**APPLICATION FOR ASSISTANCE**
DEPARTMENT OF HEALTH AND HUMAN SERVICES
SFN 405 (11-2024)

# Instructions For Application For Assistance

This application may be used to apply for Child Care Assistance Program (CCAP), Supplemental Nutrition Assistance Program (SNAP), Health Care Coverage (HCC), Basic Care Assistance Program (BCAP), and Temporary Assistance for Needy Families (TANF). See the Guidebook for more information. You may also view the guidebook and apply online at: www.applyforhelp.nd.gov

## What Do I Need to Do to Get Assistance?

Follow these steps to apply for assistance:

### Step 1: Fill out this application.

**All applicants must fill out Section 1 and Section 7.**

Depending on the program you are applying for, you will also need to complete:

- Child Care Assistance Program (CCAP) - You need to complete Section 6.
- Supplemental Nutrition Assistance Program (SNAP) - You need to complete Sections 3 and 4.
- Health Care Coverage (HCC) - You need to complete Sections 2, 3, and 5. (Medicaid, Medicare Savings Program) Information of individuals applying for HCC will be sent to the Health Insurance Marketplace for eligibility determination for help paying for private health insurance.
  - You will also need to complete SFN 1620 Application-Appendix B for any household members that are American Indian or an Alaska Native.
- Basic Care Assistance Program (BCAP) - You need to complete Sections 3 and 5.
- Temporary Assistance for Needy Families (TANF) - You need to complete Sections 3, 4, and 5.

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 human service zone office can also help you apply for assistance. If you need additional space, attach a separate sheet of paper.

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 2: **Return your signed and dated form** to your local human service zone office

**OR**

Submit by mail to:
Department Of Health and Human Services
Customer Support Center
PO Box 5562
Bismarck ND, 58506
**OR** FAX: (701)-328-1006
**OR** Email: applyforhelp@nd.gov

For questions call Customer Support Center at: 1-866-614-6005; TTY: 711
Human service zone office locations can be found here: https://www.hhs.nd.gov/human-service/zones

### Step 3: Talk with us.

When we receive 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. HCC, BCAP, and CCAP do not require an interview.

| Appointment Date: | Appointment Time: |
|---|---|
| | |

If you miss your appointment and still wish to apply, please contact the human service zone 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 workers 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)
- American Indian/Alaskan Native Tribal Document
- Birth Certificate (if born in the United States)
- Temporary Resident Card (Form I-688)
- Arrival-Departure Record (Form I-94)
- Passport

You will be asked to provide information about the 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 HCC, verification will be required if not available through electronic notifications.**
For CCAP, HCC, and SNAP: if any of these persons do not want to give information about their 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 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.)
- Savings Bonds
- Stocks/Bonds/Mutual Funds
- Trusts

If only applying for Child Care Assistance or Health Care Coverage for families with children and non-disabled adults between the ages of 19 and 65, 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, Spousal 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 (Mortgage)
  - Other Utility Bills
  - Property Taxes
  - Rent (Receipt, Lease Agreement, Housing Assistance Contract)
  - Telephone Bill

If only applying for HCC for families with children and non-disabled adults between the ages of 19 and 64, you do not need to provide expense information.

☐ **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 Form)
- Social Security Benefits
- Spousal Support
- SSI (Supplemental Security Income)
- Unemployment Benefits
- Veteran's/Military Benefits
- Workers Compensation

For HCC, proof will be requested if the information cannot be verified through our electronic verification sources.

☐ **Proof of other information such as:**

- Identity (Birth Certificate, Driver's License, Work or School ID, American Indian/Alaskan Native Tribal Document, Passport - original documents required if applying for Health Care Coverage)
- Age (Birth Certificate, Driver's License)
- Residence (Rent Receipts, Utility Bills, Lease)
- Social Security Numbers (card or proof of application for SSN)
- Verification of Pregnancy (Doctor's statement or due date)

For HCC, proof will be requested if the information cannot be verified through our electronic verification sources.

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

# APPLICATION FOR ASSISTANCE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

SFN 405 (11-2024)

Clear Fields

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 and privacy information, see the Guidebook. The Guidebook provides more detailed information about program guidelines and services offered. If you did not receive the Guidebook, contact your local human service zone office.

☐ **TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) (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 PROGRAM (CCAP)** - Assist individuals with child care costs while the individual is employed, attending high school, obtaining their GED, pursuing postsecondary education, training, or job searching.

☐ **SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)** - SNAP provides food benefits to low-income families to supplement their grocery budget so they can afford the nutritious food essential to health and well-being. You may get SNAP within 7 days of your application if:

- Your household's monthly income before taxes is $150 or less provided your liquid resources do not exceed $100; or
- You are a migrant or seasonal farm worker who is destitute provided your liquid resources do not exceed $100; or
- Your household's monthly rent/mortgage and utilities are more than your household's income before taxes.

☐ **Medicaid** - Pays for health services or insurance premiums for eligible individuals.

☐ **Medicare Savings Program** - Assists with Medicare Part B premium, coinsurance and deductibles.

☐ **BASIC CARE ASSISTANCE PROGRAM (BCAP) (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: | Suffix: |
|---|---|---|---|
| | | | |

| Address Where You Live: ** | Apartment or Unit Number: |
|---|---|
| | |

| City: | State: | ZIP Code: | Direction to Home (if rural): *** |
|---|---|---|---|
| | | | |

| Mailing Address (if different): |
|---|
| |

| Home Telephone Number: | Work or Message Number: | Cell Phone Number: |
|---|---|---|
| | | |

| If you do not speak English, what is your preferred spoken or written language? |
|---|
| |

** If you are applying for Health Care Coverage (Medicaid) and you have entered your residential and mailing address as General Delivery, or Homeless, or have left it blank, your mail will be sent to the local human service zone office. You will need to arrange to pick up your mail at the local human service zone office on a weekly basis. If you do not pick up your mail for three (3) weeks, your case may be closed due to loss of contact.

*** Not required for Medicaid.

## 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, etc.)

☐ 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 the 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.

You will be asked to provide Social Security Numbers (SSNs) for all persons for whom you want assistance, except for the Child Care Assistance Program. However, providing your SSN will assist in speeding up the application process even though you are not interested in receiving Health Care Coverage. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778. If you are applying only for emergency Medicaid because of your citizenship or immigration status, you do not need to give us information about your SSN. **(See the 'General Information Section' of the Application for Assistance Guidebook for additional information regarding use of Social Security Numbers.)**

NOTE: If you are applying for Health Care Coverage, include individuals who are in your home and also those individuals who you claim on your federal income tax return

| Household Members (Enter Legal Name) First / Middle Initial / Last | Relationship to You | Social Security Number | Date of Birth | Age | Sex | Last Grade Completed * | U. S. Citizen (Yes or No) | Hispanic or Latino (Yes or No) | Race (Use Codes Below) | Marital Status (Use Codes Below) |
|---|---|---|---|---|---|---|---|---|---|---|
| | Self | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

Race Codes: **AI** - American Indian/Alaska Native **AP** - Asian **BL** - Black/African American **HP** - Native Hawaiian/Pacific Islander **WH** - White
Marital Status Codes: **DI** - Divorced **MA** - Married **NM** - Never Married **SE** - Separated **WI** - Widowed

* Last Grade Completed is not required for Health Care Coverage or SNAP.

Are you homeless? ** ☐ Yes ☐ No

If any household members are enrolled members in a federally-recognized Indian tribe, list enrolled members, the name of the tribe and their tribal enrollment numbers (required only for individuals who are 65 or older or disabled.)

If you are applying for Health Care Coverage you may be eligible for no enrollment fees or premium payments under certain Health Care Coverage.

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 anyone in the home that is currently in foster care or has ever been in foster care.**

List anyone in the household that is currently or has every served in any branch of the military.**

Have household members received, or are they currently receiving 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): *

*** Not required for HCC**
**** Required for SNAP only**

| | |
|---|---|
| Have household members received commodities through the Tribal Commodities/Food Distribution Program on Indian Reservation (FDPIR) last month or this month? * | ☐ Yes ☐ No |
| If Yes, Who and Which Tribe? * | |
| Have you or any member of your household had a disqualification from the Tribal Commodities/Food Distribution Program on Indian Reservation (FDPIR?) * | ☐ Yes ☐ No |
| If Yes, Who and Which Tribe? * | |

*** Not required for HCC**

## 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 | Student Status |
|---|---|---|
| | | ☐ Full Time ☐ Part Time |
| | | ☐ Full Time ☐ Part Time |
| | | ☐ Full Time ☐ Part Time |

## Would You Like to Receive Text and E-mail Notification

By opting to receive text message or e-mail notifications, you agree to the following:

A text message or e-mail notification will be sent to the cell phone number or e-mail address you entered when a review or full application is needed to determine eligibility or continued eligibility for the program(s) you are enrolled in.

Cell phone carrier text message rates may apply and HHS will not be liable for any text message charges.

You are responsible for notifying your case worker of any changes to your e-mail address, cell phone carrier or cell phone number, or if your cell phone is lost or stolen.

It is the policy of HHS not to transmit confidential information by text or e-mail as unencrypted e-mail and text messaging is NOT a secure form of communication. There is some risk that any Protected Health Information (PHI) and other confidential information that may be contained in such e-mail or text messages may be misdirected, disclosed to, or intercepted by, unauthorized third parties. I consent and accept the risk in transmitting PHI and other confidential information via unencrypted e-mail or text messaging.

| | |
|---|---|
| Would you like to receive text message notifications? ☐ Yes ☐ No | If yes, list name of cell phone provider: |
| Would you like to receive e-mail notifications? ☐ Yes ☐ No | If yes, list e-mail address: |
| Signature (text and/or e-mail notifications will not be sent without your signature) | Date |

## Help with SNAP and HCC?

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

Supplemental Nutrition Assistance Program Education (SNAP-Ed) is available to SNAP recipients through NDSU Extension Services Family Nutrition Program. This program provides resources and learning opportunities to help participants make healthy food choices within a limited budget and sustain a healthy weight. Please see www.ag.ndsu.edu/foodwise for more information.

If you are applying for SNAP or HCC, you can give a trusted person permission to talk about this application with us and see your information. This individual can act on your behalf on matters related to this application, including giving and getting information, signing your application and acting for you on all future matters. This person is called an "authorized representative." If you ever need to change your authorized representative, contact your local human service zone office.

For SNAP, this person can also give information at your interview and can also receive the Electronic Benefit Transfer (EBT) card for you. This gives the representative access to your food benefits. Any benefits spent by the representative will not be replaced. You also have the choice to name a different authorized representative who will not receive notifications about your SNAP case, including the application, but can access your food benefits for you by using your EBT card. Any benefits spent by the representative will not be replaced.

For HCC, if the person you give this permission is a **legally** appointed representative for someone on this application, submit proof with the application.

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

| First Name: | Middle Initial: | Last Name: | Suffix: |
|---|---|---|---|
| | | | |

| Address: | Apartment or Suite Number: |
|---|---|
| | |

| City: | State: | ZIP Code: | Telephone Number |
|---|---|---|---|
| | | | |

By signing, you authorize this person to serve as your "authorized representative."

| Signature | Date |
|---|---|
| | |

**If you choose to have someone help you only to use your EBT card and not receive notifications, fill in the boxes below with their information:**

| First Name: | Middle Initial: | Last Name: | Suffix: |
|---|---|---|---|
| | | | |

| Address: | Apartment or Suite Number: |
|---|---|
| | |

| City: | State: | ZIP Code: | Telephone Number |
|---|---|---|---|
| | | | |

By signing, you authorize this person to serve as your "authorized representative" to use your EBT card.

| Signature | Date |
|---|---|
| | |

## Key Questions for Faster SNAP Service

If eligible, you will receive your benefits within 7 days of filing your application if you answer "yes" to any of the questions below. Otherwise, you will receive your benefits within 30 days of filing your application.

| | |
|---|---|
| Does your household expect to receive less than $150 in income this month and have $100 or less available in cash and/or in a bank account? | ☐ Yes ☐ No |
| Does your household have rent/mortgage and/or utility costs that are more than your total income, available cash, and bank accounts for this month? | ☐ Yes ☐ No |
| Does your household include a migrant or seasonal farm worker whose income has stopped and whose available cash and bank accounts do not exceed $100? | ☐ 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/or house payment?

Check all the utilities your household is responsible for:

☐ Heating ☐ Cooling ☐ Electricity ☐ Telephone ☐ Water ☐ Sewer ☐ Garbage

Has anyone in your household received LIHEAP (fuel assistance) in the past 12 months? ☐ Yes ☐ No

If Yes, List Household Member:

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

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

If yes, who?

### Agency Use Only - Expedited Formula

Eligible for expedited service if:
**Countable Income is below $150/ Month**
Examples: Wages, Child Support, SSI, Disability, Retirement, Veterans Benefits, Unemployment, Workers Compensation

If not eligible:

**Monthly**

| | |
|---|---|
| Gross Countable Income | |

Would be less than:

| | |
|---|---|
| Rent/Mortgage | |
| Appropriate Utility Standard | + |
| Total Shelter Cost | = |

HLSU - Any of the following:
- Heating
- Cooling
- LIHEAP

LUSA - Two of the following:
- Water
- Electric
- Sewer
- Telephone
- Garbage

MU - One of the following:
- Water
- Garbage
- Sewer
- Electric

TL - Telephone Only

| | |
|---|---|
| Was the screening for expedited service completed? ☐ Yes ☐ No<br>Is the household eligible for expedited service? ☐ Yes ☐ No<br>Was the identity of the applicant verified? ☐ Yes ☐ No | Worker's Initials: |

Agency Use Only

| Case Number |
|---|
| Date Requested |

## Tell Us About the Income/Money Your Household Receives

### Self-Employment

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

If yes, answer below:

| How much net income (profits once business expenses are paid) will you get from this self-employment this month? | |
|---|---|
| Name of Household Member(s): | Name of Business: |
| Type of Business: | Date Business Started: |

### Employment

Are any household members employed? ☐ Yes ☐ No

Are any household members employed with a North Dakota licensed child care program? (for CCAP only)

☐ Yes - answer the following: ☐ No

| Household Member Who Has This Income: | Employment Start Date: | Provider Name: |
|---|---|---|
| | | |

If you or any household member are employed, list information about pay from employment such as wages, commissions, bonuses, and incentives for all household members, including children. If employment stopped last month or this month, also list income received this month here.

| Household Member | 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 (Use Codes Below) | Day or Dates Paid (Use Codes Below) |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | | | | | | | | |
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| | | | | | | | | | |

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 - answer the following: ☐ No

| Name of Household Member: | Date Received: | Amount Received: |
|---|---|---|
| | | |

## 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 Benefit while on Strike
- ☐ 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 Foster Care/Subsidized Adoption Payments
- ☐ Yes ☐ No Income from CRP
- ☐ 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 Deposited into a Bank Account from an Individual Outside of Your Household **
- ☐ Yes ☐ No Money from Friends, Relatives or Others**
- ☐ Yes ☐ No Money from Inheritance**
- ☐ Yes ☐ No Oil/Mineral Rights/Royalties
- ☐ Yes ☐ No Pension/Retirement Benefits
- ☐ Yes ☐ No Railroad Benefits
- ☐ Yes ☐ No Refugee Assistance**
- ☐ Yes ☐ No Social Security Benefits
- ☐ Yes ☐ No Supplemental Security Income (SSI)**
- ☐ Yes ☐ No TANF-Temporary Assistance for Needy Families**
- ☐ Yes ☐ No Unemployment Benefits
- ☐ Yes ☐ No Veteran's/Military Benefits**
- ☐ Yes ☐ No Workers' Compensation**

Other, specify: _____

** IIM information is not required for Health Care Coverage.* *** Not required for Health Care Coverage unless over 65 or disabled.*

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

Does anyone outside of your household deposit money into a household member's bank account? ** ☐ Yes ☐ No If yes, explain:

** Not required for Health Care Coverage unless over age 65 or disabled.

Have household members applied for benefits not yet received (such as Social Security, SSI, Worker's Compensation, Unemployment Compensation, Veterans/Military Benefits, etc.?) ☐ Yes ☐ No If yes, explain:

## Tell Us About Court Ordered Expenses *

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

| If yes, who? | Who are the payments for? |
|---|---|
| Amount Court Ordered: | Amount Paid: |

* Court Order Expenses are not required for Health Care Coverage.

## Tell Us If You Have Child Care Expenses **

Will your household have child care costs this month? ☐ Yes ☐ No If yes, check the reason:

☐ Employment ☐ High School/GED ☐ Education or Training ☐ Job Search ☐ Other _____

Amount:

Does anyone help you pay your child care costs? ☐ Yes ☐ No If yes, complete the line below:

| Name of Person Paying the Child Care Costs: | Amount they are Paying: | Name of Person Paid To: |
|---|---|---|

Do you expect your child care costs for this month to be the same as last month? ☐ Yes ☐ No If no, explain:

** Not required for Health Care Coverage.

# Application For Assistance - Section 2

## Complete Section 2 if you are applying for:

### I Health Care Coverage (HCC)

Your Name:

## Tell Us About Your Household

If you do not want Health Care Coverage for all members of the household listed on Page 2, please list members you **DO NOT** want Health Coverage for:

Were any applicants who are requesting health care coverage in foster care at age 18 or older? ☐ Yes ☐ No

| If yes, who? | When: | What State: |
|---|---|---|

| Are you a U.S. Citizen or U.S. National ? ☐ Yes ☐ No | Are you a naturalized or derived citizen? *(This usually means you were born outside the U.S.)* ☐ YES. If yes, complete a and b ☐ NO. If no, continue to question c |
|---|---|

| a. Alien Number: | b. Certficate Number | After you complete a and b, SKIP to question d. |
|---|---|---|

c. If you aren't a U.S. citizen or U.S. national, do you have eligible immigration status?
☐ YES. Enter document type and ID number. See instructions.

| Immigration Document Type | Status Type (optional) | Write Your Name as it Appears on Your Immigration Document |
|---|---|---|

| Alien or I-94 Number | Card Number or Passport Number |
|---|---|
| SEVIS ID or Expiration Date (optional) | Other (category code or country of issuance) |

For any applicants who are not a U.S. Citizen or U.S. National, have they lived in the U.S. since 1996?
☐ Yes ☐ No - Date Entered the U.S.

d. Do you live with a least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No

If Yes, Name of Child(ren):

## Tell Us About Your Household's Federal Tax Filing Information

Do you plan to file a federal income tax return next year? ☐ Yes ☐ No

| If you plan to file a federal income tax return next year, will you file jointly with a spouse? ☐ Yes ☐ No | If Yes, Name of Spouse: |
|---|---|

If you plan to file a federal income tax return next year, will you claim any dependent on your tax return? ☐ Yes ☐ No

If Yes, Name of Dependents You Will Claim:

| If you plan to file a federal income tax return next year, will any dependents file a tax return? ☐ Yes ☐ No | If Yes, Who: |
|---|---|

If you do NOT plan to file a federal income tax return next year, will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

| If Yes, List Name of Tax Filer: | Relationship to Tax Filer: |
|---|---|

## Tell Us About Deductions Claimed on Your Federal Income Tax

Telling us about certain things that can be deducted on a Federal Income Tax return could make the cost of health insurance a little lower. Check the following income deductions you claimed on your Federal Income Tax:

- ☐ Alimony **(Note**: Only for divorces finalized before 1/1/19)
- ☐ Student Loan Interest
- ☐ Tax Deductible Tuition and Fees
- ☐ Other Deductions not already considered in your answer to 'Amount of net self-employment income (profits once business expenses are paid)' on Page 9. If checked, please explain:

### Ability to Use Tax Data During Renewal

Renewal of Coverage: To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Human Service Zone or State Office to use income data, including information from tax returns. The Human Service Zone or State Office will send me a notice, let me make any changes, and I can opt out at any time.

## 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 |
| 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 Health Coverage

Is any household member enrolled in health coverage from one or more of the following?*

| | |
|---|---|
| ☐ Medicaid - Who: | |
| ☐ Medicare - Who: | ☐ Peace Corps - Who: |
| ☐ TRICARE (do not check if you have direct care or Line of Duty) - Who: | |
| ☐ VA Health Care Program - Who: | |

Does any household member's employer offer health insurance?

☐ Yes ☐ No If yes, complete the 'Health Coverage from Jobs' form (SFN 1618) included in the Application Packet.

* Provide a copy, front and back, of insurance card. * Required only for individuals who are 65 or older or disabled.

## 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 | |
| Does anyone in your household require nursing care services? ☐ Yes ☐ No | If yes, when/will they start receiving nursing care services? |

If receiving nursing care services in a facility, provide name and address of facility:

| | | | |
|---|---|---|---|
| Name of Facility | | | |
| Address | City | State | ZIP Code |
| Do household members have a pending legal action from which they may receive money or medical benefits (including inheritance?) ** ☐ Yes ☐ No | | | |

** Not required unless over age 65 or disabled.

## Power of Attorney or Family Contact

| | | | |
|---|---|---|---|
| First Name | Relationship | | |
| Mailing Address Where You Want Notices Sent | City | State | ZIP Code |
| Home Telephone Number | Work or Message Number | Cell Phone Number | |
| ☐ Power of Attorney ☐ Family Contact Person | | | |

## Application Counselor, Navigator, Agent or Broker Only

**Complete this section if you are a certified application counselor, navigator, agent or broker filling out this application for someone else.**

| | | | |
|---|---|---|---|
| First Name: | Middle Initial: | Last Name: | Suffix: |
| Name of Organization: | ID Number (if applicable): | Application Start Date: | |

# Application For Assistance - Section 3

**Complete Section 3 if you are applying for:**

- **Basic Care Assistance Program (BCAP)**
- **Health Care Coverage (HCC)**
- **Supplemental Nutrition Assistance Program (SNAP)**
- **Temporary Assistance for Needy Families (TANF)**

## Tell Us About Your Household's Assets

If you are applying for HCC for someone who is disabled or age 65 or older, or if you are applying for BCAP, 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 | |

## Tell Us About Your Household Assets (continued)

### 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 Cash on Hand
- ☐ Yes ☐ No Certificates of Deposit
- ☐ Yes ☐ No Checking/Credit Union Accounts
- ☐ Yes ☐ No Debit Card Account (Not Checking/Savings)
- ☐ 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 (IIM) Accounts*
- ☐ Yes ☐ No Inheritance
- ☐ Yes ☐ No Life Estate/Life Lease
- ☐ Yes ☐ No Mineral Rights (Oil, Gas, Gravel, Coal, etc.)
- ☐ Yes ☐ No Money Market Account
- ☐ 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 Savings Bonds
- ☐ Yes ☐ No Savings/Credit Union Accounts
- ☐ Yes ☐ No Trusts

Other, specify: _____

* *IIM information is not required for Health Care Coverage.*

*** Pursuant to 42 U.S.C. 1396p(e), as a condition for the provision of medical assistance for long-term care services, the applicant must disclose a description of any interest the applicant or community spouse has in an annuity. The State becomes a remainder beneficiary under such annuity by virtue of the provision of medical assistance.*

**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 items: | Date: |
| 5 years? (does not apply to SNAP) ☐ Yes ☐ No | If yes, list items: | Date: |

Are <u>any</u> assets subject to a "Transfer of Death"? (Does not apply to SNAP). ☐ Yes ☐ No

If Yes, Describe Property and Approximate Value:

# Application For Assistance - Section 4

**Complete Section 4 if you are applying for:**

- **Supplemental Nutrition Assistance Program (SNAP)**
- **Temporary Assistance for Needy Families (TANF)**

## Tell Us the Value of 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 | Lot Rent |
| ☐ Yes | ☐ No | Condo Fees | ☐ Yes | ☐ No | Property Taxes (not in house payment) |
| ☐ Yes | ☐ No | Electricity | ☐ Yes | ☐ No | Rent |
| ☐ Yes | ☐ No | Garbage | ☐ Yes | ☐ No | Sewer/Septic Tank Installation or Maintenance |
| ☐ Yes | ☐ No | Heating (gas, propane, electric, etc.) | ☐ Yes | ☐ No | Telephone/Cell Phone |
| ☐ Yes | ☐ No | Homeowners Insurance (not in house payment) | ☐ Yes | ☐ No | Use of a Garage |
| ☐ Yes | ☐ No | House Payment (mortgage) | ☐ 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, complete the line below: |
| List the Expense: | | 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, complete the line below: |

| List the Expense: | Name of Person that Pays the Expense: | Amount Paid: |
|---|---|---|
| | | |

**Agency Use Only**

Household is entitled to one of the following mandatory utility standards:

- ☐ HL SU (heating/cooling/LIHEAP)
- ☐ LU SA (water, sewer, garbage, electricity, telephone)
- ☐ MU (water, sewer, garbage, electricity)
- ☐ 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? (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.) ☐ Yes ☐ No

| 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 adult dependent care? ☐ Yes ☐ No

Do household members pay representative payee fees? ☐ Yes ☐ No

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

## Tell Us About Your Household's Work Information

Household Members who are Unable to Work:

Reason They are Unable to Work:

Household Members who Stopped Their Employment Within the Last 30 Days:

| Date Employment Stopped: | Name of Employer: |
|---|---|

Reason for Leaving:
☐ Laid Off ☐ Quit ☐ Fired ☐ Strike ☐ Injury ☐ Illness
☐ Leave of Absence ☐ Other, specify: _____

Date of Final Paycheck Received by Household Member:

Household Members who Reduced Their Work Hours Within the Last 30 Days:

| Date Reduced: | Reason Reduced: |
|---|---|

Household Members who Refused Work Within the Last 30 Days:

| Date Refused: | Reason Refused: |
|---|---|

## Tell Us About Illegal Activities and Disqualifications

Have you or 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? ☐ Yes ☐ No

Has anyone in the household been convicted of Federal aggravated sexual abuse, murder, sexual exploitation and abuse of children, or sexual assault? An offense under State law determined by the Attorney General to be substantially similar to the previously described offenses shall also be ineligible for SNAP benefits. A conviction for one of the listed offenses only makes an individual ineligible if the conviction is for conduct on or after February 7, 2014. ☐ Yes ☐ No

Are you or any member of your household violating a condition of parole or probation? ☐ 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 your 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 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 Assistance Program (BCAP)**
- **Health Care Coverage (HCC)**
- **Temporary Assistance for Needy Families (TANF)**

## Tell Us About Your Household

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

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

List household members who are a veteran, a spouse, parent, or dependent of a veteran, or are an active-duty member in the US Military:

Name of Any Children Whose Father's Name Is Not Listed on the Birth Certificate: ***

Name of Each Household Member Who is Pregnant:

| How many babies are due? | Due Date: | Name of Father of the Unborn Baby: *** |
|---|---|---|

How was pregnancy determined? ***

☐ Physician ☐ Public Health Agency ☐ Home Pregnancy Test ☐ Other, specify: _____

Do you pay for guardianship or conservator services?*** ☐ Yes ☐ No

*** This information is not needed to determine eligibility for Health Care Coverage

## 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: | | | |

Reason Codes:

**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
**TR** - Parental Rights Terminated
**SE** - Separated
**WO** - Working Out of Town or State

*** This information is not needed to determine eligibility for Health Care Coverage

## Tell Us About Your Life Insurance (Not required for Health Care Coverage unless over age 65 or disabled)

Does any household member have life insurance? ☐ Yes ☐ No

Designated irrevocable itemized burial fund? ☐ Yes ☐ No If yes, fill in the boxes below:

| Name of Insured Person | Name and Address of Company | Policy Number | Face Value | Cash Surrender Value | Owners |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

## Tell Us About Your Health Insurance Coverage

List household members who have health insurance: Provide copy, front and back, of insurance card.

| 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** - Medicare Supplement/Advantage
**N** -Prescription Drug Insurance
**P** - Workers Compensation or Accident
**V** - Veterans Administration
**W** - Medicare Part D

| | |
|---|---|
| Are any of the policies listed above COBRA coverage? ☐ Yes ☐ No | If Yes, Name of Health Insurance |
| Date COBRA Coverage Began | Date or Expected Date COBRA Coverage Will End |
| Are any of the policies listed above a retiree health plan? ☐ Yes ☐ No | If Yes, Name of Health Insurance |
| Are any of the policies listed above a limited-benefit plan (like a school accident policy) ☐ Yes ☐ No | If Yes, Name of Health Insurance |

Are any of the policies a state employee benefit plan? ☐ Yes ☐ No

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:

Did anyone in your household have health insurance canceled or stopped within the last 3 months? ☐ Yes ☐ No If yes, complete below:

| | |
|---|---|
| Name of Person Who Had Insurance Canceled or Stopped: | Date Coverage Ended: |

Reason the Insurance was Canceled or Stopped:

Does the household member have a long term care insurance policy that has paid out benefits for long term care services (nursing care, basic care, or assisted living)? ☐ Yes ☐ No This information may allow you to protect additional assets.

| | |
|---|---|
| If yes, who: | How much has the policy paid in benefits: |

## Tell Us Where You Got This Application (optional)

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

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

## Tell Us How Or Where You Found Out About Health Care Coverage (optional)

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

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

## Information About Other Services for Children and Families

### Child Support

Child Support (CS) 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.

Medicaid Coverage
If a child is eligible for Medicaid and a parent does not live in the home, we may make a referral to CS. We will not make a referral for children when there is no adult requesting Medicaid coverage, unless the child is in foster care or when the only eligible adult is pregnant. If a referral is not made, but you would like assistance with CS, please contact them at 701-328-5440 or 1-800-231-4255.

Temporary Assistance for Needy Families (TANF)
If you receive TANF and one parent is not living in the home, your family will automatically be referred to CS. You must cooperate with CS 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 CS 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 CS?** ☐ Yes ☐ No

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

Failure to cooperate with CS does not affect your child's eligibility for Medicaid. However, if you choose not to cooperate with CS 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. However, your children will continue to be eligible for Medicaid, provided they meet all other program requirements.

# Application For Assistance - Section 6

**Complete Section 6 if you are applying for:**

**Child Care Assistance Program (CCAP)**

## Tell Us About Your Household

Total Estimated Value of Your Household Assets

Is your household currently experiencing homelessness? ☐ Yes ☐ No

*If your current address is a temporary living arrangement, you may meet the definition of homeless. Refer to the Child Care Assistance Program (CCAP) section of the Application for Assistance Guidebook.

Is a parent or caretaker currently active duty in the U.S. Military? ☐ Yes ☐ No

Is a parent or caretaker currently a member of the National Guard or a military unit? ☐ Yes ☐ No

## Tell Us About Your Child Care Needs

Does your household need assistance with child care costs for last month? ☐ Yes ☐ No

If you are requesting child care for last month, provide verification of all income received last month and a schedule of when you were participating in the activity you are requesting assistance for.

**Activity Schedule**

Name of Parent or Caretaker Participating in Activity:

Allowable Activity:

☐ Employment ☐ High School/GED ☐ Postsecondary Education ☐ Training

☐ Other - Specify: _____

**Provide a schedule of when you participate in each activity**

| Name of Child Needing Care<br><br>(If child goes to more than one provider during this activity, complete a separate line for each provider.)<br><br>**Complete a line for each child needing care for this activity.** | Time Child is: Dropped off at Provider | Time Child is: Picked up from Provider | Does this child attend preschool, Head Start, elementary, school, etc.? | Grade & School Child is in<br><br>Time School Day Starts and Ends<br><br>**Provide a copy of the child's school year schedule.** | Name, Address, City, State, ZIP Code, and Telephone Number of Child Care Provider<br><br>License Number and Expiration Date of Provider | Type of Provider<br><br>Use Codes Below |
|---|---|---|---|---|---|---|
| | | | ☐ Yes ☐ No | | | |
| | | | ☐ Yes ☐ No | | | |
| | | | ☐ Yes ☐ No | | | |
| | | | ☐ Yes ☐ No | | | |

**AR** - Approved Relative **IN** - In-Home **NF** - Non- Relative Family **NG** - Group
**RF** - Relative Family **SD** - Self-Declaration **TR** - Tribal Registration **CT** - Center

**If additional space is needed, please attach a separate sheet.**

**Activity Schedule**

(Complete this section if participating in more than one activity or for a second parent (if both parents are in the home)

| Name of Parent or Caretaker Participating in Activity: |
|---|
| Allowable Activity:<br>☐ Employment ☐ High School/GED ☐ Postsecondary Education ☐ Training<br>☐ Other - Specify: _____ |

**Provide a schedule of when you participate in each activity**

| Name of Child Needing Care<br><br>(If child goes to more than one provider during this activity, complete a separate line for each provider.)<br>**Complete a line for each child needing care for this activity.** | Time Child is:<br>Dropped off at Provider | Time Child is:<br>Picked up from Provider | Does this child attend preschool, Head Start, elementary, school, etc.? | Grade & School Child is in<br><br>Time School Day Starts and Ends<br>**Provide a copy of the child's school year schedule.** | Name, Address, City, State, ZIP Code, and Telephone Number of Child Care Provider<br><br>License Number and Expiration Date of Provider | Type of Provider<br>Use Codes Below |
|---|---|---|---|---|---|---|
| | | | ☐ Yes ☐ No | | | |
| | | | ☐ Yes ☐ No | | | |
| | | | ☐ Yes ☐ No | | | |
| | | | ☐ Yes ☐ No | | | |

**AR** - Approved Relative **IN** - In-Home **NF** - Non- Relative Family **NG** - Group
**RF** - Relative Family **SD** - Self-Declaration **TR** - Tribal Registration **CT** - Center

**If additional space is needed, please attach a separate sheet.**

## Tell Us About Your Postsecondary Education/Training

| List all household members that are currently attending postsecondary education/training: | |
|---|---|
| Name of School: | |
| Course of Study: | Anticipated Degree: |
| Length of Course: | Anticipated Completion Date: |
| What is your highest education completed?<br>☐ None ☐ High School ☐ Certificate ☐ Associate Degree ☐ Bachelor's Degree ☐ Master's Degree | Date Completed: |
| If there is a second parent or caretaker in your household, what is their highest education completed?<br>☐ None ☐ High School ☐ Certificate ☐ Associate Degree ☐ Bachelor's Degree ☐ Master's Degree | Date Completed: |

# Application For Assistance - Section 7

**Read and sign Section 7, if you are applying for any one of the following:**

- **Basic Care Assistance Program (BCAP)**
- **Child Care Assistance Program (CCAP)**
- **Health Care Coverage (HCC)**
- **Supplemental Nutrition Assistance Program (SNAP)**
- **Temporary Assistance for Needy Families (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 perjury, 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, which may include electronic verification. If any of the information is incorrect, a household's eligibility determination and level of benefits may be affected. I may be subject to criminal prosecution for knowingly providing incorrect information.**

I agree to report to the human service zone 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 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 offense.**

**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.**

**SNAP and FDPIR Nondiscrimination Statement for Joint Application Form**

In accordance with federal civil rights laws and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Programs that receive federal financial assistance from the U.S. Department of Health and Human Services (HHS), such as Temporary Assistance for Needy Families (TANF), and programs HHS directly operates are also prohibited from discrimination under federal civil rights laws and HHS regulations.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or who have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

**CIVIL RIGHTS COMPLAINTS INVOLVING USDA PROGRAMS**

USDA provides federal financial assistance for many food security and hunger reduction programs such as the Supplemental Nutrition Assistance Program (SNAP), the Food Distribution Program on Indian Reservations (FDPIR) and others. To file a program complaint of discrimination, complete the Program Discrimination Complaint Form, (AD-3027) found online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

**(1) mail:** Food and Nutrition Service
USDA1320 Braddock Place, Room 334
Alexandria, VA 22314; or

**(2) fax:** (833) 256-1665 or (202) 690-7442; or

**(3) phone:** (833) 620-1071; or

**(4) email:** FNSCIVILRIGHTSCOMPLAINTS@usda.gov

For any other information regarding SNAP issues, persons should either contact the USDA SNAP hotline number at (800) 221-5689, which is also in Spanish, or call the state information/hotline numbers (click the link for a listing of hotline numbers by state); found online at: SNAP Hotline

**CIVIL RIGHTS COMPLAINTS INVOLVING HHS PROGRAMS**

HHS provides federal financial assistance for many programs to enhance health and well-being, including TANF, Head Start, the Low Income Home Energy Assistance Program (LIHEAP), and others. If you believe that you have been discriminated against because of your race, color, national origin, disability, age, sex (including pregnancy, sexual orientation, and gender identity), or religion in programs or activities that HHS directly operates or to which HHS provides federal financial assistance, you may file a complaint with the Office for Civil Rights (OCR) for yourself or for someone else.

To file a complaint of discrimination for yourself or someone else regarding a program receiving federal financial assistance through HHS, complete the form on line through OCRs Complaint Portal at https://ocrportal.hhs.gov/ocr/. You may also contact OCR via mail at: Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201; fax: (202) 619-3818; or email: OCRmail@hhs.gov . For faster processing, we encourage you to use the OCR online portal to file complaints rather than filing via mail. Persons who need assistance with filing a civil rights complaint can email OCR at OCRmail@hhs.gov or call OCR toll-free at 1-800-368-1019, TDD 1-800-537-7697. For persons who are deaf, hard of hearing, or have speech difficulties, please dial 7-1-1 to access telecommunications relay services. We also provide alternative formats (such as Braille and large print), auxiliary aids and language assistance services free of charge for filing a complaint.

This institution is an equal opportunity provider.

The U.S. Department of Health and Human Services (HHS) prohibits discrimination against its customers, employees, and applicants for employment on the basis of race, color, national origin, age, disability, sex, gender identity, sexual orientation, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited basis will apply to all programs and/or employment activities.)

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write:

| | |
|---|---|
| Centralized Case Management Operations<br>US Department Of Health And Human Services<br>200 Independence Ave SW<br>Room 509F HHH BLDG<br>Washington D.C. 20201 | 1-800-368-1019<br>TTY 1-800-537-7697<br>FAX: (202) 619-3437<br>Email: ocrcomplaint@hhs.gov |

HHS is an equal opportunity provider and employer.

The North Dakota Department of Health and Human Services (HHS) is prohibited from discriminating on the basis of race, color, sex including gender identity and sexual orientation, age, disability, national origin, religion, or status with respect to marriage or public assistance, and in some cases political beliefs.

To file a complaint of discrimination regarding a program offered by HHS, submit a written complaint to:

| | |
|---|---|
| Department of Health and Human Services<br>Legal Division<br>600 E. Boulevard Ave Dept. 325<br>Bismarck ND 58505-0250 | (701) 328-2311<br>TTY 711<br>FAX: (701) 328-2173<br>Email: dhslau@nd.gov |

## SNAP Work Registration

I understand and agree that to receive SNAP, certain members of the household need to register for work. This means that certain members of the household must: A) Register for work at time of application and recertification. B) Not quit a job of 30 more hours/week without good cause. C) Not reduce work hours under 30 hours per week without good cause. D) Not refuse to accept a bona fide offer of suitable employment without good cause. Anyone who does not follow the work requirements may be disqualified from receiving SNAP. This form also acts as a work registration notice. You, along with other nonexempt household members, will be considered work registered and must comply with the requirements associated with work registration once this form is signed.

## Estate Recovery

State and Federal law requires the Department of Health and Human Services (Department) to make claims against the estate of a Medicaid member who: (1) was age 55 or older when the individual received Medicaid services; (2) who has been permanently institutionalized and received services, regardless of age; or (3) is a spouse of a Medicaid member who was age 55 or older or permanently institutionalized when the Medicaid benefits were provided. Effective August 1, 2015, except for the portion of the payment made to a private carrier for nursing facility services, home and community-based services and hospital and prescription drug services received while in a nursing home or while receiving home and community-based services, the Department may not file a claim against the estate to recover payments made on behalf of members who received coverage through a private carrier. Effective January 1, 2020, pharmacy services are no longer part of the coverage through a private carrier and are provided by the Department and are subject to Medicaid estate recovery. Individuals eligible under the Medicaid Expansion coverage receive their coverage through a private carrier.

## 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 Department of Health and Human Services. This authorization will remain valid until 90 days past closure or until revoked in writing. I/we authorize Child Support to release any records of child support payments that I/we have made or received. A copy of this authorization is as valid as the original.

## Sign And Date The Application Here

By signing my name, I attest that I have read and agree to information contained in Section 7 of this application.

☐ I understand that by checking this box and typing my name below, I am signing this SFN 405 Application for Assistance electronically. I agree that my electronic signature is the legal equivalent of my handwritten signature.

| Signature of Applicant | Date |
|---|---|
| Other Signature (Spouse, Guardian, or Other Adult) | Date |

**See Step 2 of Instruction Page After Completion**