

YOUR RIGHTS AND RESPONSIBILITIES

YOU HAVE THE FOLLOWING RIGHTS

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 – Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy state we cannot discriminate against you because of race, color, national origin, sex, age, or disability. Under the Food and Nutrition Act and USDA policy, we also cannot discriminate against you because of religion, political beliefs or retaliation.

If you think we have discriminated against you contact USDA or HHS. To contact USDA write USDA, Director, Office of Civil Rights, 1400 Independence Avenue SW, Washington, DC 20250-9410. You may also call toll free, 1-866-632-9992 (voice). TDD users can contact USDA through local relay or the Federal Relay at 1-800-877-8339 (TDD) or 1-866-377-8642 (relay voice users). To contact HHS, write Office for Civil Rights, Health and Human Services, 150 S. Independence Mall West – Suite 372, Philadelphia, PA 19106-3499; phone 215-861-4441. You may also call HHS toll free at 1-800-368-1019 (voice) or 1-800-537-7697 (TDD). You may also send an email to OCRMail@hhs.gov. USDA and HHS are equal opportunity providers and employers.

For the Food Supplement Program, if you need this information in a different format (Braille, 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 USDA agency responsible for the program or activity, or any USDA office.

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 your 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.

YOUR RIGHTS AND RESPONSIBILITIES

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.

YOUR RIGHTS AND RESPONSIBILITIES

FOOD SUPPLEMENT PROGRAM PENALTIES

Do not:

- Give false information or withhold information to get or continue to get Food Supplement Program (FSP) benefits
- Trade or sell FSP benefits, or electronic benefit cards.
- Use FSP benefits to buy items not allowed, such as alcohol and tobacco.
- Use someone else's FSP benefits.
- Use someone else's Electronic Benefits Card without authorization.

Your Food Supplement Program benefits will not increase if your cash assistance case 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 Food Supplement Program.

- 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 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 FSP benefits, or
 - * After the first time a court finds this person guilty of buying guns, bullets, or explosives, with FSP benefits.
 - * After a court finds this person guilty of trafficking 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.**

TCA PENALTY – If an assistance unit member is convicted of an Intentional Program Violation (IPV), everyone in your family will lose their benefits.

- The first time, you will lose benefits for **6 months** or until you repay all of the money.
- The second time, you will lose benefits for **12 months** or until you repay all of the money.
- The third time, **you cannot get TCA benefits again.**

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:

1. Pay back money, services or goods; or the value of those services or goods unlawfully received;
2. 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.

YOUR RIGHTS AND RESPONSIBILITIES

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
--	--	------

YOUR RIGHTS AND RESPONSIBILITIES

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.
- 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