



<b>5. AUTHORIZED REPRESENTATIVE (IF DESIRED)</b>						
First Name	Middle Name	Last Name	Jr., III, etc.			
Number	Street	City	State	Zip Code + 4		
Telephone Number		Relationship to you				
Check what you want the representative to do:						
<input type="checkbox"/> Complete interview for you		<input type="checkbox"/> Cash your check		<input type="checkbox"/> Receive your notices		
<input type="checkbox"/> Sign your application		<input type="checkbox"/> Cash your Food benefits		<input type="checkbox"/> Receive your Medical Assistance Card		
<b>6. INDIVIDUAL INFORMATION</b> Complete the section below.						
Last Name	First Name	Middle Name	Jr., III etc.			
Maiden/Other Name	Social Security Number	List Additional Social Security Number	Date of Birth			
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity* (see below)	Race* (see below)	Marital Status			
Resident of Maryland <input type="checkbox"/> YES <input type="checkbox"/> NO	Due date if pregnant	Number of babies expected?	Receiving Prenatal Care? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Receiving benefits in another state:						
Public Assistance? <input type="checkbox"/> YES <input type="checkbox"/> NO		Food benefits? <input type="checkbox"/> YES <input type="checkbox"/> NO		Medical Assistance? <input type="checkbox"/> YES <input type="checkbox"/> NO		
U.S. Citizen? <input type="checkbox"/> YES <input type="checkbox"/> NO	Student? <input type="checkbox"/> YES <input type="checkbox"/> NO	On Strike? <input type="checkbox"/> YES <input type="checkbox"/> NO	Disabled or Incapacitated? <input type="checkbox"/> YES <input type="checkbox"/> NO	Medical Insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO	Medicare Part A <input type="checkbox"/> YES <input type="checkbox"/> NO	Medicare#
<b>7. MIGRANT WORKER</b>		<b>8. BOARDER</b> If you are a boarder, fill in this sections:				
Are you a migrant worker? <input type="checkbox"/> YES <input type="checkbox"/> NO		Number of Meals per Day	Cost of Meals per Month \$			
<b>8 IMMIGRATION STATUS</b> — If you are not a United States citizen, fill in this section						
INS Status	Newly Legalized Status Date	Sponsored Alien <input type="checkbox"/> YES <input type="checkbox"/> NO	Country of Origin			
US Entry Date	INS Number	<b>Maryland uses the Systematic Alien Verification and Eligibility or SAVE system through the United States Citizenship and Immigration Service (USCIS) formerly known as Immigration and Naturalization Service (INS) to verify the alien status of all applicant and recipient non-citizen households. Information received from USCIS may affect your household's eligibility and benefit amount.</b>				
<b>9. SCHOOL</b> — If you are in school, fill in this section:						
Student Status <input type="checkbox"/> Full-time <input type="checkbox"/> Half-time <input type="checkbox"/> Less than half-time	Educational Level <input type="checkbox"/> Elementary <input type="checkbox"/> College <input type="checkbox"/> Secondary <input type="checkbox"/> Other, List: _____		Highest Grade Completed			
		Expected Graduation Date (If in high school)				
School Name			School Number			
School Address	City	State	Zip Code + 4			
<b>10. DISABILITY</b> — If you are disabled or incapacitated, what is the disability?						

\*Use the codes below to complete the Race and Ethnicity blocks. Enter each code that applies, using at least one code for each person.  
**Ethnicity Codes:** 1= Hispanic or Latino, 2=Not Hispanic/Latino. **Race Codes:** You can choose one or more race code - 1=American Indian/Alaskan Native, 2=Asian, 3=Black/African American, 4=Native Hawaiian/Pacific Islander, 5=White

**Note:** You do not have to give information about your race or ethnicity. If you do, it will help show how we obey the Federal Civil Rights Law. We will not use this information to decide if you are eligible. If you do not give us your race, it will not affect your application. The case manager will enter a race code for statistical purposes only. Title VI of the Civil Rights Act of 1964 allows us to ask for this information.

11. MEDICAL INSURANCE — If you have medical insurance, fill in this section:						
Policy Number		Group Number		Policy Holder Name		
Relationship to Policy Holder						
POLICY HOLDER ADDRESS						
Number		Street				
City		State	Zip Code + 4		Telephone Number	
INSURANCE COMPANY						
Insurance Company Name						
Number		Street				
City		State	Zip Code + 4		Telephone Number	
UNION						
Union Name					Union Local Number	
Number		Street				
City		State	Zip Code + 4		Telephone Number	
12. VETERAN INFORMATION — If you are a veteran or a disabled widow or widower, or a disabled child of a deceased veteran, fill in this section:						
Veteran's Name		Relationship to Veteran	Veteran's Status		Military Service Number	
13. MEDICAL EXPENSE						
If you are 60 or older, blind or disabled and applying for or receiving Food Supplement Program benefits, do you have medical bills that you must pay? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If Yes, bring in your bills.</i>						
14. LIQUID ASSETS — Complete for assets as of the 1 <sup>st</sup> day of the month. Check Yes or No for each ASSET TYPE						
ASSET TYPE	CHECK ONE	OWNER	AMOUNT Balance/value	ACCOUNT NUMBER	FDIC NUMBER	INSTITUTION
Cash on Hand	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$	N/A	N/A	N/A
Checking Accounts	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$			
Savings Accounts	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$			
Credit Union Accounts	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$			
Trust Funds	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$			
IRA or Keogh Accounts	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$			
Stocks, bonds, Certificates, Money Market Funds, mutual funds, treasury or Other Notes	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$			
Annuities:	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$			
Other, List:	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$			
Other, List	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$			
Other, List	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$			

**15. LIFE INSURANCE AND FUNERAL PLANS** — If you have any life insurance or pre-paid burial plans or funds, fill in this section. List all policies and plans no matter who pays for them.

NAME OF PERSON WHO PAYS	ORIGINAL FACE VALUE OR VALUE OF PLAN	CURRENT CASH VALUE	POLICY NUMBER OR ACCOUNT NUMBER	LIFE INSURANCE OR BURIAL PLAN	COMPANY, FUNERAL HOME OR BANK NAME
	\$	\$			
	\$	\$			

**16. REAL PROPERTY** — If you own property other than where you live, fill in this section. Include burial plots.

Number	Street	City	State	Zip Code + 4
How Used?		Current Fair Market	Amount Owed Now	Trying to Sell <input type="checkbox"/> YES <input type="checkbox"/> NO
Number	Street	City	State	Zip Code + 4
How Used?		Current Fair Market	Amount Owed Now	Trying to Sell <input type="checkbox"/> YES <input type="checkbox"/> NO

**17. OTHER ASSETS** — If you own other assets not listed, such as antiques, boat, recreational vehicle, coin collections, furs, jewelry, livestock, or stamp collections, fill in this sections:

ASSET TYPE	CURRENT FAIR MARKET VALUE	AMOUNT OWED
	\$	\$
	\$	\$

**18. POTENTIAL ASSET OR INCOME** — If you are expecting to receive an accident settlement, trust fund, inheritance or other money or property, fill in this section.

Type	Lawyer Name
Explanation	Lawyer Telephone

**19. TRANSFER OF ASSETS** — if you sold, traded or gave any property, motor vehicles, stocks, bonds, cash or other assets in the past 3 years (5 years for a trust), fill in this sections:

Transfer Date	Who Received the Asset?	Type of Assets
Fair Market Value When Transferred	Amount Received	Reason for Transfer

**20. INCOME FROM WORKING** — If you are working now, fill in this section. If not, list the last job held. Include full-time, part-time or temporary work or self-employment, such as owning a business, roomer or boarder income, babysitting, home demonstrations, cleaning houses, odd jobs, etc.

NAME OF EMPLOYER (INCLUDE ADDRESS AND PHONE NUMBER)	Rate of Pay	Number of Hours Worked	Amount Per Pay Period	How often Received?	if Job Ended, Date and amount of Last Pay

**21. OTHER INCOME AND BENEFITS** — Check if you are receiving, have applied for or have been denied any of the following. Include any income that may not be listed here.:

TYPE OF BENEFIT	RECEIVING BENEFITS	AMOUNT	APPLICATION STATUS	APPLICATION OR DENIAL DATE
Alimony	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Child Support	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Social Security Claim #:	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
SSI Claim #:	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Railroad Retirement Benefits Claim#:	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Veteran's Pension/Benefits	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Unemployment Benefits	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Worker's Compensation	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Pension or Retirement	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Disability/Sick/Maternity Benefits	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Union Benefits	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Military Allotment	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Money from Friends or Relatives (loans & other)	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Money from Rental income	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Black Lung Benefits	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Lump Sum Amounts	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Civil Service Annuity	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Public Assistance/State Disability Benefits from Another State	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Interest or Dividends from Stocks, Bonds, Savings, or Other Investments	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	
Other Income ( <i>not listed above</i> ) Specify _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> Applied for <input type="checkbox"/> Denied	

**22. SHELTER COSTS** — Are you paying for any of the following? Complete only if you are applying for Food Supplement benefits

Expenses	Check One	Amount	How Often Paid?	Who Pays?	Expenses	Check One	Amount	How Often Paid?	Who Pays?
Rent	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$			Sewer	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$		
Mortgage	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$			Garbage	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$		
Electric	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$			Coop/ Condo Fee	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$		
Oil	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$			Homeowner Insurance (if not included in mortgage)	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$		
Gas	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$			Other Utility Cost, list	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$		
Property Taxes	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$			Other Utility Cost, list	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$		
Telephone	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$			Other Utility Cost, list	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$		
Water	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$			Other Utility Cost, list	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$		

23. TYPE OF EXPENSES SHARED	WITH WHOM	TOTAL AMOUNT OF SHARED EXPENSES	AMOUNT OF YOUR SHARE
		\$	\$
		\$	\$
		\$	\$
		\$	\$

## 24. ADDITIONAL INFORMATION

## 25. HOUSEHOLD'S DECLARATION INQUIRY – Complete if you are applying for Temporary Cash Assistance or Food Supplement benefits

1. Has anyone in your household ever been convicted of a felony committed on or after August 22, 1996 that involved drugs?  
 YES    NO   If yes, who? \_\_\_\_\_
2. Is anyone in your household currently violating parole or probation or fleeing from the police or the courts?  
 YES    NO   If yes, who? \_\_\_\_\_
3. Has anyone in your household been convicted since August 22, 1996 in a Federal or State Court for not telling the truth about where they lived or their identity in order to receive food supplement benefits or cash assistance from more than one place in the same month?  
 YES    NO   If yes, who? \_\_\_\_\_
4. Has a court convicted any member of your household for trading or trafficking food supplement benefits of \$500 or more?  
 YES    NO   If yes, who? \_\_\_\_\_
5. Is anyone in your household receiving benefits under another identity or as a member of another household or in another State?  
 YES    NO   If yes, who? \_\_\_\_\_

## RIGHTS AND RESPONSIBILITIES

### **Requesting a reasonable accommodation:**

If you are an individual with a disability, you may be entitled to reasonable accommodation to help you access DHR's activities, programs and services. This applies even if you are working with a local department of social services or a vendor who provides services for DHR's customers.

A reasonable accommodation is a modification or adjustment to an activity, program or service which helps a qualified individual with a disability have meaningful access to DHR's activities, programs and services.

### **Examples of reasonable accommodations:**

Hearing Impairment: sign language interpreter; providing an assistive listening device

Visual Impairment: having a qualified reader read to a customer

Mobility Impairments: mailing forms to a customer; meeting a customer at a more accessible location

Developmental Disabilities: Having things written down; taking breaks; scheduling appointments around a customer's medical needs

You may request a reasonable accommodation from the local department of social services or a vendor at any time. Your request may be oral or written. A request for a reasonable accommodation may be made in person, in writing or over the telephone. There are no particular words that you need to use to request an accommodation. A request may be made by you or someone helping you. If you need to request a reasonable accommodation because of your disability, you should speak with the case manager or the supervisor or the ADA Field Coordinator at your local department of social services. You may ask the case manager for the name of the ADA Coordinator at your local department of social services. You may use the form on the reverse side of this notice. You may also ask for more information at the front desk.

## YOUR RIGHTS AND RESPONSIBILITIES

Name of Person needing an Accommodation	Name of Person requesting an Accommodation
Address:	
City/State/Zip Code:	Telephone number:
Nature of Disability or Impairment (specify):	
<b>Local Department of Social Services Location:</b>	
Accommodation Request (Type of accommodation requested.) Please print or type. Be as specific as possible. If required, attach additional comments.	
<b>Note:</b> If requesting <b>sign language services</b> , specify type: American Sign Language Interpreter (ASL), Certified Deaf Interpreter (CDI) or Communication Access Real Time Translation (CART). Please provide any additional information that may assist us in providing a reasonable accommodation (specify):	
Customer/Applicant's Signature : _____ Date: _____	
Return this form to the case manager or the Customer Access Coordinator in your local department of social services.	
<b><i>For Office Use Only</i></b>	
Date Request Received: Action Taken:	
_____	
_____	
_____	
CAC Signature: _____ Date: _____	

## RIGHTS AND RESPONSIBILITIES

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

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotope, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](#), (AD-3027), found online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) mail: U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW  
Washington, D.C. 20250-9410
- (2) fax: (202) 690-7442; or
- (3) email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

For any other information dealing with Supplemental Nutrition Assistance Program (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/hotlines.htm](http://www.fns.usda.gov/snap/contact_info/hotlines.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).

This institution is an equal opportunity provider.



## **FACTS YOU SHOULD KNOW ABOUT APPLYING FOR TEMPORARY CASH ASSISTANCE, FOOD SUPPLEMENT PROGRAM (FORMERLY FOOD STAMPS) AND MEDICAL ASSISTANCE**

### **Social Security Numbers**

- ✧ You must give us a social security number for each family member who wants benefits.
- ✧ If a person who wants benefits does not have a social security number, that person must apply for a number. We can help applicants get their numbers.
- ✧ If a family member has applied for a social security number, we will not delay your application while you wait for the number.
- ✧ We use social security numbers to prove income. We do not give numbers to other agencies like Immigration and Customs Enforcement.

### **Citizenship and Immigration Status**

- ✧ You must tell us about the citizenship and immigration status for each family member who wants benefits.
- ✧ Maryland uses the Systematic Alien Verification and Eligibility or SAVE system through the United States Citizenship and Immigration Service (USCIS) formerly known as Immigration and Naturalization Service (INS) to verify the alien status of all applicant and recipient non-citizen households. Information received from USCIS may affect your household's eligibility and benefit amount.

### **Information**

- ✧ If a family member will not tell us about citizenship, immigration status or social security number, that person will not get benefits.
- ✧ They must still give us proof of income, expenses and other things.
- ✧ The other family members who give us their information will get benefits if they meet the rules.

### **Emergency Medical Assistance**

- ✧ Immigrants who are not eligible for other kinds of medical assistance and apply only for emergency medical assistance do not have to tell us their social security number, immigration or citizenship status.

### **Time Limits**

- ✧ Temporary Cash Assistance has time limits.
- ✧ The Food Supplement Program (formerly Food Stamps) and Medical Assistance do not have a time limit.
- ✧ When Temporary Cash Assistance ends because of time limits, earnings or other reasons, you may still get Food Supplement benefits and Medical Assistance.

### **Interviews**

- ✧ You, a responsible family member or someone you choose to represent you must be interviewed.
- ✧ In most cases, we can interview you by telephone.
- ✧ You must give or send us the proof we ask for at your interview.

If you need help applying for benefits, or have questions about information you must give us, want to know what will happen to your benefits, do not speak English and need free translation services. **Call your case manager or call 1-800-332-6347. Si necesita ayuda para llenar el formulario favor de llamar al 1-800-332-6347.**

**RIGHT TO WRITTEN NOTICE** – We must always give you a written notice explaining your benefits when we approve your case. We must always give you written notice when we change your benefits, deny or close your case. You have 90 days from the notice date to ask for a hearing. If you ask for a hearing within 10 days, you may be able to keep getting benefits while you wait for the hearing.

**RIGHT TO APPEAL** – Ask for a hearing if you disagree with the Department's decision. Your case manager can help you write your appeal. At the hearing, you can speak for yourself or bring a lawyer, friend or relative to speak for you.

**RIGHT TO PRIVACY** – You are giving personal information in the application. We use the information to see if you are eligible for benefits. If you do not give the information, we may deny your application.

You have a right to review, change, or correct any information. We will not show your information or give it to others unless you give us permission or federal and state law allows us to do so.

**RIGHT TO CLAIM GOOD CAUSE** – If you want Temporary Cash Assistance (TCA), you must help the Department get child support. You may not have to help if it puts you or your family in danger.

**RIGHT TO REFUSE HELP** – You do not have to accept help from a religious organization if it is against your religious beliefs.

**RIGHT TO TIMELY APPLICATION PROCESSING** – If you are eligible for expedited Food Supplement Program benefits we must give you your benefits within 7 days. For the regular Food Supplement Program and other programs, except for certain Medical Assistance programs, we must process your application within 30 days. There are times when there is a delay in processing. If there is a delay, we will send you a letter to tell you why there is delay in processing your application. If you are incarcerated or in another such institution and file an application for Food Supplement benefits or cash assistance, you may not receive FSP or cash benefits until you are released. The filing date of your application for assistance will be the date of your release from the institution, if it is less than 30 days from the date your signed application was received in the Local Department of Social Services (LDSS). FSP benefits are issued from the date of your release based upon your application date.

### **Authorization to Receive Family Planning Information**

If you want information, you can ask your case manager for a Family Planning Guide. You may also contact:

1-800-546-8900 if you need help in finding a provider for birth control or arranging prenatal care, or The Center for Maternal and Child Health at 410-767-6713 [www.fha.state.md.us/mch](http://www.fha.state.md.us/mch)

### **YOU HAVE THE FOLLOWING RESPONSIBILITIES**

**PROVIDE INFORMATION** – You must give true and complete information. You may need to give us proof of this information. We will keep this information private. Any delay in providing proof may result in your case being delayed or denied.

Collecting application information, including the social security number of each household member, is authorized under the Food and Nutrition Act of 2008, U.S.C.2011-2036, Social Security Act §1137(f) and 42 U.S.C. §1320b-7(d). We use the information to find out if your household is eligible. We check this information by matching computer programs.

We also use the information to see if you meet program rules. We may contact your employer, bank or other party. We may also contact local, state or federal agencies to make sure the information is correct. We can give your information to other federal or State agencies for official use and to law enforcement officers who need it to find persons fleeing to avoid the law.

If you get too much in benefits:

You may have to repay the money for the benefits, and

We may give the application information, including social security numbers, to federal or state agencies, as well as private claims collections agencies, for action.

Giving information is voluntary. If you do not give us information such as social security numbers for everyone who wants help, we may deny benefits for each person who does not give a social security number. If you do not have a social security number, we will help you get one.

**REPORT CHANGES** - You must report all changes within ten days unless you are part of the Food Supplement Program simplified reporting group and are not receiving Cash Assistance or Medical Assistance. If you want to know if you are part of this group, ask your case manager. You may tell us about any changes in person, by telephone, or by mail to the Department.

**Warning – We may deny, lower or stop your benefits if you give us wrong information or do not report changes. A judge may fine and/or imprison you if you deliberately give wrong information or do not report changes.**

### **WORK REQUIREMENTS FOR THE FOOD SUPPLEMENT PROGRAM**

Individuals applying for or receiving Food Supplement benefits must know and understand the following information about the Food Supplement Program work registration and work requirements. Food Supplement work requirements are covered in federal law at 7 CFR 273.24.

Everyone over age 18 **is required to be registered for work** unless otherwise exempt, because they are: over age 60, caring for a child under age 6 living in their home, receiving unemployment benefits, self-employed-working a minimum of 30 hours or more per week at the equivalent of federal minimum wage, attending a recognized school or institution of higher education at least half time, or the individual is mentally or physically unfit for work. Work registration is not the same as participation.

Beginning January 1, 2016 able bodied individuals with no dependent children (ABAWDS), ages 18-47, who are not exempt under one of the above reasons or who have an individual exemption or they reside in an area that is designated as exempt, are required to be work registered and participate in a work program/activity or be employed. These individuals known as ABAWDS may only receive Food Supplement benefits for three months in a fixed 36-month period unless the individual is employed or participating in an approved work or educational activity a minimum of 80 hours per month. The individual may not receive Food Supplement benefits again until he or she meets the work requirements. You will receive additional information from the case manager and information is available on the DHR website at <http://www.dhr.state.md.us/blog/>

**AUTHORIZED REPRESENTATIVES** – In most instances, if your authorized representative gives us wrong information, you will have to pay back any amount you are overpaid.  
If your authorized representative knowingly gives us the wrong information or does not use your benefits properly, we may disqualify the person from being an authorized representative.  
If a drug and alcohol treatment center or a group living arrangement acts as your authorized representative for your food benefits and they willfully give us wrong information about your situation, we may prosecute the person under applicable State or federal law.

### **TCA and FOOD SUPPLEMENT PROGRAM PENALTIES**

**Do not:**

- Give false information or withhold information to get or continue to get TCA and/or FSP benefits.
- Trade or sell TCA or FSP benefits, or electronic benefit cards.
- Use TCA and FSP or electronic benefit cards to buy items not allowed, such as alcohol and tobacco or to pay on credit accounts.
- Use someone else's TCA or FSP benefits.
- Use someone else's Electronic Benefits Card without authorization.
- Use your EBT card containing TCA benefits in a liquor store, adult entertainment venue such as a strip club or in a gambling establishment such as a casino.

Your FSP benefits will not increase if your cash assistance is reduced or closed because you did not follow the rules.

If a household member deliberately breaks the rules, we may bar the person from the TCA or FSP.

We may bar this person for **one year** after the first violation.

We may bar this person for **two years**:

- \* After the second violation, or
- \* After the first time a court finds this person guilty of buying illegal drugs with TCA or Food Supplement Program benefits.

We may bar this person **permanently**:

- \* After the third violation, or

- \* After the second time a court finds a person guilty of buying illegal drugs with TCA or FSP benefits, or
- \* After the first time a court finds this person guilty of buying guns, bullets, or explosives, with TCA or FSP benefits.
- \* After a court finds this person guilty of trafficking TCA or FSP benefits of \$500 or more.

We may bar this person for ten years if found guilty of making a false statement about the person's identity in order to receive multiple benefits at the same time.

**A judge can also fine this person up to \$250,000, imprison the person for up to 20 years, or both. A judge can also bar this person for an additional 18 months. The person may also have to face further prosecution under other federal laws.**

**ASSIGNMENT OF SUPPORT RIGHTS FOR TEMPORARY CASH ASSISTANCE**

- I assign to the State of Maryland all rights, titles, and interest in support that I may have for myself or for any person receiving TCA.
- This includes any overdue support that has not been collected for the time that I or any person received TCA assistance.
- I agree to have the child support agency collect any support owed to me and to keep up to the amount of TCA paid to me.
- I agree to send to the State of Maryland any support I receive. If I do not turn over this support, I will have to repay this amount to the State of Maryland. I may also be prosecuted for fraud.
- When I am eligible for Medical Assistance:
- I assign all rights, title, and interest in medical support and health insurance payments I may have for myself or any person receiving Medical Assistance. This includes overdue medical support or health insurance payments that have not been collected.
- I agree to have the child support agency collect medical support payments owed to me and to keep up to the amount of Medical Assistance payments that were made for me.
- I agree to give the State of Maryland any medical support or health insurance payments I receive.
- I will cooperate to the best of my ability and knowledge with the child support agency while I am receiving TCA and Medical Assistance
- If I do not cooperate with the child support agency, I may lose all my benefits and my case may be closed

**I HAVE READ THESE STATEMENTS OR SOMEONE READ THEM TO ME. I UNDERSTAND WHAT THEY MEAN. BY SIGNING MY NAME BELOW, I AGREE TO FOLLOW WHAT THEY SAY.**

**Signature**

**Date**

**MEDICAID WARNING AND PENALTY - Only use Medical Assistance cards if you are eligible.**

Every person convicted of "Medicaid Fraud" with a value of **\$500** or more in money, services, or goods is guilty of a felony, and shall:

Pay back money, services or goods; or the value of those services or goods unlawfully received;  
Be subject to a fine of no more than \$10,000, imprisoned for no longer than five years, or both.

Every person convicted of "Medicaid Fraud" with a value of less than \$500 in money, services or goods is guilty of a misdemeanor, and shall:

1. Pay back money, services or goods; or the value of those services or goods unlawfully received;
2. Be fined no more than \$1,000 and imprisoned for no longer than three years or both.

**READ BEFORE SIGNING:**

I understand that it is important to give true information and if I do not, I am breaking the law.

I understand that I can be fined, imprisoned or have my benefits reduced for making false statements or for pretending to be another person.

I know I can be punished for not reporting changes that may affect my eligibility or benefit amount.

I understand that if I get more Food Supplement benefits than I should, all adult members of my household are liable for repaying the debt.

I know the Department can use the application against me in a court of law for fraud prosecution.

I know that failing to report or verify shelter, medical or dependent care expenses or child support payments is the same as saying I do not want a deduction for the expenses I did not verify or report.

I understand that the Department may check the information on this form to see if it is correct and may select my case for a spot check, such as for a Quality Control Review.

I agree to allow someone from the Department to visit me at home. I will help them get all needed proofs from any source.

I understand by signing this application:

- I accept cash assistance and/or medical assistance.
- I agree that Medicare Part B will make payments directly to doctors and medical suppliers.
- I give the Department the right to seek payment from private or public health insurance and any liable third party. I understand that I must cooperate with the department in securing such payments. The Department may seek payment without legal action, as long as it does not keep more than the amount Medical Assistance paid.
- I give the Department the right to inspect, review and copy all medical records for services received through the Medical Assistance Program.

I understand that when a person is deceased who was at least 55 years old when receiving Medical Assistance the state may take money from the estate to repay payments made on behalf of that person. The program may take the money only if there is no surviving spouse, unmarried child younger than 21, or blind or disabled child (married or unmarried) of any age.

**SIGNATURE SECTION**

I understand that, as required by Maryland law, certain law enforcement agencies that investigate fraud can obtain information about my application, income, benefits and other documentation as part of their investigation. While access to my application and benefit information is normally limited (under Md. Code Ann. Human Resources Article § 1-201), these limits do not apply to these investigative agencies. Such agencies include the Department of Human Resources' Office of the Inspector General. I understand that I do not need to provide consent to these agencies in order for them to investigate any allegations of fraud against me. Any information found as a result of the investigation may be used against me if an allegation of fraud is prosecuted.

I have read or someone has read and explained the entire application to me. I swear or affirm under penalty of perjury, that all the information I gave is true, correct, and complete to the best of my ability, belief and knowledge. I received a copy of my rights and responsibilities. I authorize any person, partnership, corporation, association, or governmental agency that knows the facts about my eligibility to give that information to the Department. I also authorize the Department to contact any person, partnership, corporation, association, or governmental agency that has given proof of my eligibility for benefits. I certify, under penalty of perjury, that by signing my name below, all persons for whom I am applying are U.S. citizens, lawfully admitted immigrants or individuals in satisfactory immigration status.

Signature of Applicant/ Recipient		Date
Signature of Witness (If you Signed an X)		Date
Signature of Spouse (If Applicable)		Date
Signature of Authorized Representative (If Applicable)		Date
Signature of Case Manager		Date

**I withdraw my application for:**    **Cash Assistance**    **Food Supplement Program**    **Medical Assistance**

Signature of Applicant, Recipient, Authorized Representative		Date
Printed Name of Applicant		