

**MARYLAND DEPARTMENT OF HUMAN RESOURCES
FAMILY INVESTMENT ADMINISTRATION
APPLICATION FOR ASSISTANCE**

Date Received (Agency use only)

Your Name (Last, First, Middle)		Home Telephone		Work Telephone	
Where do you live? (Number and Street)		Apt. #	City		State Zip Code

Mailing Address (If different from home)

What language do you speak? English Spanish Other _____
If you do not speak English and need free translation services, call your case manager or call 1-800-332-6347.
What type of assistance do you need now? (Check all that you need)
 Cash Assistance Child Care Services Food Stamps
 Medical Assistance - Do you have any unpaid medical bills from the past 3 months? Yes No
Do you have any of these problems?
 Utility shut off Eviction or foreclosure No place to stay No heat No food Cannot afford child care other: _____
Are you or anyone in your household pregnant? Yes No If yes, who? _____ Due Date _____
Are you or anyone in your household disabled? Yes No If yes, who? _____ Disability? _____

What type of assistance do you or any household members receive now or in the past? (Check Now if you are currently receiving this assistance)		Under what name?
Now	1.	1.
Now	2.	2.
Now	3.	3.

If you are applying for the Food Stamp Program 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 stamp benefit is based on the date you sign this application and give it to the department of social services. You may get food stamps 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 Stamps right away, we will take action on your application within 7 days from the date you sign the form. You will not get expedited food stamp benefits, if eligible, until we get a completed application form.

YOUR SIGNATURE	DATE
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FOR AGENCY USE ONLY		
LDSS Office	Programs applied for or receiving	AU ID #s
Case Manager's Name		
Application/Redetermination Date		MA #s

EXPEDITED SERVICES (DO NOT WRITE IN THIS AREA – AGENCY USE ONLY)

Applicants meeting the expedited standards below are eligible to receive food stamp benefits within 7 days. Discussion with the applicant, either in person or by telephone, may be necessary to determine eligibility for expedited service. The application must be complete, signed, and identity verified before benefits can be issued.

1. Is the total household income this month, before deductions, less than \$150 and household cash/savings \$100 or less? Yes No

a. Household's monthly rent or mortgage amount	\$ _____	
b. Appropriate utility standard	\$ _____	Total \$ _____
c. Approximate monthly income	\$ _____	
d. Household cash/savings for all members	\$ _____	Total \$ _____

2. Do total shelter costs exceed monthly income and resources? Yes No

3. Are the household members destitute migrant or seasonal farm workers whose cash and savings are \$100 or less? Yes No

IF THE ANSWER TO ANY QUESTION 1-3 IS YES, EXPEDITE **EXPEDITED ELIGIBLE?** Yes No

I certify that I screened this applicant for expedited Food Stamps and determined that the household was was not potentially eligible for expedited issuance at this time.

Signature of Case Manager	Date
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A. HOUSEHOLD MEMBERS

Fill in the blanks **everyone who lives with you**. Write **YES** for each person you are applying for. Write **NO** for each person you are not applying for.

APPLYING FOR (Yes or No)	NAME (Last, First, Middle)	How are they related to you?	DATE OF BIRTH	SEX	RACE	IN SCHOOL (Yes or No)	LAST GRADE COMPLETED
		Self					

Only Answer the questions below for each person who wants benefits ↓	
U.S. CITIZEN (Yes or No)	SOCIAL SECURITY NUMBER

Are any of the household members a roomer or boarder? Yes No If yes, who? _____

*You do not have to give information about your race. 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.

B. CITIZENSHIP/ IMMIGRATION STATUS

If anyone for whom you are applying is not a United States citizen, fill in this section. **ONLY ANSWER THESE QUESTIONS FOR EACH PERSON WHO WANTS BENEFITS. If you are not eligible for other kinds of Medical Assistance and you are applying only for Emergency Medicaid, you do not have to fill-in this section.**

Household member	INS Status	Sponsored Immigrant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Country of origin
	US Entry date:		INS Number:
Household member	INS Status	Sponsored Immigrant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Country of origin
	US Entry date:		INS Number:
Household member	INS Status	Sponsored Immigrant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Country of origin
	US Entry date:		INS Number:
Household member	INS Status	Sponsored Immigrant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Country of origin
	US Entry date:		INS Number:
Household member	INS Status	Sponsored Immigrant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Country of origin
	US Entry date:		INS Number:

C. AUTHORIZED REPRESENTATIVE:

You may choose a person to apply for you. You may also choose a person to get your benefits through your Independence Card. This person can use your benefits the same way you do. If you choose someone to help you, give us the following information about the person and check what you want this person to do.

Name (Last, First, Middle)	Relationship	Telephone Number	
Number, Street	City	State	Zip Code

Check what you want the representative to do:
 Complete interview for you Use your Independence Card (cash) Receive your notices
 Sign your application Use your Food Stamp benefits Receive your Medical Assistance card

D. STUDENTS

Are any household members between ages 18-50 attending a school for higher education (college, vocational or technical school)?

Yes No

Name of student _____ School _____

Is the student employed? Yes No

Is the student getting educational grants, scholarships, or loans? Yes No Amount \$ _____

Amount of tuition \$ _____ Books \$ _____ Fees \$ _____ Transportation \$ _____

E. RESOURCES/ASSETS

Does anyone in your household have any resources or assets such as a checking or savings account, stocks, bonds, cash on hand, property other than where you live, prepaid burial plan, trust fund, IRA or KEOGH account? Yes No If yes, list below:

NAME OF OWNER (Specify if self-employed)	TYPE OF RESOURCE/ASSET	BALANCE/VALUE	LOCATION (Name of Bank, at home, etc.)

F. TRANSFER OF ASSETS

Has anyone in your household sold, traded or given away any property, stocks bonds, cash or other assets in the past 36 months? (60-months if a trust is involved)

Former Owner	Transfer Date	Who Received the Asset?	Type of asset

Fair Market Value \$	Amount Received \$	Reason for Transfer

G. EARNED INCOME

Does anyone in your household receive any income from employment? Yes No If yes, list all gross income **before deductions** (such as full or part-time employment, self-employment, baby-sitting, odd jobs, days work, roomer/boarder payments, etc.)

NAME	NAME OF EMPLOYER (INCLUDE ADDRESS AND PHONE NUMBER)	RATE OF PAY	NUMBER OF HOURS WORKED	AMOUNT PER PAY PERIOD	HOW OFTEN RECEIVED

H. DEPENDENT CARE

If anyone in your household pays someone to care for a child or disabled adult, fill in this section:

Name of Care Provider	Telephone	Name of Care Provider	Telephone
Number Street		Number Street	
City State Zip code		City State Zip code	
Household Member Receiving Care	Under 2 years old? <input type="checkbox"/> Yes <input type="checkbox"/> No	Household Member Receiving Care	Under 2 years old? <input type="checkbox"/> Yes <input type="checkbox"/> No
Who Pays?	Cost \$	Who Pays?	Cost \$
Household Member Receiving Care	Under 2 years old? <input type="checkbox"/> Yes <input type="checkbox"/> No	Household Member Receiving Care	Under 2 years old? <input type="checkbox"/> Yes <input type="checkbox"/> No
Who Pays?	Cost \$	Who Pays?	Cost \$

I. CHILD SUPPORT/ALIMONY EXPENSE

Does any household member pay court ordered child support to a **NON-HOUSEHOLD** member? Yes No If yes, who? (Includes current payments, arrearages, health insurance)

DEPENDENT'S NAME, ADDRESS AND PHONE NUMBER	AMOUNT PAID	PERSON OR AGENCY PAID	HOW OFTEN PAID

J. OTHER INCOME AND BENEFITS

If anyone in your household receives, applied for or was denied any benefit listed below, place a check in the box next to the benefit

- Alimony Child Support Social Security SSI
- Railroad Retirement Veteran's Pension/Benefit Unemployment Benefits Education Grants or Loans
- Worker's Compensation Pension or Retirement Union Benefits Disability/Sick. Maternity Benefits
- Military Allotment Money from Rental Income Black Lung Benefits Money from Friends or Relatives
- Lump Sum Cash Amounts Civil Service Annuity Temporary Cash Assistance TEMHA Social Security Disability
- Interest Dividends from Stocks, Bonds, Savings or Other Investments Other _____

If you checked yes to receiving, applying for or being denied any benefits, fill in below:

HOUSEHOLD MEMBER	TYPE OF BENEFIT	APPLIED		CLAIM NUMBER	Received		AMOUNT
		yes	no		yes	no	

Do you agree to apply for all benefits you may be entitled to receive? Yes No

Do you live in: Public Housing Section 8 Housing FMHA 515 Housing Private Housing

K. SHELTER COSTS – Complete if you are applying for Food Stamps

Is anyone in your household paying for any of the following? Check all those paid and answer the questions.

√	Expenses	Amount	How Often?	Who Pays?	√	Expenses	Amount	How Often?	Who Pays?
	Rent					Water			
	Mortgage					Sewer			
	Electric					Garbage			
	Gas					Wood/Coal			
	Oil					Property Tax			
	Coop/Condo/ Assoc. fees					Homeowner's insurance			
	Telephone					Other			

Is heat included in your rent? Yes No

Do you pay an electric bill for lights or cooking? Yes No

If heat is not included in the rent, what is your source of heat? _____

Do you pay for air conditioning? Yes No

Does someone help you with your utility costs? Yes No If yes, who? _____

Are you sharing any of the shelter costs listed above? Yes No If yes, with whom? _____ Your share? _____

Have you received Energy Assistance at your current address within the past 12 months? Yes No

L. MEDICAL EXPENSES – Complete Appropriate Section if Applying for Medical Assistance or Food Stamps

Medical Assistance – Do you or any household members pay medical expenses? Yes No If yes, check the appropriate box

Food Stamps – Do you or any household members pay medical expenses for any person age 60 or over, or any person receiving disability benefits? Yes No If yes, check the appropriate box and list the monthly amount you pay.

DISCUSS THESE EXPENSES WITH YOUR CASE MANAGER.

- Health/Medicare Insurance \$ _____ Medical/Dental Insurance \$ _____ Others _____
- Dentures/Glasses/Hearing Aids \$ _____ Transportation Costs \$ _____ _____
- Hospital \$ _____ Nursing \$ _____ _____
- Attendant Care \$ _____ Pharmacy Expense \$ _____ _____

M. HOUSEHOLD'S DECLARATION INQUIRY – Complete if you are applying for Temporary Cash Assistance or Food Stamps

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 identify in order to receive food stamps 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 trafficking food stamp 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? _____

N. MEDICAL INSURANCE – Complete if you are applying for Medical Assistance or Temporary Cash Assistance

1. Has anyone applying dropped health insurance coverage in the past six months? YES NO
 2. Does anyone applying have any health insurance? YES NO If you answered yes to question 2, fill in the section below.

HEALTH INSURANCE POLICY NUMBER 1

POLICY HOLDER NAME	POLICY NUMBER	GROUP NUMBER
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HOUSEHOLD MEMBER(S) COVERED BY POLICY	RELATIONSHIP OF MEMBER TO POLICY HOLDER	HOUSEHOLD MEMBER(S) COVERED BY POLICY	RELATIONSHIP OF MEMBER TO POLICY HOLDER

POLICY HOLDER ADDRESS

Number	Street	City	State	Zip Code	Telephone
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INSURANCE COMPANY/UNION

Insurance Company Name

Number	Street	City	State	Zip Code	Telephone
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HEALTH INSURANCE POLICY NUMBER 2

POLICY HOLDER NAME	POLICY NUMBER	GROUP NUMBER
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HOUSEHOLD MEMBER(S) COVERED BY POLICY	RELATIONSHIP OF MEMBER TO POLICY HOLDER	HOUSEHOLD MEMBER(S) COVERED BY POLICY	RELATIONSHIP OF MEMBER TO POLICY HOLDER

POLICY HOLDER ADDRESS

Number	Street	City	State	Zip Code	Telephone
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INSURANCE COMPANY/UNION

Insurance Company Name

Number	Street	City	State	Zip Code	Telephone
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0. LIFE INSURANCE, FUNERAL PLANS or BURIAL FUNDS – Complete if you are applying for Medical Assistance or Temporary Cash Assistance

NAME OF PERSON INSURED	NAME OF PERSON WHO PAYS	FACE VALUE OR VALUE OF PLAN	CASH VALUE	POLICY NUMBER OR ACCOUNT NUMBER	COMPANY, FUNERAL HOME OR BANK NAME

PLEASE USE THIS SPACE IF YOU NEED TO GIVE US MORE INFORMATION ABOUT ANY APPLICATION QUESTION.

If you need more space, ask for the 9701- Application for Assistance Addendum.

P. CHILD SUPPORT INFORMATION – Complete this section if you want TEMPORARY CASH ASSISTANCE OR MEDICAL ASSISTANCE for a child who has an absent or deceased parent. Fill in a separate section for each absent or deceased parent.

#1 ABSENT PARENT (AP) INFORMATION													
Name of Absent Parent (First, Middle, Last)					Relationship of absent parent to you.			Check one: <input type="checkbox"/> Absent <input type="checkbox"/> Deceased					
CHILD'S NAME				MARITAL STATUS OF CHILD'S PARENTS AT BIRTH									
				<input type="checkbox"/> Married		<input type="checkbox"/> Divorced		<input type="checkbox"/> Unknown		<input type="checkbox"/> Separated		<input type="checkbox"/> Never Married	
				<input type="checkbox"/> Married		<input type="checkbox"/> Divorced		<input type="checkbox"/> Unknown		<input type="checkbox"/> Separated		<input type="checkbox"/> Never Married	
				<input type="checkbox"/> Married		<input type="checkbox"/> Divorced		<input type="checkbox"/> Unknown		<input type="checkbox"/> Separated		<input type="checkbox"/> Never Married	
				<input type="checkbox"/> Married		<input type="checkbox"/> Divorced		<input type="checkbox"/> Unknown		<input type="checkbox"/> Separated		<input type="checkbox"/> Never Married	
Social Security Number			Other Name			Date of Birth		Age	Race		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		
AP's Last Known Address		Number	Street		City		State		Zip Code		Telephone		
AP's Parent's Address		Number	Street		City		State		Zip Code		Telephone		
Driver's License State			Birth Place (City, State)										
Current or Prior Military Dates: From: To:			Paying Military Allotment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, To whom?					Military Branch					
Incarcerated <input type="checkbox"/> Currently <input type="checkbox"/> Previously <input type="checkbox"/> Never						Institution Name							
ABSENT PARENT INCOME INFORMATION													
Last Known Employer		Name, Address & Telephone											
Second Employer		Name, Address & Telephone											
Other Income/Benefits:		<input type="checkbox"/> Social Security		<input type="checkbox"/> SSI		<input type="checkbox"/> Veteran's Pension		<input type="checkbox"/> Unemployment					
<input type="checkbox"/> Worker's Compensation		<input type="checkbox"/> Pension/Retirement		<input type="checkbox"/> Union Benefits		<input type="checkbox"/> Other, list							
ABSENT PARENT COURT ORDER INFORMATION													
Paying Support? <input type="checkbox"/> YES <input type="checkbox"/> NO		To Whom?				Last Date Paid		Payment Amount					
Court Ordered? <input type="checkbox"/> YES <input type="checkbox"/> NO		If yes, where was the court order issued?						Can you give us a copy? <input type="checkbox"/> YES <input type="checkbox"/> NO					
#2 ABSENT PARENT (AP) INFORMATION													
Name of Absent Parent (First, Middle, Last)					Relationship of absent parent to you.			Check one: <input type="checkbox"/> Absent <input type="checkbox"/> Deceased					
CHILD'S NAME				MARITAL STATUS OF CHILD'S PARENTS AT BIRTH									
				<input type="checkbox"/> Married		<input type="checkbox"/> Divorced		<input type="checkbox"/> Unknown		<input type="checkbox"/> Separated		<input type="checkbox"/> Never Married	
				<input type="checkbox"/> Married		<input type="checkbox"/> Divorced		<input type="checkbox"/> Unknown		<input type="checkbox"/> Separated		<input type="checkbox"/> Never Married	
				<input type="checkbox"/> Married		<input type="checkbox"/> Divorced		<input type="checkbox"/> Unknown		<input type="checkbox"/> Separated		<input type="checkbox"/> Never Married	
				<input type="checkbox"/> Married		<input type="checkbox"/> Divorced		<input type="checkbox"/> Unknown		<input type="checkbox"/> Separated		<input type="checkbox"/> Never Married	
Social Security Number			Other Name			Date of Birth		Age	Race		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		
AP's Last Known Address		Number	Street		City		State		Zip Code		Telephone		
AP's Parent's Address		Number	Street		City		State		Zip Code		Telephone		
Driver's License State			Birth Place (City, State)										
Current or Prior Military Dates: From: To:			Paying Military Allotment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, To whom?					Military Branch					
Incarcerated <input type="checkbox"/> Currently <input type="checkbox"/> Previously <input type="checkbox"/> Never						Institution Name							
ABSENT PARENT INCOME INFORMATION													
Last Known Employer		Name & Address:	Number	Street		City		State		Zip Code		Telephone	
Second Employer		Name & Address:	Number	Street		City		State		Zip Code		Telephone	
Other Income/Benefits:		<input type="checkbox"/> Social Security		<input type="checkbox"/> SSI		<input type="checkbox"/> Veteran's Pension		<input type="checkbox"/> Unemployment					
<input type="checkbox"/> Worker's Compensation		<input type="checkbox"/> Pension/Retirement		<input type="checkbox"/> Union Benefit		<input type="checkbox"/> Other, list							
ABSENT PARENT COURT ORDER INFORMATION													
Paying Support? <input type="checkbox"/> YES <input type="checkbox"/> NO		To Whom?				Last Date Paid		Payment Amount					
Court Ordered? <input type="checkbox"/> YES <input type="checkbox"/> NO		If yes, where was the court order issued?						Can you give us a copy? <input type="checkbox"/> YES <input type="checkbox"/> NO					