APPLICATION FOR ASSISTANCE

Welcome to the Department of Health & Human Services (DHHS),
Bureau of Family Assistance (BFA)

To apply for the programs and services we offer, you must fill out this *Application for Assistance*, then have an interview, and give us proof of your household circumstances. Please read all of the information given to you, and answer all of the questions as best as you can. ***Do not answer anything that you do not understand***. If you need help in filling out this *Application,* tell us. ***You have the right to immediately file your Application as long as it contains the applicant's name and address and the signature of a responsible household member or the household's authorized representative.*** However, we will be able to more quickly figure out if you can get benefits if you complete the entire *Application*. If you only want Supplemental Nutrition Assistance Program (SNAP formerly Food Stamp) benefits and are completing the full *Application*, please complete every Section except Section I.

BFA assistance is based on your income. Some BFA programs may also look at the cash value of things that you own, your "assets," when figuring out if you qualify for a program we offer.

SNAP Benefits

The Supplemental Nutrition Assistance Program (SNAP) helps low-income people buy the food they need for good health. You will need to have an interview with a DHHS worker to see if you are eligible for this program. Your SNAP benefits are based on the date of application, which is the date your completed application is received by the District Office. If you are a resident of an institution who is jointly applying for SSI and SNAP benefits prior to leaving the institution, the filing date of your application is your date of release from the institution. With identification, you may get emergency SNAP benefits within 7 calendar days if:

- you have less than $150 in monthly gross income and no more than $100 in liquid resources;
- you have shelter costs that are higher than your gross income and liquid resources; **or**
- you are a migrant or seasonal farm worker who is destitute as defined in 7 CFR 273.10(e)(3).

Social Security Numbers (SSN)

The Federal Privacy Act of 1974 as amended, requires that we tell you the laws that allow us to ask for the SSN of each person requesting assistance, whether you are required to give them to us, and what we will do with them. SSNs are required for the following programs. After each program is the law or regulation that requires us to ask for these SSNs:

- FANF: 42 USC 405(c)(2), 45 CFR 205.52, RSA 167:4-c, & RSA 167:79,iii(h).
- SNAP: RSA 167:4-c, Food and Nutrition Act of 2008 (formerly Food Stamp Act), as amended, 7 USC 2011-2036, 7 CFR 273.2(b)(4)(i), & 7 CFR 273.6.
- Medical Assistance and other financial assistance: RSA 167:4-c, Section 2651 of PL 98-369, 42 CFR 435.910, 42 CFR 435.920, & 42 USC 1320b-7.

Each person who wants assistance from the above programs must provide a SSN or apply for a SSN at the Social Security Administration (SSA). Members of your household who do not want to apply for benefits do not need to provide a SSN. Giving us a SSN is optional for persons who are not applying for assistance. Giving us a SSN can save you time and money getting needed verifications.

If you are applying only for some members of your family, such as a parent applying for Medical Assistance just for a child, you only have to give us the child's SSN or apply for a SSN for your child. Your child's eligibility for medical coverage will not be affected if you only give us your child's SSN.

If a SSN is not provided for each person who is applying for the listed programs, your application may be denied or you may get less benefits. If someone wants help getting a SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY: 1-800-325-0778.

Applicants who only want Child Care do not have to provide a SSN, but if SSNs are provided, it may help shorten the eligibility verification process.

We ask for SSNs so we can verify identity, other benefits received, earned and unearned income, and resource information you give us. It will be shared and verified with:

- federal, state, and local entities;
- offices within DHHS as allowed by federal law;
- employment and unemployment databases;
- the Internal Revenue Service and SSA;
- contracted third parties;
- financial entities; and
- other computer matching programs.

The information will be used:

- to figure out if you are eligible or continue to be eligible for the assistance you requested;
- to figure out the amount of your benefits or errors in your eligibility or benefits; and
- in an investigation of suspected abuse of program law or rules.

It may be disclosed to Federal and State agencies for official examination, and to law enforcement officials

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for the purpose of apprehending persons fleeing to avoid the law. If a SNAP claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action.

We do not give SSNs or any other information regarding non-applicants to the US Citizenship and Immigration Services (USCIS), or any other agency not directly connected with programs and/or services offered by DHHS.

Emergency Medicaid for Non-Citizens

Emergency Medicaid may be available to certain non-citizens, regardless of their immigration status, to cover some emergency services, including labor and delivery. ***Social Security Numbers are not needed to apply for Emergency Medicaid.***

Citizenship & Identity

You must declare and prove the citizenship or non-citizenship status of each household member applying for assistance. Non-citizens applying for assistance, except Emergency Medicaid, must provide USCIS documentation of qualified alien status. USCIS documentation will be verified and non-citizen status of applicant household members will be subject to verification through the submission of information from the application to USCIS, and the submitted information received from USCIS may affect eligibility and benefits.

Third Party Insurance or Medical Payments

If you are applying for Medical Assistance, receipt of such assistance is an assignment to DHHS of your rights to all third party insurance or medical payments without anyone having to sign any other form. All available parties must be billed and all resulting payments must be applied to the cost of medical care before DHHS will pay. Also, if you receive a settlement or an award from a liable third party, you must pay DHHS back for related medical services we paid. RSA 167:14-a

Benefits Received in Error

You are required to pay back any benefits or services received in error, regardless of whether you made a mistake in the information you provided, or failed to provide, to us. If you get SNAP, you must also pay back any benefits you received in error if we made a mistake in processing your case.

Financial or Medical Child Support

If you are applying for TANF cash payments, your receipt of such assistance is an assignment to DHHS of your rights to financial child support. Without signing any other form, you give DHHS the right to collect and keep financial child support payments made on behalf of your children who receive assistance. RSA 161-C:22

DHHS collects and keeps the support to partially offset the amount of cash assistance paid to you. If support payments are equal to or more than the amount we give you, your cash assistance case will be closed and the support payments sent to you.

Receipt of Children's Medicaid is an assignment of medical child support rights. This means that you must cooperate with DHHS to establish and enforce medical child support for your children. Medical child support usually means health insurance provided by the absent parent, but can also be an ongoing dollar amount paid by the other parent to allow you to buy health insurance for your children.

If you receive money to purchase medical insurance, this money will be kept by the State if you receive Medicaid for your child and will be used to pay back the state and federal governments. If paternity is not established for any of your children who are getting Medicaid, you must also cooperate with DHHS to legally establish paternity.

The assignment of support rights is a requirement. Your rights and responsibilities and the penalty for refusal without a good reason, will be explained to you when you meet with your District Office worker.

Begin Date for Medicaid Eligibility

Your Medicaid eligibility generally begins on the day that you meet all the requirements for the program you applied for, including the resource limit.

AGENCY USE ONLY

This is your record of application and will be filled out by a Department of Health and Human Services worker and returned to you. BFA has received

a completed application for ______________________ from ______________________ on ______________

______________________ ______________________

District Office Signature of Worker

APPLICATION FOR ASSISTANCE

A. Please tell us about who you are and where you live.

Full Legal Name: ____________ **Primary Language:** ____________

Current Place of Residence: ☐ Own home ☐ Nursing Facility ☐ Adult Family Home ☐ Assisted Living ☐ Congregate Housing ☐ Homeless ☐ Hospital ☐ Hotel/Motel ☐ Residential Care Facility ☐ Other

Street Address: ____________ **Mailing Address:** (if different) ____________

City/State/Zip: ____________ ____________

Home Phone: ____________ **Work Phone:** ____________ **Cell/Message:** ____________

E-Mail Address: ____________ ☐ **I do not have an E-Mail address**

Does anyone in your family have Medicare Part A or B? ☐ Y ☐ N

Why do you need our help? ____________

Information Supplier: (if different from applicant) ____________
Name Address Phone #

B. Please tell us about the people you live with. Start with yourself and list ALL of the people living with you. *You do not have to give the Social Security Number or citizenship status of any individual who is not applying for assistance.*

Full Legal Name	SSN	DOB	Relation to you	U.S. Citizen?	Student (Yes or No. If Yes, put grade too)	RID (BFA Use Only)
1.			SELF	☐ Y ☐ N		
2.				☐ Y ☐ N		
3.				☐ Y ☐ N		
4.				☐ Y ☐ N		
5.				☐ Y ☐ N		
6.				☐ Y ☐ N		

C. I want to apply for: (TYPES OF ASSISTANCE REQUESTED)

☐ ALL PROGRAMS ☐ Cash ☐ SNAP ☐ Child Care

☐ Home and Community-Based Care (HCBC) ☐ Medicare Savings Programs (MSP) [QMB/QWDI/SLMB/SLMB135]

☐ Nursing Facility (NF) Services - Facility Name: ____________

☐ **Medical Assistance –** if you need Medical Assistance for a child, pregnant women, or parent/caretaker relative of a child, you must also complete the insert entitled *Medical Assistance for Children, Pregnant Women, and Parent/Caretaker Relatives Insert*

D. *The following information is collected to be sure that everyone is served fairly without regard to race, color, or national origin. Your answers are voluntary. The information provided will not affect your eligibility or benefit amount. For ethnicity, please select one response. For race, please select all that apply.*

Ethnicity: Are you Hispanic or Latino? ☐ Yes ☐ No

Race: Are you: White? ☐ Y ☐ N Asian? ☐ Y ☐ N Native Hawaiian or Other Pacific Islander? ☐ Y ☐ N

Black or African American? ☐ Y ☐ N American Indian or Alaskan Native? ☐ Y ☐ N

AGENCY USE ONLY:

RFA# ____________ Case # ____________ Forms Given: 725 177

Cash ____	OPEN	CLOSE	DENY	DATE: ____	DO: ____
SNAP	OPEN	CLOSE	DENY	DATE: ____	DO: ____
MA ____	OPEN	CLOSE	DENY	DATE: ____	DO: ____
CM/MCPW	OPEN	CLOSE	DENY	DATE: ____	DO: ____
Child Care	OPEN	CLOSE	DENY	DATE: ____	DO: ____

EBT Card Status: None Active Bad Address Deactivated/Cancelled Undelivered

E. Please tell us about all income for everyone in your home.

Your Wages: $ ________ ☐ Weekly ☐ Bi-Weekly ☐ Monthly

Other Wages: $ ________ ☐ Weekly ☐ Bi-Weekly ☐ Monthly

Other Wages $ ________ ☐ Weekly ☐ Bi-Weekly ☐ Monthly

Has anyone recently lost a job? ☐ Yes ☐ No

If yes, who? ________ When? ___/___/___

SSA/SSDI:	$	Spousal Support:	$
SSI:	$	Unemployment:	$
VA:	$	Child Support:	$
Pension:	$	Other:	$

F. Please tell us about all assets for everyone in your home.

Checking/Savings:	$	Other Chk/Save:	$
Stocks/Bonds/CD's:	$	IRA:	$
Your or Your Spouse's Annuity:	$	Other Assets:	$
Trusts:	$	Life Insurance:	$
Vehicle (Yr/Mdl):		Vehicle (Yr/Mdl):	

G. Your Expenses:

Rent (monthly):	$
Mortgage (monthly):	$
Lot Rent/Condo Fee (monthly):	$
Taxes (yearly):	$
Dependent Care:	$
Medical Expenses:	$
Cost of doing business:	$

Have you gotten more than $20 in fuel assistance in this or the past 12 months? ☐ Yes ☐ No

Do you pay for the following utilities separate from your rent or mortgage?

Heat: ☐ Yes ☐ No

Phone: ☐ Yes ☐ No

Electric: ☐ Yes ☐ No

Other: ☐ Yes ☐ No

H. Please answer all questions.

1. Are you a migrant or seasonal farm worker? ☐ Yes ☐ No
2. **Have you or anyone in your household received SNAP assistance for this month? ☐ Yes ☐ No**
3. Are you currently living in a shelter for battered individuals? ☐ Yes ☐ No
4. **Is anyone in your household blind or disabled? ☐ Yes ☐ No**
5. Have you sold or transferred property in the last 5 years? ☐ Yes ☐ No
6. **Is anyone in your household currently receiving assistance from another State? ☐ Yes ☐ No**
   If yes, which State? What kind of assistance?

I. Do you only want SNAP? If so, you can skip to Section J now. If you want cash, medical or child care help, please answer all questions in this Section before proceeding to Section J.

1. Is anyone in your household pregnant or has anyone given birth in the last 3 months? ☐ Yes ☐ No
2. **Do you have any unpaid medical bills from the past 3 months that you would like help paying? ☐ Yes ☐ No**
3. If you are applying for Financial Assistance to Needy Families (FANF), is the father's name blank or "not stated" on the birth certificate for any of your children? ☐ Yes ☐ No
4. **If applying for FANF, how many absent parents?** ________
5. Do you or any other household member have health insurance other than Medicaid? ☐ Yes ☐ No
   If yes, name of Insurer? Policy Number:

J. Signatures

I CERTIFY, UNDER PENALTY OF PERJURY, THAT I HAVE REVIEWED THIS INFORMATION ON THIS APPLICATION, INCLUDING ANY INFORMATION INDICATED ON THE INSERT; IT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE, INCLUDING THE INFORMATION CONCERNING CITIZENSHIP AND ALIEN STATUS OF THE MEMBERS APPLYING FOR ASSISTANCE. I UNDERSTAND A FULL FINANCIAL AND MEDICAL ELIGIBILITY INTERVIEW MAY NEED TO BE CONDUCTED BEFORE MY ELIGIBILITY CAN BE DETERMINED.

Applicant Signature ________ **Date** ________

Signature of Person Helping the Applicant ________ **Date** ________ **Relationship to Applicant** ________

I withdraw my application for: ☐ Cash ☐ Medical Assistance ☐ SNAP ☐ Child Care ☐ HCBC/NF ☐ MSP

Signature ________ **Date** ________

I certify that I have given the above individual(s) the opportunity to review this application. I also certify that I have provided a copy of this form, if one was requested.

Printed Name & Signature ________ **Title/Agency** ________ **Date** ________