize the New York State Department of Labor (DOL) to release any confidential information maintained by DOL for Unemployment Insurance (UI) purposes to the New York State Office of Temporary and Disability Assistance (OTDA). This information includes UI benefit claims and wage records. I understand that OTDA, along with state and local agency employees working in social services district offices, will use the UI information for establishing or verifying eligibility for, and the amount of, Public Assistance, Medicaid, Supplemental Nutrition Assistance Program Benefits, Home Energy Assistance Program Benefits or Child Care Assistance, applied for in this application/recertification and for investigations to determine whether I received benefits to which I was not entitled. OTDA may also share the information with the New York State Office of Children and Family Services

(OCFS) and the New York State Department of Health (DOH). OCFS will use the information to monitor the Child Care Assistance program.

Original Page 19

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**LDSS-3174 Statewide LP (Rev. 7/20)**

**RELEASE OF INFORMATION TO SERVICE**

**PROVIDERS** – I give permission to the social services district and New York State to share information regarding Public Assistance or Supplemental Nutrition Assistance Program benefits that I or any member of my household for whom I can legally give authorization have received, for purposes of verifying my eligibility for services and payment related to program administration provided by a State or local contractor. Such services may include, but are not limited to, job placement or training services provided to help me or members of my household obtain and retain employment.

**CHANGE REPORTING** – I agree to inform the agency **promptly** of any change in my needs, residency/address, living arrangements, household size, income, employment, property/resources, dependent care costs, health insurance, non-citizen with satisfactory immigration status/citizenship status, able-bodied adult without

dependents (ABAWD) status, pregnancy status or living arrangements, 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 home, employment, child care arrangements or other changes which may affect my continued eligibility or amount of my benefit.

**PENALTIES** – Federal and state laws provide for penalties of fine, imprisonment or both if you do not tell the truth when you recertify for Public Assistance, Medicaid, Supplemental Nutrition Assistance Program, Services or Child Care Assistance (“Assistance, Benefits or Services”) or at any time when you are questioned about your eligibility, or cause someone else not to tell the truth regarding your recertification or your continuing eligibility. Penalties also apply if you conceal or fail to disclose facts regarding your initial and continuing eligibility for Assistance, Benefits or Services, or if you conceal or fail to disclose facts that would affect the right of someone for whom you have recertified to obtain or continue to receive Assistance, Benefits or Services. If you are an authorized representative, 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 60 months 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 Medicaid, may render the individual ineligible for nursing facility services or home and community-based waived services for a period of time. It is unlawful to obtain Assistance, Benefits or Services by concealing information or providing false information.

## **SUPPLEMENTAL NUTRITION ASSISTANCE**

**PROGRAM DISQUALIFICATION PENALTIES** – Any information you provide in connection with your application for the Supplemental Nutrition Assistance Program (SNAP) will be subject to verification by federal, state and local officials. If any information is incorrect, you may be denied SNAP Benefits. You may be subject to criminal prosecution if you knowingly provide incorrect information which affects eligibility or the amount of benefits. Any person convicted of a felony for knowingly using, transferring, acquiring, altering or possessing SNAP authorization cards or access devices may be fined up to \$250,000, imprisoned up to 20 years or both. The individual may also be subject to prosecution under the applicable federal and state laws. Anyone who is violating

a condition of probation or parole, or anyone who is fleeing to avoid prosecution, custody or confinement of a felony and is actively being pursued by law enforcement, is not eligible to receive SNAP Benefits.

You may be found ineligible for SNAP or found to have committed an Intentional Program Violation (IPV) if you make a false or misleading statement, or misrepresent, conceal or withhold facts, in order to qualify for benefits or receive more benefits; purchase a product with SNAP benefits with the intent of obtaining cash by intentionally discarding the product and returning the container for the deposit amount; or commit or attempt to commit any act that constitutes a violation of federal or state law for the purpose of using, presenting, transferring, acquiring, receiving, possessing or trafficking SNAP Benefits, authorization cards or reusable documents used as part of the Electronic Benefit Transfer (EBT) system. Additionally, the following is not allowed and you may be disqualified from receiving SNAP Benefits and/or be subject to penalties for actions that include:

- Using SNAP benefits to buy non-food items, such as alcohol or cigarettes;

- Using SNAP benefits to pay for food previously purchased on credit;
- Allowing someone else to use your EBT card in exchange for cash, firearms, ammunition or explosives, or drugs, or to purchase food for individuals who are not members of your SNAP household; or
- Using or having in your possession EBT cards that do not belong to you, without the card owner's consent.

Individuals found to have committed an IPV either through an administrative disqualification hearing or by a federal, State or local court, or have signed either a waiver of right to an administrative disqualification hearing or a disqualification consent agreement in cases referred for prosecution shall be ineligible to participate in SNAP for a period of:

- 12 months for the first SNAP IPV;
- 24 months for the second SNAP IPV;
- 24 months for the first SNAP IPV that is based on a court finding that the individual used or received SNAP Benefits in a transaction involving the sale of a



controlled substance (illegal drugs or certain drugs for which a doctor's prescription is required); or

- 120 months if the individual is found to have made a fraudulent statement about who they are or where they live in order to get multiple SNAP Benefits simultaneously, unless permanently disqualified for a third SNAP IPV.

Additionally, a court may bar an individual from participating in SNAP for an additional 18 months.

Original Page 20

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**LDSS-3174 Statewide LP (Rev. 7/20)**

An individual can be permanently disqualified from receiving SNAP Benefits for:

- The first SNAP IPV based on a court finding that the individual used or received SNAP Benefits in a transaction involving the sale of firearms, ammunition or explosives;
- The first SNAP IPV based on a court conviction for trafficking SNAP Benefits for a combined amount of \$500 or more (trafficking includes the illegal use,

transfer, acquisition, alteration or possession of SNAP authorization cards or access devices);

- The second SNAP IPV based on a court finding that the individual used or received SNAP Benefits in a transaction involving the sale of a controlled substance (illegal drugs or certain drugs for which a doctor's prescription is required); or
- A third SNAP IPV.

**REQUIREMENT TO REPORT/VERIFY HOUSEHOLD EXPENSES** – Your household must report child care and utility expenses in order to get a Supplemental Nutrition Assistance Program (SNAP) 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 SNAP 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 these unreported/unverified expenses. A deduction for these expenses may make you eligible for SNAP or may increase your SNAP benefits. You may report/verify these expenses at any time in the future. The deduction would

then be applied to the calculation of SNAP benefits in future months, in accordance with the rules for change reporting (see Change Reporting, above).

## **SUPPLEMENTAL NUTRITION ASSISTANCE**

**PROGRAM AUTHORIZED REPRESENTATIVE** – You can authorize someone who knows your household circumstances to recertify for Supplemental Nutrition Assistance Program (SNAP) Benefits for you. You can also authorize someone outside your household to get SNAP Benefits for you or to use them to buy food for you. If you would like to authorize someone, you must do so in writing. You may authorize someone by printing the person's name, address, and phone number immediately below, and having them sign in the signature section at the end of this recertification. When an Authorized Representative is applying on behalf of a SNAP household that does not reside in an institution, both the Authorized Representative and a responsible adult member of the household must sign and date the signature section at the end of this recertification, unless the SNAP household has otherwise designated the Authorized Representative to do so in writing.

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

\_\_\_\_\_

**STANDARD UTILITY ALLOWANCE** – I understand that Public Assistance and Supplemental Nutrition Assistance Program (SNAP) recipients are categorically income eligible for the Home Energy Assistance Program (HEAP). I also understand that if I have not received a HEAP benefit of greater than \$20 in the current month or previous 12 months, or a similar energy assistance benefit, I must pay for heating or air conditioning separately from my rent in order to receive the heating/cooling standard utility allowance (i.e., a deduction) for SNAP. I understand that the State will use my Social Security Number to verify with my home energy vendors the receipt of HEAP. This authorization also includes permission for any of my home energy vendors (including my utility) to release certain statistical information, including but not limited to, my annual electricity usage, electricity cost, fuel consumption, fuel type, annual fuel cost and payment history to the New York State Office of Temporary and Disability Assistance, the local social services district and the United States Department of Health and Human Services for the

purposes of Low Income Home Energy Assistance Program performance measurement.

**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 (DOH) 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 DOH and other authorized federal, state, and local agencies for purposes of administration of Medicaid; 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 authorize the release of any health-related information about me and any members of my family for whom I can legally give authorization related to the provision of assistance and services and my ability to participate in work activities, including employment, to the New York State Office of Temporary and Disability Assistance (OTDA), the New York State Office of Children and Family Services or the local social services district, as

reasonably necessary for the provision of Public Assistance benefits; for services, including child welfare services; for determining appropriate work activity assignments; for determining the need to apply and for making application for Supplemental Security Income Benefits; for establishing appropriate treatment plans for restoring employability; and for determining eligibility for exemptions from the State sixty-month time limit on cash assistance receipt. If I am required to apply for benefits administered by the Social Security Administration, the information specified above may be shared with the Social Security Administration. 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, unless a box is checked below. If more than one adult in the family is joining a Medicaid health plan, the signature of each adult

Original Page 21

**LDSS-3174 Statewide LP (Rev. 7/20)**

applying is necessary for consent to release information. I understand that my ability to consent to the release of information relating to any minor children for whom I may give consent is limited by the extent to which I can obtain

information regarding treatment, diagnosis and procedures on their behalf.

\_\_\_\_\_ Do not disclose HIV/AIDS information

\_\_\_\_\_ Do not disclose drug and alcohol information

\_\_\_\_\_ Do not disclose mental health information

**RELEASE OF INFORMATION TO HEALTH SERVICE**

**PROVIDERS** – I give permission to the social services district and the State of New York to share information with health service providers, as designated by the social services district or the State of New York, regarding Public Assistance benefits that I or any member of my household for whom I can legally give authorization have received or are eligible to receive, for the purpose of improving the quality of my healthcare and overall well-being, and to facilitate receipt of additional benefits for which I, or members of my household, may be eligible.

**RELEASE OF EDUCATIONAL RECORDS** – I give permission to the New York State Department of Health and the social services district to:1) obtain any information regarding the educational records of myself and/or my minor child(ren), herein named, including information necessary for claiming Medicaid reimbursement for health-related educational services; and 2) 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 social services district and New York State to share my child’s Medicaid eligibility information with my county or municipal Early Intervention Program for the purpose of billing Medicaid.

**CHILD/TEEN HEALTH PROGRAM** – I understand that if my child is on Medicaid, they 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 social services district.

**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 Medicaid.

## **REIMBURSEMENT OF MEDICAL EXPENSES**



**MEDICAID** – You have a right as part of your Medicaid **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.

**ASSIGNMENT OF INSURANCE/OTHER BENEFITS AND DIRECT PAYMENT** – For Public Assistance and Medicaid, 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 district to whom this recertification is made. In addition, I will assist in making any assigned benefits available to the social services district to whom this recertification is made.

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 district for medical and other health services furnished while we are eligible for Medicaid.

**MEDICAID RECOVERIES** – Upon receipt of Medicaid, 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.

I understand that effective April 1, 2014, if I get Medicaid through New York State of Health:

- No lien will be placed on my real property prior to my death.

Original Page 22

**LDSS-3174 Statewide LP (Rev. 7/20)**

- Recovery from assets in my estate upon my death is limited to the amount Medicaid paid for the cost of nursing home care, home and community-based services, and related hospital and prescription drug services received on or after my 55th birthday.

**PUBLIC ASSISTANCE RECOVERIES** – Public Assistance (PA) 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 PA, 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 PA.

**AUTHORIZATION TO REPAY PUBLIC ASSISTANCE BENEFITS FROM RETROACTIVE SUPPLEMENTAL SECURITY INCOME** – I authorize the Commissioner of the Social Security Administration (SSA) to use my first payment of Supplemental Security Income (SSI); i.e. my retroactive SSI payment) to reimburse the local social services district (SSD) for Public Assistance (PA) the SSD pays me from State or local funds while SSA decides if I am eligible for SSI. SSA will not reimburse the SSD for PA that was paid using any federal funds.

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

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

SSA can reimburse the SSD in two situations:

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

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

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

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

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

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

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

**SUPPORT** – Applying for or receiving Family Assistance (FA), Safety Net Assistance (SNA) or Title IV-E foster care 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 their own right or on behalf of any other family member for whom the applicant or recipient is applying for, or

receiving, assistance (Social Services Law, Sections 158 and 348). This assignment is limited in certain situations. Other sections of this recertification contain additional assignments.

**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 for whom I am applying for or receiving assistance. Where applying for or receiving Family Assistance or Safety Net Assistance, my assignment of support rights is limited to support which accrues during the period that I and/or any family member receives assistance. However, any support rights that I assigned to the state on behalf of myself or any family member prior to October 1, 2009, continue to be assigned to the state.

Original Page 23

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**LDSS-3174 Statewide LP (Rev. 7/20)**

**HOME ENERGY ASSISTANCE PROGRAM – I**  
understand that by signing this application/certification, I consent to any investigation to verify or confirm the information I have given and other investigation by any authorized government agency in connection with Home

Energy Assistance Program (HEAP) benefits. I also consent to allow the information provided on this recertification to be used in referrals to available weatherization assistance programs and my utility company's low income programs.

I understand that the State will use my Social Security Number to verify with my home energy vendors the receipt of HEAP. This authorization also includes permission for any of my home energy vendors (including my utility) to release certain statistical information, including but not limited to, my annual electricity usage, electricity cost, fuel consumption, fuel type, annual fuel cost and payment history to the New York State Office of Temporary and Disability Assistance, the local social services district and the United States Department of Health and Human Services for the purposes of Low Income Home Energy Assistance Program performance measurement.

**SEXUAL ASSAULT INFORMATION** – If you are a victim of sexual assault, you have the right to request referral information from the social services district. If you request referral information, the social services district must provide you with the addresses and phone numbers of any: 1) local hospitals offering sexual assault forensic examiner services certified by the NYS Department of

Health; 2) local rape crisis centers; and 3) local advocacy, counseling, and hotline services appropriate for victims of sexual assault. In addition, the social services district must provide you with the NYS Hotline for Sexual Assault and Domestic Violence numbers: (800) 942-6906 and (800) 818-0656 (TTY).

**CERTIFICATION FOR CHILD CARE ASSISTANCE –** If I am applying for Child Care Assistance, I certify that my family resources do not exceed \$1,000,000.

**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 social services district is complete and correct.**

**APPLICANT SIGNATURE x \_\_\_\_\_**

**DATE SIGNED \_\_\_\_\_**

**SPOUSE OR PROTECTIVE REPRESENTATIVE SIGNATURE x \_\_\_\_\_**

**DATE SIGNED \_\_\_\_\_**

**AUTHORIZED REPRESENTATIVE SIGNATURE x \_\_\_\_\_**

**DATE SIGNED \_\_\_\_\_**



**ONLY COMPLETE THE FOLLOWING IF YOU WANT TO  
CLOSE YOUR CASE FOR ONE OR MORE  
PROGRAMS.**

**I REQUEST THAT MY CASE BE CLOSED FOR:**

**Public Assistance**

**Supplemental Nutrition Assistance Benefits**

**Medical Assistance**

**I understand that I may reapply at any time.**

**Give Reason: \_\_\_\_\_**

**Signature x \_\_\_\_\_**

**Date \_\_\_\_\_**

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Rev. 2/05/2020



**THE GREAT SEAL OF THE STATE OF NEW YORK**

# NYS Agency-Based Voter Registration Form

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

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

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

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

I asked for and received a mail registration form

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

Signature \_\_\_\_\_

Date \_\_\_\_\_

Please Print Name \_\_\_\_\_

## **Important!**

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

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

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

中文資料:若您有興趣索取中文資料表格,請電: 1-800-367-8683

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

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

## **VOTER REGISTRATION APPLICATION**

(instructions on back)

Yes, I need an application for an Absentee Ballot

**Please print or type in blue or black ink**

Yes, I would like to be an Election Day worker

**1. Are you a U.S. citizen?**

YES

NO

If you answered **NO**, do not complete this form

**2. A) Will you be 18 years old on or before election day?**

YES

NO

**B) Are you at least 16 years of age and understand that you must be 18 years of age on or before election day to vote, and that until you will be eighteen years of age at the time of such election your registration will be marked “pending” and you will be unable to cast a ballot in any election?**

YES

NO

If you answered **NO** to both of the prior questions, you cannot register to vote.

**For Board Use Only**

3. Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Middle Initial \_\_\_\_\_

Suffix \_\_\_\_\_

4. Address where you live (do not give P.O. box) \_\_\_\_\_

Apt. No. \_\_\_\_\_

City/Town/Village \_\_\_\_\_

Zip Code \_\_\_\_\_

County \_\_\_\_\_

5. Address where you get your mail (if different than above) \_\_\_\_\_

P.O. Box, Star Route, etc. \_\_\_\_\_

Post Office \_\_\_\_\_

Zip Code \_\_\_\_\_

6. Date of Birth \_\_\_\_\_

7. Gender (optional) \_\_\_\_\_

8. Telephone (optional) \_\_\_\_\_

Email (optional) \_\_\_\_\_

9. **ID Number** (Check the applicable box and provide your number)

New York State DMV number \_\_\_\_\_

Last four digits of your Social Security number  
\_\_\_\_\_

I do not have a New York State DMV or Social Security number

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. Political Party**

**I wish to enroll in a political party**

Democratic party

- Republican party
- Conservative party
- Working Families party
- Green party
- Libertarian party
- Independence party
- SAM party
- Other \_\_\_\_\_

**I do not wish to enroll in any political party and wish to be an independent voter**

- No party

**12. Affidavit: I swear or affirm that**

- I am a citizen of the United States.
- I will have lived in the county, city or village for at least 30 days before the election.
- I will meet all requirements to register to vote in New York State.

- This is my signature or mark on the line below.
- The above information is true, I understand that if it is not true, I can be convicted and fined up to \$5,000 and/or jailed for up to four years.

Signature or Mark in ink \_\_\_\_\_

Date \_\_\_\_\_



DONATE LIFE  
New York State

## **(Optional) Register to donate your organs and tissues**

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Middle Initial \_\_\_\_\_

Suffix \_\_\_\_\_

Address \_\_\_\_\_



Apt Number \_\_\_\_\_

City/Town/Village \_\_\_\_\_

Zip Code \_\_\_\_\_

Birth Date \_\_\_\_\_

Gender

M

F

Eye Color \_\_\_\_\_

Height

\_\_\_\_\_ Ft.

\_\_\_\_\_ In.

Email \_\_\_\_\_

DMV or ID NYC Number \_\_\_\_\_

**By signing below, you certify that you are:**

- 16 years of age or older
- Consent to donate all of your organs and tissues for transplantation, research, or both;

- Authorizing the Board of Elections to provide your name and identifying information to NYS Donate Life Registry for enrollment;
- And authorizing the Registry to allow access to this information to federally regulated organ procurement organizations and NYS-licensed tissue and eye banks and others approved by the NYS Commissioner of Health hospitals upon your death.

Signature \_\_\_\_\_

Date \_\_\_\_\_

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Rev. 2/05/2020

## **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;

- pre-register to vote if you are 16 or 17 years of age.

### To Register You Must:

- be a U.S. citizen;
- be 18 years old (you may pre-register at 16 or 17 but cannot vote until you are 18);
- be a resident of the County, or of the City of New York at least 30 days before an election;
- not be in prison or on parole for a felony conviction (unless parole pardoned or restored rights of citizenship);
- not claim the right to vote elsewhere; and
- not found to be incompetent by a court.

## **Important!**

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

NYS Board of Elections

40 North Pearl St, Suite 5

Albany, NY 12207-2729

Telephone: 1-800-469-6872;

TDD/TTY users contact the New York State Relay at 711;  
or visit our web site - [www.elections.ny.gov](http://www.elections.ny.gov)

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

## **Verifying your identity**

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

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

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

## **To complete this form:**

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

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

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

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