

INSTRUCTIONS

1. You must use a pen when answering the questions. **DO NOT** use a pencil.
2. This form is designed to be completed by you. You may have a friend or relative help you with this form, but **YOU** are responsible for the information provided on the form. If you need additional help completing this form, leave the items blank and a Worker will assist you.
3. You can authorize someone outside your household to apply for **Supplemental Nutrition Assistance Program (SNAP)** and/or use your **benefits** for you. If you wish to designate such a person, please list the person you authorize on page 22. **NOTE: This person may or may not live with you.**
4. If you make a mistake, please draw a line through the mistake, and then write the correct answer. Initial the corrected answer.

\$502.44 DM

For Example: Income - ~~\$581.04~~
5. "The U.S. Department of Agriculture (USDA) prohibits discrimination in all its programs and activities on the basis of race, color, national origin, gender, religion, age, disability, political beliefs, sexual orientation, or marital or family status. (Not all prohibited bases apply to all programs.) Persons with disabilities who require alternative means for communication or program information (Braille, large print, audiotape, etc.) should contact USDA's TARGET Center at (202) 720-2600 (voice and TDD). To file a complaint of discrimination, write to USDA, **Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, DC 20250-9410** or call **(800) 795-3272** or **(202) 720-6382 (TDD)**. USDA is an equal opportunity provider and employer."

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES APPLICATION / REDETERMINATION

The application will be considered if it contains a minimum of the Name, Address, and Signature below. The amount of **SNAP** benefits will be determined from the date of application. The amount of cash assistance will be determined from the date eligibility requirements are met, including signing the Personal Responsibility Contract (PRC) and participating in orientation.

I understand that it is a criminal violation of federal and state law to provide false or misleading information for the purpose of receiving benefits to which I am not by law entitled.

I understand my responsibility to provide complete and truthful information.

Person Providing Information:

(First Name)	(MI)	(Last Name)	(Signature)	(Date)
--------------	------	-------------	-------------	--------

If you are not the person requesting assistance, do you live in the home with the applicant? YES NO

Applicant(s) Name if Different From Above:

(First Name)	(MI)	(Last Name)	(Signature)	(Date)
--------------	------	-------------	-------------	--------

(First Name)	(MI)	(Last Name)	(Signature)	(Date)
--------------	------	-------------	-------------	--------

Address where applicant lives:

HOUSE NUMBER STREET CITY STATE ZIP CODE

Mailing Address if different:

HOUSE NUMBER STREET CITY STATE ZIP CODE

Telephone Number where the applicant can be reached: (Area Code) + (Phone Number)

Directions to the home (please be specific):

Three horizontal lines for providing directions to the home.

Name and address of a relative or friend to contact should it be necessary:

NAME ADDRESS RELATIONSHIP TELEPHONE NUMBER

SECTION I - BENEFIT INFORMATION

Are you a resident of West Virginia? YES NO

Are you currently receiving benefits? YES NO

If yes, from what State/County?

If yes, what benefits?

In whose name do you receive these benefits?

Have you received benefits in the past in West Virginia? YES NO

If yes, what type and when?

In whose name did you receive these benefits?

Are you currently residing in a shelter for battered women? YES NO

Have you moved from another state? YES NO

If yes, what State/County? Date Moved:

Were you receiving benefits from that state? YES NO

If yes, what type and when?

In whose name did you receive those benefits?

SECTION II - EXPEDITED SERVICES

You may qualify for expedited processing of your **SNAP** application. If eligible, this means that you will receive **benefits** no later than seven (7) days after the date you apply. Answers to the following questions will determine if you qualify for this service.

- A) **Have you received SNAP benefits this month?** YES NO
If so, are you staying in a shelter for battered women? YES NO
- B) **How much do you have in cash and/or bank accounts?** \$ _____
- C) **What is your household's monthly income before any deductions?** \$ _____
- D) **How much is your rent/mortgage each month?** \$ _____
- E) **Are you obligated to pay a utility expense?** YES NO
If yes, are you or anyone who lives in your residence obligated to pay a heating or cooling cost? YES NO
- F) **Is anyone in your household a migrant and/or seasonal worker?** YES NO

SECTION III - HOUSEHOLD COMPOSITION

Complete a box for each person who lives in your home. Complete all information for each person. Begin with **YOURSELF** on Page 4. **If MORE THAN five (5) persons are in the home, extra sheets are available.**

NOTE: For Nursing Home or other specialized medical care, complete for **YOURSELF** and **YOUR SPOUSE** and **DEPENDENTS** in the home.

Citizen/Alien/Age Declaration

I certify under penalty of perjury, by signing my name below, that I am a United States Citizen or alien in lawful immigration status. This declaration of citizenship or alien status is a condition of eligibility for WV WORKS, Medicaid, and **SNAP**. Any household member for whom citizenship is not declared is not eligible to receive benefits. However, his income and assets will be considered available to the remaining members of the household.

Name (month) / (day) / (year)

III.A - Applicant Information

Applicant's Legal Name: _____
First Middle Last

Social Security Number (SSN): _____
If you do not have a SSN, list the date you applied: (mm/dd/yy) _____

Applicant's Birthdate: (mm/dd/yy) _____

Are you known by any other name(s)? YES NO
If yes, list other name: _____

Marital Status (please check one): Single/Never Been Married Married
 Divorced Separated
 Widowed

If you are under age 18, have you been declared an adult? YES NO
United States Citizen? YES NO

If no, complete the following:

INS Number: _____

Country of Citizenship: _____

U.S. Entry Date: (mm/dd/yy) _____

Sponsor Name: _____

Sponsor's Address: _____

Alien Status: _____

Alien Status Date: (mm/dd/yy) _____

Do you speak English? YES NO

If no, what language do you speak? _____

Are you currently attending school? YES NO
If yes: Full-time Part-time

Name/Address of School: _____

Do you have a High School diploma or GED equivalent? YES NO

If no, last grade you completed: 12 11 10 9 8 7 6
 5 4 3 2 1 K

Did you have any schooling after High School or GED? YES NO

If yes, do you hold any degrees, licenses or certificates? YES NO

Please specify: _____

Do you receive any of the following?

SSI YES NO If YES, date began: (mm/dd/yy) _____

Foster Care YES NO If YES, date began: (mm/dd/yy) _____

Adoption Assistance YES NO If YES, date began: (mm/dd/yy) _____

Do you intend to reside in WV? YES NO

Are you under the control of the courts and work without pay? YES NO

If you are not a parent, are you acting as a parent to anyone under age 18 **who is not a** YES NO

biological or adopted child?

Social Security Number (SSN): _____
 If this person does not have a SSN, list the date this person applied: _____
 Birthdate: _____
 Relationship to Applicant: _____
 Is this person known by any other name(s)? YES NO
 If yes, list other name: _____
 Does this person live with you? YES NO
 If no, where does this person live? _____

Marital Status (please check one): Single/Never Been Married Married
 Divorced Separated
 Widowed

If under age 18, has this person been declared an adult? YES NO
 United States Citizen? YES NO

If no, complete the following:
 INS Number: _____
 Country of Citizenship: _____
 U.S. Entry Date: _____
 Sponsor Name: _____
 Sponsor's Address: _____

Alien Status: _____
 Alien Status Date: _____

Does this person speak English? YES NO
 If no, what language **is spoken?** _____

Is this person currently attending school? YES NO
 If yes: Full-time Part-time
 Name/Address of School: _____

Does this person have a High School diploma or GED equivalent? YES NO
 If no, last grade you completed: 12 11 10 9 8 7 6
 5 4 3 2 1 K

Did **this person** have any schooling after High School or GED? YES NO
 If yes, do you hold any degrees, licenses or certificates? YES NO
 Please specify: _____

Does this person receive any of the following?
 SSI YES NO If YES, date began: _____
 Foster Care YES NO If YES, date began: _____
 Adoption Assistance YES NO If YES, date began: _____

Does this person intend to reside in WV? YES NO
Is this person under the control of the courts and working without pay? YES NO
Is this person acting as a parent to anyone under age 18 **who is not a biological or adopted child?** YES NO

III.B - Other Household Member

Legal Name: _____
 First Middle Last

Social Security Number (SSN): _____ / ____ / ____
If this person does not have a SSN, list the date this person applied: (mm/dd/yy) _____

Birthdate: (mm/dd/yy) _____

Relationship to Applicant: _____

Is this person known by any other name(s)? YES NO

If yes, list other name: _____

Does this person live with you? YES NO

If no, where does this person live? _____

Marital Status (please check one):
 Single/Never Been Married Married
 Divorced Separated
 Widowed

If under age 18, has this person been declared an adult? YES NO

United States Citizen? YES NO

If no, complete the following:

INS Number: _____

Country of Citizenship: _____

U.S. Entry Date: (mm/dd/yy) _____

Sponsor Name: _____

Sponsor's Address: _____

Alien Status: _____

Alien Status Date: (mm/dd/yy) _____

Does this person speak English? YES NO

If no, what language **is spoken?** _____

Is this person currently attending school? YES NO

If yes: Full-time Part-time

Name/Address of School: _____

Do you have a High School diploma or GED equivalent? YES NO

If no, last grade you completed: 12 11 10 9 8 7 6
 5 4 3 2 1 K

Does this person have a High School diploma or GED equivalent? YES NO

If yes, do you hold any degrees, licenses or certificates? YES NO

Please specify: _____

Does this person receive any of the following?

SSI YES NO If YES, date began: (mm/dd/yy) _____

Foster Care YES NO If YES, date began: (mm/dd/yy) _____

Adoption Assistance YES NO If YES, date began: (mm/dd/yy) _____

Does this person intend to reside in WV? YES NO

Is this person under the control of the courts and working without pay? YES NO

Is this person acting as a parent to anyone under age 18 **who is not a biological or adopted child?** YES NO

III.B - Other Household Member

Legal Name: _____
First Middle Last

Social Security Number (SSN): _____ / ____ / ____

If this person does not have a SSN, list the date this person applied: _____

(mm/dd/yy)

Birthdate: _____

(mm/dd/yy)

Relationship to Applicant: _____

Is this person known by any other name(s)?

YES NO

If yes, list other name: _____

Does this person live with you?

YES NO

If no, where does this person live? _____

Marital Status (please check one):

Single/Never Been Married Married
 Divorced Separated
 Widowed

If under age 18, has this person been declared an adult?

YES NO

United States Citizen?

YES NO

If no, complete the following:

INS Number: _____

Country of Citizenship: _____

U.S. Entry Date: _____

(mm/dd/yy)

Sponsor Name: _____

Sponsor's Address: _____

Alien Status: _____

Alien Status Date: _____

(mm/dd/yy)

Does this person speak English?

YES NO

If no, what language **is spoken**? _____

Is this person currently attending school?

YES NO

If yes:

Full-time Part-time

Name/Address of School: _____

Does this person have a High School diploma or GED equivalent?

YES NO

If no, last grade you completed:

12 11 10 9 8 7 6
 5 4 3 2 1 K

Did you have any schooling after High School or GED?

YES NO

If yes, do you hold any degrees, licenses or certificates?

YES NO

Please specify: _____

Does this person receive any of the following?

SSI

YES NO If YES, date began: (mm/dd/yy)

Foster Care

YES NO If YES, date began: ((mm/dd/yy)

Adoption Assistance

YES NO If YES, date began: (mm/dd/yy)

Does this person intend to reside in WV?

YES NO

Is this person under the control of the courts and working without pay?

YES NO

Is this person acting as a parent to anyone under age 18 **who is not a biological or adopted child**?

YES NO

SECTION IV - BENEFIT QUESTIONS

Please check the box beside the benefit(s) you want to receive:

WV WORKS (Cash Assistance)

EA (Emergency Assistance)

MEDICAID (MA/Medical Card)

CHIP (Children's Health Insurance Program)

LIEAP (Low Income Energy Assistance, when available)

- NEMT (Non-Emergency Medical Transportation)
- SNAP (Supplemental Nutrition Assistance Program)**

Have you or any member of your household had any unpaid medical expenses in any of the past three (3) months? YES NO

If yes, do you wish to have your Medical Card backdated to cover these expenses? YES NO
 Indicate Starting Date: _____ (mm/dd/yy)

Is there anyone in your home who is not purchasing food and preparing meals with you? YES NO

If yes, who and why? _____

SECTION V - INDIVIDUAL QUESTIONS

Is anyone in your household pregnant? YES NO

If yes, who? _____

What is the date that the pregnancy was medically confirmed? _____ (mm/dd/yy)

What is the pregnancy due date? _____ (mm/dd/yy)

Is this person expecting more than one child? YES NO

If yes, how many? _____

Is any adult unable to work due to disability, blindness, or incapacity? YES NO

If yes, please list name: _____

Name	Reason
------	--------

Date disability/blindness/incapacity began: _____ (mm/dd/yy)

Has this person been Denied SSI/RSDI based on disability? YES NO

If yes, has an appeal been filed? YES NO

If so, when? _____ (mm/dd/yy)

Status of appeal: _____

Is any child disabled or blind? YES NO

If so, please list name: _____

Name	Reason
------	--------

Date disability/blindness/incapacity began: _____ (mm/dd/yy)

Has this child been Denied SSI/RSDI based on disability? YES NO

Has this child been Denied SSI/RSDI based on parent's income or assets? YES NO

Is this application for anyone who needs or is already receiving nursing home or other specialized medical care? YES NO

If yes, who? _____

Name	State/County of Residence (Prior to Admittance)	Date Admitted
------	---	---------------

Facility Name: _____

Facility Address: _____

Is this person still residing there? YES NO

Is this person expected to return home within six (6) months of date of admission: YES NO
Does he/she have a spouse living in the community? YES NO
If yes, spouse's name/address: _____

Does the person living in the nursing home or specialized care facility provide money to the spouse living in the community? YES NO
If yes, how much? \$ _____

Is this application for the spouse of the above individual? YES NO
Does the spouse also need or receive nursing home or other specialized medical care? YES NO

If yes, name of spouse? _____

Name	State/County of Residence (Prior to Admittance)	Date Admitted
Facility Name:	_____	_____
Facility Address:	_____	_____

Is this person still residing there? YES NO
Is this person expected to return home within six (6) months of date of admission: YES NO
Does he/she have a spouse living in the community? YES NO
If yes, spouse's name/address: _____

Does the person living in the nursing home or specialized care facility provide money to the spouse living in the community? YES NO
If yes, how much? \$ _____

Is anyone in your household who was an SSI recipient in the past not receiving SSI now? YES NO
If anyone in your household is a child under the age of 13 months, was the child's mother eligible for and receiving Medicaid at the time of the child's birth? YES NO
Has the child always lived with its mother? YES NO

SECTION VI - HOUSEHOLD MEMBERS/LEGAL HISTORY

Read each statement carefully and answer YES or NO to **EACH** statement. If you answer YES to a question, then list the name of the household member(s) to whom the YES answer applies.

YES NO (1) Is any member(s) of your household violating their probation or parole?
Member(s): _____

-
-
-
-
- YES NO (2) Is any member(s) of your household currently fleeing from law enforcement officials?
Member(s):
-
-
-
- YES NO (3) Has any member(s) of your household been convicted of receiving **SNAP benefits** because of lying or misrepresenting their identity (who they are) or their residence (where they live)?
Member(s):
-
-
-
- YES NO (4) Has anyone in your household been convicted on or after 8/23/96 of trafficking \$500 or more in Food Stamps/**SNAP benefits**?
Member(s):
-
-
-
- YES NO (5) Has any member in your household been convicted of a felony offense which occurred on or after 8/23/96 and involved the possession, distribution, and/or use of a controlled substance?
Member(s):
-
-
-
- YES NO (6) Has any member of your household been convicted in federal, state, or local court of exchanging Food Stamps/**SNAP benefits** for illegal drugs, firearms, ammunition, or explosives?
Member(s):
-
-
-

SECTION VII - ASSETS

The following page lists items that are considered assets.

Read these carefully and check YES or NO. NOTE - Your answer should be **YES** if:

- A. You or anyone living with you, including all children who live with you, have any of the assets listed below;
- B. Your name, or the name of anyone living in your home, is listed on any of the types of accounts listed below; and/or
- C. You or anyone living with you owns any of the assets listed below with someone who does not live in your home.

Beginning on the next page, if your answer is **YES**, supply the following information about the assets. If an asset is owned by more than one person, list all the owners and explain how the asset is divided. For example: Equally, One-Half, One-Third, etc.

DO NOT COMPLETE SHADED AREAS

ASSETS	YES	NO	OWNER'S NAME(S)	LOCATION	ACCOUNT NUMBER(S)	CURRENT VALUE	HOW DIVIDED
Savings Accounts							
Checking Accounts							
Money Market							
Credit Union							
Cash on Hand							
Christmas Club							
Stocks							

Bonds/Savings							
Certificates of Deposit							
Trust Funds							
IRA/Keogh							
Profit Sharing							
Escrow Account/ Home Sale							
Funeral/Burial Funds							
Burial Plots							
Livestock							
Business Equipment							
Property (Including Life Estates & Dower Rights)							
Homestead Property							
Non-Homestead Property							
Other Real Estate							
Mobile Home							
Farm/Tractor Equipment							
Mineral Rights							
Personal Collections							
Camper/Trailer							
ATV or 3-4 Wheeler							
Snowmobile							
Airplane							
Boat							
Other (Please list):							

Are any of the assets listed in the chart on the previous page not available to the owner? YES NO
 If yes, which assets and why? _____

Are any of the assets listed in the chart on the previous page set aside for burial? YES NO
 If yes, which assets? _____

Has anyone in your household received a lump sum payment in the last three (3) months? YES NO
 If yes, received from whom and for what reason? _____

Date Received: _____ (mm/dd/yy)
 Ongoing? YES NO
 Gross Amount: \$ _____

Any Expenses involved?

YES NO

Type and Amount: _____

Has anyone transferred or divested (disposed of), sold, or given away property, income, or any other asset, including vehicles or life insurance or established a trust fund within the last five (5) years (60 months) ?

YES NO

If yes, name: _____

Date of Transfer: _____ (mm/dd/yy)

Transferred to: _____

Value of Asset: _____ \$

Amount Received: _____ \$

VEHICLES (Include ALL automobiles, motor homes, trucks, and/or motorcycles.)

Does anyone in your household own a vehicle or is anyone in the process of purchasing one?

YES NO

If **yes**, complete the following section for each vehicle.

If **no**, go to the next section titled LIFE INSURANCE.

Year/Make/Model of Vehicle: _____

Name(s) on Vehicle Registration: _____

Is this vehicle in your possession? YES NO

Amount owed: _____ \$

Is it licensed? YES NO

License Number: _____

State in which it is licensed: _____

Do you have the right to sell this vehicle without the agreement of any other parties who share ownership?

YES NO

VEHICLES (Include ALL automobiles, motor homes, trucks, and/or motorcycles.) continued

Year/Make/Model of Vehicle: _____

Name(s) on Vehicle Registration: _____

Is this vehicle in your possession? YES NO

Amount owed: _____ \$

Is it licensed? YES NO

License Number: _____

State in which it is licensed: _____

Do you have the right to sell this vehicle without the agreement of any other parties who share ownership?

YES NO

Year/Make/Model of Vehicle: _____

Name(s) on Vehicle Registration: _____

Is this vehicle in your possession? YES NO
Amount owed: \$ _____
Is it licensed? YES NO
License Number: _____
State in which it is licensed: _____
Do you have the right to sell this vehicle without the agreement of any other parties who share ownership? YES NO

Year/Make/Model of Vehicle: _____
Name(s) on Vehicle Registration: _____
Is this vehicle in your possession? YES NO
Amount owed: \$ _____
Is it licensed? YES NO
License Number: _____
State in which it is licensed: _____
Do you have the right to sell this vehicle without the agreement of any other parties who share ownership? YES NO

Year/Make/Model of Vehicle: _____
Name(s) on Vehicle Registration: _____
Is this vehicle in your possession? YES NO
Amount owed: \$ _____
Is it licensed? YES NO
License Number: _____
State in which it is licensed: _____
Do you have the right to sell this vehicle without the agreement of any other parties who share ownership? YES NO

LIFE INSURANCE

Does anyone in your household have life insurance?

YES NO

If **YES**, complete the following for each person who is insured.

If **NO**, go on to the next section.

Person Insured	Owner of Policy	Face Value Amount	Insurance Company	Date Policy Purchased
		\$		
Jointly Owned:	How Divided?	Cash Surrender Value	Policy Number	
<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		

Person Insured	Owner of Policy	Face Value Amount	Insurance Company	Date Policy Purchased
		\$		
Jointly Owned:	How Divided?	Cash Surrender Value	Policy Number	
<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		

Person Insured	Owner of Policy	Face Value Amount	Insurance Company	Date Policy Purchased
		\$		
Jointly Owned:	How Divided?	Cash Surrender Value	Policy Number	
<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		

Person Insured	Owner of Policy	Face Value Amount	Insurance Company	Date Policy Purchased
		\$		
Jointly Owned:	How Divided?	Cash Surrender Value	Policy Number	
<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		

SECTION VIII – EARNED INCOME ONLY

Is anyone in your household employed or self-employed? YES NO
If **YES**, complete the following for each person who is self-employed or employed.
If **NO**, go to the next section titled UNEMPLOYMENT HISTORY.

1) Name of person who is employed: _____
Job Title: _____
Employer's Name: _____
Employer's Address: _____
Employer's Telephone Number: _____
Employment Begin Date: _____ (mm/dd/yy)
How Often Paid? Every 2 Weeks Once a Week Other (Specify):
 Twice a Month Once a Month _____
Number of Hours Worked each Pay Period: _____
Gross Payment Amount: **(For Pay Period As Stated Below)** \$ _____
Are earnings expected to stop: YES NO
Is so, when? _____ (mm/dd/yy)

2) Name of person who is employed: _____
Job Title: _____
Employer's Name: _____
Employer's Address: _____
Employer's Telephone Number: _____
Employment Begin Date: _____ (mm/dd/yy)
How Often Paid? Every 2 Weeks Once a Week Other (Specify):
 Twice a Month Once a Month _____
Number of Hours Worked each Pay Period: _____
Gross Payment Amount: **(For Pay Period As Stated Below)** \$ _____
Are earnings expected to stop: YES NO
Is so, when? _____ (mm/dd/yy)

3) Name of person who is employed: _____
Job Title: _____
Employer's Name: _____
Employer's Address: _____
Employer's Telephone Number: _____
Employment Begin Date: _____ (mm/dd/yy)
How Often Paid? Every 2 Weeks Once a Week Other (Specify):
 Twice a Month Once a Month _____
Number of Hours Worked each Pay Period: _____
Gross Payment Amount: **(For Pay Period As Stated Below)** \$ _____
Are earnings expected to stop: YES NO
Is so, when? _____ (mm/dd/yy)

Has anyone in your household refused employment or training for employment? YES NO
If yes, who? _____
Reason for refusal: _____

Date refused: _____ (mm/dd/yy)

Has anyone in your household been fired, lost, or quit a job in the last sixty (60) days? YES NO

If yes, who? _____

Reason for firing, loss, or quitting: _____

Date job lost: _____ (mm/dd/yy)

If yes, number of hours worked per week before loss: _____

Wages earned per week before loss: _____ \$

Has anyone in your household voluntarily reduced work hours to less than 30 hours per week? YES NO

If yes, who? _____

Reason for reduction: _____

If yes, number of hours worked per week before reduction: _____

Wages earned per week before reduction: _____ \$

Is anyone in your household on strike? YES NO

If yes, who? _____

Date strike began: _____ (mm/dd/yy)

Monthly earnings prior to strike: _____ \$

If anyone in your household receives rental income, does someone in the household manage the property? YES NO

If yes, who? _____

If yes, how many hours per week are spent managing this property? _____

Amount received per month: _____ \$

Is anyone in your household currently self-employed, (such as farming, babysitting, etc) or been self-employed within last 3 months? YES NO

If yes, what type of employment? _____

Does the person receive income regularly? YES NO

How Often Paid? Every 2 Weeks Once a Week Other (Specify): _____

Twice a Month Once a Month

Is this income from a new business of less than one year? YES NO

How long has this person had this business? _____

Gross Monthly Payment Amount: (For Period of Operation) _____ \$

Are there expenses related to this employment? YES NO

If yes, Type and Amount? _____

Is anyone in your household blind with work-related expenses? YES NO

If yes, what type of expenses? _____

Amount of Monthly expenses? _____ \$

SECTION IX - EMPLOYMENT HISTORY

Complete the following for your last four (4) places of employment. Begin with your most recent employment and work back. Include odd jobs.

Applicant's Name:

Name of Employer:

Employer's Address:

Job Title/Occupation:

Reason No Longer Employed:

Length/Dates of Employment

Type of Employment:

Hourly Wage:

From: (mm/dd/yy)

To: (mm/dd/yy)

Part-Time

Full-Time

Temporary

\$

Name of Employer:

Employer's Address:

Job Title/Occupation:

Reason No Longer Employed:

Length/Dates of Employment

Type of Employment:

Hourly Wage:

From: (mm/dd/yy)

To: (mm/dd/yy)

Part-Time

Full-Time

Temporary

\$

Name of Employer:

Employer's Address:

Job Title/Occupation:

Reason No Longer Employed:

Length/Dates of Employment

Type of Employment:

Hourly Wage:

From: (mm/dd/yy)

To: (mm/dd/yy)

Part-Time

Full-Time

Temporary

\$

Name of Employer:

Employer's Address:

Job Title/Occupation:

Reason No Longer Employed:

Length/Dates of Employment

Type of Employment:

Hourly Wage:

From: (mm/dd/yy)

To: (mm/dd/yy)

Part-Time

Full-Time

Temporary

\$

EMPLOYMENT HISTORY continued

Complete the following for all other household members. List the most recent **two (2)** places of employment.

Co-Applicant's Name: _____
Name of Employer: _____
Employer's Address: _____

Job Title/Occupation: _____
Reason No Longer Employed: _____
Length/Dates of Employment From: (mm/dd/yy) To: (mm/dd/yy)
Type of Employment: Part-Time Full-Time Temporary
Hourly Wage: \$ _____

Name of Employer: _____
Employer's Address: _____

Job Title/Occupation: _____
Reason No Longer Employed: _____
Length/Dates of Employment From: (mm/dd/yy) To: (mm/dd/yy)
Type of Employment: Part-Time Full-Time Temporary
Hourly Wage: \$ _____

Other Household Member's Name: _____
Name of Employer: _____
Employer's Address: _____

Job Title/Occupation: _____
Reason No Longer Employed: _____
Length/Dates of Employment From: (mm/dd/yy) To: (mm/dd/yy)
Type of Employment: Part-Time Full-Time Temporary
Hourly Wage: \$ _____

Name of Employer: _____
Employer's Address: _____

Job Title/Occupation: _____
Reason No Longer Employed: _____
Length/Dates of Employment From: (mm/dd/yy) To: (mm/dd/yy)
Type of Employment: Part-Time Full-Time Temporary
Hourly Wage: \$ _____

SECTION X - UNEMPLOYMENT BENEFIT HISTORY

Has anyone in your household received Unemployment Benefits within the last 12 months? YES NO

If yes, list who received the benefits and when. _____

If no, please proceed to the next section titled **Unearned Income**.

NAME	RECEIVED	
	FROM	TO
1.		
2.		
3.		
4.		
5.		

Has anyone in your household refused Unemployment Benefits within the last 12 months or had Unemployment payments stopped before benefits ran out? YES NO

If yes, who refused the benefits and when? _____

SECTION XI - UNEARNED INCOME

Please complete this section for EVERYONE who lives in your home. Check YES or NO and fill in the requested information. Does anyone in your household, including all children, receive any of the following income?

INCOME SOURCE	YES	NO	PERSON FOR WHOM INCOME IS RECEIVED	INCOME BEFORE DEDUCTIONS	HOW OFTEN RECEIVED	BEGIN DATE
Adoption Assistance						
Annuities/Payments						
Assistance from Another State						
Black Lung						
Charitable/Contribution from Other Sources						
Child Support						
Spousal Support (Alimony)						
Dividends						
Foster Care or Guardianship Payments						
Interest						
Military or Other Allotment						
Money from Other Person(s)						
Non-LIEAP Energy Assistance						
Payments from Sale of Property						
Railroad Retirement						
Rent/Utility Supplement <input type="checkbox"/> Non-HUD Supplement <input type="checkbox"/> HUD Rent Supplement						
Royalties (Gas, Oil, etc.)						
Sick/Disability Benefits						
Social Security						
Supplemental Security Income (SSI)						
Trust Fund Payments						
Unemployment Compensation						
United Mine Workers (UMW)						
Veterans Benefits <input type="checkbox"/> VA Compensation <input type="checkbox"/> VA Pension						
Workers' Compensation <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary						
Other Retirement/Pensions						
Other:						

SECTION XII - HIGHER EDUCATION

Does anyone in your household receive educational aid?

YES NO

If yes, Student's Name: _____
Name of School: _____

Is this student receiving a grant, scholarship, or participating in a work study program? YES NO
If yes, Name of Grant, Scholarship or Work Study Program: _____
Amount: \$ _____

Begin/End Date: From: (mm/dd/yy) _____ To: (mm/dd/yy) _____

SECTION XIII - ROOM AND MEALS

Does anyone in your household RECEIVE MONEY for room and/or meals from another person? YES NO
Does **this** individual pay for meals? YES NO
Number of meals per day: _____
Meals Payment Amount: \$ _____
Does individual pay for room? YES NO
Room Payment Amount: \$ _____

Does anyone in your household PAY ANYONE else for room and meals? YES NO
Room Payment Amount: \$ _____
Number of meals per day: _____
Meals Payment Amount: \$ _____
Does payment include heating? YES NO
Commercial Boarding Establishment? YES NO

SECTION XIV - SUPPORT PAYMENTS/FEES

Does anyone in your household pay anyone else to care for a dependent child or disabled/incapacitated adult so a household member can get to work or training/school or look for a job? YES NO
If yes, for whom? _____
If so, Care Provider's Name: _____
Provider's Address: _____

Payment Amount: \$ _____
How Often Paid? Every 2 Weeks Once a Week Other (Specify): _____
 Twice a Month Once a Month

Does anyone in your household make any support payments to/for persons living in another household (child support/health insurance/medical cost? etc.) YES NO
If yes, for whom? _____
If yes, who makes payment? _____
Is it court-ordered support? YES NO
Legal Obligation Amount: \$ _____
Actual Payment Amount: \$ _____

Does anyone in your household, or an institutionalized individual, pay or is required to pay guardian, committee, power of attorney, or attorney fees? YES NO
If yes, type of fee: _____
To whom paid? _____

For whom paid? _____
 Amount: _____ \$ _____

SECTION XV - MEDICAL EXPENSES

Does anyone in your household **who is 60 years of age or older, or is disabled** have any medical expenses? YES NO

Does anyone in your household have any unpaid medical expenses? YES NO
If yes, are any of these expenses for the previous three months? YES NO

1.	NAME: _____				
	EXPENSE TYPE	BILLED AMOUNT	BILLED FOR/PAID	FREQUENCY	DATE OF SERVICE
		\$ _____			
		\$ _____			
		\$ _____			
2.	NAME: _____				
	EXPENSE TYPE	BILLED AMOUNT	BILLED FOR/PAID	FREQUENCY	DATE OF SERVICE
		\$ _____			
		\$ _____			
		\$ _____			

SECTION XVI - MEDICAL/HEALTH INSURANCE/REIMBURSEMENTS

Does anyone in your household have health insurance coverage? YES NO

Names of persons covered: _____
 Who carries the insurance policy? _____
 Relationship to Owner: _____
 Insurance Provider's Name: _____
 Insurance Provider's Address: _____

Group Name: _____
 Premium Amount _____ \$ _____
 How often paid? _____
 Policy Begin/End Date: From: (mm/dd/yy) _____ To: (mm/dd/yy) _____

Has anyone in your household voluntarily stopped health insurance for a child within the last six (6) month? YES NO

If yes, for whom? _____
 How much was paid for the insurance that stopped? _____ \$ _____

Is there anyone in the household who will not cooperate with obtaining medical support coverage? YES NO

If yes, who? _____

1) Is anyone in the household entitled to or enrolled in Medicare Part A or Part B? YES NO
 If yes, who? _____
 Enrolled in Part A? YES NO
 If yes, begin/end date: From: (mm/dd/yy) _____ To: (mm/dd/yy) _____
 Premium Amount: \$ _____
 Enrolled in Part B? YES NO
 If yes, begin/end date: From: (mm/dd/yy) _____ To: (mm/dd/yy) _____
 Premium Amount: \$ _____
 Medicaid Claim Number: _____
 Railroad Retirement: YES NO

2) Is anyone else in the household entitled to or enrolled in Medicare Part A or Part B? YES NO
 If yes, who? _____
 Enrolled in Part A? YES NO
 If yes, begin/end date: From: (mm/dd/yy) _____ To: (mm/dd/yy) _____
 Premium Amount: \$ _____
 Enrolled in Part B? YES NO
 If yes, begin/end date: From: (mm/dd/yy) _____ To: (mm/dd/yy) _____
 Premium Amount: \$ _____
 Medicaid Claim Number: _____
 Railroad Retirement: YES NO

Has anyone in your household been involved in an accident with a financial/insurance settlement pending? YES NO

Does anyone in your household seek payment or reimbursement for travel expenses related to Medicaid? YES NO

Travel Date: _____ To: (mm/dd/yy) _____
 Provider: _____
 Reason for Travel: _____
 Expenses: \$ _____
 Who Was Transported? _____

SECTION XVII - SHELTER AND UTILITY EXPENSES

Does anyone in your household have **shelter and/or utility** costs or does an institutionalized individual who intends to return home have shelter costs for maintaining a home or apartment YES NO

Are you and/or your family currently homeless? YES NO
If yes, have you incurred any shelter/utility costs? YES NO

If yes, do you elect to use the Homeless Shelter Standard Deduction?

YES NO

Fill in all the information about the following expenses:

SHELTER EXPENSE	PERSON'S NAME WHO PAYS THE BILL	MONTHLY AMOUNT	TO WHOM PAID
Mortgage(s)		\$	
Property Tax		\$	
Rent		\$	
Lot Rent		\$	
Structure Insurance		\$	
Special		\$	
Mobile Home Loan		\$	
Land Contract Payment		\$	
Repair Costs		\$	
Condo/Association Fees		\$	
Escrow Account for Property Taxes and/or Insurance		\$	
Other		\$	

Fill in all the information about the following expenses: DO NOT COMPLETE SHADED AREAS.

UTILITY EXPENSE	PERSON'S NAME WHO PAYS THE BILL	PRIMARY SOURCE OF HEATING OR COOLING (Indicate only one heat and cooling source)	TO WHOM PAID

Gas (Natural)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Propane		<input type="checkbox"/> Yes <input type="checkbox"/> No	
LP Gas		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Fuel Oil		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Kerosene		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Coal		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Wood/Wood Products		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Electricity		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Water			
Sewer			
Trash Removal			
Telephone			
Other		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Does your household currently receive or will it receive a HUD Utility Allowance Yes No
 If yes, does the HUD Utility Allowance exceed utility expenses? Yes No

Does anyone who is NOT in your household pay any expenses/bills for you or anyone in your home? YES NO

If yes, what expense? _____
 How much is paid? \$ _____
 Who pays the expense(s)? _____

Does anyone who is NOT in your household give you or anyone in your home money to pay any bills? YES NO

If yes, how much? \$ _____
 Who gives you the money? _____

SECTION XVIII – LOW INCOME ENERGY ASSISTANCE PROGRAM (LIEAP)

Do you pay to heat your home? YES NO

Do you or have you ever received (LIEAP) payments? YES NO

If yes, when? _____ To: (mm/dd/yy) _____

Does your household request regular LIEAP assistance? YES NO

Does your household request emergency LIEAP assistance? YES NO

Does your household wish to be evaluated for an automatic issuance of LIEAP if you are determined eligible?

YES NO

SECTION XIX – SCHOOL CLOTHING ALLOWANCE (SCA)

Does your household wish to be evaluated for an automatic issuance of SCA if you are determined eligible?

YES NO

SECTION XX – EMERGENCY ASSISTANCE

Do you have an eviction or foreclosure notice?

YES NO

If yes, how much is needed to avoid the eviction/foreclosure?

\$ _____

Do you have a notice of utility service termination?

YES NO

If yes, what utility or utilities? _____

Are you without bulk fuel?

YES NO

If yes, how much is needed for a 30 day supply of fuel?

\$ _____

Are you in need of telephone service and everyone who lives in your home is 65 years of age or older, or is disabled or temporarily incapacitated for at least the next 30 days?

YES NO

Are you without any food?

YES NO

Are you in need of shelter, clothing, and/or household supplies/furnishings due to a fire or some other man-made or natural disaster?

YES NO

Are you in need of emergency child care?

YES NO

If yes, what is the reason for the emergency? _____

Are you in need of emergency transportation?

YES NO

If yes, what is your destination and transportation need? _____

Are you in need of emergency medical care?

YES NO

If yes, what is your medical emergency? _____

SECTION XXI - NON-CUSTODIAL PARENT INFORMATION

Are there children in this household who have a parent **who does not live** with them? YES NO
 If yes, complete the chart on the following page:

CHILD'S NAME	NON-CUSTODIAL PARENT'S	ADDRESS	MARRIAGE DATE	ABSENCE DATE
	NAME:		/ /	/ /
	SSN:		(mm/dd/yy)	(mm/dd/yy)
	NAME:		/ /	/ /
	SSN:		(mm/dd/yy)	(mm/dd/yy)
	NAME:		/ /	/ /
	SSN:		(mm/dd/yy)	(mm/dd/yy)
	NAME:		/ /	/ /
	SSN:		(mm/dd/yy)	(mm/dd/yy)
	NAME:		/ /	/ /
	SSN:		(mm/dd/yy)	(mm/dd/yy)

Good Cause Claimed for not cooperating with Child Support Enforcement? YES NO

Non-Custodial Parent's Place of Employment: _____
 Non-Custodial Parent's Wages: _____ \$
 Is the Non-Custodial Parent(s) Court-Ordered to provide medical support? YES NO

SECTION XXII - LEGAL GUARDIAN/PROTECTIVE PAYEE/AUTHORIZED REPRESENTATIVE

Does anyone in your household have a legal guardian, power of attorney (POA), or committee? YES NO

If yes, complete the following:

Name: _____
 Address: _____
 Telephone Number: _____

Does your household have a protective payee (substitute): YES NO

If yes, name of protective payee? _____
 Address: _____
 Telephone Number: _____

Does your household have an authorized representative? YES NO

If yes, name of authorized representative? _____
 Address: _____
 Telephone Number: _____

SECTION XXIII - MILITARY SERVICE RECORD

Is or has anyone in your household been in the Military?

YES NO

If yes, complete the chart on the following page.

If no, please go to the next section titled Potential Resources.

Name: _____	Serial Number: _____
Branch: _____	Service Disability: <input type="checkbox"/> YES <input type="checkbox"/> NO
Date of Service: From: (mm/dd/yy) _____	To: (mm/dd/yy) _____

Name: _____	Serial Number: _____
Branch: _____	Service Disability: <input type="checkbox"/> YES <input type="checkbox"/> NO
Date of Service: From: (mm/dd/yy) _____	To: (mm/dd/yy) _____

SECTION XXIV - POTENTIAL RESOURCES

Do you or anyone who lives in your household expect to receive any benefits or income, such as, but not limited to, Social Security Benefits, Wages from Employment, Unemployment Benefits, Child Support or Insurance Settlements that you are not now receiving?

YES NO

- 1) If yes, Who? _____
Type: _____
Expected Date of Receipt: _____ To: (mm/dd/yy) _____
- 2) If yes, Who? _____
Type: _____
Expected Date of Receipt: _____ To: (mm/dd/yy) _____

Applicant's Signature Date

Worker's Signature Date
(Worker Who Interviewed Client)

Co-Applicant's Signature Date

Worker's Signature Date
(Worker Who Interviewed Client)

CASE COMMENTS: (For Office Use Only - DO NOT WRITE IN THIS AREA.)