STATEMENTS OF UNDERSTANDING

All Programs

INITIALS

I certify that I have read and understand "Your Rights and Responsibilities". _____

I understand that DHHS will keep my eligibility and case information confidential and only persons involved in administering DHHS' programs or as otherwise permitted by Federal regulations or State law will review it. _____

I understand that despite other rules of confidentiality, names of children in SNAP and/or FANF households are required to be released to schools so that they may be determined automatically eligible for Free and Reduced School Meals. _____

I understand that I must provide proof of: my household situation, what I have written on the application, and what I have told DHHS. _____

I understand that the information I have provided will be verified by collateral contacts and/or Federal, State, and local officials and that if any information is found to be incorrect or false, or if I have deliberately withheld information related to my receipt of assistance, now or in the future, I may lose my benefits and may be prosecuted for fraud. _____

I understand that my signature below and/or on the application authorizes DHHS and any contracted third party to obtain verification that I or anyone in my household meet the eligibility requirements for assistance, and authorizes release of such information to DHHS. My authorization to release information to DHHS remains in effect for as long as I or anyone in my household receives any kind of DHHS assistance. _____

I understand that my signature below **and/or** on the application permits DHHS and any contracted third party entity to verify my income, identity, and assets, and the income, identity, and assets of any other person whose income, identity, and assets are required to determine eligibility for the assistance I am requesting. Failure to give permission to conduct these verifications or revoking permission to conduct these verifications will result in denial or termination of assistance. _____

I understand that if I am required to have an interview, I will be sent an Eligibility Interview Summary (EIS) after my interview. I agree to review this EIS and will notify DHHS within 10 days if any of the information is incorrect or has changed. _____

Cash & SNAP Programs

I certify that if I applied for FANF, the Domestic Violence Option has been explained to me, and I understand it. _____

I certify that if I applied for FANF, I got written information about the treatment of lump sum income. _____

I understand that my receipt of TANF cash assistance is an assignment to DHHS of each recipient's rights to child and spousal support. _____

I understand that if I get cash assistance from DHHS, the cash I get could cause my SNAP benefits to end or be reduced. I also understand that if this happens, I will not get advance notice of this change. _____

I understand that to get a cash payment from any BFA program, I must be eligible to get that cash every day of the entire payment period. If I am not eligible for cash at any time during that payment period, I understand that a cash payment will not be issued to me. _____

I understand that in NH, if anyone in my household is fleeing to avoid prosecution of a felony crime, or is violating conditions of probation or parole, that person will be ineligible to get cash or SNAP benefits until that individual has satisfied his/her legal obligations with respect to the felony crime or probation or parole violations. My signature below is my sworn statement that I will notify DHHS if anyone in my household is fleeing felony prosecution or violating conditions of probation or parole. _____

I understand that if anyone in my household has been convicted, as an adult, of a crime of aggravated sexual abuse, murder, sexual exploitation and other abuse of children, a Federal or State offense involving sexual assault, or an offense under State law determined by the Attorney General to be substantially similar to such offence, after February 7, 2014, and is out of compliance with terms of the sentence, that person will be ineligible to get cash or SNAP benefits. My signature below is my sworn statement that I will notify DHHS if anyone in my household has been convicted of such crime and is out of compliance with the terms of their sentence. _____

I understand that the use of my Electronic Benefits Transfer (EBT) card for SNAP or cash benefits is controlled by my 4-digit Personal Identification Number (PIN), that I am responsible for the security of my EBT card and PIN, and that EBT benefits will not be replaced if someone else uses my card after I have activated it. _____

PLEASE INITIAL AND SIGN THE BACK!

Cash & SNAP Programs Con't

INITIALS

I understand that my EBT card or cash from my EBT card cannot be used at stores in which more than 50% of visible inventory is alcohol, or that primarily engage in body piercing, branding, or tattooing, gaming establishments, or cigar, pipe, smoke, or tobacco stores/stands/shops, most marijuana dispensaries, or businesses in which more than 50% of visible inventory being sold or rented is material considered adult-oriented entertainment per RSA 650:1,III, and that if I use my EBT card or cash from my EBT card at one of these places, I will be sanctioned with a cash penalty, per RSA 167:7-b and He-W PART 608. _____

I understand that if I do not use my SNAP benefits on my EBT card for 274 days in a row, I will lose those benefits and not get them back. If I do not use my cash benefits for 90 days in a row, I will lose those benefits and not get them back. I understand that I will be disqualified from the SNAP Program and may be prosecuted if I use my EBT card for illegal purposes. These illegal activities include selling my card and my PIN for cash, drugs, or other items, or exchanging SNAP benefits for cash at a retailer. _____

I understand that for SNAP benefits, to get a deduction for child care expenses, rent or mortgage payments, utility or other shelter expenses, child support paid to a non-household member, or medical expenses (only for the elderly or disabled), I **must** tell DHHS about these expenses and then provide proof of them. Failure to report or verify any of the above listed expenses, or of receipt of fuel assistance, could mean that I will get less SNAP benefits each month, and will be seen as my statement that my household does not want to get a deduction for the unreported or unverified expense. _____

I certify that I have reviewed BFA Form 215 *Reporting Requirements* and BFA Form 216 *Are You An ABAWD?* and understand the requirements that have been explained to me. _____

I understand that my receipt of SNAP requires that I comply with SNAP work requirements. **I certify** that I have read and understand BFA Form 213, *SNAP Work Requirements*. _____

Medical Assistance

I understand that my receipt of medical assistance is an assignment to DHHS of my rights to all third party medical insurance or payments, including medical child support. _____

I understand that my receipt of medical assistance means DHHS must be able to obtain medical records from medical providers. My signature below and/or on the application authorizes my family's medical providers to release any records to DHHS. _____

I understand that, if I am in a nursing home, DHHS must be able to exchange eligibility information with the nursing home to best administer the program. My signature below and/or on the application authorizes that exchange and remains in effect for as long as I receive DHHS assistance for my nursing home care. _____

I understand that for long-term care services (Nursing Facility or Home and Community-Based Care), I am required to disclose to DHHS any interest that my spouse or I have in any annuity. _____

I understand that if either my spouse or I are requesting long-term care services, any annuity purchased or modified by my spouse or me on or after February 8, 2006 will be considered a transfer of assets for less than fair market value unless the State is named the beneficiary for at least the amount of Medicaid paid for long-term care services. _____

NH Child Care Scholarship

I understand that I must only use child care services paid for by DHHS for those employment-related activities approved by DHHS. I may have to reimburse DHHS for those payments made for times I was involved in other, non-approved activities. _____

Signatures

I certify, under penalty of perjury that I have reviewed the above information and it is true and complete to the best of my knowledge.

_____ _____
Applicant Signature | Date

_____ _____ _____
Printed Name and Signature of Person Helping the Applicant | Date | Relationship to Applicant

I certify that I have given the above signed individual(s) the opportunity to review this document, and that I have completely explained and given them a copy of the Rights and Responsibilities Notice. I also certify that I have given them a copy of this page, if it was requested.

_____ _____ _____
Printed Name & Signature | Title/Agency | Date

Nondiscrimination Statement

Do Not Send Applications Here

In accordance with federal civil rights laws and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on 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 in any program or activity conducted or funded by USDA. Programs that receive federal financial assistance from the U.S. Department of Health and Human Services (HHS), such as Temporary Assistance for Needy Families (TANF), and programs HHS directly operates are also prohibited from discrimination under federal civil rights laws and HHS regulations.

Persons with disabilities who require alternative means of communication for 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 who have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

CIVIL RIGHTS COMPLAINTS INVOLVING USDA PROGRAMS

USDA provides federal financial assistance for many food security and hunger reduction programs such as the Supplemental Nutrition Assistance Program (SNAP), the Food Distribution Program on Indian Reservations (FDPIR) and others. To file a program complaint of discrimination, complete the Program Discrimination Complaint Form, (AD-3027) found online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1. **mail**: Food and Nutrition Service, USDA
   1320 Braddock Place, Room 334, Alexandria, VA 22314; or
2. **fax**: (833) 256-1665 or (202) 690-7442; or
3. **phone**: (833) 620-1071; or
4. **email**: FNSCIVILRIGHTSCOMPLAINTS@usda.gov.

For any other information regarding SNAP issues, persons should either contact the USDA SNAP hotline number at (800) 221-5689, which is also in Spanish, or call the state information/hotline numbers (click the link for a listing of hotline numbers by state); found online at: SNAP hotline.

CIVIL RIGHTS COMPLAINTS INVOLVING HHS PROGRAMS

HHS provides federal financial assistance for many programs to enhance health and well-being, including TANF, Head Start, the Low Income Home Energy Assistance Program (LIHEAP), and others. If you believe that you have been discriminated against because of your race, color, national origin, disability, age, sex (including pregnancy, sexual orientation, and gender identity), or religion in programs or activities that HHS directly operates or to which HHS provides federal financial assistance, you may file a complaint with the Office for Civil Rights (OCR) for yourself or for someone else.

To file a complaint of discrimination for yourself or someone else regarding a program receiving federal financial assistance through HHS, complete the form on line through OCR's Complaint Portal at https://ocrportal.hhs.gov/ocr/. You may also contact OCR via mail at: Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201; fax: (202) 619-3818; or email: OCRmail@hhs.gov. For faster processing, we encourage you to use the OCR online portal to file complaints rather than filing via mail. Persons who need assistance with filing a civil rights complaint can email OCR at OCRMail@hhs.gov or call OCR toll-free at 1-800-368-1019, TDD 1-800-537-7697. For persons who are deaf, hard of hearing, or have speech difficulties, please dial 7-1-1 to access telecommunications relay services. We also provide alternative formats (such as Braille and large print), auxiliary aids and language assistance services free of charge for filing a complaint.

This institution is an equal opportunity provider.

Do Not Send Applications Here