RESET FIELDS

Pennsylvania
Department of Human Services

Benefits Review

This is an application for cash, health care and the Supplemental Nutrition Assistance Program (SNAP) benefits. If you need this application in another language or someone to interpret, please contact your local county assistance office. Language assistance will be provided free of charge.

Esta es una solicitud de beneficios en efectivo, beneficios de atención médica y del Programa de Asistencia Nutricional Suplementaria (SNAP). Si necesita esta solicitud en otro idioma o un intérprete, comuníquese con la oficina de asistencia de su condado. La asistencia lingüística se proporcionará de forma gratuita.

Đây là đơn xin hưởng các khoản tiền phúc lợi, bảo hiểm y tế và Chương Trình Trợ Cấp Dinh Dưỡng Bổ Sung (SNAP). Nếu bạn cần đơn này bằng ngôn ngữ khác hay cần thông dịch viên thì vui lòng liên hệ với văn phòng hỗ trợ quận tại địa phương mình. Hỗ trợ ngôn ngữ sẽ được cung cấp miễn phí.

此为现金、医疗和补充营养援助计划 (SNAP) 福利申请表。如需其他语言版本或口头翻译，请联系当地的县援助办公室。免费获取语言协助。

В этом приложении будут содержаться данные о ваших денежных пособиях, льготах по медицинскому обслуживанию и пособиях по программе «Программа дополнительной продовольственной помощи» (SNAP). Если вы хотите переключить язык приложения или вам требуются услуги перевода, обратитесь в окружное отделение социальной помощи по месту жительства. Языковые услуги предоставляются бесплатно.

នេះគឺជាពាក្យស្នើសុំប្រាក់ ទំហែទាំសុខភាព និងអត្ថប្រយោជន៍កម្មវិធីជំនួយអាហាររូបត្ថម្ភបន្ថែម (SNAP) ។ប្រសិនបើអ្នកត្រូវការជាកុពាក្យសុំជាភាសាផ្សេង ឬត្រូវការអ្នកបកប្រែ សូមទាក់ទងការិយាល័យជំនួយខោនធរបស់អ្នក។ អ្នកនឹងទទួលបានជំនួយបកប្រែភាសាដោយឥតគិតថ្លៃ។

هذا تطبيق مخصص للمستحقات النقدية، الرعاية الصحية وميزات برنامج مساعدات التغذية التكميلية (SNAP). إذا كنت تريد تصفح هذا التطبيق بلغة أخرى أو كنت تريد مترجماً فوريًا، فالرجاء الاتصال بمكتب المساعدة المحلي التابع للمقاطعة الخاصة بك، وسيتم توفير المساعدة اللغوية مجانًا.

COMPASS
CLICK. APPLY. BENEFIT.

You can renew online at: **www.compass.state.pa.us**

If you have a disability and need this form in large print or another format, please call our **helpline** at **1-800-692-7462**. Individuals who are deaf, hard of hearing, or have speech disabilities and wish to communicate with the helpline may call PA Relay Services by dialing **711**.

Family Safety: Information about Domestic Violence, Sexual Assault and your TANF benefits.

It can be very difficult to acknowledge that you yourself, or someone you are close to, is experiencing relationship or family violence.

Domestic violence is a pattern of abusive behavior in any relationship that is used by one person to gain or maintain power and control over another in an intimate or family relationship. It can be physical, sexual, emotional, or psychological. It involves behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame, hurt, injure, or wound someone. It can also involve controlling and limiting access to finances or social media.

Examples of abusive behavior include but are not limited to:

- physical abuse
- emotional abuse
- psychological abuse
- sexual abuse
- sexual assault
- sexual harassment
- stalking
- financial abuse
- technological abuse

If you are or have been a victim of domestic violence, sexual harassment, sexual abuse, sexual assault or stalking and are at risk of further violence, harassment, abuse, assault, or stalking, your caseworker can excuse you from program requirements for cash assistance. Sometimes individuals cannot safely follow cash assistance requirements because they fear that they or their children will be abused if they do so.

These program requirements include:

- Child or spousal support cooperation
- Work participation (RESET)
- Verification requirements
- Time limits
- Requirements that teen parents live at home
- Other requirements on a case-by-case basis

If you need to be excused from cash assistance requirements because of domestic violence, tell your caseworker.

Your caseworker can:

- **Talk** to you if you want to talk. You can ask to talk in private. Your caseworker and the staff will keep your personal information confidential.
- **Help** you find local programs where you can get counseling, safety planning, shelter, legal services, and other help.
- **Help** you understand the rules when applying for cash assistance, and how they affect you if you apply.

The Pennsylvania Coalition Against Domestic Violence (PCADV), https://www.pcadv.org
1-800-932-4632 (in PA) 303-839-1852 (National)

Sexual assault, sexual violence or sexual harassment is not limited to an intimate relationship. It can occur in the workplace, educational environment, or the general public by a stranger. For information about sexual assault and sexual violence contact:

The Pennsylvania Coalition to Advance Respect (PCAR), https://pcar.org
1-888-772-7227 (in PA)

PA CareerLink® - Important Information

PA CareerLink® is a program of the Pennsylvania Department of Labor and Industry to help job seekers find jobs. The Labor and Industry staff knows about current labor market conditions and can give you information and resources to help your job search.

It is recommended that you register with PA CareerLink® to get started. You can register with PA CareerLink® at **www.pacareerlink.pa.gov/**.

Benefits Review: We must review your eligibility for cash, health care and/or Supplemental Nutrition Assistance Program (SNAP) benefits.

Go paperless! Would you like to receive your notices online?
Go to **www.compass.state.pa.us** and enroll on your MyCOMPASS account.

PLEASE PRINT ALL INFORMATION

Important notice to recipient: We need to gather information about you.

1. Please print clearly. Try to complete as much information as possible. The information requested on this form is needed to determine your continued eligibility.
2. **Please review any information printed on this form. If any pre-printed information is incorrect or has changed, strike out the printed information and provide updated information. Please review all questions that do not have a printed response and provide a response unless the instructions tell you that you can choose not to answer.**
3. If you need help, another person can help you, you can get help from your county assistance office or you can call the Customer Service Center at 1-877-395-8930. TTY/TDD users should call 711.
4. **Sign and date the Benefits Review form on page 1 and on Understanding Your Rights and Responsibilities.**
5. Bring it to the county assistance office on the date and time for your scheduled interview. If you are to have a telephone interview, or if you are not required to have an interview, mail the form with any verification requested to your caseworker.
6. You can reapply online at: **www.compass.state.pa.us**.

What language do you prefer? ¿Qué idioma prefiere usted? ☐ English/Inglés ☐ Spanish/Español ☐ Other/Otro (specify/especifique) _____

Do you need an interpreter? ¿Necesita un intérprete? ☐ Yes/Sí ☐ No

If yes, what language? En caso afirmativo, ¿de qué idioma? _____

Your Information

Tell us about yourself: We need to gather some information about you. **Please review any information printed below. If this information is incorrect, please strike it out and write in the correct information**

Name (include first, middle initial, last, suffix-Jr./Sr./etc.):		
Home address (include street, apt. number, city, state & ZIP code + 4):		
Telephone number:	School district:	Township/subdivision/municipality:

Sign Here

When you sign your name it means that you are applying for benefits. It also means that you give your permission to the county assistance office to use the information on this application to decide if you qualify for these benefits.

X _____ _____

Your signature or your representative's signature — Date

Please check the box below if you do not already have health care benefits and would like to apply for health care coverage for you and your household members:

☐ **Yes, I would like to apply for health care coverage.**

If you checked yes, please list the household members you would like to apply for, including yourself:

DO NOT COMPLETE – COUNTY ASSISTANCE OFFICE ONLY

WORKER ID	CSLD	RECORD NUMBER	CAT	NAME	APPT DATE/TIME	AM ☐ PM ☐

AUTHORIZED	NOT AUTHORIZED

Are you interested in any other services?

Put a check in the box if you are interested in any of these other services:

- ☐ Supplemental Security Income (SSI)
- ☐ Immunizations (shots)
- ☐ WIC (Women, Infants and Children)
- ☐ Child care
- ☐ Long-term care (nursing home care)
- ☐ Family planning/birth control
- ☐ Home and community based services (waiver services)
- ☐ Other: _____
- ☐ Well Baby Clinic
- ☐ LIHEAP (Energy assistance)
- ☐ Food banks
- ☐ Lifeline (reduced cost phone service)
- ☐ Child support services
- ☐ Employment and training
- ☐ Special allowances for employment and training (such as tools)
- ☐ Intellectual Disability services
- ☐ Veterans' services
- ☐ School meals (free or reduced cost)
- ☐ Housing assistance
- ☐ Head Start (for children ages 3-6)
- ☐ Vocational rehabilitation

Tell Us About People In Your Home:

We need to gather information about everyone who lives at your address, even if they are not applying for benefits.

For health care applicants, be sure to include anyone on your federal income tax return, even if they do not live with you. **Note:** You do not need to file a tax return to get benefits. **Please review any information printed below. If this information is incorrect, please strike it out and write in the correct information.**

Person 1

Name (include first, middle initial, last, suffix-Jr./Sr./etc.):		Are you applying for yourself? ☐ Yes ☐ No	Social Security number:
Birthdate (MM/DD/YYYY):	Sex: ☐ M ☐ F	Do you have a PA Access/EBT card? ☐ Yes ☐ No	
Are you in school? ☐ Yes ☐ No	**If yes,** what grade?	Name of school:	Full-time student? ☐ Yes ☐ No

Answer the questions below if you are applying for yourself. You do not need to answer these questions if you are applying only for SNAP.

☐ Yes ☐ No ▶ If you are not eligible for full Medical Assistance coverage, do you want to be reviewed for coverage for the Family Planning Services program only?

☐ Yes ☐ No ▶ If you are under 21, we will consider only your income in our determination for the Family Planning Services program. If you wish to be reviewed for full Medical Assistance coverage, we will need to evaluate your household income, including your parent(s)' income. Do you want to be reviewed only for the Family Planning Services program and NOT for full Medical Assistance coverage?

☐ Yes ☐ No ▶ Regardless of age, are you afraid that information you may receive where you live about family planning services could cause physical, emotional, or other harm from your spouse, parents, or other person? **If yes,** do you have another address (other than where you live) where you'd like to get information about family planning services?

Are you a U.S. citizen or national? ☐ Yes ☐ No

If you are not a U.S. citizen or national, answer the following questions:	Do you have eligible immigration status? ☐ Yes	**If yes,** fill in the document type and ID number:	Document type:	Document ID number:
	Do you have a sponsor? ☐ Yes ☐ No		Have you lived in the U.S. since 1996? ☐ Yes ☐ No	

Person 2

Name (include first, middle initial, last, suffix-Jr./Sr./etc.):		Are you applying for this person? ☐ Yes ☐ No	Social Security number:
Birthdate (MM/DD/YYYY):	Sex: ☐ M ☐ F	Does this person have a PA Access/EBT card? ☐ Yes ☐ No	Does this person live with you? ☐ Yes ☐ No
Is this person in school? ☐ Yes ☐ No	**If yes,** what grade?	Name of school:	Full-time student? ☐ Yes ☐ No

How is this person related to you? ☐ Spouse ☐ Child ☐ Stepchild ☐ Not related ☐ Other _____

Answer the questions below if you are applying for this person. You do not need to answer these questions if you are applying only for SNAP.

☐ Yes ☐ No ▶ If not eligible for full Medical Assistance coverage, does this person want to be reviewed for coverage for the Family Planning Services program only?

☐ Yes ☐ No ▶ If this person is under 21, we will consider only their income in our determination for the Family Planning Services program. If they wish to be reviewed for full Medical Assistance coverage, we will need to evaluate their household income, including their parent(s)' income. Does this person want to be reviewed only for the Family Planning Services program and NOT for full Medical Assistance coverage?

☐ Yes ☐ No ▶ Regardless of age, is this person afraid that information they may receive where they live about family planning services could cause physical, emotional, or other harm from their spouse, parents, or other person? **If yes,** do they have another address (other than where they live) where they'd like to get information about family planning services?

Is this person a U.S. citizen or national? ☐ Yes ☐ No

If this person is not a U.S. citizen or national, answer the following questions:	Does this person have eligible immigration status? ☐ Yes	**If yes**, fill in the document type and ID number.	Document type:	Document ID number:
	Does this person have a sponsor? ☐ Yes ☐ No		Has this person lived in the U.S. since 1996? ☐ Yes ☐ No	

Person 3

Name (include first, middle initial, last, suffix-Jr./Sr./etc.):		Are you applying for this person? ☐ Yes ☐ No	Social Security number:
Birthdate (MM/DD/YYYY):	Sex: ☐ M ☐ F	Does this person have a PA Access/EBT card? ☐ Yes ☐ No	Does this person live with you? ☐ Yes ☐ No
Is this person in school? ☐ Yes ☐ No	**If yes,** what grade?	Name of school:	Full-time student? ☐ Yes ☐ No

How is this person related to you? ☐ Spouse ☐ Child ☐ Stepchild ☐ Not related ☐ Other _____

Answer the questions below if you are applying for this person. You do not need to answer these questions if you are applying only for SNAP.

☐ Yes ☐ No ▶	If not eligible for full Medical Assistance coverage, does this person want to be reviewed for coverage for the Family Planning Services program only?
☐ Yes ☐ No ▶	If this person is under 21, we will consider only their income in our determination for the Family Planning Services program. If they wish to be reviewed for full Medical Assistance coverage, we will need to evaluate their household income, including their parent(s)' income. Does this person want to be reviewed only for the Family Planning Services program and NOT for full Medical Assistance coverage?
☐ Yes ☐ No ▶	Regardless of age, is this person afraid that information they may receive where they live about family planning services could cause physical, emotional, or other harm from their spouse, parents, or other person? **If yes,** do they have another address (other than where they live) where they'd like to get information about family planning services?

Is this person a U.S. citizen or national? ☐ Yes ☐ No

If this person is not a U.S. citizen or national, answer the following questions:	Does this person have eligible immigration status? ☐ Yes	**If yes**, fill in the document type and ID number.	Document type:	Document ID number:
	Does this person have a sponsor? ☐ Yes ☐ No		Has this person lived in the U.S. since 1996? ☐ Yes ☐ No	

Person 4

Name (include first, middle initial, last, suffix-Jr./Sr./etc.):		Are you applying for this person? ☐ Yes ☐ No	Social Security number:
Birthdate (MM/DD/YYYY):	Sex: ☐ M ☐ F	Does this person have a PA Access/EBT card? ☐ Yes ☐ No	Does this person live with you? ☐ Yes ☐ No
Is this person in school? ☐ Yes ☐ No	**If yes,** what grade?	Name of school:	Full-time student? ☐ Yes ☐ No

How is this person related to you? ☐ Spouse ☐ Child ☐ Stepchild ☐ Not related ☐ Other _____

Answer the questions below if you are applying for this person. You do not need to answer these questions if you are applying only for SNAP.

☐ Yes ☐ No ▶	If not eligible for full Medical Assistance coverage, does this person want to be reviewed for coverage for the Family Planning Services program only?
☐ Yes ☐ No ▶	If this person is under 21, we will consider only their income in our determination for the Family Planning Services program. If they wish to be reviewed for full Medical Assistance coverage, we will need to evaluate their household income, including their parent(s)' income. Does this person want to be reviewed only for the Family Planning Services program and NOT for full Medical Assistance coverage?
☐ Yes ☐ No ▶	Regardless of age, is this person afraid that information they may receive where they live about family planning services could cause physical, emotional, or other harm from their spouse, parents, or other person? **If yes,** do they have another address (other than where they live) where they'd like to get information about family planning services?

Is this person a U.S. citizen or national? ☐ Yes ☐ No

If this person is not a U.S. citizen or national, answer the following questions:	Does this person have eligible immigration status? ☐ Yes	**If yes**, fill in the document type and ID number.	Document type:	Document ID number:
	Does this person have a sponsor? ☐ Yes ☐ No		Has this person lived in the U.S. since 1996? ☐ Yes ☐ No	

Person 5

Name (include first, middle initial, last, suffix-Jr./Sr./etc.):		Are you applying for this person? ☐ Yes ☐ No	Social Security number:
Birthdate (MM/DD/YYYY):	Sex: ☐ M ☐ F	Does this person have a PA Access/EBT card? ☐ Yes ☐ No	Does this person live with you? ☐ Yes ☐ No
Is this person in school? ☐ Yes ☐ No	**If yes,** what grade?	Name of school:	Full-time student? ☐ Yes ☐ No

How is this person related to you? ☐ Spouse ☐ Child ☐ Stepchild ☐ Not related ☐ Other _____

Answer the questions below if you are applying for this person. You do not need to answer these questions if you are applying only for SNAP.

☐ Yes ☐ No ▶	If not eligible for full Medical Assistance coverage, does this person want to be reviewed for coverage for the Family Planning Services program only?
☐ Yes ☐ No ▶	If this person is under 21, we will consider only their income in our determination for the Family Planning Services program. If they wish to be reviewed for full Medical Assistance coverage, we will need to evaluate their household income, including their parent(s)' income. Does this person want to be reviewed only for the Family Planning Services program and NOT for full Medical Assistance coverage?
☐ Yes ☐ No ▶	Regardless of age, is this person afraid that information they may receive where they live about family planning services could cause physical, emotional, or other harm from their spouse, parents, or other person? **If yes,** do they have another address (other than where they live) where they'd like to get information about family planning services?

Is this person a U.S. citizen or national? ☐ Yes ☐ No

If this person is not a U.S. citizen or national, answer the following questions:

Does this person have eligible immigration status? ☐ Yes — **If yes**, fill in the document type and ID number. Document type: Document ID number:

Does this person have a sponsor? ☐ Yes ☐ No — Has this person lived in the U.S. since 1996? ☐ Yes ☐ No

Person 6

Name (include first, middle initial, last, suffix-Jr./Sr./etc.): Are you applying for this person? ☐ Yes ☐ No Social Security number:

Birthdate (MM/DD/YYYY): Sex: ☐ M ☐ F Does this person have a PA Access/EBT card? ☐ Yes ☐ No Does this person live with you? ☐ Yes ☐ No

Is this person in school? ☐ Yes ☐ No **If yes,** what grade? Name of school: Full-time student? ☐ Yes ☐ No

How is this person related to you? ☐ Spouse ☐ Child ☐ Stepchild ☐ Not related ☐ Other _____

Answer the questions below if you are applying for this person. You do not need to answer these questions if you are applying only for SNAP.

☐ Yes ☐ No If not eligible for full Medical Assistance coverage, does this person want to be reviewed for coverage for the Family Planning Services program only?

☐ Yes ☐ No If this person is under 21, we will consider only their income in our determination for the Family Planning Services program. If they wish to be reviewed for full Medical Assistance coverage, we will need to evaluate their household income, including their parent(s)' income. Does this person want to be reviewed only for the Family Planning Services program and NOT for full Medical Assistance coverage?

☐ Yes ☐ No Regardless of age, is this person afraid that information they may receive where they live about family planning services could cause physical, emotional, or other harm from their spouse, parents, or other person? **If yes,** do they have another address (other than where they live) where they'd like to get information about family planning services?

Is this person a U.S. citizen or national? ☐ Yes ☐ No

If this person is not a U.S. citizen or national, answer the following questions:

Does this person have eligible immigration status? ☐ Yes — **If yes**, fill in the document type and ID number. Document type: Document ID number:

Does this person have a sponsor? ☐ Yes ☐ No — Has this person lived in the U.S. since 1996? ☐ Yes ☐ No

Person 7

Name (include first, middle initial, last, suffix-Jr./Sr./etc.): Are you applying for this person? ☐ Yes ☐ No Social Security number:

Birthdate (MM/DD/YYYY): Sex: ☐ M ☐ F Does this person have a PA Access/EBT card? ☐ Yes ☐ No Does this person live with you? ☐ Yes ☐ No

Is this person in school? ☐ Yes ☐ No **If yes,** what grade? Name of school: Full-time student? ☐ Yes ☐ No

How is this person related to you? ☐ Spouse ☐ Child ☐ Stepchild ☐ Not related ☐ Other _____

Answer the questions below if you are applying for this person. You do not need to answer these questions if you are applying only for SNAP.

☐ Yes ☐ No If not eligible for full Medical Assistance coverage, does this person want to be reviewed for coverage for the Family Planning Services program only?

☐ Yes ☐ No If this person is under 21, we will consider only their income in our determination for the Family Planning Services program. If they wish to be reviewed for full Medical Assistance coverage, we will need to evaluate their household income, including their parent(s)' income. Does this person want to be reviewed only for the Family Planning Services program and NOT for full Medical Assistance coverage?

☐ Yes ☐ No Regardless of age, is this person afraid that information they may receive where they live about family planning services could cause physical, emotional, or other harm from their spouse, parents, or other person? **If yes,** do they have another address (other than where they live) where they'd like to get information about family planning services?

Is this person a U.S. citizen or national? ☐ Yes ☐ No

If this person is not a U.S. citizen or national, answer the following questions:

Does this person have eligible immigration status? ☐ Yes — **If yes**, fill in the document type and ID number. Document type: Document ID number:

Does this person have a sponsor? ☐ Yes ☐ No — Has this person lived in the U.S. since 1996? ☐ Yes ☐ No

Person 8

Name (include first, middle initial, last, suffix-Jr./Sr./etc.): Are you applying for this person? ☐ Yes ☐ No Social Security number:

Birthdate (MM/DD/YYYY): Sex: ☐ M ☐ F Does this person have a PA Access/EBT card? ☐ Yes ☐ No Does this person live with you? ☐ Yes ☐ No

Is this person in school? ☐ Yes ☐ No **If yes,** what grade? Name of school: Full-time student? ☐ Yes ☐ No

How is this person related to you? ☐ Spouse ☐ Child ☐ Stepchild ☐ Not related ☐ Other _____

Answer the questions below if you are applying for this person. You do not need to answer these questions if you are applying only for SNAP.

☐ Yes ☐ No If not eligible for full Medical Assistance coverage, does this person want to be reviewed for coverage for the Family Planning Services program only?

☐ Yes ☐ No ▶	If this person is under 21, we will consider only their income in our determination for the Family Planning Services program. If they wish to be reviewed for full Medical Assistance coverage, we will need to evaluate their household income, including their parent(s)' income. Does this person want to be reviewed only for the Family Planning Services program and NOT for full Medical Assistance coverage?
☐ Yes ☐ No ▶	Regardless of age, is this person afraid that information they may receive where they live about family planning services could cause physical, emotional, or other harm from their spouse, parents, or other person? **If yes,** do they have another address (other than where they live) where they'd like to get information about family planning services?

Is this person a U.S. citizen or national? ☐ Yes ☐ No

If this person is not a U.S. citizen or national, answer the following questions: ▶	Does this person have eligible immigration status? ☐ Yes	**If yes**, fill in the document type and ID number.	Document type:	Document ID number:
	Does this person have a sponsor? ☐ Yes ☐ No		Has this person lived in the U.S. since 1996? ☐ Yes ☐ No	

Person 9

Name (include first, middle initial, last, suffix-Jr./Sr./etc.):		Are you applying for this person? ☐ Yes ☐ No	Social Security number:
Birthdate (MM/DD/YYYY):	Sex: ☐ M ☐ F	Does this person have a PA Access/EBT card? ☐ Yes ☐ No	Does this person live with you? ☐ Yes ☐ No
Is this person in school? ☐ Yes ☐ No	**If yes,** what grade?	Name of school:	Full-time student? ☐ Yes ☐ No

How is this person related to you? ☐ Spouse ☐ Child ☐ Stepchild ☐ Not related ☐ Other _____

Answer the questions below if you are applying for this person. You do not need to answer these questions if you are applying only for SNAP.

☐ Yes ☐ No ▶	If not eligible for full Medical Assistance coverage, does this person want to be reviewed for coverage for the Family Planning Services program only?
☐ Yes ☐ No ▶	If this person is under 21, we will consider only their income in our determination for the Family Planning Services program. If they wish to be reviewed for full Medical Assistance coverage, we will need to evaluate their household income, including their parent(s)' income. Does this person want to be reviewed only for the Family Planning Services program and NOT for full Medical Assistance coverage?
☐ Yes ☐ No ▶	Regardless of age, is this person afraid that information they may receive where they live about family planning services could cause physical, emotional, or other harm from their spouse, parents, or other person? **If yes,** do they have another address (other than where they live) where they'd like to get information about family planning services?

Is this person a U.S. citizen or national? ☐ Yes ☐ No

If this person is not a U.S. citizen or national, answer the following questions: ▶	Does this person have eligible immigration status? ☐ Yes	**If yes**, fill in the document type and ID number.	Document type:	Document ID number:
	Does this person have a sponsor? ☐ Yes ☐ No		Has this person lived in the U.S. since 1996? ☐ Yes ☐ No	

Person 10

Name (include first, middle initial, last, suffix-Jr./Sr./etc.):		Are you applying for this person? ☐ Yes ☐ No	Social Security number:
Birthdate (MM/DD/YYYY):	Sex: ☐ M ☐ F	Does this person have a PA Access/EBT card? ☐ Yes ☐ No	Does this person live with you? ☐ Yes ☐ No
Is this person in school? ☐ Yes ☐ No	**If yes,** what grade?	Name of school:	Full-time student? ☐ Yes ☐ No

How is this person related to you? ☐ Spouse ☐ Child ☐ Stepchild ☐ Not related ☐ Other _____

Answer the questions below if you are applying for this person. You do not need to answer these questions if you are applying only for SNAP.

☐ Yes ☐ No ▶	If not eligible for full Medical Assistance coverage, does this person want to be reviewed for coverage for the Family Planning Services program only?
☐ Yes ☐ No ▶	If this person is under 21, we will consider only their income in our determination for the Family Planning Services program. If they wish to be reviewed for full Medical Assistance coverage, we will need to evaluate their household income, including their parent(s)' income. Does this person want to be reviewed only for the Family Planning Services program and NOT for full Medical Assistance coverage?
☐ Yes ☐ No ▶	Regardless of age, is this person afraid that information they may receive where they live about family planning services could cause physical, emotional, or other harm from their spouse, parents, or other person? **If yes,** do they have another address (other than where they live) where they'd like to get information about family planning services?

Is this person a U.S. citizen or national? ☐ Yes ☐ No

If this person is not a U.S. citizen or national, answer the following questions: ▶	Does this person have eligible immigration status? ☐ Yes	**If yes**, fill in the document type and ID number.	Document type:	Document ID number:
	Does this person have a sponsor? ☐ Yes ☐ No		Has this person lived in the U.S. since 1996? ☐ Yes ☐ No	

Other Questions

Is anyone pregnant? ☐ Yes ☐ No	If yes, who?:	Due date?	How many babies are expected?
Is anyone disabled, seriously ill, or in need of medical attention? ☐ Yes ☐ No	If yes, who?	What is the disability?	
Was anyone in foster care at age 18 or older? ☐ Yes ☐ No	If yes, who?	In what state?	

Does anyone pay for childcare or the care of an adult with a disability so he or she can go to work, school or training? ☐ Yes ☐ No	If yes, how much each month?	Monthly amount: $	Who receives care?
Does anyone pay to travel to work? ☐ Yes ☐ No	If yes, how much each month?	Monthly amount: $	How do you travel (bus, train, car, subway)?

If you use a car:

How many round trip miles to work?	Miles:	How many days each week?	Days:	What is your monthly car payment?	Monthly amount: $

Tax Information

Complete this section if you are applying for health care. You do not need to answer these questions if you are applying only for SNAP.

Does anyone plan to file a federal income tax return **NEXT YEAR**? ☐ Yes ☐ No
If **yes**, complete the table below.

List each person who will file taxes. If filing jointly, include the spouse in the same row.
Note: A dependent can be claimed by only one tax filer. For joint filers, you only need to list dependents for the tax filer who will sign the tax form.

List name of each person who plans to file a tax return	Will this person file jointly with a spouse? Yes/No	If yes, list name of spouse	Will this person claim dependents? Yes/No	If yes, list name(s) of dependent(s)

Will anyone be claimed as a dependent on someone's tax return? ☐ Yes ☐ No **If yes,** complete the table below.

List the dependent or tax filer for whom the dependent will be claimed.
Note: You do not need to complete this table if the person who will be claimed is already listed as a dependent above.

Name of dependent	Name of tax filer	Relationship to tax filer

Tax Deductions

Complete this section if you are applying for health care. You do not need to answer these questions if you are applying only for SNAP.

If anyone pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health care coverage a little lower.

Note: If self-employed, do not include a cost that you will list as an expense on your Schedule C tax form (for example, car and truck expenses, depreciation, employee wages and fringe benefits, etc.).

Does anyone have expenses from: (✓ Check **yes**)	Yes	Whose expense is this?	How often is the expense paid? (One time, monthly, quarterly, twice a year, yearly)	How much?
Student loan interest deduction	☐			
Self-employed health insurance deduction	☐			
Deductible part of self-employment tax	☐			
Health savings account deduction	☐			
Other (Specify)	☐			

Resources (also called "assets")

You do not need to answer these questions if you are applying for SNAP benefits only or if you are applying for health care and you meet one of these exceptions: pregnant; child under age 21; have a dependent child under 21 living with you; you do not have a disability and are under age 65.

List all resources such as cash, vehicles, stocks, bonds, bank accounts, property, life insurance, etc. **Please review any information printed below. If this information is incorrect, please strike it out and write in the correct information.**

Name of Owner	Resource	Current Value ($)	Bank Name/Account Number	Percentage Owned	Comments

Income

List all income such as wages, self-employment, pensions, Social Security benefits, Unemployment Compensation, Workers' Compensation, support, gambling/lottery, etc. **Please review any information printed below.**

If this information is incorrect, please strike it out and write in the correct information.

Whose income is this?	Income Type	Income Source	**Frequency** (Weekly, every two weeks, monthly, yearly)	**Average hours worked each week:**	**Gross Amount?** (amount of income before taxes and deductions)	Comments

Pre-Tax Deductions

List any pre-tax deductions taken out of the gross income, such as health/dental/vision/life insurance premiums, 401(k) or retirement account contributions, Family Savings Account (FSA) or Health Savings Account (HSA) contributions.

Name	Deduction	Monthly Amount

Health Insurance

You do not need to answer these questions if you are applying only for SNAP.

Does anyone you are applying for have health insurance coverage? ☐ Yes ☐ No
Has anyone you are applying for had health insurance coverage in the last 90 days? ☐ Yes ☐ No

If you have (or had in the last 90 days) more than one type of health care coverage, please fill in a box for each policy.
Note: If you have more than one policy, you will need to make a copy of the pages and attach them.

Type of health care coverage ▶ ☐ Employer insurance ☐ Medicare ☐ TRICARE* ☐ Peace Corps ☐ Individual Plan
☐ Other _____

	List who is (or was) covered:	
Policy holder name:	First name:	Last name:
Insurance company name:	First name:	Last name:
Policy number:	First name:	Last name:
Group name/number:	First name:	Last name:

What is (or was) covered? ▶ ☐ Hospital care ☐ Prescriptions ☐ Eye care ☐ Doctor's visits ☐ Dental

Is (or was) this a limited-benefit plan (like a school accident policy)? ☐ Yes ☐ No

When did this insurance start? ▶

When did (or will) this insurance stop? (Leave blank if you are still covered) ▶

Did (or will) this health insurance end because the policy holder lost employment (laid off, terminated, quit) or changed jobs? ☐ Yes ☐ No

If **yes**, who lost coverage?

Did (or will) any children lose health insurance coverage because the employer stopped offering coverage? ☐ Yes ☐ No

*Don't check if you have direct care or Line of Duty.

Health Insurance From Your Employer

You do not need to answer these questions if you are applying only for SNAP.

Is anyone you are applying for offered health insurance from a job? ☐ Yes ☐ No Check **yes** even if the coverage is from someone else's job, such as a parent or spouse.

If yes, complete this section and as much information as you can in Appendix A: Health Coverage From Job(s).

Is this a state employee benefit plan? ☐ Yes ☐ No

Is this COBRA coverage? ☐ Yes ☐ No

Is this a retiree health plan? ☐ Yes ☐ No

If you are offered health coverage from your job, do (or would) you have to pay for your coverage? ☐ Yes ☐ No

Do (or would) you have to pay for your child(ren)'s coverage? ☐ Yes ☐ No

What is the cost for family coverage through your employer's group health plan? ▶

What is the cost to cover your child(ren) through your employer's group health plan? ▶

Expenses

This section is for SNAP applicants.

Please tell us about your expenses so that you can get the most benefits possible. If requested, you must provide proof of your expenses.

▶ At any time, you may report household expenses to us, and we may ask you to give us proof of them.

Does anyone in your home pay child support to a person who does not live with you? ☐ Yes ☐ No If yes, is it court-ordered? ☐ Yes ☐ No	Does anyone in your home get housing assistance? ☐ Yes ☐ No If yes, what kind? _____ If yes, do you get a utility allowance? ☐ Yes ☐ No
Are meals included in your rent? ☐ Yes ☐ No	Is there anyone outside of your household who pays any of your expenses? ☐ Yes ☐ No If so, what expenses? _____ How much? _____ How often? _____ To whom? _____
Do you pay for heat? ☐ Yes ☐ No	Do you pay for central air or to run a room air conditioner(s)? ☐ Yes ☐ No

Check any expenses paid each month by you or anyone in your home. Please check even if you only pay part of the bill.

☐ Telephone ☐ Water ☐ Garbage ☐ Utility installation ☐ Electric

☐ Oil, coal, wood, kerosene ☐ Sewer ☐ Gas ☐ Propane ☐ Other _____

If you have any of these expenses, how much do you pay per month?

Rent: $ _____ Condo fees: $ _____

Mortgage $ _____ Property taxes: $ _____ Homeowner's insurance: $ _____

Medical Expenses

This section is for SNAP applicants.

You may get more SNAP benefits if someone in your home is 60 years old or older, or disabled, and you can give proof of medical expenses.

Check any medical expense that you or someone in your home pays:	
☐ Dental bills	☐ Any costs to get to medical appointments, medical treatment, or to pick up prescriptions. These can be costs such as taxis and public transportation.
☐ Doctor bills	
☐ Hospital bills	☐ Health aides (people in your home to help with medical treatments).
☐ Health insurance or Medicare premiums	☐ Health related supplies (such as eyeglasses, hearing aids, adult diapers).
☐ Medical equipment	☐ Prescription medicines
☐ Other:	

▶ **Failure to report or verify any of the above listed expenses will be seen as a statement by your household that you do not want to receive a deduction for the unreported expense.**

Absent Relatives

This section is for cash applicants.

If anyone is applying for a child who has parents not living in your home **or** if anyone applying has a spouse not living in your home, please answer these questions so that we can try to get support. You do not need to fill out this section if providing this information or seeking support would put you or family members at risk of domestic violence or make it more difficult to escape domestic violence, or if your child was born as a result of rape or incest, or if you are considering adoption.

If it would be a problem for you to provide this information or seek support because of domestic violence, rape or incest or because you are considering putting a child up for adoption, check this box: ☐

Name of person with an absent relative:	Name of absent relative:	Absent relative is a:
		☐ Parent ☐ Spouse
Name of person with an absent relative:	Name of absent relative:	Absent relative is a:
		☐ Parent ☐ Spouse
Name of person with an absent relative:	Name of absent relative:	Absent relative is a:
		☐ Parent ☐ Spouse

▶ If you are applying for cash assistance, you must name the parents of any minor children and help the Domestic Relations Section (DRS) collect support by providing the information they need unless you have good cause. If you do not help the DRS by providing the information needed and do not have a good reason for not helping, any cash assistance amount for which you are approved will be lowered by at least 25 percent.

If approved for cash assistance, you must give the Department and DRS the right to collect cash for you and others for whom you are applying. The law says that support rights will be assigned to the state if you accept cash assistance.

If support is paid for a child who gets cash assistance, the family may get some of the support in addition to the cash assistance grant.

Criminal History Inquiry

You do not need to answer these questions if you are applying only for health care.

Please answer the following questions for yourself and anyone else for whom you are applying:		
Does anyone have a summons or warrant to appear as a defendant at a criminal court proceeding?	☐ Yes ☐ No	If **yes**, who?
Does anyone owe fines, costs or restitution for a felony or misdemeanor offense?	☐ Yes ☐ No	If **yes**, who?
Does anyone have a payment plan for fines and costs?	☐ Yes ☐ No	If **yes**, who?
Is anyone on probation or parole?	☐ Yes ☐ No	If **yes**, who?
Is anyone who is on probation or parole <u>not</u> complying?	☐ Yes ☐ No	If **yes**, who?
Has anyone been convicted of welfare fraud?	☐ Yes ☐ No	If **yes**, who?
Is anyone fleeing from law enforcement?	☐ Yes ☐ No	If **yes**, who?
Is anyone required to register as a convicted sexual offender?	☐ Yes ☐ No	If **yes**, who?
Is anyone who is required to register as a convicted sexual offender <u>not</u> complying with their registration requirements?	☐ Yes ☐ No	If **yes**, who?

Voter Registration (Optional): This section is for U.S. Citizens only

If you are not registered to vote where you live now, would you like to apply to register to vote here today? ☐ Yes ☐ No

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

To register, you must:
1) Be at least 18 on the day of the next election;
2) Be a citizen of the United States for at least one month PRIOR TO THE NEXT ELECTION;
3) Reside in Pennsylvania and the voting district at least 30 days prior to the next election.

Applying to register or declining to register to vote will not affect the amount of assistance you will be provided by this agency.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. Please contact the county assistance office if you would like help.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Secretary of the Commonwealth, PA Department of State, Harrisburg, PA 17120. (Toll-free telephone number 1-877-VOTESPA.)

COUNTY ASSISTANCE OFFICE STAFF WILL COMPLETE THIS BOX BASED UPON YOUR RESPONSE ABOVE

☐ Given to Client __/__/__ ☐ Sent to voter registration __/__/__ ☐ Mailed to Client __/__/__

☐ Declined, not interested __/__/__ ☐ Not a U.S. citizen __/__/__ ☐ Declined, already registered __/__/__

Your Rights and Responsibilities Read about your rights and responsibilities:

RIGHT TO NONDISCRIMINATION

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, 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.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or 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.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, 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: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (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: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

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: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

RIGHT TO CONFIDENTIALITY

We will keep your information private. It will only be used to decide which programs you may be eligible for. The county assistance office (CAO), when requested, must provide federal, state and local law enforcement officials with the address, Social Security number (SSN) and photograph (if available) of an individual who is fleeing to avoid prosecution, custody or confinement for a felony or violating probation or parole. Any person knowingly violating any of the rules and regulations of this department shall be guilty of a misdemeanor and, upon conviction shall be sentenced to pay a fine, not exceeding one hundred ($100) dollars, or to undergo imprisonment, not exceeding six months, or both (62 P.S. section 483).

RIGHT TO A WRITTEN NOTICE

We will give you a written notice explaining your benefits. If we deny, change, suspend or stop benefits, we will give you a written explanation of why. You have 30 days (90 days for Supplemental Nutrition Assistance Program (SNAP) benefits) from the mailing date of the notice to ask for a hearing.

RIGHT TO APPEAL

You have the right to ask for a Department of Human Services (DHS) hearing to appeal a decision if you believe it is unfair or incorrect, or if DHS fails to act on your application for benefits. You may file the appeal at the CAO. If you appeal, you may also request an agency conference before the hearing. If your appeal involves expedited SNAP benefits, you have the right to have this conference with a supervisor within two work days. At the hearing you may represent yourself, or someone else, such as a lawyer, friend or relative may represent you.

RIGHT TO CLAIM GOOD CAUSE

If you apply for cash or Medical Assistance benefits, the law requires you to cooperate with establishing paternity and seeking support. You may be excused from these requirements if you prove it may be dangerous for you and/or your children. This is known as good cause. Unless a good cause exemption is established, you will be required to meet employment and training requirements. You will also be required to meet semi-annual reporting requirements unless good cause is granted.

RIGHT TO CERTIFICATE OF CREDITABLE COVERAGE

Federal law limits when health coverage may be denied or limited for a pre-existing condition. If you enroll in a group health plan that excludes treatment for a condition you already had, you can be credited for the time you received Medical Assistance coverage. This may help you obtain coverage. Contact your caseworker to request this certificate.

RESPONSIBILITY TO PROVIDE INFORMATION

You must give true, correct and complete information. You must help in proving the information you give. Benefits may be denied if you fail to provide certain proof. If you cannot provide proof, you should ask the CAO to help you obtain it. If you are contacted by DHS or the Office of State Inspector General, you must fully cooperate with those persons or investigators. If you are age 55 or older and receive Medical Assistance to pay for nursing facility services, home and community-based waiver services and any related hospital and prescription drug service, you may be required to repay the cost of these services from your probate estate. If you are applying for cash assistance, we may require you to sign an agreement to repay benefits that you, your spouse and your children have received.

RESPONSIBILITY TO PROVIDE SOCIAL SECURITY NUMBERS

For cash, Medical Assistance and/or SNAP benefits, you must provide an SSN for each person for whom you are applying. If you do not have an SSN, you must apply for one. Not providing an SSN may result in not being able to receive benefits. For cash benefits, we may ask for an SSN for anyone whose income or resources may affect your eligibility or the amount of benefits. Your SSN will be used for identity, for computer matches which verify income and resources, and to prevent duplication of state and federal benefits. A non-citizen who is applying for emergency Medical Assistance only is not required to provide an SSN. (42 U.S. Code 1320b-7)

RESPONSIBILITY TO USE THE PA ACCESS CARD LAWFULLY

Once you are eligible for benefits, you will be issued a PA ACCESS card. This card may only be used for the person who is eligible and only during the eligibility period. You may only use the card for services that are needed and reasonable.

RESPONSIBILITY TO REPORT CHANGES

If you qualify for benefits, you will be required to report changes in your circumstances to your caseworker or to the Customer Service Center. Types of changes reported would include people leaving or moving into the house, a new address, a new job for someone, if someone loses a job, birth of a child, new sources of income or changes to income, and lottery and gambling winnings. Your caseworker and notices you receive will cover the specifics in detail based on the programs and benefits you are eligible for. Failure to report required changes within the program guidelines could result in a loss of benefits, sanctions, or civil or criminal charges. You may report changes to the CAO in person, by phone, fax, mail or through a MyCOMPASS account. You may also report changes to the Customer Service Center at 1-877-395-8930, or for Philadelphia, 1-215-560-7226 any time.

PRIVACY ACT STATEMENT

(i) The collection of this information, including the Social Security number (SSN) of each household member, is authorized under the Food and Nutrition Act of 2008, as amended, 7 U.S.C. 2011-2036d. The information will be used to determine whether your household is eligible or continues to be eligible to participate in the SNAP Program. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management.

(ii) This information may be disclosed to other Federal and State agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law.

(iii) If a SNAP claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action.

(iv) Providing the requested information, including the SSN of each household member, is voluntary. However, failure to provide an SSN will result in the denial of SNAP benefits to each individual failing to provide an SSN. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible household members.

Prohibitions and Penalties Read about your responsibilities:

IF THIS HAPPENS WITHOUT GOOD CAUSE			THIS MAY HAPPEN (PENALTY)
ALL BENEFITS SNAP CASH MEDICAL ASSISTANCE	Misuse Electronic Benefits Transfer (EBT) Card or PA ACCESS Card.		**Fine, prison, or both.**
	Do not report changes, as required.		**Benefits cut or stopped.**
	On purpose, give information that is false, incorrect or incomplete, or not report changes.		**Fine, disqualification and/or jail time for Welfare Fraud, disqualification for administrative hearing proceedings.** **Not eligible for cash:** • **First time - 6 months.** • **Second time - 12 months.** • **Third time - forever.** **Not eligible for SNAP:** • **First time - 12 months.** • **Second time - 24 months.** • **Third time - forever.**
	Trade, sell or attempt to trade, sell, buy or use another person's ACCESS Card.		**Not eligible:** • **All court convictions - 12 months.**
SNAP	On purpose, misuse SNAP benefits, for example, trade, sell, or buy EBT Card or SNAP benefits; convert benefits; or dump containers purchased with SNAP benefits to receive deposits – or buy things not covered by SNAP, such as alcohol or tobacco – or use SNAP benefits to pay for food already received or food on credit.		**Not eligible:** • **First time - 12 months.** • **Second time - 24 months.** • **Third time - forever.** • **First time court conviction over $500 - forever.**
	Purchase a product with SNAP benefits with the intent of obtaining cash or consideration other than eligible food by reselling the product in exchange for cash or consideration other than eligible food.		
	On purpose, purchase products originally purchased with SNAP benefits in exchange for cash or consideration other than eligible food.		
	Use/receive SNAP benefits to buy drugs or controlled substances.		**Not eligible:** • **First time - 24 months.** • **Second time - forever.**
	Use/receive SNAP benefits in sale of firearms, ammunition, or explosives.		**First time - not eligible forever.**
	Be convicted for buying, selling or trading SNAP benefits for total of $500 or more.		**Not eligible forever.**
	Lie about who you are or where you live to receive more than one SNAP benefit.		**Not eligible for 10 years.**
	Flee to avoid prosecution, custody, or confinement because of a felony/attempted felony – or flee because of breaking probation or parole.		**Not eligible until you do what the law says.**
CASH	Do not comply with your court penalty, including payment of fines, for a felony or misdemeanor.		**Not eligible until you comply with your penalty.**
	Lie about where you live to receive cash in two or more states.		**Not eligible for 10 years.**
	Flee to avoid prosecution, custody, or confinement because of a felony conviction/attempted felony; fail to appear as a defendant at a criminal court proceeding when issued a summons or a bench warrant for a summary offense, felony or misdemeanor; flee because of breaking probation/parole; or have any active warrant against you.		**Not eligible until you do what the law says.**
If you are found guilty of fraud or breaking the above rules:			• **Fine up to $250,000 for SNAP and up to $15,000 for Cash;** • **Jail up to 20 years for SNAP and up to seven years for Cash; and/or** • **Paying back benefits received.** • **Disqualification from benefits for periods stated above by program.**
SNAP WORK RULES	For household members – physically and mentally fit – over age 15 and under 60 – not otherwise exempt or with good cause.		**Not eligible:** • **First time - one month and until you do what is required.** • **Second time - three months and until you do what is required.** • **Three or more times - six months each time and until you do what is required.**
	Refuse to: • Accept a job. • Tell CAO about work status and job availability.	On purpose, take action to: • Quit a job. • Cut work hours to less than 30 per week (unless another job already meets work requirements).	
CASH WORK RULES	Do not meet cash work requirements on purpose, as written on the Agreement of Mutual Responsibility (AMR).		**Not eligible:** • **First violation – You will be ineligible for a minimum of 30 days or until the failure to comply ceases, whichever is longer.** • **Second violation – You will be ineligible for a minimum of 60 days or until the failure to comply ceases, whichever is longer.** • **Third violation – You will be permanently disqualified.** **If the reason for sanction occurs within the first 24 months of receipt of cash assistance, whether consecutive or interrupted, the sanction applies only to the individual.** **If the reason for sanction occurs after 24 months of receipt of cash assistance, whether consecutive or interrupted, the sanction applies to the entire family.**

Understanding Your Rights and Responsibilities

When I sign this form:

- I understand that Pennsylvania receives information from the Income Eligibility Verification System (IEVS), financial institutions, consumer reporting and state and federal agencies to verify the information I give them. Information available through IEVS and other entities will be requested, used and may be verified through collateral contact when conflicting details are found by the State agency, and such information may affect my household's eligibility and level of benefits.
- I understand that by signing this application, I am authorizing any financial institution to disclose, through electronic or any other means, any and all financial information held by that institution, to the Department of Human Services or its designated agent or contractor for the purpose of identifying and verifying resources (also called "assets") when needed to determine and redetermine eligibility for Medical Assistance. I understand that financial information includes deposits, withdrawals, account closures and other relevant information requested or received from the financial institution, including other transactions undertaken by the financial institution with respect to the account or asset. I understand that this authorization is effective until Medical Assistance eligibility is denied or ends, or if I decide to revoke it by written notification to the Department, whichever happens first. I understand that if I revoke this authorization, that may make me or my household ineligible for Medical Assistance.
- I understand that if I misrepresent, hide or withhold facts that may affect my eligibility for benefits, I may be required to repay my benefits and I may be prosecuted and disqualified from receiving certain future benefits.
- I understand that I can designate an authorized representative by completing the Authorized Representative section and submitting it with this application.
- I understand and agree that I am responsible for any fraudulent statements made on this application, even if the application is being submitted by someone acting on my behalf.
- I understand any person enriched as a result of a transfer of assets or income, which would have affected my eligibility for Long-Term Care or Home and Community-Based Services, will be liable for repayment of those benefits issued incorrectly.
- I received a copy of my rights and responsibilities, have read them or someone has read them to me, and I understand them.
- I understand that the Department of Human Services or its designees may contact me via methods including email and text messaging to help process my application or request feedback on the application process. If I do not want email or text messages, I understand the Department of Human Services will still process my application.
- I understand that the information entered in this application will be kept confidential and only to administer benefits. I authorize the release of personal, financial and medical information for the purpose of determining eligibility.
- I understand that any changes I am required to report must be reported within the first 10 days of the month following the month of change or, for Long-Term Care and Home and Community-Based Services, within 10 days of the change.
- I understand that my household may lose SNAP benefits if a household member receives lottery or gambling winnings equal to or greater than the SNAP resource limit for elderly or disabled households.
- I understand that I will receive a written notice explaining the benefits. If benefits are denied, changed, suspended or stopped, the written notice will explain why.
- I understand that I will have 30 days (90 days for SNAP (food stamp) benefits) from the date of the notice to request a hearing if I do not agree with the decision made on this application.
- I understand that my situation is subject to verification from employers, financial sources and other third parties.
- I understand that applicants must provide their Social Security number or apply for one if they do not have one. This number may be used to check the information on this application.
- I understand that I must use the Electronic Benefit Transfer (EBT) or the PA ACCESS Card only during the period I am eligible. I must use the EBT or the PA ACCESS Card only for the person who is eligible and may get only the benefits that are needed and reasonable.
- I understand that I may not use Cash Assistance funds issued through my PA ACCESS card to make EBT transactions in liquor stores, casinos (gambling casinos, gaming establishments), or places for adult entertainment.
- I understand that I do not have to provide a Social Security number for anyone who is not applying for assistance. If I do provide their Social Security number, it may be used to check the information on this application.
- I certify that all information that has been entered is true under penalty of perjury.
- I understand that I have the right to a certificate of creditable coverage to verify my medical coverage. Federal law limits when Medical Assistance coverage may be denied or limited for a pre-existing condition. If I enroll in a group health plan that has a pre-existing condition clause, I can get credit for the time I received Medical Assistance.
- I understand that if I am determined eligible for Medical Assistance, I will be placed in the most comprehensive Medical Assistance benefit package that is available to me. I understand that I may be required to enroll in a health plan. I understand that enrolling in a health plan may be free or low cost to me, because the Department pays a monthly fee to the health plan for me. I understand that the monthly fee is a capitation fee. I understand that if I receive Medical Assistance that I am not eligible for, due to error, fraud, or any other reason, then I may be required to repay the Department all monthly fees paid on my behalf.
- If I receive cash benefits, I will cooperate with the requirements of the child support enforcement program as directed by the Department. I give the Department and the Domestic Relations Section the right to pursue and collect cash and/or medical support for me and others for whom I am applying.
- I understand that if I report or provide proof of the household expenses, I will get the maximum amount of SNAP (food stamp) benefits allowed. Failure to report or provide proof of the household expenses will be regarded as my statement that I do not want to receive a deduction for the unreported or unproved expense. (Authority: United States Department of Agriculture, Food and Nutrition Service, Mid-Atlantic Region, Administrative Notice 6-99, issued January 4, 1999).
- I understand that I have the right to receive credit for the household expenses at the time I report and provide proof of them at any time during my SNAP (food stamps) certification period.
- I understand that I have the right to ask the county assistance office (CAO) for assistance in getting proof of expenses and that the CAO can contact other people for confirmation if I am having trouble getting proof of anything.
- I understand that if some or all of the individuals applying do not qualify for Medical Assistance, that they may be eligible for CHIP.
- I understand that if some or all of the individuals applying do not qualify for Medical Assistance through the Department, that they may be eligible for federal benefits and/or explore private health care options through Pennsylvania's Health Insurance Marketplace (Pennie). If this is the case, I authorize the Department to give my name and information on this application to Pennie.
- **Renewal of coverage in future years:** To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow Pennsylvania's Health Insurance Marketplace (Pennie) to use my income data, including information from tax returns. Pennie will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next: (Check one):

- ☐ Five years (the maximum number of years allowed)
- ☐ Four years
- ☐ Three years
- ☐ Two years
- ☐ One year
- ☐ Do not use my information from tax returns to renew my coverage.

Sign Here:

X

Signature of Applicant or Authorized Representative | Date

IMPORTANT: If your household is eligible for SNAP/LIHEAP, you may receive a Fast Track consent form in the mail that could allow you and your household members to be automatically enrolled in Medical Assistance.

Name of Authorized Representative	Address of Authorized Representative	Phone Number

COUNTY ASSISTANCE OFFICE ONLY

I have explained to the applicant her or his rights and responsibilities.

CAO Signature | Date

BE SURE TO SIGN AND DATE THIS APPLICATION AND INCLUDE REQUIRED DOCUMENTS

Appendix A

Health Coverage from Job(s)

Tell us about the job that offers coverage. You DO NOT need to answer these questions unless someone in the household is eligible for health coverage from a job. **You do not need to complete this appendix if you are applying only for SNAP.**

Write your name and Social Security number in the Employee Information section. You may need to ask your employer to help you complete the Employer Information section. If you are unable to get this information from your employer timely, or you feel like completing this would delay the start of your application, you may submit your application without Appendix A.

Attach a copy of this page for each job that offers coverage.

EMPLOYEE Information

Employee name (first, middle, last):	Social Security number:

EMPLOYER Information

Employer name:		Employer identification number (EIN)
Employer address (include street, number, city, state & ZIP code +4):		Employer phone number: ( )
Who can we contact about employee health coverage at this job? ▶	Phone number (if different from above): ( )	Email address:

Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next three months?

☐ **Yes** (continue) If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____

☐ **No** (STOP and return this form to employee)

Tell us about the **health plan** offered by this **employer.**

Does the employer offer a health plan that covers an employee's spouse or dependent(s)? ☐ Yes. Which people: ☐ Spouse ☐ Dependent(s) ☐ No (go to the next question)

Does the employer offer a health plan that meets the minimum value standard?* ☐ Yes (go to the next question) ☐ No (STOP and return form to employee)

For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

How much would the employee have to pay in premiums for this plan? $_____

How often? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If your plan will end soon and you know that the health plans offered will change, go to the next question. If you don't know, STOP and return form to employee.

What change will the employer make for the new plan year?

☐ Employer will not offer health coverage.

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question above.)

How much would the employee have to pay in premiums for this plan? $ _____

How often? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

Date of change: (mm/dd/yyyy) _____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(C)(2)(C)(ii) of the Internal Revenue Code of 1986).

Pennsylvania
Department of Human Services

The Pennsylvania Department of Human Services (DHS) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. DHS does not exclude people or treat them differently because of race, color, national origin, age, disability, creed, religious affiliation, ancestry, gender, gender identity or expression, or sexual orientation.

DHS 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)
- 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 your local county assistance office.

If you believe that DHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: The Bureau of Equal Opportunity, Room 223, Health and Welfare Building, P.O. Box 2675, Harrisburg, PA 17105-2675, (717) 787-1127, PA Relay Services 711, fax - (717) 772-4366, or email - RA-PWBEOAO@pa.gov. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Bureau of Equal Opportunity is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Your Rights and Responsibilities Read about your rights and responsibilities:

RIGHT TO NONDISCRIMINATION
This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, 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.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or 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.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, 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: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (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: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

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: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

RIGHT TO CONFIDENTIALITY
We will keep your information private. It will only be used to decide which programs you may be eligible for. The county assistance office (CAO), when requested, must provide federal, state and local law enforcement officials with the address, Social Security number (SSN) and photograph (if available) of an individual who is fleeing to avoid prosecution, custody or confinement for a felony or violating probation or parole. Any person knowingly violating any of the rules and regulations of this department shall be guilty of a misdemeanor and, upon conviction shall be sentenced to pay a fine, not exceeding one hundred ($100) dollars, or to undergo imprisonment, not exceeding six months, or both (62 P.S. section 483).

RIGHT TO A WRITTEN NOTICE
We will give you a written notice explaining your benefits. If we deny, change, suspend or stop benefits, we will give you a written explanation of why. You have 30 days (90 days for Supplemental Nutrition Assistance Program (SNAP) benefits) from the mailing date of the notice to ask for a hearing.

RIGHT TO APPEAL
You have the right to ask for a Department of Human Services (DHS) hearing to appeal a decision if you believe it is unfair or incorrect, or if DHS fails to act on your application for benefits. You may file the appeal at the CAO. If you appeal, you may also request an agency conference before the hearing. If your appeal involves expedited SNAP benefits, you have the right to have this conference with a supervisor within two work days. At the hearing you may represent yourself, or someone else, such as a lawyer, friend or relative may represent you.

RIGHT TO CLAIM GOOD CAUSE
If you apply for cash or Medical Assistance benefits, the law requires you to cooperate with establishing paternity and seeking support. You may be excused from these requirements if you prove it may be dangerous for you and/or your children. This is known as good cause. Unless a good cause exemption is established, you will be required to meet employment and training requirements. You will also be required to meet semi-annual reporting requirements unless good cause is granted.

RIGHT TO CERTIFICATE OF CREDITABLE COVERAGE
Federal law limits when health coverage may be denied or limited for a pre-existing condition. If you enroll in a group health plan that excludes treatment for a condition you already had, you can be credited for the time you received MA coverage. This may help you obtain coverage. Contact your caseworker to request this certificate.

RESPONSIBILITY TO PROVIDE INFORMATION
You must give true, correct and complete information. You must help in proving the information you give. Benefits may be denied if you fail to provide certain proof. If you cannot provide proof, you should ask the CAO to help you obtain it. If you are contacted by DHS or the Office of State Inspector General, you must fully cooperate with those persons or investigators. If you are age 55 or older and receive Medical Assistance to pay for nursing facility services, home and community-based waiver services and any related hospital and prescription drug service, you may be required to repay the cost of these services from your probate estate. If you are applying for cash assistance, we may require you to sign an agreement to repay benefits that you, your spouse and your children have received.

RESPONSIBILITY TO PROVIDE SOCIAL SECURITY NUMBERS
For cash, Medical Assistance and/or SNAP benefits, you must provide an SSN for each person for whom you are applying. If you do not have an SSN, you must apply for one. Not providing an SSN may result in not being able to receive benefits. For cash benefits, we may ask for an SSN for anyone whose income or resources may affect your eligibility or the amount of benefits. Your SSN will be used for identity, for computer matches which verify income and resources, and to prevent duplication of state and federal benefits. A non-citizen who is applying for emergency Medical Assistance only is not required to provide an SSN. (42 U.S. Code 1320b-7)

RESPONSIBILITY TO USE THE PA ACCESS CARD LAWFULLY
Once you are eligible for benefits, you will be issued a PA ACCESS card. This card may only be used for the person who is eligible and only during the eligibility period. You may only use the card for services that are needed and reasonable.

RESPONSIBILITY TO REPORT CHANGES
If you qualify for benefits, you will be required to report changes in your circumstances to your caseworker or to the Customer Service Center. Types of changes reported would include people leaving or moving into the house, a new address, a new job for someone, if someone loses a job, birth of a child, new sources of income or changes to income, and lottery and gambling winnings. Your caseworker and notices you receive will cover the specifics in detail based on the programs and benefits you are eligible for. Failure to report required changes within the program guidelines could result in a loss of benefits, sanctions, or civil or criminal charges. You may report changes to the CAO in person, by phone, fax, mail or through a MyCOMPASS account. You may also report changes to the Customer Service Center at 1-877-395-8930, or for Philadelphia, 1-215-560-7226 any time.

PRIVACY ACT STATEMENT
(i) The collection of this information, including the Social Security number (SSN) of each household member, is authorized under the Food and Nutrition Act of 2008, as amended, 7 U.S.C. 2011-2036d. The information will be used to determine whether your household is eligible or continues to be eligible to participate in the SNAP Program. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management.

(ii) This information may be disclosed to other Federal and State agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law.

(iii) If a SNAP claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action.

(iv) Providing the requested information, including the SSN of each household member, is voluntary. However, failure to provide an SSN will result in the denial of SNAP benefits to each individual failing to provide an SSN. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible household members.

Prohibitions and Penalties Read about your responsibilities:

IF THIS HAPPENS WITHOUT GOOD CAUSE			THIS MAY HAPPEN (PENALTY)
ALL BENEFITS SNAP CASH MEDICAL ASSISTANCE	Misuse Electronic Benefits Transfer (EBT) Card or PA ACCESS Card.		**Fine, prison, or both.**
	Do not report changes, as required.		**Benefits cut or stopped.**
	On purpose, give information that is false, incorrect or incomplete, or not report changes.		**Fine, disqualification and/or jail time for Welfare Fraud, disqualification for administrative hearing proceedings.** **Not eligible for cash:** • **First time - 6 months.** • **Second time - 12 months.** • **Third time - forever.** **Not eligible for SNAP:** • **First time - 12 months.** • **Second time - 24 months.** • **Third time - forever.**
	Trade, sell or attempt to trade, sell, buy or use another person's ACCESS Card.		**Not eligible:** • **All court convictions - 12 months.**
SNAP	On purpose, misuse SNAP benefits, for example, trade, sell, or buy EBT Card or SNAP benefits; convert benefits; or dump containers purchased with SNAP benefits to receive deposits – or buy things not covered by SNAP, such as alcohol or tobacco – or use SNAP benefits to pay for food already received or food on credit.		**Not eligible:** • **First time - 12 months.** • **Second time - 24 months.** • **Third time - forever.** • **First time court conviction over $500 - forever.**
	Purchase a product with SNAP benefits with the intent of obtaining cash or consideration other than eligible food by reselling the product in exchange for cash or consideration other than eligible food.		
	On purpose, purchase products originally purchased with SNAP benefits in exchange for cash or consideration other than eligible food.		
	Use/receive SNAP benefits to buy drugs or controlled substances.		**Not eligible:** • **First time - 24 months.** • **Second time - forever.**
	Use/receive SNAP benefits in sale of firearms, ammunition, or explosives.		**First time - not eligible forever.**
	Be convicted for buying, selling or trading SNAP benefits for total of $500 or more.		**Not eligible forever.**
	Lie about who you are or where you live to receive more than one SNAP benefit.		**Not eligible for 10 years.**
	Flee to avoid prosecution, custody, or confinement because of a felony/attempted felony – or flee because of breaking probation or parole.		**Not eligible until you do what the law says.**
CASH	Do not comply with your court penalty, including payment of fines, for a felony or misdemeanor.		**Not eligible until you comply with your penalty.**
	Lie about where you live to receive cash in two or more states.		**Not eligible for 10 years.**
	Flee to avoid prosecution, custody, or confinement because of a felony conviction/attempted felony; fail to appear as a defendant at a criminal court proceeding when issued a summons or a bench warrant for a summary offense, felony or misdemeanor; flee because of breaking probation/parole; or have any active warrant against you.		**Not eligible until you do what the law says.**
If you are found guilty of fraud or breaking the above rules:			• **Fine up to $250,000 for SNAP and up to $15,000 for Cash;** • **Jail up to 20 years for SNAP and up to seven years for Cash; and/or** • **Paying back benefits received.** • **Disqualification from benefits for periods stated above by program.**
SNAP WORK RULES	For household members – physically and mentally fit – over age 15 and under 60 – not otherwise exempt or with good cause.		**Not eligible:** • **First time - one month and until you do what is required.** • **Second time - three months and until you do what is required.** • **Three or more times - six months each time and until you do what is required.**
	Refuse to: • Accept a job. • Tell CAO about work status and job availability.	On purpose, take action to: • Quit a job. • Cut work hours to less than 30 per week (unless another job already meets work requirements).	
CASH WORK RULES	Do not meet cash work requirements on purpose, as written on the Agreement of Mutual Responsibility (AMR).		**Not eligible:** • **First violation – You will be ineligible for a minimum of 30 days or until the failure to comply ceases, whichever is longer.** • **Second violation – You will be ineligible for a minimum of 60 days or until the failure to comply ceases, whichever is longer.** • **Third violation – You will be permanently disqualified.** **If the reason for sanction occurs within the first 24 months of receipt of cash assistance, whether consecutive or interrupted, the sanction applies only to the individual.** **If the reason for sanction occurs after 24 months of receipt of cash assistance, whether consecutive or interrupted, the sanction applies to the entire family.**

Understanding Your Rights and Responsibilities

When I sign this form:

- I understand that Pennsylvania receives information from the Income Eligibility Verification System (IEVS), financial institutions, consumer reporting and state and federal agencies to verify the information I give them. Information available through IEVS and other entities will be requested, used and may be verified through collateral contact when conflicting details are found by the State agency, and such information may affect my household's eligibility and level of benefits.
- I understand that by signing this application, I am authorizing any financial institution to disclose, through electronic or any other means, any and all financial information held by that institution, to the Department of Human Services or its designated agent or contractor for the purpose of identifying and verifying resources (also called "assets") when needed to determine and redetermine eligibility for Medical Assistance. I understand that financial information includes deposits, withdrawals, account closures and other relevant information requested or received from the financial institution, including other transactions undertaken by the financial institution with respect to the account or asset. I understand that this authorization is effective until Medical Assistance eligibility is denied or ends, or if I decide to revoke it by written notification to the Department, whichever happens first. I understand that if I revoke this authorization, that may make me or my household ineligible for Medical Assistance.
- I understand that if I misrepresent, hide or withhold facts that may affect my eligibility for benefits, I may be required to repay my benefits and I may be prosecuted and disqualified from receiving certain future benefits.
- I understand that I can designate an authorized representative by completing the Authorized Representative section and submitting it with this application.
- I understand and agree that I am responsible for any fraudulent statements made on this application, even if the application is being submitted by someone acting on my behalf.
- I understand any person enriched as a result of a transfer of assets or income, which would have affected my eligibility for Long-Term Care or Home and Community-Based Services, will be liable for repayment of those benefits issued incorrectly.
- I received a copy of my rights and responsibilities, have read them or someone has read them to me, and I understand them.
- I understand that the Department of Human Services or its designees may contact me via methods including email and text messaging to help process my application or request feedback on the application process. If I do not want email or text messages, I understand the Department of Human Services will still process my application.
- I understand that the information entered in this application will be kept confidential and only to administer benefits. I authorize the release of personal, financial and medical information for the purpose of determining eligibility.
- I understand that any changes I am required to report must be reported within the first 10 days of the month following the month of change or, for Long-Term Care and Home and Community-Based Services, within 10 days of the change.
- I understand that my household may lose SNAP benefits if a household member receives lottery or gambling winnings equal to or greater than the SNAP resource limit for elderly or disabled households.
- I understand that I will receive a written notice explaining the benefits. If benefits are denied, changed, suspended or stopped, the written notice will explain why.
- I understand that I will have 30 days (90 days for SNAP (food stamp) benefits) from the date of the notice to request a hearing if I do not agree with the decision made on this application.
- I understand that my situation is subject to verification from employers, financial sources and other third parties.
- I understand that applicants must provide their Social Security number or apply for one if they do not have one. This number may be used to check the information on this application.
- I understand that I must use the Electronic Benefit Transfer (EBT) or the PA ACCESS Card only during the period I am eligible. I must use the EBT or the PA ACCESS Card only for the person who is eligible and may get only the benefits that are needed and reasonable.
- I understand that I may not use Cash Assistance funds issued through my PA ACCESS card to make EBT transactions in liquor stores, casinos (gambling casinos, gaming establishments), or places for adult entertainment.
- I understand that I do not have to provide a Social Security number for anyone who is not applying for assistance. If I do provide their Social Security number, it may be used to check the information on this application.
- I certify that all information that has been entered is true under penalty of perjury.
- I understand that I have the right to a certificate of creditable coverage to verify my medical coverage. Federal law limits when Medical Assistance coverage may be denied or limited for a pre-existing condition. If I enroll in a group health plan that has a pre-existing condition clause, I can get credit for the time I received Medical Assistance.
- I understand that if I am determined eligible for Medical Assistance, I will be placed in the most comprehensive Medical Assistance benefit package that is available to me. I understand that I may be required to enroll in a health plan. I understand that enrolling in a health plan may be free or low cost to me, because the Department pays a monthly fee to the health plan for me. I understand that the monthly fee is a capitation fee. I understand that if I receive Medical Assistance that I am not eligible for, due to error, fraud, or any other reason, then I may be required to repay the Department all monthly fees paid on my behalf.
- If I receive cash benefits, I will cooperate with the requirements of the child support enforcement program as directed by the Department. I give the Department and the Domestic Relations Section the right to pursue and collect cash and/or medical support for me and others for whom I am applying.
- I understand that if I report or provide proof of the household expenses, I will get the maximum amount of SNAP (food stamp) benefits allowed. Failure to report or provide proof of the household expenses will be regarded as my statement that I do not want to receive a deduction for the unreported or unproved expense. (Authority: United States Department of Agriculture, Food and Nutrition Service, Mid-Atlantic Region, Administrative Notice 6-99, issued January 4, 1999).
- I understand that I have the right to receive credit for the household expenses at the time I report and provide proof of them at any time during my SNAP (food stamps) certification period.
- I understand that I have the right to ask the county assistance office (CAO) for assistance in getting proof of expenses and that the CAO can contact other people for confirmation if I am having trouble getting proof of anything.
- I understand that if some or all of the individuals applying do not qualify for Medical Assistance, that they may be eligible for CHIP.
- I understand that if some or all of the individuals applying do not qualify for Medical Assistance through the Department, that they may be eligible for federal benefits and/or explore private health care options through Pennsylvania's Health Insurance Marketplace (Pennie). If this is the case, I authorize the Department to give my name and information on this application to Pennie.
- **Renewal of coverage in future years:** To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow Pennsylvania's Health Insurance Marketplace (Pennie) to use my income data, including information from tax returns. Pennie will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next: (Check one):

- ☐ Five years (the maximum number of years allowed)
- ☐ Four years
- ☐ Three years
- ☐ Two years
- ☐ One year
- ☐ Do not use my information from tax returns to renew my coverage.

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-800-692-7462 (TDD: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-692-7462 (TDD: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-692-7462 (TDD: 711)。

ВНИМАНИЕ: Если вы говорите на русском языке, то вы можете воспользоваться бесплатными услугами перевода. Звоните 1-800-692-7462 (телетайп: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-692-7462 (TDD: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-692-7462 (TTY: 711)។

ملحوظة: إذا كنت تتحدث لغة أخرى، فسوف تتوفر لك خدمات المساعدة اللغوية مجانا. اتصل برقم 1-800-692-7462 (رقم هاتف الصم والبكم: 711)

주: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-692-7462 (TDD: 711)번으로 전화해 주십시오.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-692-7462 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-692-7462 (ATS : 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-692-7462 (TDD: 711).

লক্ষ্য করুন: আপনি যদি বাংলায় কথা বলতে পারেন, তাহলে আপনি বিনা খরচে ভাষা সহায়তা পরিষেবা নিতে পারেন। 1-800-692-7462- নম্বরে কল করুন (TTY: 711)।

သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 1-800-692-7462 (TTY: 711) သို့ ခေါ်ဆိုပါ။

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-692-7462 (TDD: 711).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-692-7462 (TDD: 711).

ध्यान दिनुहोस्: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने भाषा सहायता सेवाहरू तपाईंको लागि नि:शुल्क रूपमा उपलब्ध छन्। 1-800-692-7462 (TDD: 711)

Pennsylvania
Department of Human Services