# DEPARTMENT OF HUMAN RESOURCES
# FAMILY INVESTMENT ADMINISTRATION

## Assistance Request

**The Family Investment Administration is committed to providing access, and reasonable accommodation in its services, programs, activities, education and employment for individuals with disabilities. If you need assistance or need to request a reasonable accommodation, please contact your case manager or call 1-800-332-6347. If you are applying for the Food Supplement Program (FSP) you can complete all of the form and give it to us now. You may also fill in your name, address, sign this page and give it to us. You can then finish the rest of the application at home and bring or mail it back to the office.**

Your Food Supplement benefit is based on the date you sign this application and give it to the department of social services. You may get Food Supplement benefits right away if you meet one of the following conditions:

- Your household's monthly rent or mortgage and utilities are more than your household's income and resources.
- Your household's gross monthly income is less than $150, and your resources, such as bank accounts, are $100 or less.
- Your household is a migrant or seasonal farm worker household.

If you qualify to get Food Supplement Program benefits right away, **you will receive** them within 7 days from the date you sign the form. You may not get expedited Food Supplement benefits, if eligible, until we get a completed application form and interview you.

Name: ______________________________________________
Last First Middle Initial

Mailing Address: ______________________________________
(If different from street address)

Address: ____________________________________________
Number and Street

______________________________________________________
City State Zip Code

______________________ ______________________
Home Telephone Number Cell Number

______________________________________________________
E-mail address

Signature: __________________________________________ Date: ____________________

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*Please fill out the sections below. Complete for yourself and all persons who live with you. List your own name on Line #1.*

| **A. Name**<br>**Last, First, Middle, Maiden** | **Relationship to you** | **Marital Status** | **Social Security Number** | **Date of Birth** | **Sex M/F** | **Race*** **See codes on the back page** | **Applying for this person?** | **Client ID#** (Office Use Only) |
|---|---|---|---|---|---|---|---|---|
| 1. | | | | | | | | |
| 2. | | | | | | | | |
| 3. | | | | | | | | |
| 4. | | | | | | | | |
| 5. | | | | | | | | |
| 6. | | | | | | | | |

**B. Please list any absent parents of children and past or present spouses not living with you.**

| **Absent Parent's Full Name** | **Date of Birth** | **Social Security Number** | **Client ID#** (Office Use Only) |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

**-OVER-**

**C.** List any household member who is pregnant: ____________ NAME ____________ DUE DATE / ____________ NAME ____________ DUE DATE

**D**. List any household member who is disabled: ____________ NAME ____________ TYPE OF DISABLITY / ____________ NAME ____________ TYPE OF DISABILITY

**E.** What type of assistance do you or any household member receive now?

| Under what name: | Type of Assistance: |
|---|---|
| 1.________________ | 1.________________ |
| 2.________________ | 2.________________ |
| 3.________________ | 3.________________ |

What types of assistance have you or any household member received in the past?

| Under what name: | Type of Assistance: |
|---|---|
| 1.________________ | 1.________________ |
| 2.________________ | 2.________________ |
| 3.________________ | 3.________________ |

**F**. What kind of income did you get or expect to get this month?_______________ Type $_________Amt. _____None

**G**. Are you or any members of your household employed? _______ YES ______NO

**H**. **What type of assistance do you need now? (*Check all that you need*)**
_____ Cash Assistance _____ Child Care Services_____ Medical Assistance_____ Food Supplement (formerly called food stamps)

Do you have any unpaid bills from the past 3 months? _______ YES ______NO

**I**. Do you have any of these problems? _____ Utility Shut Off _____ No Heat _____ Eviction or Foreclosure _____ No Food _____ No Place to Stay
_____ Cannot afford Child Care _____ Other: *please specify*________________________

**J.** Have you or anyone in your household received benefits from any state other than Maryland?_____ YES ______NO
If yes: Where____________________________ When______________________________

**K**. Does anyone applying for Maryland Children's Health Program have any employee based health insurance? _______ YES ______NO

**L**. Has anyone applying for Maryland Children's Health Program dropped any employee based insurance coverage in the past 6 months? _______ YES ______NO

**I. 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.**

**II. *Race codes**-Use the following codes 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.**

| Cat. | AU#'s | Status |
|---|---|---|
| | | |

| Cat. | AU#'s | Status |
|---|---|---|
| | | |

| MABS and WORKS Screens | Screened for Exp. FSP |
|---|---|
| | |

**Clearer's initial:**_____________

**I certify that I screened this applicant for expedited Food Supplement Program benefits and determined that the household □ was □ was not eligible for expedited issuance at this time.**

**Signature of Case Manager:**

## YOU HAVE THE FOLLOWING RIGHTS

**The Family Investment Administration is committed to providing access, and reasonable accommodation in its services, programs, activities, education and employment for individuals with disabilities. If you need assistance or need to request a reasonable accommodation, please contact your case manager or call 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.

**EQUAL RIGHTS** – This institution is prohibited from discriminating on the bases 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 bases 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 the Department.(Not all bases apply to all programs and or employment activities.) USDA and HHS are equal opportunity providers and employers.

If you think we have discriminated against you contact USDA or HHS. To contact USDA for the Food Supplement Program complete the **USDA Program Discrimination Complaint Form found on-line at www.ascr.usda.gov/complaint_filing_cust.html ,** or write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at USDA, Director, Office of Adjudication 1400 Independence Avenue SW, Washington, DC 20250-9410. You may fax your complaint to 202-690-7442 or e-mail it to program intake@usda.gov. Individuals who are deaf, hard of hearing or have speech disabilities are TDD users may contact USDA through local relay or the Federal Relay at 1-800-877-8339 (TDD) or 1-866-377-8642 (relay voice users) or 800-845-6136 or Spanish.

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 Ave. S.W. Washington, D.C.A 20201 or call 202-619-0403 (voice) or 800-537-7697 (TTY).

**If you need this information in a different format (large print, audiotape, etc.), contact the USDA's TARGET Center at 202-720-2600 (Voice or TDD). If you need information about this program, activity or facility in a language other than English, contact the Department of Social Services or Department of Human Resources at 1(800)332-6347. For any other information dealing with Food Supplement Program issues, persons should either contact the USDA Supplemental Nutrition Assistance Program (SNAP ) Hotline at 800-221-5689, which is also in Spanish or call the State Information /Hotline Numbers (click www.fns.gov/snap/contact_info/hotlines.htm.**

**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

## 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.**

**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.**

***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 |
|---|---|---|