SFN 405 (Rev. 03-11)

Instructions For Application For Assistance

This application may be used to apply for Temporary Assistance for Needy Families (TANF), Child Care Assistance, Supplemental Nutrition Assistance Program (SNAP), Health Care Coverage and Basic Care. See the Guidebook for more information.

What Do I Need To Do To Get Assistance?

Follow these steps to apply for assistance.

Step 1. Fill out this application.

If you are applying for:

- Child Care Assistance - You need to complete Sections 1, 2 and 6.
- SNAP - You need to complete Sections 1, 2, 3, 4 and 6.
- Health Care Coverage - You need to complete Sections 1, 2, 3, 5 and 6.
  (Aid to the Blind, Healthy Steps, Medicaid, Medicare Savings Program)
- Basic Care – You need to complete Sections 1, 2, 3, 5 and 6.
- TANF - You need to complete all Sections.

Answer as many questions as you can. If you need help applying for assistance, you may have a friend, relative or someone else help you apply. Your local county social service office can also help you apply for assistance. If you need additional space, attach a separate sheet of paper.

Step 2. Return the application to your local county social service office.

If you cannot fill out the whole application today, turn in Section 1. **If you do not fill out all of Section 1, you have the right to file an incomplete application as long as it contains the applicant's name, address and signature of either the applicant or the authorized representative. If you are eligible, your assistance will start from the date we receive Section 1 or an incomplete application.**

Fill out and turn in the rest of the application as soon as you can. You can mail or drop off your application.

Step 3. Talk with us.

When we get your application for SNAP or TANF, we will set up an interview with you. For SNAP, a face-to-face interview may be waived in favor of a telephone interview on a case-by-case basis determined by household hardship reasons. Health Care Coverage and Child Care Assistance do not require an interview.

Appointment Date: ______________________ **Appointment Time:** ______________________

If you miss your appointment and still wish to apply, please contact the county social service office to schedule a second appointment.

To speed up the processing of your application, turn in proof of the following items with your application. You may also bring proof with you to your interview. Your worker will help you obtain these things if needed.

❑ Proof of Alien or Citizenship Status such as (original documents required if applying for Health Care Coverage):

- Resident Alien Card (Form I-551)
- Employment Authorization Card (Form I-688A)
- Temporary Resident Card (Form I-688)
- Arrival-Departure Record (Form I-94)

You will be asked to provide information about the SSN and citizenship or immigration status for all persons for whom you want to receive assistance. This information may be subject to verification by the United States Citizenship and Immigration Service (USCIS), and that the submitted information received from USCIS may affect the household's eligibility and level of benefits.

- For SNAP and Medicaid, if any of these persons do not want to give information about their SSN, citizenship or immigration status, they will not be eligible for benefits. These persons must provide their financial information to determine eligibility for other household members. Other household members may still get benefits if they are otherwise eligible. We will not share alien or citizenship information about non-applicants with the United States Citizenship and Immigration Service (USCIS).
- For TANF, if an individual who is required to be included in the TANF household does not want to give information about their SSN, citizenship or immigration status, the entire household will be ineligible to receive benefits.

❑ Proof of the value of current assets such as:

- Annuities
- Business Accounts
- Certificates of Deposit
- Checking/Savings/Credit Union Accounts
- IRA/401K/KEOGH plans
- Life Insurance
- Real Property (Land, Rental Property, etc.)
- Saving Bonds
- Stocks/Bonds/Mutual Funds
- Trusts

If only applying for Child Care Assistance or Health Care Coverage for children and family coverage, you do not need to report or bring records of your assets.

❑ Proof of most current expenses such as:

- Child/Dependent Care
- Court Ordered Payments (Child Support, Health Insurance Premiums, Other Support)
- Medical or Health Insurance Premiums (If applying for SNAP only, you do not need to provide information for household members under age 60 unless they are disabled.)
- Utility/Shelter Expenses (If applying for SNAP)
  - Heating and Cooling Costs
  - Home Owner's Insurance
  - House Payment
  - Other Utility Bills
  - Property Taxes
  - Rent (Receipt, Lease Agreement, Housing Assistance Contract)
  - Telephone Bill

❑ Proof of most current income (last month and this month) such as:

- Bonuses
- Child Support
- Commissions
- Lease Income
- Money from Friends, Relatives or Others
- Pay (Pay Stubs or Employer Statement)
- Pension/Retirement Benefits
- Rental Income
- Self-Employment Income (most recent copy of Federal Income Tax Forms)
- Social Security Benefits
- Spousal Support
- SSI
- Unemployment Benefits
- Veterans'/Military Benefits
- Workers Compensation

❑ Proof of other information such as:

- Identity (Birth Certificate, Driver's License, Work or School ID - original documents required if applying for Health Care Coverage)
- Age (Birth Certificate, Driver's License)
- Residence (Rent Receipts, Utility Bills, Lease)
- Social Security Numbers
- Verification of Pregnancy (Doctor's statement of due date)

To learn when you may get assistance, go to the General Information section of the Guidebook. If you have questions, contact your local county social service office.

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Agency Use Only	
Case Number:	Date Requested:
Date Received:	Interview Date:
Individual Interviewed:	

Application For Assistance – Section 1

Check the assistance you are applying for. Sign and date below. If you would like more information on these programs, see the Guidebook. If you did not receive the Guidebook, contact your local county social service office.

- ❑ **Temporary Assistance for Needy Families (A program for families with children) -** Apply for this program **IF** you are a family with limited income who has a child deprived of the support of a parent (one parent is absent, disabled or no longer living) AND the child is under age 18. This program provides temporary cash assistance to assist families while they pursue training and employment opportunities to become self-reliant.
- ❑ **Child Care Assistance –** Helps adults continue working to support their families and helps teen parents remain in school by assisting with the costs of child care.
- ❑ **Supplemental Nutrition Assistance Program (SNAP) -** formerly known as Food Stamps, helps people buy food for good health.
  You may get SNAP within 7 days of your application date if any of the following are true:
  - Your household's monthly income before taxes is $150 or less; or
  - You are a migrant or seasonal farm worker; or
  - Your household's monthly rent/mortgage and utilities are more than your household's income before taxes.
- ❑ **Health Care Coverage –** Assistance available for families with children, pregnant women, elderly, or disabled people to help pay medical bills and health insurance premiums.
  Check the Health Care Coverage(s) you are applying for:
  - ❑ **Aid to the Blind –** Assists with treatment for people who are not eligible for Medicaid and are in danger of losing their vision or require restorative eye services.
  - ❑ **Healthy Steps (Children's Health Insurance Program - CHIP)** – Provides premium-free health insurance coverage to uninsured children.
  - ❑ **Medicaid –** Pays for health services for families with children, pregnant women and people who are elderly or disabled.
  - ❑ **Medicare Savings Program –** Assists with Medicare Part B premium, coinsurance and deductibles.
- ❑ **Basic Care Assistance (A program for residents of Basic Care Facilities only) -** Apply for this program **IF** you live in a licensed Basic Care Facility to meet your health and living needs **AND** you are age 18 or older, blind, disabled or aged. This program helps pay for room and board costs.

Tell Us About You

First Name:	Middle Initial:	Last Name:
Address Where You Live:		Apt. or Unit #:
City:	State & Zip Code:	E-mail:
Mailing Address (If different):		
Home Telephone Number:	Work or Message Number:	Cell Phone Number:
Direction to Home (if rural):		

Sign And Date Application Here

Signature of Applicant: ______________________ Date: __________

Other Signature (Spouse, Guardian or Other Adult): ______________________ Date: __________

Tell Us About The People In Your Home

Check the boxes below for all the people who live in your home, including members temporarily out of your home (working away from home, attending school or boarding school, in the military):

- ❑ Yourself
- ❑ Your husband or wife
- ❑ Your children
- ❑ Other adults or children living in your home

For each person checked, fill in the boxes below. These people make up your household.

If you need additional space, continue on a separate sheet of paper.

You are asked to provide information about the race and ethnic background for all persons for whom you want assistance. This information is voluntary and is used to make sure that benefits are provided without regard to race, color, or national origin. Providing this information will not affect your eligibility or benefit amount.

You are also asked to provide information about the sex, last grade completed and marital status of all persons for whom you want assistance. This information is voluntary.

Household Members (Enter Legal Name) First / Middle Initial / Last	Relation To You	Social Security Number	Date of Birth	Age	Sex	Last Grade Com-pleted	U.S. Citizen (Yes or No)	Hispanic or Latino (Yes or No)	Race (Use Codes Below)	Marital Status (Use Codes Below)

Race Codes: AI - American Indian/ Alaska Native AP - Asian BL - Black/ African American HP - Native Hawaiian/ Pacific Island WH - White

Marital Status Codes: DI - Divorced MA - Married NM - Never Married SE - Separated WI - Widowed

If you do not want Medicaid for all members of the household listed above, please list members you **DO NOT** want Medicaid for: ____________________

List other names that have been used by household members (maiden name, prior married name or nicknames): _______

____

List household members temporarily out of the home: ____

Why are they out of the home? ______________________ Date expected to return: ______________________

List household members who are disabled: ____

List household members who are a veteran, or a dependant or spouse of a veteran: ______________________

Have household members received assistance in another state (cash, food, medical assistance)? ❑ Yes ❑ No

If yes, when? ______________________________ Which city, county and state? ______________________

List household members who are boarders (paying someone to provide meals): ______________________

Tell Us About Students In Your Home

List each household member age 14 or older who is a student or planning to attend school.

Student Name	Name of School	PT - Part Time FT - Full Time

Help With SNAP?

Did the Great Plains Food Bank offer you SNAP information or application assistance? ❑ Yes ❑ No

If you are applying for SNAP you can have someone help you, if you wish. This person can fill out your application, answer questions for you, give information at your interview, and buy your food with an EBT card. We will be able to share information with this person.

If you choose to have someone help you, fill in the boxes below with their information:

Name:		Telephone Number:	
Address:	City:	State:	Zip Code:

Help Us Decide If You Can Receive SNAP Within Seven Days

If you are applying for SNAP, completing this section may help you receive benefits within seven days:

Are you a migrant or seasonal farm worker? ❑ Yes ❑ No

About how much total earned income will your household receive this month before taxes (gross)? _______________

About how much total unearned income or other money will your household receive this month? _________________

How much is your household's monthly rent, lot rent and house payment? ___________________________________

Check all the utilities your household is responsible for:

❑ Heating ❑ Cooling ❑ Electricity ❑ Telephone ❑ Water ❑ Sewer ❑ Garbage

Do household members receive heating assistance (LIHEAP)? ❑ Yes ❑ No

Do household members plan to apply for heating assistance (LIHEAP)? ❑ Yes ❑ No

Do you have a North Dakota Electronic Benefit Transfer (EBT) card or for SNAP? ❑ Yes ❑ No

Have you received EBT training? ❑ Yes ❑ No

Have household members received commodities through the Tribal Food Distribution Program on Indian Reservations, last month or this month? ❑ Yes ❑ No

Do household members purchase and prepare meals separately? ❑ Yes ❑ No

If yes, who? ____

<table>
<tr><th colspan="3">Agency Use Only – Expedited Formula</th></tr>
<tr>
<td>Eligible for benefits if:
Countable Income below $150/Month
Wages, Child Support, SSI, Disability, Retirement, Veterans Benefits, Unemployment, Workers Compensation</td>
<td>If not:
Monthly
Gross Countable Income ____________
Would be less than:
Rent/Mortgage ____________
Appropriate Utility Standard +____________
Total Shelter Cost = ____________</td>
<td>HLSU – Any of the following:
• Heating
• Cooling
• LIHEAP
LUSA – Two of the following
• Water
• Sewer
• Garbage
• Electric
• Telephone
MU – One of the following:
• Water
• Sewer
• Garbage
• Electric
TL – Telephone Only</td>
</tr>
<tr>
<td colspan="2">Was the screening for expedited service completed? ❑ Yes ❑ No
Is the household eligible for expedited service? ❑ Yes ❑ No
Was the Identity of applicant verified? ❑ Yes ❑ No</td>
<td>Workers Initials:</td>
</tr>
</table>

Agency Use Only
Case Number:
Date Received:

Application For Assistance – Section 2

Complete Section 2 if you are applying for:

- **Basic Care**
- **Child Care Assistance**
- **Health Care Coverage**
- **SNAP**
- **TANF**

Your Name: ____

Tell Us About The Income/Money Your Household Receives

Self-Employment

Are any household members self-employed? ❑ Yes ❑ No

If yes, list the household member, name and type of business and date business started: ____________________

____

Employment

Are any household members employed? ❑ Yes ❑ No

If yes, list information about pay from employment such as wages, commissions, bonuses, and incentives for all household members including children:

Household Members	Employer	Hours Worked Per Week	Hourly Pay	This Month's Pay Before Taxes (Gross)	Next Month's Pay Before Taxes (Gross)	Amount of Tips	Date of Next Check	How Often Paid	Day or Dates Paid
								Use Codes Below	

How Often Paid Codes:
M – Monthly 2X – Twice a Month W – Weekly EX – Every Two Weeks Other, specify: ________________

Day Paid Codes:
M – Monday T – Tuesday W – Wednesday TH – Thursday F – Friday S – Saturday SU – Sunday

Has any household member received commissions, bonuses or incentives other than those included above within the last year? ❑ Yes ❑ No

If yes, list the household member, date received and amount. ______________________________

Unearned Income or Other Money Received

The following is a list of different kinds of unearned income. Check yes for each unearned income or other money received by household members. Check no, if not received.

❑ Yes ❑ No BIA/Tribal General Assistance
❑ Yes ❑ No Bingo/Gambling Winnings
❑ Yes ❑ No Child Support or Spousal Support
❑ Yes ❑ No Contract Sale or Rental Income
❑ Yes ❑ No Income from Tribes
❑ Yes ❑ No Income from Roomer/Boarder
❑ Yes ❑ No Individual Indian Monies (IIM)
❑ Yes ❑ No Insurance/Lawsuit Settlement
❑ Yes ❑ No Interest/Dividend Income
❑ Yes ❑ No Money from Friends, Relatives or Others
❑ Yes ❑ No Oil/Mineral Rights/Royalties
❑ Yes ❑ No Pension/Retirement Benefits
❑ Yes ❑ No Railroad Retirement Benefits
❑ Yes ❑ No Social Security Benefits
❑ Yes ❑ No Supplemental Security Income (SSI)
❑ Yes ❑ No TANF
❑ Yes ❑ No Unemployment Benefits
❑ Yes ❑ No Veterans'/Military Benefits
❑ Yes ❑ No Workers' Compensation
Other, specify:________________________________

For all items checked yes, fill in the boxes below:

Type of Unearned Income or Other Money Received	Household Member	How Often Received	Amount This Month	Amount Next Month

Have household members applied for benefits not yet received (Social Security, SSI, Workers' Compensation, Unemployment Compensation, Veterans'/Military Benefits)? ❑ Yes ❑ No If Yes, explain: ____________________
____

Tell Us If You Have Child Care Needs

Are you already receiving Child Care Assistance? ❑ Yes ❑ No If no, have you applied? ❑ Yes ❑ No

Does or will your household have child care expenses? ❑ Yes ❑ No If yes, when? ____________________________
What is the monthly billed amount? ____________ What amount do you pay? _________________________________

Check the reason for needing child care: ❑ High School ❑ Employment ❑ Vocational Training ❑ Other, specify: ____

The Child Care Assistance Program can help pay child care expenses for attending high school, vocational training, and employment, for the month prior to the application. Would you like help paying for last month's child care expenses? ❑ Yes ❑ No

Does anyone help you pay your child care expenses? ❑ Yes ❑ No If yes, list who is paying, how much they are paying and who do they pay the child care to: ____

Do you expect changes in the child care expenses next month? ❑ Yes ❑ No If yes, explain: ___________________

Post Secondary Education Information
Do any household members have: ❑ Vocational Certification/Training ❑ Associate Degree ❑ Bachelors Degree ❑ Certificate of Completion? If so, who and where is the degree or certificate from: ___________________________

List household members that are currently attending school: ____
School: _________________ Course Study: ____
Length of course:________________________ Anticipated Completion Date: _________________________________

Application For Assistance – Section 3

Complete Section 3 if you are applying for:

- **Basic Care**
- **Health Care Coverage**
- **SNAP**
- **TANF**

Tell Us The Value Of Your Household's Assets

If you are applying for Health Care Coverage for a child or pregnant woman, answer one of these questions. Answering the question may help North Dakota get additional funding for Health Care Programs. Your answer will not affect your eligibility or the amount of your benefits.

If you **live alone**, is the value of all assets more than $3,000? (Do not count the value of one vehicle, your home, clothing, household goods, and real property used as part of your business.) ❑ Yes ❑ No

If you **live with someone**, is the value of all assets more than $6,000? (Do not count the value of one vehicle, your home, clothing, household goods, and real property used as part of your business.) ❑ Yes ❑ No

Tell Us About Your Household's Assets

If you are applying for Medicaid for someone who is disabled or age 65 or older, or if you are applying for Basic Care, SNAP or TANF, you must complete the Vehicles and Other Assets sections.

Vehicles

List vehicles (car, truck, motor home, snowmobile, motorcycle, 3 wheeler/4 wheeler, boat or other watercraft, camper, trailer, etc.) owned, jointly owned or being purchased for all household members, even if the vehicle is not running or not in your possession. Include vehicles licensed through North Dakota, tribal motor vehicle or another state.

Make/Model	Year	Value	Amount Owed	Licensed	Owners
		$	$	❑ Yes ❑ No	
		$	$	❑ Yes ❑ No	
		$	$	❑ Yes ❑ No	
		$	$	❑ Yes ❑ No	
		$	$	❑ Yes ❑ No	
		$	$	❑ Yes ❑ No	

Other Assets

Check yes by the assets owned, jointly owned or being purchased by household members. Check no, if none.

❑ Yes ❑ No Annuities
❑ Yes ❑ No Assets Owned with Another Person
❑ Yes ❑ No Burial Plots
❑ Yes ❑ No Burial Space Items (Casket, Vault, Marker, etc.)
❑ Yes ❑ No Business Accounts
❑ Yes ❑ No Business Inventory/Equipment
❑ Yes ❑ No Cash on Hand
❑ Yes ❑ No Certificates of Deposit
❑ Yes ❑ No Checking/Credit Union Accounts
❑ Yes ❑ No Farm Equipment, Livestock, Stored Grain
❑ Yes ❑ No Home/Mobile Home (Not Owner occupied)
❑ Yes ❑ No Home/Mobile Home (Owner Occupied)
❑ Yes ❑ No Income Producing Tools/Equipment
❑ Yes ❑ No Individual Indian Monies Accounts
❑ Yes ❑ No Life Estate/Life Lease
❑ Yes ❑ No Mineral Rights (Oil, Gas, Gravel, Coal, etc.)
❑ Yes ❑ No Notes or Contract for Deed
❑ Yes ❑ No Prepaid Funeral Plans
❑ Yes ❑ No Real Property (Land, Rental Property, Buildings, etc.)
❑ Yes ❑ No Retirement Funds (IRA/KEOGH/401K)
❑ Yes ❑ No Safety Deposit Box
❑ Yes ❑ No Savings Bonds
❑ Yes ❑ No Savings/Credit Union Accounts
❑ Yes ❑ No Stocks/Bonds/Mutual Funds
❑ Yes ❑ No Trusts

Other, specify: ______________________

For all items checked yes, fill in the boxes below:

Type of Asset	Location/Description	Total Value	Amount Owed	Owners

List household members who have made arrangements for funeral expenses or gave money, property, or insurance to someone else to pay for funeral expenses: ______________________

Explain: ______________________

Do you expect changes in assets next month? ❑ Yes ❑ No

If yes, explain: ______________________

Transfer of Assets

Have household members sold, given away or transferred anything of value within the past:

3 months? ❑ Yes ❑ No

If yes, list the items: ______________________ Date: ____________

5 years? ❑ Yes ❑ No

If yes, list the items: ______________________ Date: ____________

Tell Us About Court Ordered Expenses

Is any household member court ordered to pay child support, health insurance, or other support payments? ❑ Yes ❑ No

If yes, who? ______________ Who are the payments for? ______________

Amount court ordered: ______________ Amount paid: ______________

Application For Assistance – Section 4

Complete Section 4 if you are applying for:

- **SNAP**
- **TANF**

Tell Us About Your Housing Expenses

Check yes by each expense household members have during any time of the year. Check no, if none.

❑ Yes ❑ No Air Conditioning or Central Air
❑ Yes ❑ No Condo Fees
❑ Yes ❑ No Electricity
❑ Yes ❑ No Garbage
❑ Yes ❑ No Heating (gas, propane, electric, etc.)
❑ Yes ❑ No Homeowners Insurance (not in house payment)
❑ Yes ❑ No House Payment (mortgage)
❑ Yes ❑ No Lot Rent
❑ Yes ❑ No Property Taxes (not in house payment)
❑ Yes ❑ No Rent
❑ Yes ❑ No Sewer/Septic Tank Installation or Maintenance
❑ Yes ❑ No Telephone/Cell Phone
❑ Yes ❑ No Use of a Garage
❑ Yes ❑ No Water/Well Installation or Maintenance

For all items checked yes, fill in the boxes below:

Type of Expense	Who Pays the Expense	Total Amount	Amount Household Member Pays

Do household members work off part of an expense (rent, lot rent, utilities, etc.)? ❑ Yes ❑ No

If yes, list the expense and the amount worked off: ______________________

Do household members receive heating assistance (LIHEAP)? ❑ Yes ❑ No

Do household members plan to apply for heating assistance (LIHEAP)? ❑ Yes ❑ No

Do you expect changes in expenses (rent, lot rent, utilities, etc.) next month? ❑ Yes ❑ No

If yes, explain: ______________________

Does anyone help you pay these expenses (government agency, family member, etc.)? ❑ Yes ❑ No

If yes, list the expense, who is paying the expense and the amount they pay: ______________________

Agency Use Only
Household is entitled to one of the following mandatory utility standards: ❑ HL SU (heating/cooling/LIHEAP) ❑ MU (water, sewer, garbage, electricity) ❑ LU SA (water, sewer, garbage, electricity, telephone) ❑ TL (telephone only)

Tell Us About Expenses For Elderly Or Disabled Household Members

Do household members, who are disabled or age 60 or older, pay health insurance or medical expenses? ❑ Yes ❑ No (include doctor, dental and eye care visits, hospital bills, in-house-care, nursing home care, prescriptions, medical supplies, hearing aids, eyeglasses and contacts, and cost of transportation and lodging to obtain medical treatment.)

If yes, who? ______________________________

Health insurance amount: ______________ Medical expense amount: ______________

Does anyone help you pay these expenses? ❑ Yes ❑ No If yes, explain: ______________

Do household members pay representative payee/guardian fees? ❑ Yes ❑ No

Do you expect changes in expenses next month? ❑ Yes ❑ No If yes, explain: ______________

Tell Us About Your Household's Work Information

List household members who are unable to work: ______________________________

Reason: ______________________________

List household members who stopped their employment within the last 30 days: ______________

When: ______________ Employer: ______________

Check the reason for leaving: ❑ Laid Off ❑ Quit ❑ Fired ❑ Leave of Absence ❑ Strike ❑ Illness ❑ Injury ❑ Other, specify: ______________

When did the household member receive their last paycheck? ______________

List household members who reduced their work hours within the last 30 days: ______________

When: ______________ Reason: ______________

List household members who refused work within the last 30 days: ______________

When: ______________ Reason: ______________

Tell Us About Illegal Activities And Disqualifications

Have you are any member of your household been convicted of fraudulently receiving duplicate SNAP or TANF benefits in any State after September 22, 1996? ❑ Yes ❑ No

Are you or any member of your household hiding or running from the law to avoid prosecution, being taken into custody, going to jail, for a felony crime or attempted felony crime, or violating a condition of parole or probation? ❑ Yes ❑ No

Have you or any member of your household been convicted of a felony under Federal or State law for possession, use or distribution of a controlled drug substance (felony drug conviction) after August 22,1996? ❑ Yes ❑ No

Have you or any member of your household been convicted of buying or selling SNAP benefits over $500 after September 22, 1996? ❑ Yes ❑ No

Have you or any member of you household been convicted of trading SNAP benefits for guns, ammunitions, or explosives after September 22, 1996? ❑ Yes ❑ No

Have you or any member of your household been convicted of trading SNAP benefits for drugs after September 22, 1996? ❑ Yes ❑ No

Are you or any household member participating in SNAP or TANF in another location? ❑ Yes ❑ No

Are you or is any household member disqualified or have you or any household member ever been disqualified from SNAP or TANF for providing incorrect information or failing to provide information that affected SNAP or TANF eligibility or benefits? ❑ Yes ❑ No

Application For Assistance – Section 5

Complete Section 5 if you are applying for:

- **Basic Care**
- **Health Care Coverage**
- **TANF**

Tell Us About Your Household

I/We have lived in North Dakota since (month, day, year): ______________________

Do you intend to remain in North Dakota? ❑ Yes ❑ No

List any children whose father's name is not listed on the birth certificate: ______________________

List each household member who is pregnant: ______________________

How many babies are due? ______________ When is the due date? ______________

How was pregnancy determined? ❑ Physician ❑ Public Health Agency ❑ Home Pregnancy Test

❑ Other, specify: ______________________

List the father of the unborn baby: ______________________

Do you pay for guardianship or conservator services? ❑ Yes ❑ No

Do both parents (natural or adoptive) live together in the home with a child under age 19? ❑ Yes ❑ No

If yes, list the name of the parent who had the most income from employment or self-employment in the past 24 months: ______________________

Tell Us About Parents Not Living In The Home

List each child under age 21 whose parents do not live in the home:

Name of Child Whose Parent Is Not Living in the Home	Name of Parent Who Is Not Living in the Home	Parent's Date of Birth	Parent's Social Security Number	Reason Parent Is Not Living in the Home (Use Codes Below)
	Mother:			
	Father:			
	Mother:			
	Father:			
	Mother:			
	Father:			
	Mother:			
	Father:			

AB - Abandoned
AN - Legally Annulled
AS - Attending School
DE - Deceased
DI - Divorced
JP - Jail/Prison
LW - Looking for Work
MC - Medical Care
MS - Military Service
NM - Never Married
PR - Parental Rights Terminated
SE - Separated
WO - Working Out of Town or State

Tell Us About Your Life Insurance

Does any household member have life insurance? ❑ Yes ❑ No If yes, fill in the boxes below:

Name of Insured Person	Name and Address of Company	Policy Number	Face Value	Owners

Tell Us About Your Medical Bills

Medicaid can help pay medical bills, including prescription costs, for up to three months prior to the month of your application. Would you like help paying any of these bills? ❑ Yes ❑ No

If yes, list each month: ______________________________

Medicaid can allow unpaid medical bills older than three months to reduce your out-of-pocket costs. Do household members have unpaid medical bills older than three months? ❑ Yes ❑ No

If yes, explain: ______________________________

Tell Us About Your Primary Care Provider (PCP)

Your primary care provider (PCP) is the doctor, nurse practitioner, or you see for medical care. List the primary care provider for each household member except for those age 65 or older, a refugee or disabled. If you do not have a primary care provider, list the clinic. (rural health clinic, federally qualified health clinic or Indian Health Services Clinic) in which you receive your medical care.

Household Member	Name of PCP

Tell Us About Your Health Insurance Coverage

List household members who have health insurance:

Persons Covered	Policy Holder Name and Address	Health Insurance Name, Address and Telephone Number	Effective Date	Policy Number	Group Number	Monthly Premium	Type of Coverage Use Codes Below

List all that apply

A - Hospital
B - Doctor
C - Major Medical/Lab/X-Ray
D - Dental
E - Vision
F - Nursing Home
G - Cancer
H - Champus/Tricare
I - HMO Insurance
J - Court Ordered
K - Medicare Part A
L - Medicare Part B
M - Medicine Supplement/Advantage
N - Drug Insurance
P - Workers Compensation or Accident
V - Veterans
W Medicare Part D

Does anyone outside the household pay the premium? ❑ Yes ❑ No

If yes, who: ______________________________

Do household members expect changes in health insurance coverage? ❑ Yes ❑ No

If yes, explain: ______________________________

Does any household member's employer offer health insurance? ❑ Yes ❑ No

If yes, does the employer pay 50% or more of the premium? ❑ Yes ❑ No

If yes, list the name of the insurance? ______________________________

Did anyone in your household have health insurance canceled or stopped within the last six months? ❑ Yes ❑ No

If yes, who: ____________________ Date coverage ended: ____________________

Reason: ______________________________

Tell Us If You Receive Help With Your Medical Costs

Does anyone help pay your medical costs? ❑ Yes ❑ No

If yes, explain: ______________________________

Do household members have medical problems due to an accident? ❑ Yes ❑ No

If yes, list the date and type of the accident: ______________________________

Do household members have a pending legal action from which they may receive money or medical benefits (including inheritance)? ❑ Yes ❑ No

Tell Us Where You Got This Application

Where did you get this Health Care Coverage application (check only one)?

- ❑ 1-877-KIDS-NOW
- ❑ Capitol in Bismarck
- ❑ Caring for Children
- ❑ Community Resource Coordinator
- ❑ Daycare
- ❑ Faith-Based Organization
- ❑ Food Pantry
- ❑ Friend/Relative
- ❑ Head Start
- ❑ Insurance Agent
- ❑ Internet
- ❑ Medical Provider
- ❑ Pharmacy
- ❑ Public Health Agency
- ❑ School
- ❑ Social Service Agency
- ❑ WIC
- ❑ Other

Tell Us How You Found Out About Health Care Coverage

How did you find out about Health Care Coverage in North Dakota (check only one)?

- ❑ Business/Service Club
- ❑ Capitol in Bismarck
- ❑ Caring Program
- ❑ Daycare
- ❑ Faith-Based Organization
- ❑ Food Pantry
- ❑ Friend/Relative
- ❑ Head Start
- ❑ Insurance Agent
- ❑ Internet
- ❑ Medical Provider
- ❑ Newspaper/Magazine/ Newsletter
- ❑ Pharmacy
- ❑ Public Health Agency
- ❑ Radio
- ❑ Social Service Agency
- ❑ Television
- ❑ WIC
- ❑ Other

Information About Other Services For Children and Families

Caring For Children

If children listed on this application are not eligible for Health Care Coverage through either the Medicaid or Healthy Steps program, they may be eligible for the Caring for Children program. The North Dakota Caring Foundation, a private nonprofit organization, offers this program.

If you have children who are not eligible for Health Care Coverage through either Medicaid or Healthy Steps program, we may forward information from this application to the Caring for Children program. They will determine if any of the children listed are eligible for their program. If you do not want us to send the information to the North Dakota Caring Foundation, please check below:

❑ Check this box if you **do not** want us to forward information to the Caring for Children program.

Please note that the North Dakota Department of Human Services or county social services do not determine eligibility for the Caring for Children program and any appeal of their decision regarding this program must be made to the North Dakota Caring Foundation.

Child Support Enforcement

Child Support Enforcement (CSE) may help children get financial and medical coverage from parents who do not live in the home and who are or can be court ordered to provide financial or medical coverage.

<u>Medical Coverage</u>

If a child is eligible for Medicaid and a parent does not live in the home, we may make a referral to CSE. We will not make a referral for children when there is no adult requesting Medicaid coverage, unless the child is in foster care; when the only eligible adult is pregnant; or for children who are eligible for Healthy Steps (Children's Health Insurance Program (CHIP)). If a referral is not made, but you would like assistance with CSE, please contact them at 1-800-231-4255.

<u>Temporary Assistance for Needy Families (TANF)</u>

If you receive TANF and one parent is not living in the home, your family will automatically be referred to CSE. You must cooperate with CSE in establishing paternity and in establishing and enforcing child support.

If you are interested in receiving Medicaid or TANF coverage for yourself and/or your children and you do not want assistance from CSE because your cooperation might not be in the best interest of your child (example: domestic violence situation), you may claim "good cause". If you do, a form SFN 446, will be sent to you to provide additional information so we can decide if there is "good cause".

Are you interested in claiming "good cause" for not cooperating with CSE? ❑ Yes ❑ No

Claiming "good cause" does not affect you or your child's eligibility for Medicaid and TANF.

Failure to cooperate with CSE does not affect your child's eligibility for Medicaid. However, if you choose not to cooperate with CSE efforts and you have not claimed "good cause" or your claim of "good cause" has been "denied, you will not be eligible for Medicaid coverage and TANF benefits. <u>However, your children will</u> continue to be eligible for Medicaid or Healthy Steps coverage, provided they meet all other program requirements.

Application For Assistance – Section 6

Read and sign Section 6 if you are applying for any one of the following:

- **Basic Care**
- **Child Care Assistance**
- **Health Care Coverage**
- **SNAP**
- **TANF**

Read The Following Information

I have received, reviewed and understand my rights and responsibilities as explained in the Guidebook.

I declare under penalty of law, the information on this application is correct. This includes information about identity, citizenship and alien status of the household members applying for assistance.

I understand that alien status information and other information will be verified when discrepancies are found. The alien status of applicant household members may be subject to verification by USCIS through the submission of information from the application to USCIS. Verification received may affect eligibility and level of benefits.

I understand the information I provide on or with this application is subject to verification by federal, state and local officials to determine if the information is correct. If any of the information is incorrect, assistance may be denied and I may be subject to criminal prosecution for knowingly providing incorrect information.

I agree to report to the county social service office any changes in income, assets, or living arrangements as required.

I understand I will not receive a deduction for any allowable expenses I do not report and provide proof of.

I understand that unless I have indicated otherwise for the Caring for Children program, in the 'Other Services' section above, information may be forwarded to the Caring for Children program so they can determine if any of the children listed on this application are eligible for their program.

I have been informed my household is authorized to receive TANF Information and Referral services. I have been given the Guidebook that has information about these services.

An individual who breaks any of the rules on purpose can be barred from SNAP for one year to permanently, fined up to $250,000, imprisoned up to 20 years or both. An individual may also be subject to prosecution under other applicable federal and state laws and may also be barred from SNAP for additional 18 months if court ordered.

Any member of the household who intentionally breaks the rules may not get SNAP benefits for one year for the first offense, two years for the second offense and permanently for the third offense.

If a court of law finds you guilty of using or receiving benefits in a transaction involving the sale of a controlled substance, you will not be eligible for benefits for two years for the first offense, and permanently for the second offence.

If a court of law finds you guilty of having used or received benefits in a transaction involving the sale of firearms, ammunition or explosives you will be permanently ineligible to participate in SNAP upon the first offense.

If a court of law finds you guilty of having trafficked benefits for an aggregate amount of $500 or more, you will be permanently ineligible to participate in SNAP upon the first offense.

If you are found to have made a fraudulent statement or representation with respect to the identity or place of residence in order to receive multiple SNAP benefits simultaneously, you will be ineligible to participate in SNAP for a period of 10 years.

In accordance with Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited for discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food and Nutrition Act and USDA policy, discrimination is prohibited also on the basis of religion and political beliefs.

To file a complaint of discrimination, contact USDA or HHS. Write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). Write HHS, Director, Office of Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TTY). USDA and HHS are equal opportunity providers and employers.

Authorization To Release Information

I/We authorize any person having custody or knowledge of the information relating to me or other household members to disclose any requested information, including confidential information other than protected health information, to any authorized agent of the North Dakota Department of Human Services. I also authorize the North Dakota Department of Human Services and the carrier providing Healthy Steps insurance to release to each other information regarding any services or benefits I received under Healthy Steps. This authorization will remain valid until canceled in writing or until coverage ends. A copy of this authorization is as valid as the original.

Sign and Date the Application Here

Signature of Applicant: ______________________________ Date: ________________

Other Signature (Spouse, Guardian or Other Adult): ________________ Date: ________________