



APPLICATION FOR SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES

SFN 405 (4-2026)

Instructions For Application For Assistance

This application may be used to apply for Child Care Assistance Program (CCAP), Supplemental Nutrition Assistance Program (SNAP), Medicaid, 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.
- Medicaid - You need to complete Sections 2, 3, and 5. Medicaid, Medicare Savings Program Information of individuals applying for Medicaid 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. For TANF, interviews may be in person, by phone or virtual. Medicaid, BCAP, and CCAP do not require an interview.

Appointment Date	Appointment Time
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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 Medicaid

- Permanent Resident Card - Form I-551
- Employment Authorization Document - Form I-766
- American Indian/Alaskan Native Tribal Document
- Birth Certificate - if born in the United States
- 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 Medicaid, verification will be required if not available through electronic resources.

For CCAP, Medicaid, 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.

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 Medicaid 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 Medicaid 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 Medicaid, 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 or Alaskan Native Tribal Document, Passport - original documents required if applying for Medicaid
- Age - Birth Certificate, Driver's License
- Residence - Rent Receipts, Utility Bills, Lease Agreement
- Social Security Numbers - card or proof of application for SSN
- Verification of Pregnancy - Doctor's statement or due date

For Medicaid, 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.

Agency Use Only

Case Number	Date Requested	Date Received	Date Interviewed
Individual Interviewed			

Section 1: Application for Assistance

Select the assistance you are applying for. Sign and date. 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.
 - Workers with Disabilities** - Disabled gainfully employed individuals ages 16 to less than age 65 can buy into Medicaid.
 - Children with Disabilities** - Disabled children under age 19 can buy into Medicaid.
- 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			
Name - First, Middle, Last, Suffix			
Address Where You Live		City	State ZIP Code
Apartment or Unit Number	Direction to Home, If Rural - Not required for Medicaid		
Mailing Address - If different		City	State ZIP Code
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 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 weeks, your case may be closed due to loss of contact.

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
Select the boxes below for all the people who live in your home, including members temporarily out of your home. Example: working away from home, attending school or boarding school, or in the military. <input type="checkbox"/> Yourself <input type="checkbox"/> Your husband or wife <input type="checkbox"/> Your children <input type="checkbox"/> Other adults or children living in your home

For each person selected, complete household member 1 through 5. 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. Providing your SSN will assist in speeding up the application process even though you are not interested in receiving Medicaid.. If someone wants help getting a 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 Medicaid, include individuals who are in your home and also those individuals who you claim on your federal income tax return

Household Member 1

Legal Name: First, Middle Initial, Last			Relationship	Social Security Number
Date of Birth	Age	Sex	Last Grade Completed - not required for Medicaid or SNAP	
U.S. Citizen <input type="radio"/> Yes <input type="radio"/> No	Hispanic or Latino <input type="radio"/> Yes <input type="radio"/> No	Marital Status: Select One <input type="radio"/> Divorced <input type="radio"/> Married <input type="radio"/> Never Married <input type="radio"/> Separated <input type="radio"/> Widowed		
Race: Select One <input type="radio"/> American Indian/Alaska Native <input type="radio"/> Asian <input type="radio"/> Black/African American <input type="radio"/> White/Caucasian <input type="radio"/> Native Hawaiian/Pacific Islander				

Household Member 2

Legal Name: First, Middle Initial, Last			Relationship	Social Security Number
Date of Birth	Age	Sex	Last Grade Completed - not required for Medicaid or SNAP	
U.S. Citizen <input type="radio"/> Yes <input type="radio"/> No	Hispanic or Latino <input type="radio"/> Yes <input type="radio"/> No	Marital Status: Select One <input type="radio"/> Divorced <input type="radio"/> Married <input type="radio"/> Never Married <input type="radio"/> Separated <input type="radio"/> Widowed		
Race: Select One <input type="radio"/> American Indian/Alaska Native <input type="radio"/> Asian <input type="radio"/> Black/African American <input type="radio"/> White/Caucasian <input type="radio"/> Native Hawaiian/Pacific Islander				

Household Member 3

Legal Name: First, Middle Initial, Last			Relationship	Social Security Number
Date of Birth	Age	Sex	Last Grade Completed - not required for Medicaid or SNAP	
U.S. Citizen <input type="radio"/> Yes <input type="radio"/> No	Hispanic or Latino <input type="radio"/> Yes <input type="radio"/> No	Marital Status: Select One <input type="radio"/> Divorced <input type="radio"/> Married <input type="radio"/> Never Married <input type="radio"/> Separated <input type="radio"/> Widowed		
Race: Select One <input type="radio"/> American Indian/Alaska Native <input type="radio"/> Asian <input type="radio"/> Black/African American <input type="radio"/> White/Caucasian <input type="radio"/> Native Hawaiian/Pacific Islander				

Household Member 4

Legal Name: First, Middle Initial, Last			Relationship	Social Security Number
Date of Birth	Age	Sex	Last Grade Completed - not required for Medicaid or SNAP	
U.S. Citizen <input type="radio"/> Yes <input type="radio"/> No	Hispanic or Latino <input type="radio"/> Yes <input type="radio"/> No	Marital Status: Select One <input type="radio"/> Divorced <input type="radio"/> Married <input type="radio"/> Never Married <input type="radio"/> Separated <input type="radio"/> Widowed		
Race: Select One <input type="radio"/> American Indian/Alaska Native <input type="radio"/> Asian <input type="radio"/> Black/African American <input type="radio"/> White/Caucasian <input type="radio"/> Native Hawaiian/Pacific Islander				

Household Member 5

Legal Name: First, Middle Initial, Last			Relationship	Social Security Number
Date of Birth	Age	Sex	Last Grade Completed - not required for Medicaid or SNAP	
U.S. Citizen <input type="radio"/> Yes <input type="radio"/> No	Hispanic or Latino <input type="radio"/> Yes <input type="radio"/> No	Marital Status: Select One <input type="radio"/> Divorced <input type="radio"/> Married <input type="radio"/> Never Married <input type="radio"/> Separated <input type="radio"/> Widowed		
Race: Select One <input type="radio"/> American Indian/Alaska Native <input type="radio"/> Asian <input type="radio"/> Black/African American <input type="radio"/> White/Caucasian <input type="radio"/> Native Hawaiian/Pacific Islander				

Are you homeless? Required for SNAP only Yes No

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

List Households Members Enrolled in a Federally Recognized Indian Tribe

Member Name	Tribe Name	Tribal Enrollment Number

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

Explain why are they out of the home?	Date Expected to Return
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List household members who are disabled

List anyone in the home that is currently in foster care or has ever been in foster care.
Required for SNAP only.

List anyone in the household that is currently or has every served in any branch of the military.
Required for SNAP only.

List anyone in the home that is living in a domestic violence shelter, fleeing from domestic violence, or needing to keep their identity or location private. Required for SNAP only.

Have household members received, or are they currently receiving assistance in another state? For example: cash, food, or medical assistance.		<input type="radio"/> No <input type="radio"/> Yes
If Yes, When?	Which City, County, and State?	
List household members who are boarders, paying someone to provide meals - Not required for Medicaid		
Have household members received commodities through the Tribal Commodities/Food Distribution Program on Indian Reservation (FDPIR) last month or this month? Not required for Medicaid.		<input type="radio"/> No <input type="radio"/> Yes
If Yes, Who and Which Tribe? Not required for Medicaid		
Have you or any member of your household had a disqualification from the Tribal Commodities/Food Distribution Program on Indian Reservation (FDPIR) Not required for Medicaid		<input type="radio"/> No <input type="radio"/> Yes
If Yes, Who and Which Tribe? Not required for Medicaid		

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
		<input type="radio"/> Full Time <input type="radio"/> Part Time
		<input type="radio"/> Full Time <input type="radio"/> Part Time
		<input type="radio"/> Full Time <input type="radio"/> 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 programs 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?

No Yes-Specify name of cell phone provider:

Would you like to receive e-mail notifications?

No Yes-Specify e-mail address:

Signature - Text and/or e-mail notifications will not be sent without your signature

Date

Help with SNAP and Medicaid?

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

If you are applying for SNAP or Medicaid, 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 Medicaid, 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 these boxes with their information:

Name - First, Middle, Last, Suffix			
Address			Apartment or Unit Number
City	State	ZIP Code	Telephone Number

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

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

Name: First, Middle, Last Name, Suffix			
Address			Apartment or Unit Number
City	State	ZIP Code	Telephone Number

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

Signature	Date
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Help Us Decide if you Can Receive SNAP within Seven Days

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.

Are you a migrant or seasonal farm worker with less than \$100 in liquid resources? <input type="radio"/> No <input type="radio"/> Yes
How much total earned income will your household receive this month before taxes - gross income?
How much total unearned income or other money will your household receive this month?
Approximately how much does your household currently have in liquid assets? This includes cash on hand, checking or savings accounts, savings certificates, and any lump-sum payments such as tax refunds, retroactive Social Security or public assistance payments, or security deposit refunds from rental properties.

How much is your household's monthly rent, lot rent, and/or house payment?
Utilities your household is responsible for: Select all that apply <input type="checkbox"/> Heating <input type="checkbox"/> Cooling <input type="checkbox"/> Electricity <input type="checkbox"/> Telephone <input type="checkbox"/> Water <input type="checkbox"/> Sewer <input type="checkbox"/> Garbage
Has anyone in your household received LIHEAP, fuel assistance, in the past 12 months? <input type="radio"/> No <input type="radio"/> Yes
If Yes, List Household Member Who Received LIHEAP
Do you have a North Dakota Electronic Benefit Transfer (EBT) card for SNAP? <input type="radio"/> No <input type="radio"/> Yes
Do household members purchase and prepare meals separately? <input type="radio"/> No <input type="radio"/> Yes
If Yes, specify which household members purchase and prepare meals separately

Agency Use Only - Expedited Formula

Eligible for expedited service if:

Countable Income is below \$150/Month and \$100 or less in liquid resources.

Examples: Wages, Child Support, SSI, Disability, Retirement, Veterans Benefits, Unemployment, Workers Compensation

SUA - Any of the following: Heating Cooling LIHEAP (Elderly/Disabled)	LUA - Two of the following: Water Electric Sewer Telephone Garbage	MU - One of the following: Water Garbage Sewer Electric TL - Telephone Only
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If not eligible for expedited service, complete table below:

Monthly		
Gross Countable Income	+	Countable Assets
	=	Total Income/Assets
Would be less than:		
Rent/Mortgage	+	Appropriate Utility Standard
	=	Total Shelter Cost

Was the screening for expedited service completed? <input type="radio"/> No <input type="radio"/> Yes	Worker's Initials
Is the household eligible for expedited service? <input type="radio"/> No <input type="radio"/> Yes	
Was the identity of the applicant verified? <input type="radio"/> No <input type="radio"/> Yes	

Agency Use Only

Case Number	Date Requested
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Tell Us About the Income or Money Your Household Receives

Self-Employment

Are any household members self-employed? <input type="radio"/> No <input type="radio"/> Yes - If yes, answer following questions:		
How much net income, profits once business expenses are paid, will you get from this self-employment this month?		
Name of Household Members	Name of Business	
Type of Business		Date Business Started

Employment

Are any household members? <input type="radio"/> No <input type="radio"/> Yes - answer following questions:		
Are any household members employed with a North Dakota licensed child care program? For CCAP Only <input type="radio"/> No <input type="radio"/> Yes		
If yes, answer following questions:		
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 1

Household Member Name		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: Select One <input type="radio"/> Monthly <input type="radio"/> Twice A Month <input type="radio"/> Weekly <input type="radio"/> Every Two Weeks <input type="radio"/> Other-Specify:		
Day Paid: Select One <input type="radio"/> Monday <input type="radio"/> Tuesday <input type="radio"/> Wednesday <input type="radio"/> Thursday <input type="radio"/> Friday <input type="radio"/> Saturday <input type="radio"/> Sunday		

Household Member 2

Household Member Name		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: Select One <input type="radio"/> Monthly <input type="radio"/> Twice A Month <input type="radio"/> Weekly <input type="radio"/> Every Two Weeks <input type="radio"/> Other-Specify:			
Day Paid: Select One <input type="radio"/> Monday <input type="radio"/> Tuesday <input type="radio"/> Wednesday <input type="radio"/> Thursday <input type="radio"/> Friday <input type="radio"/> Saturday <input type="radio"/> Sunday			

Household Member 3

Household Member Name		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: Select One <input type="radio"/> Monthly <input type="radio"/> Twice A Month <input type="radio"/> Weekly <input type="radio"/> Every Two Weeks <input type="radio"/> Other-Specify:			
Day Paid: Select One <input type="radio"/> Monday <input type="radio"/> Tuesday <input type="radio"/> Wednesday <input type="radio"/> Thursday <input type="radio"/> Friday <input type="radio"/> Saturday <input type="radio"/> Sunday			

Household Member 4

Household Member Name		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: Select One <input type="radio"/> Monthly <input type="radio"/> Twice A Month <input type="radio"/> Weekly <input type="radio"/> Every Two Weeks <input type="radio"/> Other-Specify:			
Day Paid: Select One <input type="radio"/> Monday <input type="radio"/> Tuesday <input type="radio"/> Wednesday <input type="radio"/> Thursday <input type="radio"/> Friday <input type="radio"/> Saturday <input type="radio"/> Sunday			

Household Member 5

Household Member Name		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: Select One <input type="radio"/> Monthly <input type="radio"/> Twice A Month <input type="radio"/> Weekly <input type="radio"/> Every Two Weeks <input type="radio"/> Other-Specify:			
Day Paid: Select One <input type="radio"/> Monday <input type="radio"/> Tuesday <input type="radio"/> Wednesday <input type="radio"/> Thursday <input type="radio"/> Friday <input type="radio"/> Saturday <input type="radio"/> Sunday			

Has any household member received commissions, bonuses or incentives other than those described previously within the last year? No Yes - answer the following questions:

Name of Household Member	Date Received	Amount Received
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Are any household members participating in CCAP Workforce?

No Yes - answer the following questions:

Name of Household Member Who Has This Income	Start Date
Provider Name	

Unearned Income or Other Money Received

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

Benefit while on Strike	<input type="radio"/> No <input type="radio"/> Yes	Bingo, Gambling Winnings	<input type="radio"/> No <input type="radio"/> Yes
Contract Sale or Rental Income	<input type="radio"/> No <input type="radio"/> Yes	Income from CRP	<input type="radio"/> No <input type="radio"/> Yes
Income from Roomer, Boarder	<input type="radio"/> No <input type="radio"/> Yes	Income from Tribes	<input type="radio"/> No <input type="radio"/> Yes
Interest, Dividend Income	<input type="radio"/> No <input type="radio"/> Yes	Oil, Mineral Rights, Royalties	<input type="radio"/> No <input type="radio"/> Yes
Pension, Retirement Benefits	<input type="radio"/> No <input type="radio"/> Yes	Railroad Benefits	<input type="radio"/> No <input type="radio"/> Yes
Social Security Benefits	<input type="radio"/> No <input type="radio"/> Yes	Spousal Support	<input type="radio"/> No <input type="radio"/> Yes
Foster Care, Subsidized Adoption Payments		<input type="radio"/> No <input type="radio"/> Yes	
Individual Indian Monies (IIM) - Not required for Medicaid		<input type="radio"/> No <input type="radio"/> Yes	
Unemployment Benefits		<input type="radio"/> No <input type="radio"/> Yes	

The following unearned income list is not required for Medicaid unless over 65 or disabled.

BIA/Tribal General Assistance	<input type="radio"/> No <input type="radio"/> Yes	Child Support	<input type="radio"/> No <input type="radio"/> Yes
Insurance, Lawsuit Settlement	<input type="radio"/> No <input type="radio"/> Yes	Refugee Assistance	<input type="radio"/> No <input type="radio"/> Yes
Supplemental Security Income (SSI)	<input type="radio"/> No <input type="radio"/> Yes	Veteran's, Military Benefits	<input type="radio"/> No <input type="radio"/> Yes
Workers' Compensation	<input type="radio"/> No <input type="radio"/> Yes	Money from Inheritance	<input type="radio"/> No <input type="radio"/> Yes
Money Deposited into a Bank Account from an Individual Outside of Your Household		<input type="radio"/> No <input type="radio"/> Yes	
Money from Friends, Relatives or Others		<input type="radio"/> No <input type="radio"/> Yes	
Temporary Assistance for Needy Families (TANF)		<input type="radio"/> No <input type="radio"/> Yes	

If Other, Specify:

For all income or money received that were selected yes, enter the following information:

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?
 Not required for Medicaid unless over age 65 or disabled.
 No Yes

If yes, explain:

Have household members applied for benefits not yet received such as Social Security, SSI, Worker's Compensation, Unemployment Compensation, Veterans, Military Benefits, etc.?
 No Yes

If yes, explain:

Tell Us About Court Ordered Expenses - Not required for Medicaid

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

If yes, who is ordered to pay insurance?	Who are the payments for?
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Amount Court Ordered	Amount of Court Ordered Expenses Paid
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Tell Us If You Have Child Care Expenses - Not required for Medicaid

Will your household have child care costs this month? No Yes - Select the reason-select one:
 Employment High School GED Education or Training Job Search
 Other-Specify:

Amount of Child Care Expenses

Does anyone help you pay your child care costs? No Yes

If you receive help paying child care costs, answer the following:

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? No Yes

If no, explain

Section 2: Application For Assistance

Complete Section 2 if you are applying for:

- Medicaid

Your Name

Tell Us About Your Household

If you do not want Medicaid for all members of the household, please list members you DO NOT want Health Coverage for:

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

If Yes, Name of Applicant	When were they in foster care?	What State
---------------------------	--------------------------------	------------

Are you a U.S. Citizen or U.S. National? No Yes

Are you a naturalized or derived citizen, this usually means you were born outside the U.S.
 No Yes

If Yes, List Alien Number	If Yes, Certificate Number
---------------------------	----------------------------

If you are not a U.S. citizen or U.S. national, do you have eligible immigration status? No Yes

If yes, answer the following document type and ID number questions. See guidebook for instructions

Immigration Document Type	
Your Name as it Appears on Your Immigration Document	Status Type - Optional
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 Applicant Entered the U.S.:

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

If Yes, Name of Child or Children

Tell Us About Your Household's Federal Tax Filing Information

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

If you plan to file a federal income tax return next year, will you file jointly with a spouse?

No Yes - Name of Spouse: _____

If you plan to file a federal income tax return next year, will you claim any dependents on your tax return?

No Yes

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?

No Yes - Specify Dependents: _____

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? No Yes

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.

Select the following income deductions you claimed on your Federal Income Tax: Select all that apply

- Alimony - **Note:** Only for divorces finalized before 1/1/2019
- 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 expense are paid.

If other deductions is selected, 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? No Yes

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? No Yes

If yes, explain:

Tell Us About Your Health Coverage

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

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

<input type="checkbox"/> Medicaid - Who:	
<input type="checkbox"/> Medicare - Who:	<input type="checkbox"/> Peace Corps - Who:
<input type="checkbox"/> TRICARE-do not check if you have direct care or Line of Duty - Who:	
<input type="checkbox"/> VA Health Care Program - Who:	
Does any household member's employer offer health insurance? <input type="radio"/> No <input type="radio"/> Yes - Complete the 'Health Coverage from Jobs' form, SFN 1618, included in the Application Packet.	

Tell Us if You Receive Help With Your Medical Costs

Does anyone help pay your medical costs?

No Yes - Explain: _____

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

Does anyone in your household require nursing care services?

No 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? Not required unless over age 65 or disabled. <input type="radio"/> No <input type="radio"/> Yes			

Power of Attorney or Family Contact

Specify Type: Select one

Power of Attorney Family Contact Person

First Name	Relationship to Applicant: Example - Family or Friend		
Mailing Address Where You Want Notices Sent	City	State	ZIP Code
Home Telephone Number	Work or Message Number	Cell Phone Number	

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.

Name: First, Middle, Last, Suffix		
Name of Organization	ID Number, if applicable	Application Start Date

Section 3: Application For Assistance

Complete Section 3 if you are applying for any of the following:

- Basic Care Assistance Program (BCAP)
- Medicaid
- Supplemental Nutrition Assistance Program (SNAP)
- Temporary Assistance for Needy Families (TANF)

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 BCAP, SNAP, or TANF, you must complete the Vehicles and Assets questions.

Vehicles

List vehicles such as, cars, trucks, motor home, snowmobile, motorcycle, 3 wheeler, 4 wheeler, boat or other watercraft, camper, trailer. Owned, jointly owned or being purchased for all household members, even if these vehicles are 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
				No	Yes	
				<input type="radio"/>	<input type="radio"/>	
				<input type="radio"/>	<input type="radio"/>	
				<input type="radio"/>	<input type="radio"/>	
				<input type="radio"/>	<input type="radio"/>	
				<input type="radio"/>	<input type="radio"/>	
				<input type="radio"/>	<input type="radio"/>	

Other Assets

Select yes by the assets owned, jointly owned, or being purchased by household members.

Select no, if no such asset

Assets Owned with Another Person	<input type="radio"/> No <input type="radio"/> Yes	Burial Plots	<input type="radio"/> No <input type="radio"/> Yes
Business Accounts	<input type="radio"/> No <input type="radio"/> Yes	Cash on Hand	<input type="radio"/> No <input type="radio"/> Yes
Certificates of Deposit	<input type="radio"/> No <input type="radio"/> Yes	Checking, Credit Union Accounts	<input type="radio"/> No <input type="radio"/> Yes
Income Producing Tools, Equipment	<input type="radio"/> No <input type="radio"/> Yes	Inheritance	<input type="radio"/> No <input type="radio"/> Yes
Life Estate, Life Lease	<input type="radio"/> No <input type="radio"/> Yes	Money Market Account	<input type="radio"/> No <input type="radio"/> Yes
Notes or Contract for Deed	<input type="radio"/> No <input type="radio"/> Yes	Prepaid Funeral Plans	<input type="radio"/> No <input type="radio"/> Yes
Retirement Funds-IRA/KEOGH/401K	<input type="radio"/> No <input type="radio"/> Yes	Savings Bonds	<input type="radio"/> No <input type="radio"/> Yes
Savings, Credit Union Accounts	<input type="radio"/> No <input type="radio"/> Yes	Trusts	<input type="radio"/> No <input type="radio"/> Yes

Annuities No Yes

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.

Burial Space Items - Casket, Vault, or Marker	<input type="radio"/> No <input type="radio"/> Yes
Debit Card Account - Not Checking or Savings	<input type="radio"/> No <input type="radio"/> Yes
Farm Equipment, Livestock, Stored Grain	<input type="radio"/> No <input type="radio"/> Yes
Home, Mobile Home - Not Owner Occupied	<input type="radio"/> No <input type="radio"/> Yes
Home, Mobile Home - Owner Occupied	<input type="radio"/> No <input type="radio"/> Yes
Individual Indian Monies (IIM) - Not required for Medicaid	<input type="radio"/> No <input type="radio"/> Yes
Mineral Rights - Oil, Gas, Gravel, or Coal	<input type="radio"/> No <input type="radio"/> Yes
Real Property - Land, Rental Property, or Buildings	<input type="radio"/> No <input type="radio"/> Yes

If Other, Specify:

For all assets that were selected yes, enter the following information:

Type Of Asset	Land/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? No Yes

If yes, explain:

Transfer of Assets

Have household members sold, given away or transferred anything of value within the past 3 months?
 No Yes

If yes, list items	Date
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Have household members sold, given away or transferred anything of value within the past 5 years?
Does not apply to SNAP No Yes

If yes, list items	Date
--------------------	------

Are any assets subject to a "Transfer of Death"? Does not apply to SNAP No Yes

If Yes, Describe Property

Approximate Value of Property

Section 4: Application For Assistance

Complete Section 4 if you are applying for any of the following:

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

Tell Us the Value of Your Housing Expenses

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

Air Conditioning or Central Air	<input type="radio"/> No	<input type="radio"/> Yes	Condo Fees	<input type="radio"/> No	<input type="radio"/> Yes
Electricity	<input type="radio"/> No	<input type="radio"/> Yes	Garbage	<input type="radio"/> No	<input type="radio"/> Yes
Heating - Gas, Propane, Electric	<input type="radio"/> No	<input type="radio"/> Yes	House Payment - Mortgage	<input type="radio"/> No	<input type="radio"/> Yes
Lot Rent	<input type="radio"/> No	<input type="radio"/> Yes	Rent	<input type="radio"/> No	<input type="radio"/> Yes
Telephone, Cell Phone	<input type="radio"/> No	<input type="radio"/> Yes	Use of a Garage	<input type="radio"/> No	<input type="radio"/> Yes
Homeowners Insurance - not in house payment	<input type="radio"/> No <input type="radio"/> Yes				
Property Taxes - not in house payment	<input type="radio"/> No <input type="radio"/> Yes				
Sewer or Septic Tank Installation or Maintenance	<input type="radio"/> No <input type="radio"/> Yes				
Water or Well Installation or Maintenance	<input type="radio"/> No <input type="radio"/> Yes				

For all items selected yes, enter the following information:

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

Do household members work off part of an expense such as rent, lot rent, utilities, or similar costs?
 No Yes

If Yes, List the Expense	If Yes, List Expense Amount Worked Off
--------------------------	--

Do household members receive heating assistance, LIHEAP? No Yes

Do household members plan to apply for heating assistance, LIHEAP? No Yes

Do you expect changes in expenses such as rent, lot rent, utilities, or similar costs next month?
 No Yes-Explain: _____

Does anyone help you pay these expenses such as government agency, family member, or others?
 No Yes

If yes, complete the following questions:

Name of Person that Pays the Expense	List the Expense	Total Expenses Paid
--------------------------------------	------------------	---------------------

Agency Use Only

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

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. No Yes

If Yes, Name of Household Member	
Health Insurance Amount Paid by Member	Medical Expense Amount Paid by Member

Does anyone help you pay these expenses?
 No Yes-Explain: _____

Do household members pay adult dependent care? No Yes

Do household members pay representative payee fees? No Yes

Do you expect changes in expenses next month?
 No 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: Select one
 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
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Household Members who Refused Their Work Hours Within the Last 30 Days

Date Refused	Reason Refused
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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?	<input type="radio"/> No <input type="radio"/> Yes
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?	<input type="radio"/> No <input type="radio"/> Yes
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.	<input type="radio"/> No <input type="radio"/> Yes
Are you or any member of your household violating a condition of parole or probation?	<input type="radio"/> No <input type="radio"/> Yes
Have you or any member of your household been convicted of buying or selling SNAP benefits over \$500 after September 22, 1996?	<input type="radio"/> No <input type="radio"/> Yes
Have you or any member of your household been convicted of trading SNAP benefits for guns, ammunitions, or explosives after September 22, 1996?	<input type="radio"/> No <input type="radio"/> Yes
Have you or any member of your household been convicted of trading SNAP benefits for drugs after September 22, 1996?	<input type="radio"/> No <input type="radio"/> Yes
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?	<input type="radio"/> No <input type="radio"/> Yes

Section 5: Application For Assistance

Complete Section 5 if you are applying for any of the following:

- **Basic Care Assistance Program (BCAP)**
- **Medicaid**
- **Temporary Assistance for Needy Families (TANF)**

Tell Us About Your Household

I/We have lived in North Dakota since this month, day, and year

Do you intend to remain in North Dakota? No Yes

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 - Not needed to Determine Medicaid Eligibility

Name of Each Household Member Who is Pregnant

How many babies are due?	What are the babies due dates?
--------------------------	--------------------------------

Name of Father of the Unborn Baby - Not Needed to Determine Medicaid Eligibility

How was pregnancy determined? Select one - Not needed to determine Medicaid eligibility

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

Do you pay for guardianship or conservator services? Not needed to determine Medicaid eligibility

- No Yes

Tell Us About Parents Not Living in the Home

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

Child 1

Name of Child Whose Parent is Not Living in the Home			
Name of Mother Who is Not Living in the Home	Mother's Date of Birth-Not needed for Medicaid		
Mother's Social Security Number-Not needed for Medicaid			
Reason Mother is Not Living in the Home: Select all that apply - Not needed for Medicaid			
<input type="checkbox"/> Abandoned	<input type="checkbox"/> Attending School	<input type="checkbox"/> Deceased	<input type="checkbox"/> Divorced
<input type="checkbox"/> Jail/Prison	<input type="checkbox"/> Legally Annulled	<input type="checkbox"/> Looking for Work	<input type="checkbox"/> Medical Care
<input type="checkbox"/> Military Service	<input type="checkbox"/> Never Married	<input type="checkbox"/> Parental Rights Terminated	<input type="checkbox"/> Separated
<input type="checkbox"/> Working Out of Town or State			
Name of Father Who is Not Living in the Home	Father's Date of Birth-Not needed for Medicaid		
Father's Social Security Number-Not needed for Medicaid			
Reason Father is Not Living in the Home: Select all that apply - Not needed for Medicaid			
<input type="checkbox"/> Abandoned	<input type="checkbox"/> Attending School	<input type="checkbox"/> Deceased	<input type="checkbox"/> Divorced
<input type="checkbox"/> Jail/Prison	<input type="checkbox"/> Legally Annulled	<input type="checkbox"/> Looking for Work	<input type="checkbox"/> Medical Care
<input type="checkbox"/> Military Service	<input type="checkbox"/> Never Married	<input type="checkbox"/> Parental Rights Terminated	<input type="checkbox"/> Separated
<input type="checkbox"/> Working Out of Town or State			

Child 2

Name of Child Whose Parent is Not Living in the Home			
Name of Mother Who is Not Living in the Home	Mother's Date of Birth-Not needed for Medicaid		
Mother's Social Security Number-Not needed for Medicaid			
Reason Mother is Not Living in the Home: Select all that apply - Not needed for Medicaid			
<input type="checkbox"/> Abandoned	<input type="checkbox"/> Attending School	<input type="checkbox"/> Deceased	<input type="checkbox"/> Divorced
<input type="checkbox"/> Jail/Prison	<input type="checkbox"/> Legally Annulled	<input type="checkbox"/> Looking for Work	<input type="checkbox"/> Medical Care
<input type="checkbox"/> Military Service	<input type="checkbox"/> Never Married	<input type="checkbox"/> Parental Rights Terminated	<input type="checkbox"/> Separated
<input type="checkbox"/> Working Out of Town or State			
Name of Father Who is Not Living in the Home	Father's Date of Birth-Not needed for Medicaid		
Father's Social Security Number-Not needed for Medicaid			
Reason Father is Not Living in the Home: Select all that apply - Not needed for Medicaid			
<input type="checkbox"/> Abandoned	<input type="checkbox"/> Attending School	<input type="checkbox"/> Deceased	<input type="checkbox"/> Divorced
<input type="checkbox"/> Jail/Prison	<input type="checkbox"/> Legally Annulled	<input type="checkbox"/> Looking for Work	<input type="checkbox"/> Medical Care
<input type="checkbox"/> Military Service	<input type="checkbox"/> Never Married	<input type="checkbox"/> Parental Rights Terminated	<input type="checkbox"/> Separated
<input type="checkbox"/> Working Out of Town or State			

Child 3

Name of Child Whose Parent is Not Living in the Home			
Name of Mother Who is Not Living in the Home	Mother's Date of Birth-Not needed for Medicaid		
Mother's Social Security Number-Not needed for Medicaid			
Reason Mother is Not Living in the Home: Select all that apply - Not needed for Medicaid			
<input type="checkbox"/> Abandoned	<input type="checkbox"/> Attending School	<input type="checkbox"/> Deceased	<input type="checkbox"/> Divorced
<input type="checkbox"/> Jail/Prison	<input type="checkbox"/> Legally Annulled	<input type="checkbox"/> Looking for Work	<input type="checkbox"/> Medical Care
<input type="checkbox"/> Military Service	<input type="checkbox"/> Never Married	<input type="checkbox"/> Parental Rights Terminated	<input type="checkbox"/> Separated
<input type="checkbox"/> Working Out of Town or State			
Name of Father Who is Not Living in the Home	Father's Date of Birth-Not needed for Medicaid		
Father's Social Security Number-Not needed for Medicaid			
Reason Father is Not Living in the Home: Select all that apply - Not needed for Medicaid			
<input type="checkbox"/> Abandoned	<input type="checkbox"/> Attending School	<input type="checkbox"/> Deceased	<input type="checkbox"/> Divorced
<input type="checkbox"/> Jail/Prison	<input type="checkbox"/> Legally Annulled	<input type="checkbox"/> Looking for Work	<input type="checkbox"/> Medical Care
<input type="checkbox"/> Military Service	<input type="checkbox"/> Never Married	<input type="checkbox"/> Parental Rights Terminated	<input type="checkbox"/> Separated
<input type="checkbox"/> Working Out of Town or State			

Child 4

Name of Child Whose Parent is Not Living in the Home			
Name of Mother Who is Not Living in the Home	Mother's Date of Birth-Not needed for Medicaid		
Mother's Social Security Number-Not needed for Medicaid			
Reason Mother is Not Living in the Home: Select all that apply - Not needed for Medicaid			
<input type="checkbox"/> Abandoned	<input type="checkbox"/> Attending School	<input type="checkbox"/> Deceased	<input type="checkbox"/> Divorced
<input type="checkbox"/> Jail/Prison	<input type="checkbox"/> Legally Annulled	<input type="checkbox"/> Looking for Work	<input type="checkbox"/> Medical Care
<input type="checkbox"/> Military Service	<input type="checkbox"/> Never Married	<input type="checkbox"/> Parental Rights Terminated	<input type="checkbox"/> Separated
<input type="checkbox"/> Working Out of Town or State			
Name of Father Who is Not Living in the Home	Father's Date of Birth-Not needed for Medicaid		
Father's Social Security Number-Not needed for Medicaid			
Reason Father is Not Living in the Home: Select all that apply - Not needed for Medicaid			
<input type="checkbox"/> Abandoned	<input type="checkbox"/> Attending School	<input type="checkbox"/> Deceased	<input type="checkbox"/> Divorced
<input type="checkbox"/> Jail/Prison	<input type="checkbox"/> Legally Annulled	<input type="checkbox"/> Looking for Work	<input type="checkbox"/> Medical Care
<input type="checkbox"/> Military Service	<input type="checkbox"/> Never Married	<input type="checkbox"/> Parental Rights Terminated	<input type="checkbox"/> Separated
<input type="checkbox"/> Working Out of Town or State			

Tell Us About Your Life Insurance Not required for Medicaid unless over age 65 or disabled

Does any household member have life insurance? No Yes

Designated irrevocable itemized burial fund? No Yes - If Yes Complete the following table:

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.

Household Member 1

Name of Person Covered		Policyholder Name		
Policyholder Address		City	State	ZIP Code
Name of Health Insurance Company			Telephone Number	
Health Insurance Address		City	State	ZIP Code
Effective Date	Policy Number	Group Number	Monthly Premium	

Type of Coverage: Select all that apply

<input type="checkbox"/> Hospital	<input type="checkbox"/> Doctor	<input type="checkbox"/> Major Medical/Lab/X-Ray	<input type="checkbox"/> Dental
<input type="checkbox"/> Vision	<input type="checkbox"/> Nursing Home	<input type="checkbox"/> Cancer	<input type="checkbox"/> Champus/Tricare
<input type="checkbox"/> HMO Insurance	<input type="checkbox"/> Court Ordered	<input type="checkbox"/> Medicare Part A	<input type="checkbox"/> Medicare Part B
<input type="checkbox"/> Medicare Supplement/Advantage		<input type="checkbox"/> Prescription Drug Insurance	<input type="checkbox"/> Medicare Part D
<input type="checkbox"/> Workers Compensation or Accident		<input type="checkbox"/> Veterans Administration	

Household Member 2

Name of Person Covered		Policyholder Name	
Policyholder Address		City	State ZIP Code
Name of Health Insurance Company			Telephone Number
Health Insurance Address		City	State ZIP Code
Effective Date	Policy Number	Group Number	Monthly Premium
Type of Coverage: Select all that apply <input type="checkbox"/> Hospital <input type="checkbox"/> Doctor <input type="checkbox"/> Major Medical/Lab/X-Ray <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Nursing Home <input type="checkbox"/> Cancer <input type="checkbox"/> Champus/Tricare <input type="checkbox"/> HMO Insurance <input type="checkbox"/> Court Ordered <input type="checkbox"/> Medicare Part A <input type="checkbox"/> Medicare Part B <input type="checkbox"/> Medicare Supplement/Advantage <input type="checkbox"/> Prescription Drug Insurance <input type="checkbox"/> Medicare Part D <input type="checkbox"/> Workers Compensation or Accident <input type="checkbox"/> Veterans Administration			

Household Member 3

Name of Person Covered		Policyholder Name	
Policyholder Address		City	State ZIP Code
Name of Health Insurance Company			Telephone Number
Health Insurance Address		City	State ZIP Code
Effective Date	Policy Number	Group Number	Monthly Premium
Type of Coverage: Select all that apply <input type="checkbox"/> Hospital <input type="checkbox"/> Doctor <input type="checkbox"/> Major Medical/Lab/X-Ray <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Nursing Home <input type="checkbox"/> Cancer <input type="checkbox"/> Champus/Tricare <input type="checkbox"/> HMO Insurance <input type="checkbox"/> Court Ordered <input type="checkbox"/> Medicare Part A <input type="checkbox"/> Medicare Part B <input type="checkbox"/> Medicare Supplement/Advantage <input type="checkbox"/> Prescription Drug Insurance <input type="checkbox"/> Medicare Part D <input type="checkbox"/> Workers Compensation or Accident <input type="checkbox"/> Veterans Administration			

Are any of the policies selected COBRA coverage? <input type="radio"/> No <input type="radio"/> Yes - Name of Health Insurance: _____	
Date COBRA Coverage Began	Date or Expected Date COBRA Coverage Will End
Are any of the policies listed a retiree health plan? <input type="radio"/> No <input type="radio"/> Yes - Name of Health Insurance: _____	
Are any of the policies listed a limited-benefit plan like a school accident policy? <input type="radio"/> No <input type="radio"/> Yes - Name of Health Insurance: _____	
Are any of the policies a state employee benefit plan? <input type="radio"/> No <input type="radio"/> Yes	
Does anyone outside the household pay the premium? <input type="radio"/> No <input type="radio"/> Yes - Who? _____	
Do household members expect changes in health insurance coverage? <input type="radio"/> No <input type="radio"/> Yes - Who? _____	
Did anyone in your household have health insurance canceled or stopped within the last 3 months? <input type="radio"/> No <input type="radio"/> Yes - answer following questions:	
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 such as nursing care, basic care, or assisted living? This information may allow you to protect additional assets. <input type="radio"/> No <input type="radio"/> Yes	
If yes, who?	How much has the policy paid in benefits?

Tell Us Where You Got This Application - optional		
Where did you get this Medicaid application? Select one		
<input type="radio"/> 1-877-KIDS-NOW	<input type="radio"/> Capitol in Bismarck	<input type="radio"/> Community Resource Coordinator
<input type="radio"/> Daycare	<input type="radio"/> Faith-Based Organization	<input type="radio"/> Food Pantry
<input type="radio"/> Friend/Relative	<input type="radio"/> Head Start	<input type="radio"/> Human Service Agency
<input type="radio"/> Insurance Agent	<input type="radio"/> Internet	<input type="radio"/> Medical Provider
<input type="radio"/> Pharmacy	<input type="radio"/> Public Health Agency	<input type="radio"/> School
<input type="radio"/> WIC	<input type="radio"/> Other	

Tell Us How Or Where You Found Out About Medicaid - optional

How did you find out about Medicaid in North Dakota? Select one

- | | | |
|--|--|---|
| <input type="radio"/> Business/Service Club | <input type="radio"/> Capitol in Bismarck | <input type="radio"/> Daycare |
| <input type="radio"/> Faith-Based Organization | <input type="radio"/> Food Pantry | <input type="radio"/> Friend/Relative |
| <input type="radio"/> Head Start | <input type="radio"/> Human Service Agency | <input type="radio"/> Insurance Agent |
| <input type="radio"/> Internet | <input type="radio"/> Medical Provider | <input type="radio"/> Newspaper/Magazine/Newsletter |
| <input type="radio"/> Pharmacy | <input type="radio"/> Public Health Agency | <input type="radio"/> School |
| <input type="radio"/> Television | <input type="radio"/> WIC | <input type="radio"/> 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 for 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? No Yes

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.

Section 6: Application For Assistance

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?	<input type="radio"/> No <input type="radio"/> Yes

*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?	<input type="radio"/> No <input type="radio"/> Yes
Is a parent or caretaker currently a member of the National Guard or a military unit?	<input type="radio"/> No <input type="radio"/> Yes

Tell Us About Your Child Care Needs

Does your household need assistance with child care costs for last month?	<input type="radio"/> No <input type="radio"/> Yes
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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: Select all that apply	
<input type="checkbox"/> Employment	<input type="checkbox"/> High School/GED
<input type="checkbox"/> Postsecondary Education	<input type="checkbox"/> Training
<input type="checkbox"/> Other - Specify: _____	

Provide a schedule of when you participate in each activity

Complete a schedule for each child needing care for this activity.

If child goes to more than one provider during this activity, complete a separate activity schedule for each provider.

Activity Schedule 1

Name of Child Needing Care	Does this child attend preschool, Head Start, or elementary school? <input type="radio"/> No <input type="radio"/> Yes
Name of School the Child Attends	Grade Child is In
Time School Day Starts	Time School Day Ends
Time Child is Dropped Off at Provider	Time Child is Picked Up from Provider
Child Care Provider Name	Child Care Provider Number

Provide a copy of the child's school year schedule.

Activity Schedule 2

Name of Child Needing Care	Does this child attend preschool, Head Start, or elementary school? <input type="radio"/> No <input type="radio"/> Yes
Name of School the Child Attends	Grade Child is In
Time School Day Starts	Time School Day Ends
Time Child is Dropped Off at Provider	Time Child is Picked Up from Provider
Child Care Provider Name	Child Care Provider Number

Provide a copy of the child's school year schedule.

Activity Schedule 3

Name of Child Needing Care	Does this child attend preschool, Head Start, or elementary school? <input type="radio"/> No <input type="radio"/> Yes
Name of School the Child Attends	Grade Child is In
Time School Day Starts	Time School Day Ends
Time Child is Dropped Off at Provider	Time Child is Picked Up from Provider
Child Care Provider Name	Child Care Provider Number

Provide a copy of the child's school year schedule.

Activity Schedule 4

Name of Child Needing Care	Does this child attend preschool, Head Start, or elementary school? <input type="radio"/> No <input type="radio"/> Yes
Name of School the Child Attends	Grade Child is In
Time School Day Starts	Time School Day Ends
Time Child is Dropped Off at Provider	Time Child is Picked Up from Provider
Child Care Provider Name	Child Care Provider Number

Provide a copy of the child's school year schedule.

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: Select all that apply <input type="checkbox"/> Employment <input type="checkbox"/> High School/GED <input type="checkbox"/> Postsecondary Education <input type="checkbox"/> Training <input type="checkbox"/> Other - Specify: _____

Provide a schedule of when you participate in each activity

Complete a schedule for each child needing care for this activity.

If child goes to more than one provider during this activity, complete a separate activity schedule for each provider.

Activity Schedule 1

Name of Child Needing Care	Does this child attend preschool, Head Start, or elementary school? <input type="radio"/> No <input type="radio"/> Yes
Name of School the Child Attends	Grade Child is In
Time School Day Starts	Time School Day Ends
Time Child is Dropped Off at Provider	Time Child is Picked Up from Provider
Child Care Provider Name	Child Care Provider Number

Provide a copy of the child's school year schedule.

Activity Schedule 2

Name of Child Needing Care	Does this child attend preschool, Head Start, or elementary school? <input type="radio"/> No <input type="radio"/> Yes
Name of School the Child Attends	Grade Child is In
Time School Day Starts	Time School Day Ends
Time Child is Dropped Off at Provider	Time Child is Picked Up from Provider
Child Care Provider Name	Child Care Provider Number

Provide a copy of the child's school year schedule.

Activity Schedule 3

Name of Child Needing Care	Does this child attend preschool, Head Start, or elementary school? <input type="radio"/> No <input type="radio"/> Yes
Name of School the Child Attends	Grade Child is In
Time School Day Starts	Time School Day Ends
Time Child is Dropped Off at Provider	Time Child is Picked Up from Provider
Child Care Provider Name	Child Care Provider Number

Provide a copy of the child's school year schedule.

Activity Schedule 4

Name of Child Needing Care	Does this child attend preschool, Head Start, or elementary school? <input type="radio"/> No <input type="radio"/> Yes
Name of School the Child Attends	Grade Child is In
Time School Day Starts	Time School Day Ends
Time Child is Dropped Off at Provider	Time Child is Picked Up from Provider
Child Care Provider Name	Child Care Provider Number

Provide a copy of the child's school year schedule.

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 level completed? Select one <input type="radio"/> None <input type="radio"/> High School <input type="radio"/> Certificate <input type="radio"/> Associates Degree <input type="radio"/> Bachelor's Degree <input type="radio"/> Masters's Degree		Date Completed
If there is a second parent or caretaker in your household, what is their highest education level completed? Select one <input type="radio"/> None <input type="radio"/> High School <input type="radio"/> Certificate <input type="radio"/> Associates Degree <input type="radio"/> Bachelor's Degree <input type="radio"/> Masters's Degree		Date Completed

Section 7: Application For Assistance

Complete Section 7 if you are applying for any of the following:

- Basic Care Assistance Program (BCAP)
- Child Care Assistance Program (CCAP)
- Medicaid
- 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.

N.D. HHS NONDISCRIMINATION STATEMENT

In accordance with federal and state law, HHS is prohibited from discriminating on the basis of race, color, sex, age, disability, national origin, religion, or status with respect to marriage or public assistance. In accordance with the U.S. Department of Agriculture (U.S.D.A.), HHS is also prohibited from discriminating against family/parental status political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by the U.S.D.A. These laws must be followed by anyone who contracts with or receives funds to provide services for HHS, including the state's eight regional Human Service Centers, the State Hospital, the Life Skills and Transition Center, and Human Service Zone offices. <https://www.hhs.nd.gov/nondiscrimination-policy>

U.S.D.A. F.N.S. Nondiscrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (U.S.D.A.) civil rights regulations and policies, the U.S.D.A., its Agencies, offices, employees, and institutions participating in or administering U.S.D.A. programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by U.S.D.A., not all bases apply to all programs. Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information. For example: Braille, large print, audiotape, American Sign Language, and others, should contact the State or local Agency that administers the program or contact U.S.D.A. through the Telecommunications Relay Service at 711, voice and TTY. Additionally, program information may be made available in languages other than English.

U.S.D.A. is an equal opportunity provider, employer, and lender.

F.N.S.: <https://www.fns.usda.gov/civil-rights/nds>

U.S. HHS NONDISCRIMINATION STATEMENT

The U.S. Department of Health and Human Services (HHS) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, religion, or sex. HHS does not exclude people or treat them differently because of race, color, national origin, age, disability, religion, or sex.

HHS:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats large print, audio, accessible electronic formats, other formats

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact HHS at 1-877-696-6775.

<https://www.hhs.gov/civil-rights/for-individuals/nondiscrimination/index.html>

To file a program discrimination complaint: Complete a Civil Rights Complaint Form or write a letter and provide the following information:

- Name
- Address
- Program Name
- Details of complaint including date it occurred

N.D. HHS SFN 143 Civil Rights Complaint Form is available online at:

<https://www.hhs.nd.gov/nondiscrimination-policy>

To request a copy of the complaint form, call (701) 328-2311 or (800) 472-2622; TTY 711.

U.S.D.A./F.N.S. Civil Rights Complaint Form (AD-3027) is available online at:

<https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint>

To request a copy of the complaint form, call (866) 632-9992; TDD 202-260-1026

U.S. HHS Civil Rights Complaint Form (HHS-700) is available online at:

<https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

To request a copy of the complaint form, call (800) 368-1019; TDD (800) 537-7697

Where do I file a complaint? Forms or written letters may be submitted by mail, fax, email or online portal if available to the following offices:

NORTH DAKOTA HHS

Legal Division Department of Health and Human Services 600 E. Boulevard Ave - Dept 325 Bismarck ND 58505-0250	FAX: (701) 328-2173 Email: dhslau@nd.gov
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U.S.D.A.

U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Mail Stop 9410 Washington, D.C. 20250-9410	FAX: (833) 256-1665 or (202) 690-7442 Email: program.intake@usda.gov
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Online Portal: <https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint>

U.S.D.A. F.N.S.

U.S.D.A Food and Nutrition Service 1320 Braddock Place Room 334 Alexandria VA 22314	FAX: (833) 256-1665 or (202) 690-7442 Email: fncivilrightscomplaints@usda.gov
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Online Portal: <https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint>

U.S. HHS

Central Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

FAX: (202) 619-3818
Email: OCRMail@hhs.gov

Online Portal: <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>

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 or more hours per 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 HHS to make claims against the estate of a deceased Medicaid member:

1. Who was age 55 or older when the individual received Medicaid services; or
2. Who was permanently institutionalized regardless of age and received a Notice of Permanent Institutionalization; or
3. Upon the death of the surviving spouse of the Medicaid member.

Effective January 1, 2010, payments made for Medicare cost sharing after January 1, 2010, are exempt from Medicaid estate recovery. 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, payments made to a private insurance carrier are exempt from Medicaid estate recovery. Effective January 1, 2020, pharmacy services provided through Medicaid Expansion are subject to Medicaid estate recovery.

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

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>