

## 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
<b>For Example:</b>	Income - <del>\$581.04</del>
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)
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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)
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(First Name)	(MI)	(Last Name)	(Signature)	(Date)
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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 biological or adopted child?  YES  NO

### III.B - Co-Applicant / 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 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, does this person 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

If you are not a parent, are you 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:

- |   |   |
|---|---|
| <input type="checkbox"/> WV WORKS (Cash Assistance)                           | <input type="checkbox"/> EA (Emergency Assistance)                  |
| <input type="checkbox"/> MEDICAID (MA/Medical Card)                           | <input type="checkbox"/> CHIP (Children's Health Insurance Program) |
| <input type="checkbox"/> LIEAP (Low Income Energy Assistance, when available) |   |
| <input type="checkbox"/> NEMT (Non-Emergency Medical Transportation)          |   |
| <input type="checkbox"/> 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

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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

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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

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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)

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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)

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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)

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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 From: (mm/dd/yy) To: (mm/dd/yy)  
Type of Employment:  Part-Time  Full-Time  Temporary  
Hourly Wage: \$ \_\_\_\_\_

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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: \$ \_\_\_\_\_

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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: \$ \_\_\_\_\_

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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: \$ \_\_\_\_\_

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**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: \$ \_\_\_\_\_

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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: \$ \_\_\_\_\_

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**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: \$ \_\_\_\_\_

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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: \$ \_\_\_\_\_

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**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?  
If yes, when? \_\_\_\_\_ To: (mm/dd/yy) \_\_\_\_\_  YES  NO
- 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?  
If yes, how much is needed to avoid the eviction/foreclosure? \_\_\_\_\_  YES  NO  
\$ \_\_\_\_\_
- Do you have a notice of utility service termination?  
If yes, what utility or utilities? \_\_\_\_\_  YES  NO
- Are you without bulk fuel?  
If yes, how much is needed for a 30 day supply of fuel? \_\_\_\_\_  YES  NO  
\$ \_\_\_\_\_
- 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?  
If yes, what is the reason for the emergency? \_\_\_\_\_  YES  NO
- Are you in need of emergency transportation?  
If yes, what is your destination and transportation need? \_\_\_\_\_  YES  NO
- Are you in need of emergency medical care?  
If yes, what is your medical emergency? \_\_\_\_\_  YES  NO

**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)**

