

# MARYLAND DEPARTMENT OF HUMAN SERVICES FAMILY INVESTMENT ADMINISTRATION ELIGIBILITY DETERMINATION DOCUMENT FOR

Date Signed Application Received in Local Dept:. Must be Date Stamped

# CHILD UNDER 21 IN DHS FOSTER CARE OR SUBSIDIZED ADOPTION

	LDSS Office:	Programs Applied For/Receiving	Assistance Unit IDs:
FOR			
WORKER USE ONLY	MA Worker's Name:	Service Worker's Name:	Worker's D & T:
	Application/Reapplication Date:	Service Worker's Telephone:	Client ID:

# ANSWER THE FOLLOWING QUESTIONS COMPLETELY. PLEASE PRINT ALL ANSWERS

Child's Last Name	First Nam	е		Middle Name		
2. BENEFITS INFORMATION (DEM1)						
The child is currently receiving:	ssistance nental Security Assistance, Ma hild have any u enefits, list:	Income (SSI) A#:		ance Program (SNAP) onths? ☐ Yes ☐ No		
Is Maryland paying for your Medical Assis	tance benefits?	Yes No	o If no, which state	e is paying for th	ese benefits?	
a child is receiving Medical Assistance in ne foster parent or adoptive parent does r (If the original card is found, it must be de child's Medical Assistance and Health Ch 3. Do not complete this section for sub (not for entry to CARES)	ot have the card stroyed after the oice MCO cards	d? No   e replacement o s in the child's l	☐ Yes☐ card is received bed Health Passport.)	cause it will no lor	nger be valid. Keep the	
Child's Former Caregiver's Name:		Address: (Nu	mber, Street, City,	State, Zip Code)	Relationship to Child:	
Current Placement Date in Foster Care:		Name of Cur	rent Caregiver:	Relationship to Child:		
Address of Current Caregiver: (Number,	Street, Apt. #)	City	State	Zip Code	Telephone Number	
4. AUTHORIZED REPRESENTATIVE A	ND MAILING A	DDRESS (NAM	IE/ADDR 01/option	nal for AREP)		
Name of Authorized Representative (service worker or adoptive parent) (First, Middle, Last):	Title/Rela	ationship to the	Child:	Telephone N	umber	
Representative's Address: Number, Stree (enter as child's residential address)	et City			State	Zip Code	
Current Mailing Address (If different from (Number, Street)	above: local de (City)	partment for ch	ild in foster care or	adoptive parent's (State)	mailing address) (Zip Code)	

5. INFO	ORMATION ABOUT THI	E CHILD (CLRE/STAT	/DEM1/DEM2/S	SSN	A/AL	.AS)				
Resident of MD? (Yes or No)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	U.S. Citizen (Yes or No)	SEX	RACE	IN SCHOOL (Yes or No)	LAST GRADE COMPLETED	School Address	s:	
6 CIT	ZENSHIP/ IMMIGRATIO	N STATUS (DEM2/AL	A (2)					Half-time Not in Scl (check one) Sc Secondary	ends School: Less than I hool hool Level:Ele College	mentary
o. Citi	ZENSHIF/ IMMIGRATIO	ON STATUS (DEMZ/AL	.A3)							
identify	hild <b>is not</b> a United State ring documentation of the lement Agency:			VIĹL	NO	ΓBE SH	IARED \			
Status			INS Stati	us a	veni	ication	Spi	Yes No	rant? Country	or origin
	— INS Entr	y dat	e:		INS Number & Verification:					
7. MED	U.S. born child of re DICAL INSURANCE (DE									
Does th	ne child have Medicare c	overage? NO	YES UNF	(NO)	ΝN	M	ledicare	#:		
			NOWN							
Does th	ne child have any private	health insurance?	NO YES	UN	IKNC	а			in the section be ack of the health	
			H INSURANCE			NUMB	ER 1			
POLICY	HOLDER NAME	Relations	ship to Child P	OLIC'	Y NU	MBER	GROU	JP NUMBER	Effective Date	
	2: :	·	POLICY HOLD	ER A				7: 0 1		
Numbe	er Street		City		5	tate		Zip Code	ı elej	hone
Inquiror	nce Company Name	IN	ISURANCE CC	)MP/	ANY/	UNION				
IIISUIAI	ice Company Name									
Numbe	r Street		C:4		St	ate		Zip Code	Tele	hone
			City					•		710110
		HEALT	H INSURANCE	E PO			ER 2			
POLICY	HOLDER NAME		H INSURANCE		LICY			JP NUMBER	Effective Date	and the
	' HOLDER NAME	Relations	CH INSURANCE Ship to Child POLICY HOLD	OLIC'	LICY Y NU	NUMB MBER RESS		JP NUMBER	Effective Date	
POLICY	' HOLDER NAME	Relations	H INSURANCE	OLIC'	LICY Y NU	<b>/ NUMB</b> MBER		· 	Effective Date	phone
Numbe	' HOLDER NAME er Street	Relations	CH INSURANCE Ship to Child POLICY HOLD	OLIC ER A	LICY Y NU ADDF St	Y NUMB MBER RESS tate		JP NUMBER	Effective Date	
Numbe	' HOLDER NAME	Relations	CH INSURANCE Ship to Child Posting to Child Posting Policy Hold City	OLIC ER A	LICY Y NU ADDF St	Y NUMB MBER RESS tate		JP NUMBER	Effective Date	

8. HOUSEHOLD'S DECLARATION INQUIRY - Complete if you are applying for Temporary Cash Assistance or
Supplemental Nutritional Assistance Program
1. Has anyone in your household been convicted of?
a. A drug kingpin felony on or after August 22, 1996?
(Drug kingpin-An organizer, supervisor, financier, or manager who acts as a co-conspirator in a conspiracy to manufacture,
distribute, dispense, transport in, or bring into the State a controlled dangerous substance).
□ YES □ NO If yes, who?
b. A volume dealer drug felony on or after August 22, 1996?
(Volume dealer - An individual, who manufactures, distributes, dispenses, or possesses certain quantities of a controlled dangerous
substance).
□ YES □ NO If yes, who?
and other abuse of children, sexual assault as defined in the Violence Against Women Act of 1994, or a similar state law, and is
also not in compliance with the terms of their sentence?
□ YES □ NO If yes, who?
3. Is anyone in your household currently violating parole or probation or fleeing from the police or the courts?
4. 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?
5. Has a court convicted any member of your household for trading or trafficking SNAP benefits of \$500 or more?
□ YES □ NO If yes, who?
6. 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?
1 1 LO 1 NO 11 yes, wild:
9. PLEASE USE THIS SPACE IF YOU NEED TO GIVE US MORE INFORMATION ABOUT ANY APPLICATION QUESTION.
3.1 ELAGE GGE THIS OF AGE IF TOO NEED TO GIVE GO MORE INFORMATION ABOUT ANT ATTEICATION QUESTION.

								plete this section
	has an absent of deceased parer		rent, parental	rights hav	e not beer	n terminated. F	ill in a separa	ate section for
#1 ABSENT	PARENT (AP) IN PID/APAD/APDE	FORMATION (	MOTHER or o	ther:	_	) 🗌 Absent	Deceas	ed
	Parent (First, Mi			Other Na	me (Maider	n, other):	Check on Abs Date of D	ent Deceased
	US OF PARENT  Divorced	S AT CHILD'S E  Unknown	BIRTH   Separated	Wido	wed $\square$	Never Married	ł	
Social Security I		Other Name	Coparatoa		e of Birth	Age	Race	Sex
AP's Last Known Address	Number Street			City		State	Zip Code	e Telephone
AP's Previous Address	Number Street			City		State	Zip Code	e Telephone
Driver's License	: State and Plate	Number		Birth	Place (City	v, State)		
Current/Prior N Dates: From:	<b>Iilitary Service</b> To:	Paying Militar If yes, To who	ry Allotment? [ om?	Yes [	] No	ſ	Military Branch	ו
Incarcerated  Currently	☐ Previously	☐ Neve	er	Ins	stitution Nam	ne		
ABSENT PARE	NT INCOME INF	ORMATION		•				
Last Known N Employer	lame & Address:	Number Stre	eet	City		State	Zip Cod	le Telephone
Second N Employer	lame & Address:	Number Str	reet	City		State	Zip Code	e Telephone
Other Income/B  Worker's Co		Social Security Pension/Retire		SI ion Benefit		eteran's Pension her, list	n 🗌 Une	employment
ABSENT PARE	NT COURT ORD	ER INFORMAT	TION					
Paying Support	)				Last Date	e Paid	Payment A	
Court Ordered?		was the court or	rder issued?					ve us a copy? NO

	PARENT (AP) IN PID/APAD/APDE/		FATHER or ot	her:	)			
	t Parent (First, Mic			Other Na	ame:		Check one:	
	,	,					☐ Absent	Deceased
MADITAL STAT	TUS OF PARENTS		DIDTU				Date of Death:	
☐ Married	Divorced	<b>-</b>	Separated	пω	idowed	Never Married	d	
Social Security		Other Name	<u> </u>		te of Birth	Age	Race Sex	x Male  ☐ Female
AP's Last	Number Street			City		State	Zip Code	Telephone
Known Address				-				
AP's Previous	Number Street			City		State	Zip Code	Telephone
Address								
Driver's License	e: State and Plate	Number		Birth	n Place (City, S	State)		
	Military Service		ry Allotment?	Yes	No		Military Branch	
Dates: From:	To:	If yes, To wh	om?	1 1	notitution Name			
Incarcerated  Currently	☐ Previousl	, □ N	ever	"	nstitution Name			
ABSENT PARE	ENT INCOME INF	ORMATION						
	Name & Address:	Number Str	eet		City	State	Zip Code	Telephone
Employer								
O I	Name of O. Addresses	Niconale au Cán			Cir.	Ctata	Zin Code	Talanhana
Second N Employer	Name & Address:	Number Str	reet		City	State	Zip Code	Telephone
, ,,,								
Other Income/B	Renefits:	Social Securit	v 🗆 S	SI	□ Vetera	an's Pension	☐ Unemplo	yment
☐ Worker's C	ompensation 🔲	Pension/Retire	ement 🔲 Uı	nion Bene			<u> </u>	ymon.
	NT COURT ORD	ER INFORMA	TION		1			
Paying Support ☐ YES ☐ NO					Last Date F	Paid	Payment Amou	nt
Court Ordered?		was the court o	rder issued?				Can you give us	s a copy?
☐ YES ☐ NO							☐ YES ☐	NO
To be comp	leted by IV-E R	epresentativ	e:					
-	-							
Foster Ca	areSubsidi	zed Adoption	Intersta	ite Comp	act, State:		SSI	
	IV-E elig	ible	Not IV-E	eligible		V-E status no	t determined ye	t
Signature of	IV-E Specialist:				_Date:			
To be comp	leted by Medica	al Assistance	e Case Mana	ger:				
E01			or SSI, MA to				a mat	
	Subsidize	ed adoption, i	V-E eligible o	r 551, IVI <i>P</i>	technicai ei	igibility criteria	amet	
E02	foster care	. Not IV-E eli	gible, MA tech	nnical elic	ibility criteria	met		
							ligible, MA techr	nical eligibility
	criteria m							- •
Ena	other feets	r coro Not IV	/ E aliaibla M	A tooks:	al aliaibility -	ritorio not ma	<b>*</b>	
E03	other loste	i care, NOUIV	'-E eligible, M	A LECTIFIC	ai eligibility C	interia not me	;t	
E04	other subs	idized adoption	on, Not IV-E e	eligible, no	special nee	ds, MA techr	nical eligibility cr	iteria not met
Signature of	Medical Assista	nce Case Ma	nager:				_Date:	
-								_

### 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 SNAP Act and USDA policy, we also cannot discriminate against you because of religion, political beliefs.

If you think we have discriminated against you contact USDA or HHS. To contact USDA write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, DC 20250-9410. You may also call toll-free, (202)720-5964 (voice and TDD). Write HHS, Director, Office for Civil Rights, Room 506F, 200 Independence Avenue, S.W Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). USDA and HHS are equal opportunity providers and employers.

**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.

#### 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.

Collecting application information, including the social security number of each household member, is authorized under the SNAP Act of 1977 as amended, 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, 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 (10) days unless you have a job and are part of the SNAP 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.

# YOUR RIGHTS AND RESPONSIBILITIES

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.

Sl	JPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) PENALTY - Household members shall not:
	Give false information or withhold information to get or continue to get SNAP.  Trade or sell SNAP, or electronic benefit cards.  Use SNAP to buy items not allowed, such as alcohol and tobacco.  Use someone else's SNAP benefits.
•	Use someone else's Electronic Benefits Card without authorization.
Yc	our SNAP will not increase if your cash assistance case is reduced or closed because you did not follow the rules. If a
ho	busehold member deliberately breaks the rules, we may bar the person from the SNAP Program.
	We may bar this person for <b>one year</b> after the first violation.
	We may bar this person for <b>two years</b> :  * After the second violation, or  * After the first time, a court finds this person guilty of buying illegal drugs with SNAP.
	We may bar this person <b>permanently</b> :  * After the third violation, or  * After the second time, a court finds a person guilty of buying illegal drugs with SNAP, or  * After the first time, a court finds this person guilty of buying guns, bullets, or explosives, with SNAP.  * After a court finds this person guilty of trafficking SNAP benefits of \$500 or more.
•	We may bar this person for <b>ten years</b> 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.
	CA PENALTY – If an assistance unit member is convicted of an Intentional Program Violation (IPV), everyone in our 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.
М	EDICAID WARNING AND PENALTY - Only use Medical Assistance cards if you are eligible.
	very person convicted of "Medicaid Fraud" with a value of <b>\$500</b> or more in money, services, or goods is guilty of a felony, and shall:
	Payback 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.
	very person convicted of "Medicaid Fraud" with a value of less than \$500 in money, services, or goods is guilty of misdemeanor, and shall:
	Payback money, services or goods; or the value of those services or goods unlawfully received;  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 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 SNAP 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 select my case for a spot check.

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

understand by signing this application, I accept cash assistance and/or medical assistance and:

Agree that Medicare Part B will make payments directly to doctors and medical suppliers.

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.

Give the Department the right to inspect, review and copy all medical records for services received through the Medical Assistance Program.

Understand that when a person is deceased who were 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, an unmarried child younger than 21, or blind or disabled child (married or unmarried) of any age.

## SIGNATURE SECTION

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 or lawfully admitted immigrants.

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 ☐ SNAP ☐ Medical	Assistance
Signature of Applicant / Recipient/Authorized Representative	Date

# 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 t	case may be closed
I HAVE READ THESE STATEMENTS OR SOMEONE READ THEM TO ME. I UNDERSTAND V	WHAT THEY MEAN. BY
SIGNING MY NAME BELOW, I AGREE TO FOLLOW WHAT THEY SAY.	
Signature	Date