Commonwealth of Virginia
Department of Social Services
APPLICATION FOR BENEFITS

GENERAL INFORMATION

With this application, you may apply for one or more of the following assistance programs. Refer to the fold-out page for instructions.

- Supplemental Nutrition Assistance Program (SNAP), (formerly food stamps)
- Temporary Assistance for Needy Families (TANF)
- TANF Emergency Assistance
- General Relief – Unattached Child
- Auxiliary Grants
- Refugee Cash Assistance

COMPLETING THE APPLICATION

If you need help completing this Application, a friend or relative or your eligibility worker can help you. If you are completing this application for someone else, answer each question as if you were that person. If you need to change an answer or make a correction, write the correct information nearby and put your initials and date next to the change. If there are more than 8 people are living in your home and you need more space to list everyone, tell the agency you need extra pages.

Individuals who have a disability or who have difficulty with English may receive extra help to make sure they get assistance or services they are eligible to receive.

COMPLETE AND ACCURATE INFORMATION

You must give complete, accurate, and truthful information. If you do not give needed information, we may not be able to determine your eligibility for assistance. Information regarding your race is not required. However, if you decide not to give this information, your worker will complete that section. If you knowingly give false, incorrect or incomplete information, or fail to report changes, you could lose your benefits and be arrested, prosecuted, fined and/or imprisoned. If you knowingly give false, incorrect, or incomplete information in order to help someone else receive benefits, you could be arrested and prosecuted for fraud.

FILING THE APPLICATION

You may turn in a partially completed Application which contains at least your name, address, and signature (or the signature of your authorized representative), **but you must complete the rest of this Application before your eligibility can be determined.** For some programs, you must also be interviewed, but you may turn in your Application before your interview. You may turn in your Application any time during office hours the same day as you contact your local agency. You have the right to turn in your Application even if it looks like you may not be eligible for benefits.

032-03-0824-29-eng (09/13)

SPECIAL INFORMATION FOR SNAP APPLICANTS

You may apply for SNAP benefits by leaving a completed Application for Benefits at the agency <u>or</u> by leaving a partially completed Application with at least your name, address, and signature, <u>or</u> by tearing off and leaving this half-sheet with your name, address, and signature. **You must complete the rest of this Application before your eligibility can be determined**.

You must also be interviewed in the office or by telephone. You may turn in your application before you are interviewed. This is important because if you are eligible for the month in which you apply, your SNAP amount will be based on the date you actually turn in your application.

EXPEDITED SERVICE FOR SNAP BENEFITS

Your household may qualify for Expedited Service and receive SNAP benefits within 7 days if you are eligible and if your gross monthly income is less than $150 and liquid resources are $100 or less; or your monthly shelter bills are higher than your household's gross monthly income plus your liquid resources; or if someone in your household is a migrant or seasonal farm worker with little or no income and resources. **GIVE THE INFORMATION BELOW SO YOUR ELIGIBILITY FOR EXPEDITED SERVICE CAN BE DETERMINED.**

Total income received/expected this month before deductions $_____

Total cash, money in checking/savings accounts, CDs $_____

Total rent or mortgage for this month $_____

Utility expenses for this month $_____
    Which utilities do you pay? (check all that apply)
    ❑ Heat   ❑ Lights   ❑ Telephone   ❑ Electricity for Air Conditioning
    ❑ Water   ❑ Sewer   ❑ Garbage   ❑ Other

Is anyone in your household a migrant or seasonal farm worker? **YES ( ) NO ( )**

NAME	DATE OF BIRTH
ADDRESS	SOCIAL SECURITY NUMBER
	TELEPHONE NUMBER
SIGNATURE	DATE

AGENCY USE ONLY

CASE NAME

CASE NUMBER

LOCALITY	SCREENER	DATE

EXPEDITED SERVICE DETERMINATION

Income < $150 + resources ≤ $100   **YES ( )   NO ( )**

Income + resources < shelter bills   **YES ( )   NO ( )**

For migrant or seasonal farm workers:

Resources ≤ $100 and ≤ $25 is expected in next 10 days
from new income;   **YES ( )   NO ( )**

OR

Resources ≤ $100 and $0 income is expected from a terminated
source for the rest of this month or next month.
          YES ( )   NO ( )

EXPEDITE IF <u>YES</u> TO ANY OF THE ABOVE.

VERIFICATION AND USE OF INFORMATION

Information you give on this application, including Social Security numbers (SSN), may be matched against federal, state, and local records. These records include:
Virginia Employment Commission (VEC)
Internal Revenue Service (IRS)
Department of Motor Vehicles (DMV)
US Citizenship and Immigration Services (USCIS)
Social Security Administration (SSA)

Any difference between the information you give and these records will be investigated. Information from these records may affect your eligibility and benefit amount. Information may be used to:
- determine the correctness, accuracy, and truthfulness of the application:
- verify your identity and citizenship; verify wages and salary, unemployment benefits, and unearned income, such as Social Security and Supplemental Security Income (SSI) benefits; verify quarters of coverage under Social Security for an alien, or to verify the status of aliens;
- prevent receipt of benefits from more than one social service agency at the same time;
- make required program changes;
- allow disclosure for official examination and to law enforcement officials to assist in apprehending persons fleeing to avoid the law; or
- assist in SNAP claims collection actions.

NONDISCRIMINATION STATEMENT

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion and political beliefs.

The U.S. Department of Agriculture (USDA) also prohibits discrimination against its customers, employees, and applicants for employment on the basis of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by Department. Not all prohibited based will apply to all program and/or employment activities.

If you wish to file a Civil Rights program complaint of discrimination with USDA, complete the USDA Program Discrimination Complaint Form found online at
 http://www.ascr.usda.gov/complaint_filing_cust.html or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8338, or (800) 845-6136 (Spanish).

For any other information dealing with 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 http://www.fns.usda.gov/snap/contact_info/hotline.htm.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S. W , Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

USDA and HHS are equal opportunity providers and employers.
.

Commonwealth of Virginia
Department of Social Services

APPLICATION FOR BENEFITS

AGENCY USE ONLY				
Case Name	Case Number	Program	Worker Caseload	Date Received
Locality		Date of Service Referral	Date of Interview ❑ In office ❑ Telephone	

Applicant's Name	Social Security Number	Phone Number (Home/Messages) (Work/Other)
Residence Address (Include City, State and Zip Code)		Directions to Home
Mailing Address (If Different)		E-Mail Address

Language: (Enter Code) _____   1 - English   2 - Spanish   3 - Cambodian   4 - Vietnamese   5 - Farsi   6 - Haitian-Creole   7 - Laotian   8 - Chinese   9 - Korean

A - Somali   B - Kurdish   C – Arabic   F - French   G - German   J - Japanese   O - Other

1. **YES ( ) NO ( )** Have you or anyone for whom you are applying ever applied for, or received, or are currently receiving any benefits from a social services agency, including SNAP (Food Stamps), AFDC, TANF, Medicaid, General Relief, Auxiliary Grants, Foster Care, Adoption Assistance, or Refugee Cash Assistance?

Applicant's Name	Social Security Number	Type of Benefits Received
When	From What County, City, or State	

2. **YES ( ) NO ( )** Have you or anyone for whom you are applying ever been convicted of making false or misleading statements about your identity or address to receive TANF, SNAP, or Medicaid in two or more states at the same time? If **YES**, give date and place of conviction _____

3. **YES ( ) NO ( )** Are you or anyone for whom you are applying in violation of parole or probation or fleeing capture to avoid prosecution or punishment of a felony?
 If **YES,** explain_____

4. **YES ( ) NO ( )** Do you or anyone in your home have a felony conviction for drugs after August 22, 1996 for ( ) Use? ( ) Possession? ( ) Distribution of drugs? (check all that apply)
 If **YES,** who?_____ Did the court assign ( ) Periodic Testing? ( ) Drug Treatment? ( ) Other Action? **YES ( ) NO ( )** If **YES,** have you finished the plan or are you cooperating? **YES ( ) NO ( )**

INSTRUCTIONS

1. Do not write in the shaded areas. These areas are for agency use only.

2. Unfold this page. Use this folded page to complete **SECTION A: GENERAL INFORMATION.** Answer the questions in **SECTION A** for everyone who lives in your home, even if you are not applying for that person. You may leave questions about citizenship, immigration and Social Security Number blank for anyone for whom you are NOT requesting assistance.

3. Answer the questions in **SECTION B: INCOME** for everyone for whom you are applying. In addition, if applying for **TANF,** also provide income information for children age 18 or under, even if you are not applying for that child, and the stepparent of the children for whom you are applying.

4. Answer the questions in **SECTION C: RESOURCES** for everyone for whom you are applying unless you are applying for TANF.

5. After completing Sections A, B, and C, answer the questions in the sections indicated below, depending on the type of assistance you are requesting.

SNAP (Food Stamps)	**Section D,** pages 7-8	**General Relief – Unattached Child**	**Section F,** page 10
TANF	**Section F,** page 10	**TANF Emergency Assistance**	**Section G,** page 11
Refugee Cash Assistance	**Section F,** page10	**Auxiliary Grants**	**Section H,** page 11

6. Read and complete **VOTER REGISTRATION** on this page.

7. Read **YOUR RESPONSIBILITIES** on page 13.

8. Read and complete the last page of this application. Be sure to sign and date the application.

Commonwealth of Virginia Voter Registration Agency Certification

If you are not registered to vote where you live now, would you like to apply to register to vote here today? (Please check only one)

- ❏ I am already registered to vote at my current address, or I am not eligible to register to vote and do not need an application to register to vote.
- ❏ Yes, I would like to apply to register to vote. (please fill out the voter registration application form)
- ❏ No, I do not want to register to vote.

If you do not check any box, you will be considered to have decided **not to** register to vote at this time. Applying to register to vote or declining to register to vote will not affect the assistance or services that you will be provided by this agency. If you decline to register to vote, this fact will remain confidential. If you do register to vote, the office where your application was submitted will be kept confidential, and it will be used only for voter registration purposes. If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private if you desire.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, you may file a complaint with: Secretary of the Virginia State Board of Elections, Washington Building, 1100 Bank Street, Richmond, VA 23219-3497, Telephone (804) 864-8901.

_____ _____ _____
Applicant Name   **Signature**   **Date**

Voter Registration form completed: ❏ Yes ❏ No   Voter Registration form given to applicant for later mailing (at applicant's request)   ❏
_____   _____
Agency Staff Signature   Date:

A. GENERAL INFORMATION (ALL APPLICANTS MUST COMPLETE THIS SECTION)

1. EVERYONE IN YOUR HOME

LIST EVERYONE LIVING IN YOUR HOME, even if you are not applying for assistance for that person.

LIST YOURSELF ON LINE #1.

Check (√) **YES ( ) NO ( )** Do you expect any change in who lives in your home, either this month or next month? If YES, explain:
_____
_____
_____

LAST NAME, FIRST, MI, AND MAIDEN
(DO NOT make any entry in the ID# space)

2. TEMPORARILY AWAY FROM HOME

Is this person temporarily away from home?

Check (√) **YES** or **NO**

If **YES**, give the date the person left and expected return date If more than 60 days, give the reason for the absence.

3. RELATIONSHIP TO PERSON ON LINE #1

Give the relationship of each person to the person listed on Line #1.

4. TYPE OF ASSISTANCE REQUESTED (Check (√) type of assistance requested for each person. If no assistance is requested, check **NONE** for that person. Note that an application for TANF will also be an application for SNAP. Check TANF - No SNAP if you do not want to apply for SNAP benefits.

#	LAST NAME, FIRST, MI, AND MAIDEN / ID#	TEMPORARILY AWAY	RELATIONSHIP	SNAP (FOOD STAMPS)	TANF	TANF – NO SNAP	GENERAL RELIEF UNATTACHED CHILD	TANF EMERGENCY ASSISTANCE	AUXILIARY GRANTS	REFUGEE CASH ASSISTANCE	NONE
1	ID#	YES ( ) NO ( ) Date Left_____ Expected Return Date_____ Reason									
2	ID#	YES ( ) NO ( ) Date Left_____ Expected Return Date_____ Reason									
3	ID#	YES ( ) NO ( ) Date Left_____ Expected Return Date_____ Reason									
4	ID#	YES ( ) NO ( ) Date Left_____ Expected Return Date_____ Reason									
5	ID#	YES ( ) NO ( ) Date Left_____ Expected Return Date_____ Reason									
6	ID#	YES ( ) NO ( ) Date Left_____ Expected Return Date_____ Reaon									
7	ID#	YES ( ) NO ( ) Date Left_____ Expected Return Date_____ Reason									
8	ID#	YES ( ) NO ( ) Date Left_____ Expected Return Date_____ Reason									

USE THE FOLDOUT TO COMPLETE THIS SECTION

5. U.S. CITIZEN* Check (√) **YES** or **NO** If YES, do not answer Question 6. You may leave this blank for anyone not in the assistance request	6. ANSWER <u>ONLY IF</u> AN ALIEN Give the **Alien Number** and **Date of Entry** for anyone for whom you are requesting assistance. You may leave this blank for anyone not in the assistance request.	7. PLACE OF BIRTH Give the **State** if born in the U.S. or the **Country** if born outside of the U.S. 8. DATE OF BIRTH	9a. RACE (not required) Select all that apply 1. White 2. Black/African American 3. American Indian/Alaska Native 4. Asian 5. Native Hawaiian/ Pacific Islander	9b. ETHNICITY (not required) Give the **code** to show ethnicity. 1 - Hispanic or Latino 2 - Not Hispanic or Latino	10. SEX Give the **code** to show Sex. M - Male F - Female	11. SOCIAL SECURITY NUMBER Give the number for anyone for whom you are requesting assistance.	12. MARITAL STATUS Give the **code** to show Marital status. 1 - Married 2 - Never Married 3 - Divorced 4 - Widowed 5 - Separated	13. VETERAN/ DEPENDENT OF A VETERAN Check (√) **YES or NO**
YES ( ) NO ( )	**Alien Number** **Date of Entry**	**Place of Birth** **Date of Birth**						YES ( ) NO ( )
YES ( ) NO ( )	**Alien Number** **Date of Entry**	**Place of Birth** **Date of Birth**						YES ( ) NO ( )
YES ( ) NO ( )	**Alien Number** **Date of Entry**	**Place of Birth** **Date of Birth**						YES ( ) NO ( )
YES ( ) NO ( )	**Alien Number** **Date of Entry**	**Place of Birth** **Date of Birth**						YES ( ) NO ( )
YES ( ) NO ( )	**Alien Number** **Date of Entry**	**Place of Birth** **Date of Birth**						YES ( ) NO ( )
YES ( ) NO ( )	**Alien Number** **Date of Entry**	**Place of Birth** **Date of Birth**						YES ( ) NO ( )
YES ( ) NO ( )	**Alien Number** **Date of Entry**	**Place of Birth** **Date of Birth**						YES ( ) NO ( )
YES ( ) NO ( )	**Alien Number** **Date of Entry**	**Place of Birth** **Date of Birth**						YES ( ) NO ( )

USE THE FOLDOUT TO COMPLETE THIS SECTION

14. EDUCATION			15. DISABILITY STATUS	16. ANSWER ONLY IF DISABLED
Give the **Last Grade Completed** in school. Check (√) **YES or NO** Is the person a High School (HS) or GED graduate? Check (√) **YES or NO** Is the person **Currently Enrolled** in school? If **YES**, give the **school name** and use one of the **codes** to show enrollment. FT - Enrolled full time HT - Enrolled half time LT - Enrolled less than half time	SCHOOL NAME	ENROLLMENT CODE	Give the **code** to show Disability/Pregnant Status ND - Not disabled DS - Disabled BL - Blind CD - Needed to care for disabled person	A. Check (√) if the disability reduces or prevents the ability to work or to obtain work. B. Check (√) if the disability reduces or prevents the ability to care for a child in the home. C. Check (√) if the disability requires someone to be in the home to provide care.
A. **Last Grade Completed:** _____ B. **( ) YES ( ) NO HS or GED Graduate** C. **( ) YES ( ) NO Currently Enrolled**				A. **( ) Ability to work is reduced** B. **( ) Ability to care for child is reduced** C. **( ) Someone is needed in the home**
A. **Last Grade Completed:** _____ B. **( ) YES ( ) NO HS or GED Graduate** C. **( ) YES ( ) NO Currently Enrolled**				A. **( ) Ability to work is reduced** B. **( ) Ability to care for child is reduced** C. **( ) Someone is needed in the home**
A. **Last Grade Completed:** _____ B. **( ) YES ( ) NO HS or GED Graduate** C. **( ) YES ( ) NO Currently Enrolled**				A. **( ) Ability to work is reduced** B. **( ) Ability to care for child is reduced** C. **( ) Someone is needed in the home**
A. **Last Grade Completed:** _____ B. **( ) YES ( ) NO HS or GED Graduate** C. **( ) YES ( ) NO Currently Enrolled**				A. **( ) Ability to work is reduced** B. **( ) Ability to care for child is reduced** C. **( ) Someone is needed in the home**
A. **Last Grade Completed:** _____ B. **( ) YES ( ) NO HS or GED Graduate** C. **( ) YES ( ) NO Currently Enrolled**				A. **( ) Ability to work is reduced** B. **( ) Ability to care for child is reduced** C. **( ) Someone is needed in the home**
A. **Last Grade Completed:** _____ B. **( ) YES ( ) NO HS or GED Graduate** C. **( ) YES ( ) NO Currently Enrolled**				A. **( ) Ability to work is reduced** B. **( ) Ability to care for child is reduced** C. **( ) Someone is needed in the home**
A. **Last Grade Completed:** _____ B. **( ) YES ( ) NO HS or GED Graduate** C. **( ) YES ( ) NO Currently Enrolled**				A. **( ) Ability to work is reduced** B. **( ) Ability to care for child is reduced** C. **( ) Someone is needed in the home**
A. **Last Grade Completed:** _____ B. **( ) YES ( ) NO HS or GED Graduate** C. **( ) YES ( ) NO Currently Enrolled**				A. **( ) Ability to work is reduced** B. **( ) Ability to care for child is reduced** C. **( ) Someone is needed in the home**

B. INCOME (ALL APPLICANTS MUST COMPLETE THIS SECTION)

Answer the income questions for everyone for whom you are applying. If applying for **TANF or TANF Emergency Assistance,** , also provide income information for the additional persons indicated on the INSTRUCTIONS page and also provide income information for the child's parent or stepparent living in the home; or any person living with the parent as husband or wife. If the parent is a minor under age 18 (for **TANF**), also provide income information for the parent of the minor parent.

1. Does anyone receive any of the following types of money from working? Check (√) **YES or NO** for each type. If **YES**, give the information requested.

YES ( ) NO ( ) Wages/salary   YES ( ) NO ( ) Vacation Pay   YES ( ) NO ( ) Farming/fishing   YES ( ) NO ( ) Other self- employment
YES ( ) NO ( ) Contract income   YES ( ) NO ( ) Earned sick pay   YES ( ) NO ( ) Domestic work   YES ( ) NO ( ) Any other money from working
YES ( ) NO ( ) Commissions, bonuses, tips   YES ( ) NO ( ) Babysitting/day care   YES ( ) NO ( ) Odd jobs

Person Receiving Money From Working	Employer's Name, Address Phone Number	Employment Begin Date	Hours Worked Per Month	Rate of Pay	How Often Paid	Day of The Week Paid	Gross Monthly Pay Before Deductions
				$ PER			$
				$ PER			$
				$ PER			$

2. Does anyone receive any other type of money? Check (√) **YES OR NO** for each type. If **YES**, give the information requested.

YES ( ) NO ( ) Social Security   YES ( ) NO ( ) Child support, alimony   YES ( ) NO ( ) Cash gifts or contributions   YES ( ) NO ( ) Loans
YES ( ) NO ( ) SSI   YES ( ) NO ( ) Military Allotment   YES ( ) NO ( ) Public Assistance   YES ( ) NO ( ) Training allowances, including WIA
YES ( ) NO ( ) VA benefits   YES ( ) NO ( ) Unemployment benefits   YES ( ) NO ( ) Room/board income   YES ( ) NO ( ) Inheritance
YES ( ) NO ( ) Black Lung benefits   YES ( ) NO ( ) Worker compensation   YES ( ) NO ( ) Rental Income   YES ( ) NO ( ) All food, clothing, utilities, or rent
YES ( ) NO ( ) Railroad retirement   YES ( ) NO ( ) Strike benefits   YES ( ) NO ( ) Prize winnings   YES ( ) NO ( ) Any other type of money
YES ( ) NO ( ) Other retirement   YES ( ) NO ( ) Interest, dividends   YES ( ) NO ( ) Insurance settlement

Person Receiving Money	Type of Money Received	How Often Received	When Received	Gross Monthly Amount Before Deductions
				$
				$
				$
				$

YES ( ) NO ( ) **3**. Does anyone besides the people for whom you are applying pay directly for you, help you pay, or lend you money to pay rent, utilities, medical bills or any other bills? Or, does anyone totally supply food or clothing for you or someone else on a regular basis?

Person Receiving Help	Person Providing Help	Type of Help Received	Amount	Does Money Come Directly to You?	Is This a Loan?	Is Repayment Expected
			$ PER	YES ( ) NO ( )	YES ( ) NO ( )	YES ( ) NO ( )
			$ PER	YES ( ) NO ( )	YES ( ) NO ( )	YES ( ) NO ( )

YES ( ) NO ( ) **4**. Has anyone been fired, laid off, gone on sick or maternity leave, gone on strike, quit a job or reduced hours worked in the last 60 days?

Name of Person	Employer's Name, Address, Phone	Employed From/To	Hrs./Wk. Worked	Rate of Pay	How Often Paid	Date Last Pay Received	Reason For Leaving, Reducing Hours
				$ PER			

YES ( ) NO ( ) **5**. Does anyone expect any change in the type of money received, employment, or hours worked, either this month or next month?

If **YES**, explain and give date: _____

YES ( ) NO ( ) **6**. Does anyone have a day care expense for a child, an elderly person, or an adult with a disability?

Person Paying For Care	Person Receiving Care	Check (√) If Disabled	Provider's Name, Address, Phone Number	Amount Paid
		( ) Disabled		$ PER
		( ) Disabled		$ PER

YES ( ) NO ( ) **7**. Does anyone pay legally obligated child support to someone not in the household? If **YES,** person paying: _____

Person supported: _____ Amount paid and how often: _____

YES ( ) NO ( ) **8**. **ANSWER ONLY IF SOMEONE IS APPLYING FOR AUXILIARY GRANTS AND IS BLIND OR DISABLED:** Does this person have a work related expense?

If **YES,** give amount and explain: _____

C. RESOURCES

Do not complete this section if you are applying only for TANF, TANF Emergency Assistance or General Relief-Unattached Child. For all other programs, answer the resource questions for everyone for whom you are applying. Include any resources jointly owned with someone else, even if that person does not live with you. List the names of all joint owners. After each joint owner's name, list the percentage (%) of the resource owned by that person. TALK TO YOUR ELIGIBILITY WORKER IF YOU NEED HELP ANSWERING THESE QUESTIONS, INCLUDING THE PERCENTAGE OWNED.

YES ( ) NO ( ) 1. Cash on hand and not in a bank? If **YES**, list owner(s)_____ Amount_____

YES ( ) NO ( ) 2. Checking account, savings or investment account, credit union account, Christmas Club account, CDs or money market account, individual development account, patient funds for people in a nursing facility or Assisted Living Facility, or special welfare fund account? List all accounts, even if there is no money in the account. If **Yes** to savings or investment account, has the savings account been set up to pay for school expenses, to make a down payment on a house, or to start a business? Check (√) **YES ( ) NO ( )** If the savings account is to pay for school expenses, list the person(s) whose expenses will be paid _____. If the savings or investment account is for another purpose, explain _____

Owner(s)	Type of Account Account #	Where	YES ( ) NO ( ) Is this resource used in your business, trade, or farming?	Amount $	Date Acquired
Owner(s)	Type of Account Account #	Where	YES ( ) NO ( ) Is this resource used in your business, trade, or farming?	Amount $	Date Acquired
Owner(s)	Type of Account Account #	Where	YES ( ) NO ( ) Is this resource used in your business, trade, or farming?	Amount $	Date Acquired

YES ( ) NO ( ) 3. Stocks or bonds, trust funds, pension plans, retirement accounts, promissory notes, deeds of trust, mutual funds, IRAs, or annuities?

Owner(s)	Type of Account Account #	Where	Amount $	Date Acquired
Owner(s)	Type of Account Account #	Where	Amount $	Date Acquired

YES ( ) NO ( ) 4. Has anyone sold, transferred, or given away any resources in the last 3 months if applying for **SNAP** benefits or he last 3 years, if applying for **Auxiliary Grants**?

Property Transferred		Value at Transfer $	Amount Received $	Explain Reason for Transfer
From Whom?	To Whom?	Date Acquired	Date Transferred	

Answer the questions below this point (5-10B) only if this is an application for Auxiliary Grants.

YES ( ) NO ( ) 5. Burial plots, burial arrangement or trust funds for burial?

Owner(s)	Number of Plots, Type of Arrangement	Where	Value $ Amount Owed $	Date Acquired

YES ( ) NO ( ) 6. Personal property, such as campers/trailers, non-motorized boats, utility trailers, tools, equipment, supplies, or livestock?

Owner(s)	Type	YES ( ) NO ( ) Is this property necessary to your business, trade, or farming?	Value $ Amount Owed $	Date Acquired

YES ( ) NO ( ) 7. Real property, including life estates, land, buildings, or mobile homes? If **YES**, do you live there? Check (√) **YES ( )   NO ( )**

Owner(s)	Type (Include number of acres)	YES ( ) NO ( ) Currently rented YES ( ) NO ( ) Income producing YES ( ) NO ( ) Currently for sale	Value $ Amount Owed $	Date Acquired

YES ( ) NO ( ) 8. Licensed or unlicensed vehicles, such as cars, trucks, vans, motorboats, motor homes, mobile homes, recreational vehicles, or motorcycles/mopeds?

Owner(s)	Type of Vehicle: Year--Make--Model Vehicle Id#	Currently Licensed? YES ( ) NO ( )	License #	Value $ Amount Owed $	Explain How Vehicle Is Used	Date Acquired
Owner(s)	Type Of Vehicle: Year-Make-Model Vehicle Id#	CURRENTLY LICENSED? YES ( ) NO ( )	License #	Value $ Amount Owed $	Explain How Vehicle Is Used	Date Acquired

YES ( ) NO ( ) **9**. Life insurance policies?

OWNER(S)	PERSON(S) INSURED	COMPANY NAME, ADDRESS, PHONE	TYPE OF POLICY	POLICY NUMBER	FACE VALUE $	CASH VALUE $	DATE ACQUIRED
OWNER(S)	PERSON(S) INSURED	COMPANY NAME, ADDRESS, PHONE	TYPE OF POLICY	POLICY NUMBER	FACE VALUE $	CASH VALUE $	DATE ACQUIRED

YES ( ) NO ( ) 10A. Does anyone expect to receive any money because of a legal suit involving personal injury or property damage? If **YES**, explain.

YES ( ) NO ( ) 10B. Does anyone expect a change in resources this month or next month? If **YES**, explain and give date change is expected.

EXPLAIN

D. SNAP (formerly FOOD STAMPS)

1. List the name of the person who is the head of your household for SNAP purposes _____.

YES ( ) NO ( ) 2. Would you like to name a representative who could apply for SNAP benefits for you, access your SNAP benefit account to buy food for you, or receive SNAP correspondence and notices for you? You may have only one representative who can access your benefits. You may fill in the name of your representative here or you may write a letter to identify a representative.

	Name, Address, Phone Number of Authorized Representative(s)	Check (√) Each Duty Authorized for the Representative
1		( ) Apply for SNAP benefits ( ) Receive correspondence ( ) Receive SNAP benefits
2		( ) Apply for SNAP benefits ( ) Receive correspondence ( ) Receive SNAP benefits

YES ( ) NO ( ) 3. Is there anyone else living with you that you have NOT included on your SNAP application? If **YES**, do you and everyone for whom you are applying usually purchase and prepare meals apart from these people? Or, do you intend to do so if your application for SNAP benefits is approved? Check (√) **YES ( )   NO ( )**.
IF YES, list names: _____

YES ( ) NO ( ) 4. Is anyone living in your home a roomer or a boarder? If **YES**, list names: _____

YES ( ) NO ( ) 5. Is anyone age 60 or older, **OR** approved to receive Medicaid because of a disability, **OR** receiving any type of disability check? If **YES**, list all current medical expenses for these people. Include Medicare and other medical insurance premiums, medical and dental bills, psychotherapy, prescription drugs, eye glasses, dentures, hearing aids, transportation for medical services, nursing services, and any other medical bills. .

Person with Expense	Type of Expense	AMOUNT	Name, Address, Phone Number of Doctor, Hospital, Pharmacy
		$	
		$	

YES ( ) NO ( ) 6. Does anyone have any of the shelter expenses listed below? Check (✓) here ❑ if these expenses are for a house you do not live in.
Reason for not living there_____ Is someone else living there? **YES ( ) NO ( )**
If someone else lives there, does that person pay rent? **YES ( ) NO ( )**

Expenses	Rent/mortgage	Taxes	Insurance	Electricity	Gas/ oil/Kerosene	Coal/wood	Water/sewer/ garbage	Telephone	Installation
Amount billed	$	$	$	$	$	$	$	$	$
How often									
Who pays bill									

a. **YES ( )   NO ( )** Do you have a heating or cooling expense for your home? If **YES**, what is the average amount for heating or cooling your home?_____.
b. **YES ( )   NO ( )** Did you receive energy/fuel assistance during this past year?
c. **YES ( )   NO ( )** Are you staying temporarily in someone else's home, an emergency shelter, welfare hotel, other halfway house, or a place not usually used for sleeping? If **YES**, how much does it cost to stay there during the month?_____
If you are staying temporarily in someone else's home, tell us the date you moved there:_____

E.   FINANCIAL ASSISTANCE

(ASK FOR AN EXTRA PAGE IF YOU NEED MORE SPACE)

1. CHILD/PARENT INFORMATION List each child for whom you are applying. Then, list the names of both parents. YOU MUST IDENTIFY BOTH PARENTS IN ORDER TO RECEIVE TANF. IF YOU INTENTIONALLY MISIDENTIFY A PARENT, YOU SHALL BE PROSECUTED	2. PARENT'S STATUS (Not needed for Medicaid) Check if either PARENT is:				3. IMMUNIZATION (Not needed for Medicaid) (Answer **only if applying for TANF and the child is not in school.)** Has the child received **ALL** of the immunizations required according to the child's age? Check (√) **YES** or **NO** or **UNKNOWN**
	UNEMPLOYED	DISABLED	DEAD	ABSENT	
CHILD'S NAME					YES ( ) NO ( ) UNKNOWN ( )
MOTHER					
FATHER					
CHILD'S NAME					YES ( ) NO ( ) UNKNOWN ( )
MOTHER					
FATHER					
CHILD'S NAME					YES ( ) NO ( ) UNKNOWN ( )
MOTHER					
FATHER					
CHILD'S NAME					YES ( ) NO ( ) UNKNOWN ( )
MOTHER					
FATHER					

TANF APPLICANTS: The diversionary assistance program was explained to me.   **YES ( )   NO ( )**
The family cap provision was explained to me.   **YES ( )   NO ( )**

F. TANF EMERGENCY ASSISTANCE

YES ( ) NO ( )   1. Have you or your family experienced a natural disaster or fire in the past 30 days? If **YES**, give date and explain _____

_____

YES ( ) NO ( )   2. Does anyone have any emergency needs, such as clothing, repair or replacement of household equipment and supplies which were destroyed?

Description and cause of emergency

G. AUXILIARY GRANTS

YES ( ) NO ( )   1. Is the applicant living in an Assisted Living Facility, an Adult Foster Care Home, a Nursing Facility, or other institution?
If **YES**, Date Applicant Entered_____ City\County and State Applicant lived before entering _____-_
If outside Virginia, was placement made by a government agency? **YES ( ) NO ( )**

YES ( ) NO ( )   2. Do you have a spouse who does not live in the home?   If **YES**, enter the Spouse's Name and address _____

_____

YES ( ) NO ( )   3. Have you lived in Virginia for the past 90 days?

YES ( ) NO ( )   4. Do you owe or did you pay any bills you had in the month of entry into an assisted living facility or adult foster care?

Description of Bills	Dates of Bills	Dates Bills Paid

YES ( ) NO ( )   5. Do you own any household goods or personal effects worth more than $500, such as silver, fine china, furs, artwork, jewelry, or other items held for their value or as an investment?

Description and Value of Items

CHANGE REPORTING AND PENALTIES (READ THIS SECTION CAREFULLY BEFORE SIGNING THIS APPLICATION)

REPORTING CHANGES

You must report changes that occur. What you need to report and when you need to report it varies by each program as listed below.
.
SNAP: Report within 10 days, but no later than the 10th day of the month after the change occurs. Report these changes:

- Your household income goes over 130% of the Federal poverty level. See the Change Report or the Notice of Action for the amount.
- The number of work hours in a week goes under 20 for anyone who is 18-50 if there are no children in your household.

TANF/Refugee Cash Assistance: Report within 10 days, but no later than the 10th day of the month after changes occur. Report these changes:.

- Your household income goes over 130% of the Federal poverty level. See the Change Report or the Notice of Action for amount.
- Your address changes.
- An eligible individual leaves or enters the home.
- Changes that may affect your participation in VIEW such as, changes in income, employment, education, training, transpotation, and child care.

General Relief-Unattached Child: Report the day the change occurs or the first day that the agency is open after the change occurs. Report these changes:

- Your address changes.
- The amount of your monthly income changes.
- There are other changes that may affect eligibility.

Auxiliary Grants: Report changes within 10 days. Report these changes:

- Your address changes.
- The amount of your monthly income changes.
- There are changes in your resources, including transferring assets/property or in any motor vehicles owned

:

PENALTIES FOR SNAP VIOLATIONS

You must not give false information or hide information to get SNAP benefits. You must not trade or sell EBT cards. You must not use SNAP benefits to buy non-food items, such as alcohol, tobacco or paper products. You must not use someone else's, EBT card for your household.

If you intentionally break any of these rules you could be barred from getting SNAP benefits for 12 months (1st violation), 24 months (2nd violation), or permanently (3rd violation); subject to $250,000 fine, imprisoned up to 20 years, or both; and suspended for an additional 18 months and further prosecuted under other Federal and State laws.

If you intentionally give false information or hide information about identity or residence to get SNAP benefits in more than one locality at the same time, you could be barred for 10 years.

If you are convicted in court of trading or selling SNAP benefits of $500.00 or more, you could be barred permanently.

If you are convicted in court of trading SNAP benefits for a controlled substance, you could be barred for 24 months for the 1st violation, permanently for the 2nd violation.

If you are convicted in court of trading SNAP benefits for firearms, ammunition, or explosives, you could be barred permanently for the first violation.

PENALTIES FOR TANF AND REFUGEE CASH ASSISTANCE (RCA) VIOLATIONS

You must not knowingly give false information, hide information, or fail to report changes on time in order to receive TANF/RCA or to receive supportive or transitional services such as child care or assistance with transportation.

If you are found guilty of intentionally breaking these rules, you will be ineligible to receive TANF/RCA for yourself for 6 months (1st violation), 12 months (2nd violation), or permanently (3rd violation). In addition, you may be prosecuted under Federal or State law.

Anyone convicted of misrepresenting his or her residence to get TANF, Medicaid, SNAP benefits or SSI in two or more states is ineligible for TANF for 10 years.

Anyone convicted of a drug-related felony for actions that occurred after August 22, 1996, could be barred permanently.

INFORMATION ABOUT THE DIVISION OF CHILD SUPPORT ENFORCEMENT (DCSE)

In order to receive TANF, you are required to assign all of your rights to financial support paid to you and to everyone else for whom you are receiving TANF. After your case is approved, you must give any support payments you receive to DCSE.

.

BY MY SIGNATURE BELOW, I DECLARE:

- I read the information in the GENERAL INFORMATION and the YOUR RESPONSIBILITIES sections of this application.
- I understand that if I refuse to cooperate with any review of my eligibility including review by Quality Assurance, my benefits may be denied until I cooperate.
- I understand that if my application is for SNAP benefits, failure to report or verify any of my expenses will be seen as a statement by my household that I do not want to receive a deduction for these expenses.
- I have given true and correct information on this application to the best of my knowledge and belief. I understand that if I give false information, withhold information, or fail to report a change promptly or on purpose, I may be breaking the law and could be prosecuted for perjury, larceny, and/or welfare fraud. I understand that if I help someone complete this form so as to get benefits he or she is not entitled to receive, I may be breaking the law and could be prosecuted.
- I authorize the Department of Social Services and refugee service contractors to obtain any verification necessary to both determine and review financial assistance eligibility. This authorization is valid for one year from the date of my signature below. I understand that this time limit does not apply as long as my medical assistance case is open or to investigations regarding possible fraud.
- I understand that different state agencies provide different services and benefits. Each agency must have specific information to determine eligibility services and benefits.
  ❑ **I allow**   ❑ **I do not allow** the Department of Social Services to disclose certain information about me to other state agencies, including information in electronic databases, for the purpose of determining my eligibility for benefits/services provided by that agency. This disclosure will make it easier for agencies to work together efficiently to provide or coordinate services and benefits. Agencies include, but are not limited to, the Department of Health, the Department for the Aging, the Department of Rehabilitative Services and the Department of Vocational Rehabilitation. I can withdraw this authorization at any time by notifying my eligibility worker.

  I filled in this application myself. **YES ( )   NO ( )**   If **NO**, it was read back to me when completed. **YES ( )   NO ( )**

Applicant's or Authorized Representative's Signature or Mark	Date	Spouse's or Authorized Representative's Signature or Mark (Not Needed for Snap))	Date
Witness To Mark Or Interpreter	**Date**		

Complete the box below if this application was completed for the applicant by someone else.

Name of Person Completing Application	Date	Address
Phone Number (Home) (Other)		**Realationship to Applicant**