CENTER/ INTERVIEW DATE OFFICE		WORKER ID	CASE TYPE	CASE NUMBER			DISTRI	ст		CATEGORY	L	LANG	NUMBER REUSE INDICATOR	
					EFFECTIVE DA	ATE	DISPOSITIO			CLOSE		REA	ASON CODE	
ELIGIBILITY DETERMINED BY (WO	RKER):	ATE	ELIGIBILITY APP	ROVED BY (SUPER	RVISOR):	DATE		ORM	SIGNATURE OF PE	RSON WHO OBTAI	NED ELIGIB	BILITY	DATE	
DATE RECEIVED BY AGENCY	EMPLOYED BY:	SOCIAL SER	VICES DISTRICT		R AGENCY SPE									
PA AUTHOR	ZATION PERIOD			MA	AUTHORIZATIO	N PERIOD				SNAP AU	THORIZATIO	ON PERIOD)	
FROM	ТО			FROM			то			FROM			то	
NFW			CERTIE			M FO							S	<u> </u>

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 for this form (PUB-1313 Statewide), available at www.otda.ny.gov or https://www.health.ny.gov/.

If you are blind or seriously visually impaired, would you	J	
like to receive written notices in an alternative format?	□ Yes	🗆 No

lf yes,	check the t	ype of format	you would like: 🗌	Large Print	Data CD
, j, j		J	J		

 \Box Audio CD \Box 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. 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." 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.

		GRAM YOU OR ANY	Public	Assistance (PA) 🛛 Suppl	emental Nutrition A	ssistance Prog	ram (SNAP) 🗆 Medicaid (MA)	and SNAP 🛛 Medicaid (MA) and PA	
SECTION 2										
WHAT IS YOUR PRIMARY LANGUAGE?	□ ENGLISH □ OTHER (spec	□ SP/	ANISH	DO YOU WANT TO RECEIVE NOTICES IN	: DENGLISH O		SH AND SP/	ANISH	SECTION 5 DO ANY OF THESE APPLY TO	YOU?
SECTION 3		RECIPI	ENT INFORMATI	ON		PLEASE PR	RINT CLEAI	RLY	□ Pregnant	1
FIRST NAME		M.I. LAST NAME			MARITAL STATUS	PHONE NUMBER		MOBILE NUME	ER? Uictim of Domestic Violence	2
						ÀREA CODE		□YES □NO	□ Need to Establish Parentage	3
STREET ADDRESS			APT. NO	CITY	COUNT	(STATE	ZIP CODE	□ Need Child Support	4
IN CARE OF NAME (COM	IPLETE IF YOU RECE	IVE YOUR MAIL IN CARE	OF ANOTHER PER	SON)					Drug/Alcohol Problem	5
				,					□ Fuel or Utility Shutoff	6
MAILING ADDRESS (IF D	IFFERENT FROM AB	OVE)	APT. NO	CITY	COUNT	(STATE	ZIP CODE	□ No Place to Stay/Homeless	7
HOW LONG	YEARS MONTHS	IS THIS A SHELTER?	ANOTHER PHONE	PHONE NUMBER		EMAIL ADDRES			□ Fire or Other Disaster	8
HAVE YOU LIVED AT YOUR	TEARS MONTHS	YES NO	WHERE YOU CAN BE	() AREA CODE			55 (UPTIONA	L)	□ Have No Income	9
PRESENT ADDRESS?			REACHED	AREA CODE					□ Serious Medical Problem	10
DIRECTIONS TO CORRE	NT ADDITESS								□ Pending Eviction	11
FORMER ADDRESS			APT. NO.	CITY	COUNT	(STATE	ZIP CODE	□ No Food	12
									□ Need Foster Care	13
IF YOU ARE CURRENTLY	WITHOUT A HOME,	CHECK HERE							□ Need Child Care	14
AGENCY HELPING APPL		REON					PHONE N		□ Problems with English	15
AGENCI HELFING AFFE		NSON					() AREA CO		□ Reasonable Accommodations	16
							1112100		□ Other	17
DO YOU NEED THE MEDI	ICAID PORTION OF T	HIS RECERTIFICATION F	ORM AND THE POT	ENTIAL RECEIPT OF ANY MEDIC	CAID COVERAGE TO BE	KEPT CONFIDENT	IAL? 🗆 YE	ES 🗆 NO		
LIST THE THINGS THAT	HAVE CHANGED SIN	CE YOUR APPLICATION	OR LAST RECERTIF	ICATION (such as moved, had a b	oaby, income, etc.)				_	
below. You must co be told, within 30 da expenses are more Supplemental Secu	omplete the recerting ays of the date you than your incom rity Income (SSI) a	fication process, inclu u turned in (filed) your e and liquid resource and SNAP benefits pri	ding signing the la recertification for es, you may be e	ast page of the recertification SNAP benefits, if your rece	n and being interview ertification is approve s within five calenda he recertification is th	ved. If eligible, yo d or denied. If yo ar days of the da	ou will get S our househo ate you file.	SNAP benefits back t Id has little or no inc If you are a reside	r name, address (if you have one) and sig o the date you filed the recertification. You ome or liquid resources, or if your rent and nt of an institution and are recertifying fo	u must d utility
SNAP RECIPIENT/REPRE	SENTATIVE SIGNATU	JRE			DATE SIGNED					
x										

LDSS-3174 Statewide (Rev. 07/23)

	SECT	ION 6 – HOUSEHOLD INFO	ORM	ATION	I – List e	verybo	dy who) lives wi	th you, e	ven if t	they ar	e not re	certifying	g with y	vou. List yo	ourself on the fi	irst lir	ne.			Does This Person (Including Minor Children) Buy Food or Prepare Meals with You? Highest School Grade Completed			
R	I LN	First Name	e Mi	ddle In	itial Las	t Name	2		This pe	erson is	recertify	/ing for:	Date of		Sex: (M/F/X)	Gender Iden (Male, Female Transgender, I	tity (C	Optional): Binary, X,	Relationship	of Rec	Social Security Number ertifying Household Members			
		i not nume	C, 1911		indai, Euc	, ruanic	•		PA	SN	AP	MA	(mm/dd/	уууу)	(M/F/X)	Transgender, I [please	Differei describ	nt Identity be])	to you:		uction book, PUB-1313 Statewide, or to your social services district)	•	YES	NO
	01																		SELF				120	
	02																							
	03																							
	04																							
	05																							
L	06								_															\vdash
-	07 08																							-
┝		Line	No.	ONC	FIRST NA	ME				1	M.I.	LAST N	AME						1					
		SE LIST MAIDEN OR		SINC		uvi 🗠					171.1.	LAGIN												
		R NAMES BY WHICH	1																					
	HOUS	SEHOLD HAVE BEEN	e No.	ONC	FIRST NA	ME					M.I.	LAST N	AME											
	KNOV																							
	ECTIC																							
H	AS ANY	ONE MOVED INTO THE HOUSE	HOLD) IN THE	E PAST YE	AR?	YES	□ NO _{DI}	ID THEY E	VER LI	/E IN NE	=vv	HAS ANY	ONE MC	OVED OUT O	F THE HOUSEHC	DLD IN	THE LAST	YEAR?					
IF	F YES, I	INDICATE BELOW.						Y	ORK STAT	E BEFC	ORE NO	W?	□ YES) IF YI	ES, INDICATE BE	LOW.							
N/	AME												NAME					WHEN [®]	?					
									□ `	′ES														
NA	AME								□Y	ES			NAME					WHEN:	?					
	ANYO	NE I YES I	NO				IF YES,	WHO			RI	EASON						END D	ATE					
N	ION-AP	PLICANT INFORMATION																						
							_			GALLY ONSIBL			FO WHC			CONTRIBUT DEEMED INC			IECK IF MEMB SNAP HOUSEH					
LN	•	FIRST NAME			LA	AST NAM	IE		YES	N	0		WIIC			DELINED INC			SNAF HOUSEH	OLD				
-																	_	_						
N	ION-CI	TIZEN WITH SATISFACTORY IMI	IMIGR	ATION S			TION		1							INDIVIDUAL	EDUC	ATION			CONSIDER			
		NON-CITIZEN STATUS			STA ADJU		EN	DATE OF		APPLIE CITIZE	D FOR	SPON	SORED	LN	DEGRE	E RECEIVED	LN	DEG	REE RECEIVE	D	✓ RCA/RMA REFERRAL			
L١	N				YES	NO	MONT H	DAY	YEAR	YES	NO	YES	NO	01			05							
														02			06							
														03			07							
														04			08							

lt w ber tha	ill not a nefits re- t progra ional ori ional ori H I B B W W U	ffect the ceived. m benefi gin. HISP/ NATIN ASIAN BLAC NATIN WHIT UNKN FOR EAC	K OR AFRICAN /E HAWAIIAN C	De persons or requestin uted withou ODR ALASKAN AMERICAN OR PACIFIC I Y) SECTION 6, OR L	I recertifying ing this infor ut regard to N NATIVE ISLANDER PLEASE ENT ATINO.) or the level mation is to race, color,	l of ensure or HISPANIC					
	н	I	Α	В	Р	w	U					
01			1	ļ		l						Г
01												
02												
03												
04												
05												
06												
07												
08									1	-		
LINE			TURE ACTION DATE	C/	ASE TYPE		RELATED	CASE NUMBERS	CONSIDER	REQUESTED	DOCUMENTATION	IN FILE
									✓ Relationship	REQUESTED		
									 ✓ Filing Unit ✓ Legally Responsible Relative 		Photo ID Birth Verification	
									✓ Single Economic Unit		Marriage License	
									✓ SNAP Household Composition		Social Security Card	
									✓ SNAP Aged/Disabled Individual		Code 9 Resolution	
	NEEDE	Ð		F	REFERRALS			COMPLETED	✓ Photo ID		Immigration Status	
					Legal				✓ AFIS (PA Only) ✓ CBIC/PIN		Multi-Suffix/Co-op Case Notice (Single	
					Services				✓ RFI/OCA		Economic Unit Questionnaire)	
					SSA				✓ Health Insurance			
				Cherry	NYSoH	Rolated			✓ Child Support Pass-Through			
				Chron	ic Care/SSI- MA-Only	Related			-			
				Medica	are Savings	Program						
					<u> </u>	v						

		ons, see the instruction book (PUB-1313 Statewide) or talk to your social services district.												
SECTION 9 – CITIZENSHIP/NON-CITIZEN WITH S	ATISFACTORY IMMIGRATION STATUS				SE	CTION 10 – CERTIFICATION								
LIST EVERYONE WHO IS RECERTIFYING OR WHO IS	LIST EVERYONE WHO IS RECERTIFYING OR WHO IS REQUIRED TO RECERTIFY. 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 U.S., or a non-citizen with satisfactory immigration status, and you are recertifying for: • Public Assistance, or • Public Assistance, or • Medicaid 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. NEEDED REFERRALS COMPLETED													
					System	atic Alien Verification for Entitlements (SA	VE)							
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 an non-citizen with a satisfactory immigration status, or provide an 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.														
The nousehold will receive reduced benefits. If you are a Native American, check citizen/national. Use Citizen/national. Description FIRST NAME MI LAST NAME Check either "CITIZEN / NATIONAL" or for each person. USCIS NUMBER (ALIEN REGISTRATION NUMBER) OR NON-CITIZEN NUMBER (If Applicable) DATE PA NA														
01	CITIZEN/ NATIONAL NON-CITIZEN A					Sign Name X								
02	CITIZEN/ NATIONAL NON-CITIZEN A					Sign Name X								
03	CITIZEN/ NATIONAL NON-CITIZEN A					Sign Name X								
04	CITIZEN/ INNALINAL NON-CITIZEN A					Sign Name X								
05	CITIZEN/ NATIONAL NON-CITIZEN A					Sign Name X								
06	CITIZEN/ NATIONAL NON-CITIZEN A					Sign Name X								
07	CITIZEN/ NATIONAL NON-CITIZEN A					Sign Name X								
08	CITIZEN/ NATIONAL NON-CITIZEN A					Sign Name X								
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 with					Date Signed:								

ECTION 11 – INFORMATION REGARDI	NG REFERRAL TO THE CHILD SUPPORT ENFORCEMENT UNIT			r				
 obtain medical support for yourself and y section. Include yourself, as appropriate: 1. Are you recertifying for an individual been established? Yes 2. Are you recertifying for an individual You do not need to complete this section if you the age of 21 for whom you are recertifying parent(s). 3. Are you under the age of 21? You You<!--</td--><td>tion to Public Assistance or the Supplemental Nutrition Assistance Program, your recertifying children. Answer the following questions to determine if you under the age of 21 who was born to unmarried parents and/or for whom leg No under the age of 21 who has an absent parent (noncustodial parent)? Yo nif you answered "No" to both of these questions. Go to the next sect answered "Yes" to either or both of these questions. Provide the name ing and any information you currently have about those individuals' noncustod parent information for your noncustodial, alleged, or intended parent parent for your noncustodial, alleged, or intended parent parent for your noncustodial, alleged, or intended parent parent parent for your noncustodial, alleged, or intended parent parent parent for your noncustodial, alleged, or intended parent parent parent for your noncustodial, alleged, or intended parent parent parent for your noncustodial, alleged, or intended parent parent parent for your noncustodial, alleged, or intended parent paren</td><td>a need to al parenta es ion. s of all in ial, alleg</td><td>o comple age has □ No dividuals</td><td>not</td><td>✓ Health custod Spouse</td><td>Acknowle or Paternii Child Sup Good Cat IV-D Atter Death Ce Divorce D VA Benef Order of Filiation/P Birth Certi CTHP CAP Referral f Services Parentag</td><td>pport Order use Form (LDSS-4279) station (LDSS-4281) rtificate Decree fits aternity/Parentage ficate REFERRALS or Child Support (LDSS-5145) e/Paternity CONSIDER of Non- ✓ Child Hea Absent ✓ TASA</td><td></td>	tion to Public Assistance or the Supplemental Nutrition Assistance Program, your recertifying children. Answer the following questions to determine if you under the age of 21 who was born to unmarried parents and/or for whom leg No under the age of 21 who has an absent parent (noncustodial parent)? Yo nif you answered "No" to both of these questions. Go to the next sect answered "Yes" to either or both of these questions. Provide the name ing and any information you currently have about those individuals' noncustod parent information for your noncustodial, alleged, or intended parent parent for your noncustodial, alleged, or intended parent parent for your noncustodial, alleged, or intended parent parent parent for your noncustodial, alleged, or intended parent parent parent for your noncustodial, alleged, or intended parent parent parent for your noncustodial, alleged, or intended parent parent parent for your noncustodial, alleged, or intended parent parent parent for your noncustodial, alleged, or intended parent paren	a need to al parenta es ion. s of all in ial, alleg	o comple age has □ No dividuals	not	✓ Health custod Spouse	Acknowle or Paternii Child Sup Good Cat IV-D Atter Death Ce Divorce D VA Benef Order of Filiation/P Birth Certi CTHP CAP Referral f Services Parentag	pport Order use Form (LDSS-4279) station (LDSS-4281) rtificate Decree fits aternity/Parentage ficate REFERRALS or Child Support (LDSS-5145) e/Paternity CONSIDER of Non- ✓ Child Hea Absent ✓ TASA	
NAME OF INDIVIDUAL UNDER AGE 21	NONCUSTODIAL, ALLEGED, OR INTENDED PARENT'S NAME AND ADDRESS	ALLEG	T'S DATE	DIAL, ITENDED OF BIRTH YEAR	NONCUSTODIAL, ALLEGE INTENDED PARENT'S SOCIAL SECURITY NUM	3		
			DAT	TENIC				

SECTION 12 – TAX FILING/DEPENDENT STATUS - Please select the tax status for each individual living in the household.													
FIRST NAME	MIDDLE INITIAL	LAST NAME		SINGLE	MARRIED FILING JOINTLY	MARRIED FILING SINGLE	G HOUSEHOLD		QUALFIYING WIDOW(ER) WITH DEPENDENT CHILD		DEPENDENT AND WILL BE FILING TAXES	WILL NOT BE FILING TAXES	
													-
													-
													1
													_
Tax dependents not li	vina in th	e household. P	lease list a	inv tax depende	nts who do not li	ve with vo	u and are claime	d by you or	anvone	in vour house	hold. If you do r	not file taxes. vou	-
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 NAME OF TAX FILER													_
FIRST NAME	M	11DDLE INITIAL		LAST NAME		-	FIRST NAM	1E		MIDDLE INITIAI	. L/	AST NAME	_
						-							-
													-
SECTION 13 – ABSEN					•		• .			· · ·			
NAME OF PERSON RECERT	IFYING	NAME OF SPOUS	E		DATE OF SPOUSE	SBIRTH	DATE OF SPOUSE'S F APPLICABLE	DEATH, SP	008E'S S	OCIAL SECURI	I Y NUMBER		
SPOUSE'S ADDRESS, IF AP	PLICABLE				CITY		COL	JNTY		STATE	ZIP CODE		
SECTION 14 – ABSEN	IT CHILD I	INFORMATION	– If anyone	e recertifying ha	l is a child under th	ne age of	21 living somepla	ace else, ple	ease indi	icate below.			-
					ADDRESS	OF CHILD	(STREET, CITY,			ESTABLISHED		Y CHILD SUPPORT?	
NAME OF PERSON RECERT	IFYING	NAME OF ABSEN	I CHILD	DATE OF BIR	COUNTY	, STATE, A	ND ZIP CODE)	Yes		No	Yes	No	_
 													-
													-
SECTION 15 – TEEN PA		TEEN PARENT						TEEN PARENT CHILDREN					
Is there a parent under the age of 18 ("teen parent") in the household? 🗆 Yes 🔅 No 📃 No Marital Status											LN NO		
-	-		-					ploma/High	_				
Name							-	-					LN NO
							4						
Does the teen parent's	child live ir	n the household?	? □ Yes	□ No			0						
Name of teen parent's child													

SECTION 16 – INCOME INFORMATION:												
Indicate if you or anyone who lives with you receives money from:	YES	NO	WHO	AMOUNT/VALUE & FREQUENCY	WHO	AMOUNT/VALUE & FREQUENCY						
Unemployment Insurance Benefits 1							LN No.	SOURCE CODE	AMOUNT	PERIOD		
Supplemental Security Income (SSI) Benefits (State and Federal Total) 2												
Social Security Disability (SSD) Benefits 3												
Social Security Dependent Benefits 4												
Social Security Survivor's Benefits 5												
Social Security Retirement Benefits 6												
Railroad Retirement Benefits 7												
Retirement Benefits (Pensions) 8												
Dividends/Interest from Stocks, Bonds, Savings, etc. 9												
Workers' Compensation 1)											
NYS Disability Benefits 1	1											
Veteran's Pension/Benefits/Aid and Attendance 1	2											
Public Assistance Grant 1	3											
GI Dependency Allotments 1	1											
Education Grants or Loans 1	5											
Contributions/Gifts (Received) 1	6											
Foster Care Maintenance Payments (Received) 1	7											
Child Support Payments (Received) Received From:									CONSIDER			
							√ C	hild Supp	oort Disregard/Pass-Throug	gh		
Spousal Support (Received) 1	9								ined □ Budgeted d/Disabled Indicator			
Private Disability Insurance - Health/Accident Insurance Policy								isability F				
Income 2								-	and Placement Grant (SN/	AP Only)		
No-Fault Insurance Benefits 2 Union Benefits (including Strike Benefits) 2									latching Grant	- ,,		
Loans, Other than Education (Received) 2									Income from Last Budget			
Income from a Trust (including income you are currently entitled to)						• •	inange in	moome nom Last Dudget			
receive, or were entitled to receive in the past, that has not been												
distributed) 2												
Training Allotments/Stipends 2	ō											
Rental Income (Received) 2	5											
Boarders/Lodgers Income (Received) 2	7											
Other												
Income												
(Please												
Specify)												
		1										

section: Deductions: Certain applicants/recipients t that they take on their the Internal Revenue	g for Medicaid, please complete the following types of Medicaid budgeting allow to reduce their countable income with deductions federal taxes. These are specific expenses that Service (IRS) allows people to deduct to reduce Only record deductions here if you will claim them tax return.	YES	NO	WHO	AMOUNT/VALUE FREQUENCY	& WHO	AMOUNT/VALUE & FREQUENCY	
Educator expenses	1							
Individual Retirement	Account (IRA) deduction 2							
Student loan interest	deduction 3							
Tuition and fees	4							
officials)	enses (reservists, artists, fee-based government 5							
Health savings accou	nt deduction 6							
Job-related moving ex								
Deductible part of self	f-employment (S/E) tax 8							
S/E, SIMPLE & qualifi	ied plans 9							
S/E health insurance	deduction 10							
Penalty on early witho	drawal of savings 11							
Alimony paid	12							
Domestic production a	activities deduction 13							
Additional adjustment	s added on line 36 (IRS Form 1040 only) 14							
Archer MSA deduction	n 15							
Other Adjustment _ (Please Specify)								
IMMIGRATION STAT	PARENT/NON-CITIZEN WITH SATISFACTORY US SPONSOR INFORMATION							
Answer all questions								
Does the stepparent of	of any children who live with			WHO?			NI	EEDED REFERRAL COMPLETED
you have any resourc kind?	es or receive income of any							UIB
satisfactory immigra for admission into th	busehold a non-citizen with tion status who was sponsored le U.S.?							
NAME OF SPONSOR:	РНО	NE NO	.:					
ADDRESS:								

LDSS-3174 Statewide (Rev. 07/23)

If not employed, when was the last time you or anyone who	lives with you worked?							
Who:	When:					DEPENDENT CARE EXPENSES		
Where:			6	Who Pays	Amount	Name	Age	Care Provider
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					\$			
					\$			
Are you or is anyone who lives with you participating in a st	rike? 🗆 Yes	□ No	7		\$			
Who:			'					
When the strike began:					\$			
Are you or is anyone who lives with you a migrant or season worker?	nal farm 🛛 Yes	□ No						
Who:			8					
Do you or any other adult who lives with you have any mediwork that can be performed? \Box Yes \Box No		lity to work or the	e type of					
Who:								
Describe Limitations:								
			9					
Could you accept a job today?	□ Yes	□ No	10					
If not, why?								
What type of work would you like to do?								
			11					

LDSS-3174 Statewide (Rev. 07/23)

IN FILE

YES

NO

SECTION 19 – EDUCATION/TRAINING								
What is your highest level of education completed?								
Less than high school diploma				REQUES	TED	DOCUMENTATION		IN
If so, last grade completed?					Scho	ol Attendance Verification		
Completion of an Individualized Education Plan (IEP)	0				(LDS	S-3708)		
 High school diploma or General Equivalency Diploma (GED) or Test Assessing Secondar Associate's Degree (2-year college degree) 	y Completion	ו (TASC™) 1			Educ	ational Grant Worksheet		
Bachelor's Degree (4-year college degree) or higher		1			Child	Care Statement		
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:		2		_	NEEDED	REFERRALS	COMPI	LETED
Date completed:		2		-		Supportive Services		
Indicate if you or anyone who lives with you who is recertifying for or getting assistance:			-	L		I		
Is or has been in any training program in the last 12 months?	□ Yes	□ No	1			CONSIDER		
Who						9 who is attending college half	-time or n	nore
Where		3				gibility requirement? or dependent care to attend sc	hool or	
Program			train	ing?	<u> </u>	arent who does not have a higl		or
Dates attended						ho is not attending school?		
Dates completed				yone in tra				
Is 16 years of age or older and is attending school or college?	□ Yes	□ No				ervices appropriate? ed expenses?		
Who		4	740	ancie any				
Where								
Is getting a Training Allowance? □ Yes □ No		5						
Who Amt. \$								
Is getting Educational Grants or Loans?		6						
Who Amt. \$		-						
Is under 16 years of age and is attending school?						7		
Who			Who					
School			school					
Who								
			Who					
School			School					

SECTI	ON 20 – RESOUR	RCES INFORMATI	ON												
Indicat	e if you or anyone	e who lives with you	u who is recertifying:	YES	NO	WHO	IF YES, AMOUNT/VALU	E v	VHO	IF YES, AMOUNT/VALUE	NEEDED		REFERRAL	COMPLETE	D
Has c	ash available		1				\$;	\$			Legal		
Has a	checking account	t(s)	2										Resource		
Has a	savings account(s) or certificate(s)	of deposit 3												
Has a	credit union acco	ount(s)	4												
Has li	fe insurance		5												
	tle or registration t er vehicle(s):	to a motor vehicle(5)												
		Model									FACE A	MOUNT	САЗН	VALUE	
		Nodel													
Other			6												
Has s	tocks, bonds, cert	ificates or mutual f	unds 7												
Has s	avings bonds		8												
Has an	IRA, Keogh, 401	(k) or deferred com	pensation account(s) 9												
Has a	n irrevocable buri	al trust	10												
Has a	burial fund		11								REQUESTED	DO	CUMENTATION	IN FILE	1
Has a	burial space		12									Resou	rce Checklist		
Has th	neir own home		13									Market	Value		
		ng income-producir	-									DMV C	learance		
	come-producing		14									Bank S	Statement		
, v	ible for an income	e tax refund	15									Assign	ment of Proceeds		
	n annuity		16										hicle Title	-	4
	beneficiary of a tr		17									Car/Ve (Older	hicle Registration Models)		
	e from any other s		tlement, inheritance or 18										Clearance		
	n "in trust" accour		19									RFI/OC	CA		
	safe deposit box(· · /	20									1099			
	•	an those listed abo											•		
			if not recertifying or												
living	with you) given av	way any cash, or so	old/transferred any real												
		onal property in the										CON	ISIDER		
Has a	nyone (including y	your spouse, even	if not recertifying or								✓ Children				
assets	s to a trust within t	the past 60 months	past or transferred any ?								✓ Lump S				
	when?	P	23									•	s, Snowmobiles	-	
					VEHICLE				✓ Individual Development Account (ID/ ✓ Exempt Vehicles		IDA)				
YR.	MAKE	MODEL	OWNER'S N	AME		AMOUNT OWED		EXEMPT 'ES* NO	LIEN HOLDE	ER ACCOUNT NO.					
						\$	\$				✓ Change	in Resc	ources from Last B	udget	
	MPT, WHY?					\$	\$								

SECTION 21 – MEDICAL INFORMATION					REQUESTED	DOCUMENTATION		IN FILE
Indicate if you or anyone who lives with you who is recertifying:	YES	NO	IF YES, WHO			Pregnancy Statement		
	TLS	NO	II TES, WHO			Med/Psych Statement		
Has any medical bills or medically-related expenses 1				-		Drug/Alcohol Screening (LDSS-457	71)	
Is on Medicaid with a spend-down 2						Drug/Alcohol Statement		
Has health or hospital/accident insurance (including insurance				POLICY NO.:		Paid or Unpaid Medical Bills		
from employer) 3				AMOUNT:		SSI Application Verification (PA ON	NLY)	
				FREQUENCY OF PAYMENT:		CONSIDER I Related		
Has health insurance available through an employer 4				INSURANCE COMPANY NAME:		Aged/Disabled Indicator		
				_		Medical Deduction		
Has Medicare (red, white, and blue card)5				WHO IS COVERED:		Reimbursement		
				_	✓ Buy-In	Eligibility		
Has a health attendant/home health aide 6				EFFECTIVE DATE:	✓ Kreige	r (LDSS-3664)		
					✓ Domes	stic Violence		
Is blind, sick or disabled 7				Is the answer to question 7 in this section consistent with Section 18 asking if the applicant or any other adult	🗸 SSI Re	eferral		
Is a child with a developmental disability 8				who lives in the household have any medical conditions		I Income Credit		
				that limit their ability to work or the type of work that they can perform?		e in Resources	1	
					NEEDED	REFERRALS	COMPI	PLETED
Is in a hospital, nursing home or other medical institution 9						SSI (D-CAP)		
Has paid or unpaid medical bills within 3 months preceding						Disability Interview (LDSS-1151)		
the month of this recertification 10						Medical Report (LDSS-486, 486t)		
Is or was drug or alcohol dependent 11						Disability Report		
Needs home care/personal care 12				7		AD		
Is on SSI or has ever applied for SSI 13				7		TPHI ACCES-VR		
Is pregnant				-				
If pregnant, due date: 14						CTHP		
Expected number of births:						Family Planning		
Receives treatment from a drug abuse or alcohol treatment						SSA (RSDI)		
program 15						Veteran's Benefits		
Has not been able to work for at least 12 months because of						Veteran's Counseling		
a disability or illness 16						Child Health Plus		
Has daily activity limited because of a disability or illness that						COBRA Eligibility		
has lasted or will last at least 12 months 17						Nurse's Aide Service		
Has been in a car accident or work-related accident in the past two	þ					Home Care		
years 18						NYSoH		
Has had a government agency (public program) besides Medicaid						MA-Only (DOH-4220)		
or Medicare pay any of your medical bills						SSI-Related/Chronic Care DOH-4220 with Supplement A)		
If yes, what agency 19						LDSS-4526 or local equivalent		
Will billing any other health insurance cause harm to your physical or emotional health or safety, and/or will it interfere with the privac and confidentiality of your application for or receipt of Medicaid? 20								

IN FILE

RETROACTIVE MEDICAID	who	DATE		w	но	AMOUNT	\$			
			RECURRING							
			MEDICAL EXPENSES							
			_							
MEDICAL B	ILLS: YES NO		TPHI							
	nrolled in Medicaid are required call 1-800-505-5678.	d to join a managed care	e health plan unles			N SELECTION ategory. Use this section	to choose a healt	n plan.	lf you do not know what health pla	ns are available, ask
Name of F	Plan You Are Enrolling In	Last Name	First Name	Date Of Birth mm/dd/yy	Sex M/F/X	ID# (from Medicaid Caro if you have one)	Social Secur	ty #	Primary Care Provider (PCP) or Health Center (check box if current provider)	Name and ID# of OB/GYN (check box if current provider)

		COSTS					IN
		50313	ACTUAL COST	_		Landlord Statement	
	A. Room	and Board				Rent Receipt	
	B. Rent					Tenant of Record	
	C. Trailer	Lot Rent				Customer of Record	
	D. Mortga	age Payment				Voluntary Restrict	
	1.	Principal				Mandatory Restrict	
	2.	Interest				Subsidized Housing	
	3.					Mortgage/Title Search	
						Section 8 Lease or Statement from Section 8 Office	
	4.					Property Lien	
						Shelter/Utility Repayment Agreement	
		Insurance)				CONSIDER	
IF YES,	0.	Included in Mortgage (Escrow			✓ Utility G✓ HEAP	uarantee	
\$	E. Total N	(Sewer, etc.) lortgage			✓ Foster C✓ SNAP H	Care-Related Additional Allowances lousehold Composition Rules	nt
\$	-]	✓ Real Pro✓ AIDS/HI✓ Property	opperty Tax Credit V Emergency Shelter Allowance / Lien	0
\$	 IF YES, AMOUNT	D. Mortga 1. 2. 3. 4. 4. 5. IF YES, AMOUNT 6. E. Total M Payme	S. Property Tax (including School Tax) 4. Homeowner's Insurance (incl. Fire Insurance) 5. Taxes Included in Mortgage (Escrow Payment)	D. Mortgage Payment D. Mortgage Payment Interest 3. Property Tax (including School Tax) 4. Homeowner's Insurance (incl. Fire Insurance) 5. Taxes (Included in Mortgage (Escrow Payment)) 6. Assessments (Sewer, etc.) E. Total Mortgage Payment (Line 1-6) TOTAL	D. Mortgage Payment D. Mortgage Payment 1. Principal 2. Interest 3. Property Tax (including School Tax) 4. Homeowner's Insurance (incl. Fire Insurance) 5. Taxes Included in Mortgage (Escrow Payment) 6. Assessments (Sewer, etc.) E. Total Mortgage Payment (Line 1-6)	D. Mortgage Payment 1. Principal 2. Interest 3. Property Tax (including School Tax) 4. Homeowner's Insurance (incl. Fire Insurance) 5. Taxes Included in Mortgage (Escrow Payment) 6. Assessments (Sewer, etc.) E. Total (Lines A - E) Yoral Yoral Yore	D. Mortgage Payment Voluntary Restrict 1. Principal Mandatory Restrict 2. Interest Subsidized Housing 3. Property Tax (including School Tax) Mortgage/Title Search 4. Homeowner's Insurance (incl. Fire Insurance) Section 8 Lease or Statement from Section 8 Office 5. Taxes Shelter/Utility Repayment Agreement Included in Mortgage (Escrow Vultility and/or Fuel Restrict Vultility Guarantee HEAP Subsidized Housing May Show Total Rent, NOT Client Amount Foster Care-Related Additional Allowances SNAP Household Composition Rules SNAP Aged/Disabled Indicator Values A - E) Real Property Tax Credit AlDS/HIV Emergency Shelter Allowance Property Lien

LDSS-3174 Statewide	(Rev	07/23)
LD00-5174 Otatewide	(1.0.0.	011201

SECTION 22 – SHELTER (CONT.)										
Do you or anyone who lives with you have the following expenses separate from your rent or other shelter expense?	YE	s no	IF YES, AMOUNT							
Electricity (for needs other than heat; example: lights, cookin hot water, etc.)	g, 1		\$							
Natural Gas (for needs other than heat; example: cooking, h water, etc.)	ot 2		\$		MONTHLY	MONTHLY	NAME OF	ACCOUNT	IN WHOSE NAME IS THE BILL? (CUSTOMER OF	WHO IS THE TENANT
Water	3		\$	A. Heat*	EXPENSES	ACTUAL COST	DEALER	NUMBER	RECORD)	OF RECORD?
Air Conditioning	4		\$		y (for cooking, lights, hot water) cooking, hot water)					
Propane (for needs other than heat)	5		\$	D. Liquid Pr	opane Gas lities or Expenses					
Sewer	6		\$	F. Air Cond	itioning					
Trash	7		\$	G. Utility Ins H. Sewer	tallation Fees					
Other Utilities and Expenses Specify	8		\$	I. Trash J. Water						
Do you live in public housing?	9									
Do you live in Section 8, HUD, or other subsidized housing?	10									
Do you live in a drug/alcohol treatment facility?	11		*Check Prima Natural G Kerosene		□ PSC Electr opane □ Municipal E		□ Coal □ Wood	Othe	er	
ADDITIONAL INFORMATION										
SECTION 23 – OTHER EXPENSES										
Indicate if you or anyone who lives with you who is recertifying:	YES	NO	IF YES	s, amount	HOW LEGALLY CHILE OFTEN OBLIGATED SNAP PAID					
Pays child support 1			\$		YES NO YES	NO				
Pays spousal support 2			\$							
Pays for child care 3			\$							
Pays for dependent care 4			\$							
Pays tuition, fees, or other educational expenses 5			\$							
Has additional expenses (Example: car payment, car insurance payment, credit card payments, other loan payments, etc.)			\$							
Specify: 6										
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? 7		YES								

SECTION 24 – OTHER INFORMATION			Γ	_	
Do you buy or plan to buy meals from a home delivery or communal dining service? 8	י 🗆	/ES			
Are you able to cook or prepare meals at home? 9	ר 🗆	/ES		VETERAN STATUS	VETERAN CODE
Have you or anyone in your household ever been in the U.S. military? Who? 10		/ES			
Has your spouse ever been in the U.S. military? 11	<u>ا</u> ا	/ES			
Is anyone in your household a dependent of someone who is or was in the U.S. military? Who? 12	□ ١	/ES	□ NO		
Indicate if you or anyone who lives with you who is recertifying:	YES	NO	WHO		
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?					
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?					
Have you or anyone who lives with you received benefits for which they were not entitled, which have not been fully repaid to this or another agency?					
Have you or any member of your household been convicted of making a fraudulent statement or representation of residence in order to receive Public Assistance in two or more states?					
Have you or any member of your household been convicted of fraudulently receiving duplicate SNAP benefits in any state after September 22, 1996?					
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?					
Have you or any member of your household been convicted of trading SNAP benefits for firearms, ammunition or explosives, or drugs?					
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?				_	
Are you or any member of your household violating probation or parole according to a court order?					
PROPERTY TRANSFER STATUS				4	
I have I have not Sold, transferred or given away any of my pro Assistance or SNAP benefits.	perty to	o anyo	ne to get Public		

NEEDED	REFERRAL	s co	OMPLETED		CONSIDER
	Services			✓ SNAP I	Dependent Care Deductions
	UIB		✓ District 62.5)	of Fiscal Responsibility (SSL	
		1			1
REQU	ESTED		DOCUMENT		IN FILE
		Statem	Dependent nent	Care	
		1	pments		
		Outsta	nding Over	payment	
			ng Disqualif		
					BUDGET DETERMINATION) IOUSEHOLD IS MEETING ITS
					CONSIDER
Actual Expense	s \$		7		xpenses, including: shelter,
	-3 φ			✓ Actual S	ty costs, telephone costs, etc.
					uel/Utility Costs
			_		ne Expenses
	\$			✓ Car Exp	
Actual Income					e/Appliance Rental
			1	✓ Cable T	V
= Difference	\$]	✓ Tuition	
	, T		l	✓ Out-of-P	ocket Medical Expenses
Does Client Re If Yes, From Wi			ards Differe	nce 🗌	Yes 🗆 No
category. For F		consider			e sure you reconsider the
	ential Persons				
• Ess	nily Anniatanaa	Extensio	ons		
	nily Assistance				

NOTES/COMMENTS

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 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.

NONDISCRIMINATION NOTICE –In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity.

New York State additionally prohibits discrimination based on transgender status, gender dysphoria, 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.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), 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.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form, which can be obtained online at https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the Complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted by: 1) mail: Food and Nutrition Service, USDA, 1320 Braddock Place, Room 334, Alexandria, VA 22314; 2) fax at (833) 256-1665 or (202) 690-7442; or 3) email: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the Complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted by: 1) mail: Food and Nutrition Service, USDA, 1320 Braddock Place, Room 334, Alexandria, VA 22314; 2) fax at (833) 256-1665 or (202) 690-7442; or 3) email: FNSCIVILRIGHTSCOMPLAINTS@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 available in Spanish, or call the State Information/Hotline Numbers found online at: <u>http://www.fns.usda.gov/snap/contact_info/hotlines.htm</u>.

This institution is an equal opportunity provider.

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.

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.

RELEASE OF EDUCATIONAL RECORDS I give permission to the New York State Department of Health and the social services district to obtain any information regarding the educational records of myself and/or my minor child(ren) for the following purposes: 1) verifying my eligibility for Public Assistance, the Supplemental Nutrition Assistance Program, and/or Medicaid; 2) conducting reviews or investigations that result from conflicting information provided as part of the eligibility process; 3) claiming Medicaid reimbursement for health-related educational services; and 4) providing the appropriate federal government agency with access to this information for the sole purpose of audit.

NEW YORK CITY HOUSING AUTHORITY RESIDENT CONSENT TO SHARE INFORMATION – If you are applying for assistance in New York City, this consent will allow the New York City Housing Authority ("NYCHA") to share information about you with the New York City Human Resources Administration/Department of Social Services (HRA) to help you and your household apply for assistance under the Supplemental Nutrition Assistance Program ("SNAP"), and/or for HRA cash assistance, which may include payment of rental arrears.

PAGE 19

If you sign this application below, NYCHA may share with HRA information relevant to your eligibility for, or level of, SNAP and/or cash assistance benefits including your name, address, date of birth, and rent and utility payment information (such as monthly rent amount, rent payment history, rent balance, and appliance fees). Additionally, by signing this application below, you represent that you have the authority to consent on behalf of minor children listed in this application and you authorize NYCHA to share that child's name, address, and date of birth with HRA.

HRA will keep confidential any information that NYCHA shares and may only share the information with the local, state, and federal agencies that oversee HRA's SNAP and cash assistance benefit programs.

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 waivered 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.

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 involved in caring for me or my family, 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 give consent by my primary 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 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 applying is necessary for consent to release abox is checked below. If more than one adult in the family is joining a Medicaid health plan, the signature of each adult is limited by the exten

Do no	ot disclose	HIV/AIDS	information	
 Don	at diaglaga	montal ha	alth informa	tion

Do not disclose mental health information

Do not disclose drug and alcohol 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 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 UNDER MEDICAID – I understand that I have a right as part of my Medicaid recertification, or within two years from the date of my application, to request reimbursement of expenses I paid for covered medical care, services, and supplies received during the three-month period prior to the month of my application. I understand that after the date of my 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.
- 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 whom you are legally responsible to support is recoverable from money you possess or may acquire. 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 <u>I and</u> 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.

PAGE 22

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 understand that I 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, I understand that I am required to cooperate with the Child Support Enforcement Unit to locate any noncustodial, alleged, or intended parent; establish legal parentage for each individual under the age of 21 born to unmarried parents; and establish, modify, and/or enforce orders of support. I also understand that I will be provided with the LDSS-4279 form, "Notice of Responsibilities and Rights for Support," which explains my responsibilities and rights if I do not cooperate with the Child Support Enforcement Unit.

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.

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	DATE SIGNED	SPOUSE OR PROTECTIVE REPRESENTATIVE SIGNATURE	DATE SIGNED						
x		x							
AUTHORIZED REPRESENTATIVE SIGNATURE DATE SIGNED									
x									

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 _____

Y	NYS Agen	icy-Based	l Voter	Registration	str	ation Form
*	"If you are not registered	to vote where you live now, would you	live now, wo	not plu		Important!
≔ [like to apply to register here today?"	s nease complete the	If you	lf you do not check		Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.
	YES VOTER REGISTRATION APPLICATION NO because I choose not to register OR	VITER REGISTRATION APPLICATION below sause I choose not to register OR		any box, you will be considered to have decided not		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 on the application form in private
	 I am already registered at my current address OR I asked for and received a mail registration form 	l at my current addre d a mail registration f		at this time.		Información en español: si le interesa obtener este formulario en español, lame 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
N I	Signature		Date			한국어: 한국어 한국어 양식을 원하시면 1-800-367-8683 으로 전화 하십시오.
١œ	Please Print Name					খাপ আশাল এহ কপাঢ হবেতাওে শেতে চাল তাহলে 1-800-367-8683 লম্বুরে (ফাল করুন
		VOTER	STRATI		PLI	
٥L	Yes, I need an application for I	an Absentee Ballot		rint or type	e in b	Please print or type in blue or black ink
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-	If you answered NO , do not complete this form	ot complete this form		arked "pendin swered NO to b	g" and oth of tl	you will be unable to cast a ballot in any Prior questions, you cannot register to vote.
e	Last Name	Fire	First Name			Middle Initial Suffix
4	Address where you live (do not give P.O. box)	ot give P.O. box)	Ā	Apt. No.		City/Town/Village Zip Code County
ß	Address where you get your r	mail (if different than above)	ve)	P.O. Box, Star Route, etc.	r Route	etc. Post Office Zip Code
9	Date of Birth	7 Gender (optional)	B Telephone	Telephone (optional)		Email (optional)
	The last year you voted Y	/our address was (give house number, street and city)	use number, stre	et and city)		
10	In county/state	Under the name (if different from your name now)	nt from your nam	le now)	 ຄ	 New York State DMV number Last four digits of your Social Security number Ido not have a New York State DMV or Social Security number
	Political Party					Affidavit: I swear or affirm that
	wish to enroll in a po Democratic party	litical party				 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.
11		arty			12	 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. Junderstand that if it is not true. I can be
	Ouner lo not wish to enroll in ar	1) political party and wish to be an independent voter	to be an independ	dent voter		convicted and tined up to \$5,000 and/or jailed for up to four years.
	No party				-	Signature or Mark in ink Date Date
		(Optional) Re	Register to	o donat	e X	donate your organs and tissues
Las	Last Name			By signi	ng be	By signing below, you certify that you are:
Firs	First Name	Middle Initial	I Suffix	16 ye Cons trans	ears of sent to solants	16 years of age or older Consent to donate all of your organs and tissues for transplantation. research. or both:
Adc	Address			 Auth iden 	orizinę tifying	Authorizing the Board of Elections to provide your name and identifying information to NYS Donate Life Registry for enrollment:
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Birt	Birth Date	Gender D M	ъ	รั 2 5	OVer	ע נופוא אס כטוווווווואאטטופו טו חפמונו ווטאטונמוא ערטון אַטעני מפמניו.
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Qualifications for Registration	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
 be a resident of the County, or of the City of New York at least 30 days before an election; not be in prison for a felony conviction; not claim the right to vote elsewhere; and not found to be incompetent by a court. 	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.	the DMV number (driver's license number or non-driver ID 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.	use a valid photo ID, a current utility bill, bank statement, iment that shows your name and address. You may include
If we are unable to verify your identity before Election Day, you will be asked for ID when you vote for the first time	u will be asked for ID when you vote for the first time.
To complet	To complete this form:
It is a crime to procure a false registration or to furnish false information to the Board of Elections.	se information to the Board of Elections.
Box 9: You must make one selection. For questions refer to Verifying your identity above.	srifying your identity above.
<i>Box 10:</i> 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."	an't remember when you last voted, put a question mark (?). ne. If not, write "Same"
<i>Box 11:</i> 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.	nal but that, in order to vote in a primary election of a political arty rules allow otherwise.