

If you need assistance completing this application, please ask an Office of Public Assistance staff member.

COMPLETION INSTRUCTIONS:

The Montana Department of Public Health and Human Services (DPHHS) offer several programs to help you. You may either complete this paper application or apply online at <http://apply.mt.gov>

Use this application to apply for:

- Medicaid and Healthy Montana Kids *Plus* (HMK *Plus*), Healthy Montana Kids(HMK)
- Medicare Savings Programs
- Supplemental Nutrition Assistance Program (SNAP) benefits
- Temporary Assistance for Needy Families (TANF) cash assistance
- Refugee Cash Assistance (RCA), Refugee Medical Assistance (RMA) or Refugee Social Services (RSS) – including Refugee Employment & Training (RET).

1. **If you don't have time to complete the full application now, complete the entire first page, including signature, and turn in only the top copy of the first page today.**
2. If you are eligible for **SNAP benefits or RCA**, benefits may start from the date the front page of the application is received. If you are eligible for **TANF cash assistance**, benefits may start from the date the front page of the application is received, or the date you enroll in the WoRC program, if referred, whichever is later. If you are eligible, **Medicaid and Healthy Montana Kids Plus** may begin up to three (3) months prior to the month of application. If you are eligible for **RMA**, benefits start the first of the month in which you applied or the date your refugee/asylee status was granted, whichever is later.
3. You may be entitled to receive **SNAP benefits** within seven days (expedited service). See the back of page 1 for details.
4. Applications will be processed in accordance with SNAP procedures, including timeliness, notice and Fair Hearing requirements, regardless of whether the application is for SNAP and other programs. The SNAP application will not be denied solely because the household was denied benefits from other programs.
4. Complete the entire application to the best of your ability. For SNAP, you have the right to immediately file an application as long as it contains the name, address and signature of a responsible household member or that of an authorized representative. However your eligibility will not be determined until the application is completed and all verification has been turned in.
5. Please use black or blue ink (it is easy to read and copies best). Print your answers.
6. If more space is needed to answer any question, attach an additional sheet with appropriate information about each additional person.
7. The application should be filled out by a household member or an authorized representative who knows the financial situation of all household members. The person completing the application is responsible for the answers given.
8. Any question that refers to "household" is referring to those persons applying for assistance and those financially responsible for them. For Medicaid, Refugee Medical, TANF and SNAP benefits, you need to enter the Social Security number and citizenship.
9. All questions are marked to indicate the program(s) to which they apply.
M for Medicaid, Healthy Montana Kids Plus, or Refugee Medical Assistance
S for SNAP Benefits
C for TANF or Refugee Cash assistance
If only applying for Refugee Social Services, with or without employment and training services, only the first page of this application is needed. Please request a Refugee Services Assessment form to complete prior to your interview, if possible.

Please pay particular attention to these codes in the white section of the application.

10. If applying for **Medicaid, Healthy Montana Kids Plus, Healthy Montana Kids or Refugee Medical Assistance (M)**, complete questions 35 through 44 (light blue background).
11. If applying for **SNAP Benefits (S)**, complete questions 45 through 55 (green background).
12. If applying for **TANF or Refugee Cash Assistance (C)**, complete questions 60 through 62 (light orange background).

For SNAP, the collection of information on the application, including SSN of each household member, is authorized under the Food and Nutrition Act of 2008. As amended, 7 U.S.C. 2011-2036.

APPLICATION FOR ASSISTANCE

GRAY SHADED AREAS ARE FOR INSTRUCTIONS AND AGENCY USE ONLY.

Name: _____ County: _____
 Street Address: _____ City: _____ Zip: _____ Home Phone Number: _____
 Mailing Address: _____ City: _____ Zip: _____ Message Phone Number: _____
 E-Mail Address: _____ Cell Phone Number: _____

Do you live within the geographic boundaries of an Indian Reservation? Yes No

If you do not live at a street address, on a separate piece of paper describe how to get to your home.

Fill in all required blanks for everyone who lives with you either permanently or temporarily. **You must list** yourself first, then your spouse and children, including unborn children, then other adults and children. (Individuals under age 22 must list their parents if living in the same home with their parents.) If you are only applying for SNAP benefits, please list yourself, your spouse, children under age 22, and any others who purchase and prepare meals with you.

M - required for Medicaid/Medicare Savings Program (MSP), Healthy Montana Kids Plus (HMK Plus), Healthy Montana Kids(HMK) and Refugee Medical Assistance, S - required for SNAP, C - required for TANF or Refugee Cash Assistance

Name (Last, First, Middle)	Relation- ship To You	Requesting Yes/No			Birth date	(M,C)	(M,C)	Social Security Number	(M,C)	U.S. Citizen Yes/No
		Medical	SNAP	TANF		Place of Birth	Sex		Marital Status	
1.	SELF									
2.										
3.										
4.										
5.										
6.										

(S) SNAP Expedited Service Questions

What is the total income before deductions your household has received or expects to receive this month?
 If zero, enter zero. \$ _____

How much do the members of your household have in cash and savings? (Give your best estimate)
 If zero, enter zero. \$ _____

How much is your monthly rent/mortgage?
 If zero, enter zero. \$ _____

How much are your current monthly utilities?
 If zero, enter zero. \$ _____

Is anyone in your household a migrant or seasonal farm worker? Yes No

County Use

Income less than \$150 and cash and savings no more than \$100? Yes No
 (If yes, expedite)

Combined income and resources less than rent/mortgage and utilities? Yes No
 (If yes, expedite)

Destitute migrant/seasonal farm worker with liquid resources not exceeding \$100? Yes No
 (If yes, expedite)

Screened for expedited services: Yes No
 Eligible for expedited services: Yes No
 _____ Worker Initial

Penalty Warning: I swear or affirm the statements made on this application are true or correct.

X _____ Date _____
 Signature or Mark of Applicant (or legal guardian/authorized representative).

_____ Date _____
 Witness to Mark (necessary only if applicant cannot sign full name)

INTERVIEW:

1. After your application is filed, you will be notified of the time and date of your interview (if needed). **An interview is not required, but is recommended for Medicaid/HMK Plus. Complete as much of the application as you can.** A worker will help you with any unanswered questions at the interview. If you do not have all necessary information, this could delay a decision on your application.
2. For SNAP benefits, TANF cash assistance and Refugee programs, if you cannot keep your appointment (if needed), **you must schedule another appointment within 30 days of the application date.** If you do not schedule another appointment, your application will be denied.
3. If you are not able to complete a telephone interview or you are unable to find someone to represent you, you can go to your County Office of Public Assistance and request an in person interview.

TO GET SNAP BENEFITS WITHIN 7 DAYS (EXPEDITED SERVICE): You may be entitled to expedited services if your income and resources are not enough to cover your monthly rent/mortgage and utilities, or you have very little income or resources, or your household includes a migrant or seasonal farm worker.

1. Complete the application and provide proof of identity of the person listed as number 1 on the first page. If an authorized representative applies for the household, the identity of the person listed as number 1 on the first page and the authorized representative must be verified.
2. If you do not have time to complete this form now, complete the front page and turn it in now. This will ensure your benefits start from today if you are eligible for SNAP benefits.
3. You must complete all questions not marked with a specific code and all questions marked with the letter S.
4. If you are eligible for expedited service, you will receive SNAP benefits for this month even if you cannot provide all the proof needed at this time.
5. If you feel you are eligible for expedited services but your worker says you are not, you may ask for an administrative review or may request a fair hearing either orally or in writing.
6. If you are not eligible for expedited service, your application will be processed within 30 days following the date the signed application was received.

RIGHTS AND RESPONSIBILITIES:

1. You have the right to file an application on the same day you contact us. You may either leave the entire application or completed front page or mail it to your County Office of Public Assistance.
2. You do not have to be interviewed or have a scheduled appointment before filing the application.
3. Your application will be processed within 30 days for SNAP benefits and Cash Assistance, and 45 days for Medicaid and Refugee Medical Assistance from the date of application except in unusual circumstances as defined by regulation.
4. Applicants soon to be released from an institution may make application for SNAP benefits prior to their release. The application filing date for pre-release applicants is the date of release from the institution if applying for SNAP and SSI at the same time.
5. **Each time you apply for SNAP benefits, do not:**
 - trade or sell SNAP benefits;
 - use SNAP benefits to get ineligible items such as alcoholic drinks, tobacco, or pay on credit accounts; or
 - use someone else's SNAP benefits for your household or let someone use your benefits.
6. For SNAP and RCA benefits you will be required to repay any benefits for which you aren't eligible, including errors caused by this agency. You will be required to repay any TANF, RMA and/or Medicaid, benefits that you aren't eligible to receive for any reason other than this agency's error.
7. The U.S Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the **USDA Program Discrimination Complaint Form**, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

SNAP WORK REQUIREMENTS:

1. Individuals who are physically and mentally fit and between the ages of **16 and 60** shall be **ineligible** if they: (1) refuse without good cause to provide sufficient information to allow a determination of their employment status or job availability; (2) voluntarily and without good cause quit a job; or (3) voluntarily and without good cause reduce their work effort (and after the reduction, are working less than 30 hours a week).
2. Individuals who reside in a county with a SNAP Employment and Training Program may attend this program.
3. Cash Assistance work requirements do not apply to SNAP.

TIME LIMITED BENEFITS:

1. The household may not be eligible for TANF cash assistance benefits if a member of the household has received 60 months of TANF cash assistance benefits in any state. TANF time limits do not apply to Medicaid, SNAP benefits or Refugee programs.
2. An individual who is an able bodied adult without dependents may not be eligible for SNAP benefits if they have received 3 months of SNAP benefits in a 36-month period, unless they meet an exemption, or meet the work requirement.
3. Refugee Cash Assistance and Refugee Medical Assistance are only available to eligible refugees/asylees for 8 months from date of entry or from the date their asylum status was granted. However, Refugee Social Services, such as employment and training assistance, could extend up to five years from date of entry/ date asylee status was granted, depending on federal funding. This application form is not required to apply for Refugee Social Services. For more information about the Refugee Social Service Program, please ask your Office of Public Assistance Case Manager

PENALTIES: SNAP AND TANF CASH ASSISTANCE PROGRAMS:

1. **It is unlawful for you to knowingly make false statements, misrepresent facts, or conceal information to obtain benefits.**
2. **Individuals who knowingly and intentionally break a rule can be prosecuted and fined. Under SNAP, the fine may be up to \$250,000 or you may be imprisoned up to 20 years, or both. Individuals are also subject to prosecution under other applicable federal laws. Individuals may also be barred for an additional 18 months if court ordered.**
3. **Any household member who knowingly and intentionally breaks a SNAP or TANF cash assistance rule can be barred from the program for one year for the first violation; for two years for the second violation; and permanently disqualified after the third violation.**
4. **Any SNAP recipient who has been found guilty in a federal, state or local court of trading SNAP benefits for controlled substances (illegal drugs or certain drugs for which a doctor's prescription is required) will be disqualified from participation for two years for the first offense and permanently for the second offense.**
5. **Any SNAP recipient who has been found guilty in a federal, state or local court of trading SNAP benefits for firearms, ammunition, or explosives will be permanently disqualified from participation upon the first occasion of such violation.**
6. **An individual shall be permanently disqualified from SNAP if he/she has been found guilty in a federal, state or local court of trafficking SNAP benefits of \$500 or more.**
7. **An individual shall be ineligible to participate in SNAP for ten years if he/she is found to have made a fraudulent statement or representation with respect to identity and/or residence in order to receive multiple benefits simultaneously.**
8. **For TANF cash assistance, an individual shall be ineligible to participate in the TANF cash assistance program for 10 years if he/she is found to have made a fraudulent statement or representation with respect to where they live or benefits received in another state in order to receive multiple benefits simultaneously.**

(M-S-C) 1. Are you a Montana resident? Yes No

(M-S-C) 2. If you moved to Montana in the last 12 months, what county and state did you come from and when did you move?

Please check one reason why you moved to Montana:

- Work Like Montana Relatives
 Cash Assistance (TANF) time limits used up in another state Other

(M-S-C) 3. You can choose an AUTHORIZED REPRESENTATIVE to help you with your Medicaid/HMK Plus, RMA, SNAP or Cash Assistance.

Do you want your authorized representative to help you with your cash assistance or Medicaid card? Yes No

Do you want your authorized representative to help you apply for your SNAP assistance? Yes No

Do you want your authorized representative to have access to your Montana Access SNAP account and use your benefits to buy food for you? Yes No

Do you want your authorized representative to receive copies of your letters or notices? Yes No

Do you have a Power of Attorney or legal guardian? Yes No

List the authorized representative's, Power of Attorney, or Legal Guardian's name, address, and telephone number below. (You can name multiple authorized representatives for a case but for Medicaid, HMK Plus and RMA, only one per individual. If additional representatives are named please complete the following information on an additional piece of paper. Be sure to provide the legal documents.)

Last Name	First Name	Middle Initial	Phone
Mailing Address			Zip
City			

(M-S-C) 4. Is any household member temporarily out of the home? Yes No
If yes, list name, date left, date to return, where person went (such as in the hospital, away at school, looking for work, etc.)

(M-C) 5. Is anyone in your home pregnant? Yes No

Who is Pregnant?	How Many Babies? (Twins, triplets, etc?)	Estimated Due Date	Father of Unborn

(Medical proof may be required)

(S-C) 6. Do you share your home with others not listed on the front page? Yes No
If so, please list names

(M-S-C) 7. Has anyone listed on page 1 ever used another name (such as a maiden name, former married name, etc.) or Social Security Number? Yes No
If yes, please provide details:

(M-C) 8. Do you share custody of a child with another adult not included in your household? Yes No
 If yes, please complete the following:

Name of child	Who shares custody with you?	What percentage of the time does this child live with you?

(M-S-C) 9. Is any household member currently a student (beyond high school level)? Yes No
 If Yes and applying for Medicaid, HMK Plus, Refugee Medical Assistance, TANF or Refugee Cash,
 please complete the following box by entering data for each household member age 16 or older.

Household Member Name	Attending school (list name of school)	No Degree/ GED/ Diploma	High School Diploma/ GED	Associate's Degree	Bachelor's Degree	Other Credentials

VOLUNTARY: Please complete questions 10 and 11 for all household members. These questions regarding ethnic and racial background will not be used to determine your benefit level or eligibility. If you do not answer, your worker will complete this section. Questions about ethnic and racial background are authorized by Title VI of the Civil Rights Act of 1964. The reason for the information is to assure that program benefits are distributed without regard to race, color, or national origin.

(M-S-C) 10. Please mark one ethnic category for each household member.

Household Member Name	Hispanic/Latino	Non-Hispanic/Latino

IF MORE SPACE IS NEEDED, ATTACH A SEPARATE SHEET

(M-S-C) 11. Please mark one or more racial heritage categories for each household member.

Household Member Name	American Indian or Alaskan Native	Asian	Native Hawaiian or Pacific Islander	Black or African American	White

IF MORE SPACE IS NEEDED, ATTACH A SEPARATE SHEET

****If you are an Alaskan Native or Native American Please complete Appendix B at the end of the application****

(M-C) 12. If anyone in the household is an enrolled tribal member, enter the individual's name, the name of the tribe, and the tribal enrollment number.

Enrolled Member's Name	Name of Tribe	Tribal Enrollment Number

IF MORE SPACE IS NEEDED, ATTACH A SEPARATE SHEET

(M-S-C) 13. Is anyone in your household a roomer or boarder (pays for room and/or meals)? Yes No
 If yes, please list who. _____

(M-S-C) 14. Is anyone unable to work or disabled because of physical or mental health problems?
 (If a payment is not being received, additional information or proof may be required.) Yes No

If yes, complete the following:

Name	Medical condition	Source of disability payment

(M-S-C) 15. Is any household member unable to work outside the home because he or she is caring for a disabled household member? Yes No

If yes, please complete the following:

Disabled member's name	Name of person providing care	Name of physician	Expected length of disability

(M-C) 16. Is anyone applying for assistance an alien (not a U.S. Citizen)? Yes No

If yes, please complete the following:

Alien's Name	Alien Status	Date of Entry into US or date asylum status was granted	Sponsor's Name/Address (if applicable)

(M-C) 17. Have you ever been declared a Refugee or applied for asylum in the U.S? Yes No
 If yes, what year _____ and what services do you currently need?

- | | |
|---|--|
| <input type="checkbox"/> Medical | <input type="checkbox"/> Cash |
| <input type="checkbox"/> Case Management | <input type="checkbox"/> Employment & Training |
| <input type="checkbox"/> Immigration/Legal Assistance | |

*****If you are applying for only Family or Child related Medical coverage, please skip to question 22 *****

(M-S-C) 18. Put a check mark in the box in front of the property/account owned by household members (including children). Include property/accounts jointly owned with others in or outside the household. (If not applicable, please check none).

- | | |
|---|--|
| <input type="checkbox"/> Bank Account(s) | <input type="checkbox"/> Stocks / Bonds |
| <input type="checkbox"/> Cash | <input type="checkbox"/> Trust Funds |
| <input type="checkbox"/> Individual Indian Money Accounts | <input type="checkbox"/> Child Support MAC Account |
| <input type="checkbox"/> Retirement Accounts | <input type="checkbox"/> Other (Specify) |
| <input type="checkbox"/> Certificates of Deposit | <input type="checkbox"/> None |

For all items checked, fill in the boxes below.

Names of Financial Institutions	Type of Property/Account	Owner(s)/Joint Owner(s)	Amount

(M-S-C) 19. Put a check mark in the box in front of the property owned or being purchased by any household member. Include property co-owned with others in or outside the household. (Copies of the contracts will be required for all such arrangements.) (If not applicable, please check none)

- | | |
|---|--|
| <input type="checkbox"/> The Home You Live In (Include mobile homes) | <input type="checkbox"/> Income Producing Property |
| <input type="checkbox"/> Camper/Trailer (other than the home you live in) | <input type="checkbox"/> Contracts for Deed |
| <input type="checkbox"/> Life Insurance (List all policies)
(Optional if applying for SNAP only) | <input type="checkbox"/> Burial Trust/Contracts/Policies |
| <input type="checkbox"/> Farm/Business Equipment | <input type="checkbox"/> Life Estates |
| <input type="checkbox"/> Livestock | <input type="checkbox"/> Mineral Rights (oil, gas, coal, etc.) |
| <input type="checkbox"/> Tools/Equipment for Work | <input type="checkbox"/> Annuity |
| <input type="checkbox"/> Other Houses, Land or Buildings | <input type="checkbox"/> Other (specify) _____ |
| | <input type="checkbox"/> None |

For all items checked, fill in the boxes below.

Owner(s)/Joint Owners	Type of Property/Account	Value	Amount Owed	Location/Account Number	For Sale Yes/No	Equity

(M-C) 20. Put a check mark in the box in front of all vehicles owned or being purchased by any household member. Include vehicles owned with others in or outside the household. (If not applicable, please check none).

- | | |
|---|---|
| <input type="checkbox"/> Car | <input type="checkbox"/> Snowmobile |
| <input type="checkbox"/> Truck | <input type="checkbox"/> Boat and/or Boat Motor |
| <input type="checkbox"/> Motorcycle/ATV | <input type="checkbox"/> Motor Home or Recreational Vehicle |
| <input type="checkbox"/> Trailer | <input type="checkbox"/> Airplane |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> None |

Fill in the boxes below for all vehicles, including vehicles that are not running or are not licensed.

Year	Make	Model	Owner(s)/Joint Owner(s)	Licensed or Unlicensed	Amount Owed	County Use

(M-S-C) 21. List any vehicles, money, property or other assets sold, traded or given away by any household member within the last 3 months for SNAP applications or within the last 5 years for Medical.

****This is evaluated on a case by case basis. If additional information is needed you will be notified.****

Item	Date sold, traded or given away	Name of person who sold, traded or gave away item	Name of person item was sold, traded or given to	Relationship to person who sold, traded or gave away item

(M-S-C) 22. Put a check mark in the box in front of all unearned income (not from employment) received by any household members. (If not applicable, please check none)

- | | |
|--|---|
| <input type="checkbox"/> Social Security | <input type="checkbox"/> Veterans Benefits |
| <input type="checkbox"/> Supplemental Security Income | <input type="checkbox"/> Military Allotment |
| <input type="checkbox"/> Unemployment Insurance | <input type="checkbox"/> Retirement Benefits/Pensions |
| <input type="checkbox"/> Workers' Compensation | <input type="checkbox"/> Lease Income |
| <input type="checkbox"/> Alimony | <input type="checkbox"/> Royalties |
| <input type="checkbox"/> Child Support Current | <input type="checkbox"/> Foster Care Payments/Adoption Payments |
| <input type="checkbox"/> Child Support Arrears(Back Pay) | <input type="checkbox"/> Insurance Settlement |
| <input type="checkbox"/> Gifts/Contributions | <input type="checkbox"/> Loans |
| <input type="checkbox"/> Assistance Payments from a Tribe or Other State | <input type="checkbox"/> Temporary Disability Insurance |
| <input type="checkbox"/> General Assistance (includes County or BIA) | <input type="checkbox"/> Other (<i>Specify</i>) |
| <input type="checkbox"/> Interest/Dividends/Annuity payments | <input type="checkbox"/> None |
| <input type="checkbox"/> Trust Payments: | |
- Do you pay taxes on trust payments? Yes No

Name	Type of Income	How Often Paid	Amount

(M-S-C) 23. Has anyone in your household applied for or received Unemployment Insurance (UI) or Workers' Compensation (WC) within the last 12 months? Yes No

If yes, complete the following:

UI <input type="checkbox"/> WC <input type="checkbox"/>	UI <input type="checkbox"/> WC <input type="checkbox"/>
Name: _____	Name: _____
Start Date: _____ End Date: _____	Start Date: _____ End Date: _____
Reason Terminated/Denied: _____	Reason Terminated/Denied: _____
Received During Past 12 Months: <input type="checkbox"/> Yes <input type="checkbox"/> No	Received During Past 12 Months: <input type="checkbox"/> Yes <input type="checkbox"/> No

(M-S-C) 24. Mark the box and list the amount of student financial aid applied for or received within the last 12 months by any household member.

- | | | | |
|---|----------|---|----------|
| <input type="checkbox"/> Student Loan | \$ _____ | <input type="checkbox"/> Veterans Assistance | \$ _____ |
| <input type="checkbox"/> PELL Grant | \$ _____ | <input type="checkbox"/> Scholarships | \$ _____ |
| <input type="checkbox"/> Bureau of Indian Affairs | \$ _____ | <input type="checkbox"/> Other (include family, work study, church, employer, etc.) | \$ _____ |

(M-S-C) 25. Does anyone expect to receive any money (such as settlement from a legal action, child support, retirement, pensions, disability or accident insurance)? Yes No

If yes complete the following:

Who will receive money	Source	Expected date	Expected amount

County Use Only:	Date of Accident: _____
Name of Person Injured: _____	Lawyer's Name: _____
Person or insurance company who is or may be responsible for paying any of these medical costs: _____	

(M-S-C) 26. Is anyone in the household currently working or have they worked in the past 4 months? Yes No

List all household members who **have worked, will work, or are currently working any kind of job this month, or will receive wages this month due to work done in a previous month.** Include: Present Employment (full-time and part-time)-Spot Jobs-Tips-Commissions-Work Study. **PLEASE PROVIDE WAGE VERIFICATION FOR THIS MONTH AND LAST MONTH**

	Complete a column for each job held by any household member		
Person Employed			
This Month's Total Wages <u>Before Taxes</u>			
Business Name			
Business Address			
Business Phone			
Date Job Starts			
Average Hours Per Week			
Pay Per Hour			
Average Tips Per Week			
How Often Paid			
Dates Pay Received			
Ending Pay Period Date			
(M) Is Health Insurance available from your job?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

(M-C) 27. Do you or any household member expect a change in earnings or number of hours worked (e.g., vacation, seasonal employment)? Yes No
If yes, please explain. _____

(S-C) 28. Has anyone in your household stopped working or reduced work hours in the last 30 days? Yes No
If yes, fill in the boxes below, and include any wages paid **this month** in question 24.

Name		Name of Employer	Date Left Job or Reduced Hours
Date & Amount of Final Check	Reason for Leaving	Is it a Temporary Layoff?	Date Expected to Return to Work

Use separate sheet for additional persons.

(S-C) 29. Is anyone in your household on strike? Yes No
If yes, please list who, when the strike began, employer's name and amount of strike income.

(M-C) 30. Is any member of your household a veteran, a spouse or child of a veteran (living or deceased)? Yes No

If yes, complete the following:

Name of Active Duty/Veteran	Relationship to You

Is any member of your immediate family (living with you or are not part of the household) an active duty member of the U.S. Armed Forces? (Including reservists on active duty.) Yes No

If yes, complete the following:

Name of Active Duty/Veteran	Relationship to You

(M-S-C)31. Is anyone in the household self-employed or have they been self-employed within the past year?

Yes No

If yes, complete the following:

Name and Type of Business	Name of Owner	Tax status of Business	Gross Income	For Sale? Yes/No
		<input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Liability Corporation <input type="checkbox"/> Corporation <input type="checkbox"/> S Corporation		
		<input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Liability Corporation <input type="checkbox"/> Corporation <input type="checkbox"/> S Corporation		

****Please Provide Self-Employment Records****

County Use Only:

(M-S-C)32. Is anyone in your household working in exchange for any living expense or housing cost(s)?

Yes No

If yes, please explain. _____

(M-S-C)33. List expenses for which you are billed, and responsible to pay. If you do not report and verify expenses, the expense deduction will not be allowed. Not all expenses are allowed for all programs. If anyone outside the household pays any expense for the household, please write their name in the last column.

Item	Current Total Monthly Cost	Household's Share	Who Assists in Paying the Expense?
Rent	\$		
Lot Rent	\$		
Mortgage	\$		
Property Taxes (if separate from mortgage)	\$		
Home Insurance (if separate from mortgage)	\$		
Electricity	\$		
Natural Gas/Propane	\$		
Oil	\$		
Wood/Coal/Other Heat Source	\$		
Water/Sewer	\$		
Garbage/Trash	\$		
Basic Phone Rate (do not include long distance calls)	\$		
Utility Installation Fee (not deposit)	\$		
Dependent Care (adult or child)	\$		
Child Support (paid) Current	\$		
Child Support (paid) Arrears/Back pay	\$		
Alimony/Spousal Support (not for SNAP)	\$		
Medical Insurance Premiums	\$		
Medical Payments/Bills (elderly or disabled only)	\$		
Medicare Premiums	\$		
Other Expenses (specify)	\$		

(M-C-S) Please check: I live with others and do not pay rent. Yes No

(M-S) Please list your primary heating and cooling source _____
 Are your utilities included in your rent? Yes No

(M-S-C)34. If you indicated a dependent care expense above, please complete the following:

Child(ren) Name	Person or Program Paying for care	Name of Provider	Monthly Amount Paid	Reason for Care (Check all that apply)	Type of Provider	Is provider a Relative of the Household?	Is provider Licensed ?
				<input type="checkbox"/> Looking for Work <input type="checkbox"/> Training/School <input type="checkbox"/> Employment	<input type="checkbox"/> In Home Daycare <input type="checkbox"/> Family Daycare <input type="checkbox"/> Group Daycare <input type="checkbox"/> Daycare Center	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
				<input type="checkbox"/> Looking for Work <input type="checkbox"/> Training/School <input type="checkbox"/> Employment	<input type="checkbox"/> In Home Daycare <input type="checkbox"/> Family Daycare <input type="checkbox"/> Group Daycare <input type="checkbox"/> Daycare Center	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
				<input type="checkbox"/> Looking for Work <input type="checkbox"/> Training/School <input type="checkbox"/> Employment	<input type="checkbox"/> In Home Daycare <input type="checkbox"/> Family Daycare <input type="checkbox"/> Group Daycare <input type="checkbox"/> Daycare Center	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

IF MORE SPACE IS NEEDED, ATTACH A SEPARATE SHEET

COMPLETE THE BLUE SECTION (QUESTIONS 36 THROUGH 42) ONLY IF YOU ARE APPLYING FOR MEDICAID, HMK PLUS, HEALTHY MONTANA KIDS, OR REFUGEE MEDICAL ASSISTANCE.

ATTENTION: ALL MEDICAL APPLICANTS:

All Medicaid recipients under 21 years of age are eligible for the Early Periodic Screening Diagnostic Treatment (EPSDT) Program. This program promotes preventive health care and offers a comprehensive well-child examination. The examination includes:

- measurement of height and weight
- blood pressure test
- lab tests
- hearing test
- growth and developmental assessment
- immunizations
- dental exam
- vision test

The EPSDT Program also offers follow-up diagnosis and treatment for any problems found.

ATTENTION: ALL LONG TERM CARE AND HOME AND COMMUNITY BASED SERVICE(WAIVER) APPLICANTS:

You MUST contact the Mountain Pacific Quality Foundation Screening Team immediately at 1-800-219-7035 or 406-443-0320(In Helena Area). The screening team will set the effective date for Medicaid payment (provided all other eligibility criteria are met). Medicaid payment may not be available for care provided before the screening date.

(M) 35. Does anyone in the household have medical benefits through either Medicare (Part A, B, C or D) or railroad retirement? Yes No

If yes, please list their name(s) and provide verification.

Who: _____ **Medicare Number** _____

Who: _____ **Medicare Number** _____

(M) 36. Is a group health insurance plan available to anyone in your household? Yes No
Is coverage available through an absent parent? Yes No
Is anyone in your household enrolled a group or private insurance? Yes No

(M) 37. Is anyone in the household covered by health and/or dental insurance? Yes No

If yes, Complete the following information. If you have separate insurance cards for medical, dental or eye care, the following information must be completed for each coverage. For additional policies, please attach a sheet containing this information.

Policy Holder: _____ **SSN:** _____

Insurance Company(Name and Address): _____

Policy Number: _____ **Group Number:** _____

Covered Persons: _____

(M) 38. Does anyone in the household have medical bills for services received during the last three months OR is anyone making payments on unpaid medical bills for services received at any time? Yes No

If yes, do you want Medicaid coverage for the services received in the last three months? Yes No

If yes, list months: _____
 (Verification of income, resources and medical expenses for each month listed will be required)

(M) 39. Do you intend to file a tax return next year? Yes No
 Will you file jointly with a spouse? Yes No Name of spouse: _____
 Will you claim any dependents? Yes No Who: _____

Will you be claimed as a dependent on someone else's taxes? Yes No
 If yes, who and what is your relation to that person: _____

Is there a second tax filer in the household? Yes No
 Who? _____ Will they file with a spouse? Yes No
 Name of Spouse: _____ Any Dependents? _____
 (If more space is needed attach separate paper)

(M) 40. Were you or anyone in the household in Foster Care and receiving Medicaid at age 18 or older? Yes No
 Who: _____

(M) 41. Do you want your Medicaid cost share/cash option slips mailed to someone other than yourself? Yes No
 If yes: Name and address: _____

(M) 42. Do you have any of the following taxable (by the IRS) Income? Check all that apply (if not applicable please select none).

- | | |
|--|--|
| <input type="checkbox"/> Taxable Interest | <input type="checkbox"/> Tax Exempt Interest |
| <input type="checkbox"/> Dividends (ordinary or Qualified) | <input type="checkbox"/> IRA Distributions |
| <input type="checkbox"/> Other (Example: Jury Duty) | <input type="checkbox"/> None |

Who?	What Type?	How Often?	How much?

(M) 43. Do you have any of the following tax expenses?

- | | |
|---|---|
| <input type="checkbox"/> Moving Expenses | <input type="checkbox"/> Self-Employed health insurance deduction |
| <input type="checkbox"/> IRA Deduction | <input type="checkbox"/> Student Loan Interest Deduction |
| <input type="checkbox"/> Tuition and Fees | <input type="checkbox"/> Other |
| <input type="checkbox"/> None | |

Who?	What Type?	How Often?	How much?

(M) 44. Did anyone in your home once receive Supplemental Security Income(SSA) which later stopped? Yes No
 If yes, does this person now receive Social Security Administration(SSA)benefits? Yes No

COMPLETE THE GREEN SECTION (QUESTIONS 43 and 52) ONLY IF YOU ARE APPLYING FOR SNAP BENEFITS.

- (S) 45. Are you approved for or receiving LIEAP? (Low Income Energy Assistance Program) Yes No
- (S) 46. Do you pay heating or cooling costs separate from rent? Yes No

- (S) 47. Does anyone in your household purchase and prepare food separately from other household members? Yes No

- (S) 48. Is anyone in your household certified to receive Tribal food commodities? Yes No

If yes, who and where? _____

- (S) 49. Has anyone in your household received SNAP benefits in the last 30 days? Yes No

If yes, where and when? _____

- (S) 50. Have you ever had an EBT card issued from Montana? Yes No
Do you still have your EBT card? Yes No

- (S) 51. Have you or any member of your household ever been disqualified from SNAP for providing incorrect information or failing to provide information to a caseworker that affected SNAP eligibility and benefits? Yes No

If yes, list the person's name, date it happened, date disqualified, and the length of the disqualification period.

- (S) 52. Have you or any member of your household been found guilty of trading SNAP benefits for drugs after September 22, 1996? Yes No

- (S) 53. Have you or any member of your household ever been convicted of trafficking SNAP benefits of \$500 or more after September 22, 1996? Yes No

- (S) 54. Have you or any member of your household been found guilty of trading SNAP benefits for drugs, guns, ammunition or explosives after September 22, 1996? Yes No

- (S) 55. Have you or any member of your household been convicted of fraudulently receiving duplicate SNAP benefits in any State after September 22, 1996? Yes No

- (S-C) 56. Are you, or any member of your household, fleeing to avoid prosecution, or custody/confinement after conviction for a crime which is a felony? Yes No

- (S-C) 57. Are you, or any member of your household, currently in violation of probation or parole? Yes No

- (S-C) 58. Are you, or any member of your household, a convicted felon (after August 22, 1996) for possession, use, or distribution of a controlled substance (illegal drugs or certain drugs for which a doctor's prescription is required)? Yes No

If yes, please explain. (Has the sentence been discharged? Are you in compliance with the conditions of supervision or actively participating in treatment, if required, or for a crime committed while under the influence of a controlled substance?)

(S-C) 59. Have you, or any member of your household, ever been found to have fraudulently misrepresented identity or residence in order to obtain multiple benefits at the same time after September 22, 1996? Yes No

If yes, who? _____ Where? _____

COMPLETE THE ORANGE SECTION (QUESTIONS 57 THROUGH 60) IF YOU ARE APPLYING FOR TANF OR REFUGEE CASH ASSISTANCE.

(C) 60. Has any household member received family cash assistance in any other state or tribal program between October 1, 1996 and today's date? Yes No

If yes, list the household member(s), state, name of tribal program (if applicable), and estimated time period of assistance.

Household Member Name	State	Tribal Program	Time Period

(C) 61. Does any agency help you in paying your shelter costs? Yes No

If yes, please put a check mark in front of the type of assistance received:

- Public Housing--Housing units or buildings owned or under the control of the Public Housing Authority.
- Rent Subsidy--Any other form of housing in which money is paid from a government-funded housing program.

Amount you pay: \$ _____

(C) 62. Enter the appropriate education level and status for each household member as follows:

EDUCATION LEVEL	EDUCATION STATUS
Enter the highest grade COMPLETED for each household member of any age or enter one of the following codes for household members who have not yet started or never attended school: PS Pre-school HS Head start KI Kindergarten NS Never attended school	Enter the appropriate education status for all household members sixteen (16) years of age or older from the following code table: H GED/High School Diploma A Associate Degree B Bachelor Degree M Master Degree O Other Degree N No Degree/GED/Diploma

NAME	EDUCATIONAL LEVEL	EDUCATION STATUS

(M-C) 63. Do you expect any changes within the next three months regarding the information you gave us today? Yes No

If yes, please explain. _____

**READ CAREFULLY BEFORE SIGNING.
IF YOU DO NOT UNDERSTAND SOMETHING, ASK YOUR WORKER ABOUT IT.**

I UNDERSTAND THAT:

- I must report any changes in my situation to the county Office of Public Assistance. For Medicaid, HMK *Plus*, HMK, Refugee Medical, TANF or Refugee Cash Assistance, changes must be reported within 10 days of knowledge of the change. Late reporting may cause incorrect benefits.
- I must provide information and proof as requested to help determine that I am eligible for assistance. DPHHS may help me obtain the proof or contact other persons or agencies to assist me. If I need help with gathering proof, I must tell the Office of Public Assistance that I do need help.
- The information I (we) give here is subject to verification by federal, state, and local officials to determine if the information is factual. If any information is incorrect, my application may be denied and I may be subject to the criminal penalties for knowingly providing incorrect information. If a SNAP claim arises against your household the information on this application, including all SSN's, may be referred to Federal or State agencies, as well as private claims collection agencies, for claims collection action.
- The collection of information on the application including my (our) Social Security number(s) will be used by state and federal agencies to check identity of household members, to prevent duplicate participation, and to exchange information by computer with other agencies (Social Security Administration, Internal Revenue Service, employers, and banks). The information obtained from these sources may affect my eligibility or benefit level and may be verified through collateral contacts when discrepancies are found by the State agency. The Social Security number(s) may also be disclosed to other Federal and State agencies for official examination, and to law enforcement officials for the purpose of apprehending fleeing felons/probation or parole violators. It will also be used for claims collection purposes and used to monitor compliance with program regulations and program management. For SNAP the collection of this information on the application, including SSN of each household member, is authorized under the Food and Nutrition Act of 2008. As Amended, 7 U.S.C 2011-2036.
- My (our) alien status information may be verified with United States Citizenship and Immigration Services (USCIS). This information may affect eligibility or level of benefits.
- By asking for and receiving TANF or Refugee Cash Assistance, adults may be required to participate in an employment or training activity. may be pro-rated from the date all adults negotiate and sign an agreement to participate in employment or training activities.
- Federal and state laws and regulations limit the use and disclosure of confidential or protected health information about applicants and recipients of assistance programs.
- If approved for Medicaid/ HMK *Plus*, my (our) rights to any health insurance or other third party payment are automatically assigned by law to the State of Montana.
- If approved for TANF cash assistance, my (our) rights to medical and child support are automatically assigned to the State of Montana.
- If approved for Medicaid under certain family-related programs, my (our) rights to medical support are automatically assigned to the State of Montana.
- Under Montana law, medical assistance paid on behalf of individuals age 55 or older or anyone who lived in a nursing home (regardless of age) may be subject to recovery from the individual's estate. Additionally, a lien may be placed on any real property owned by any individual who receives medical assistance for nursing home services.
- I may request a fair hearing if I disagree with any action taken on my case. For SNAP, the request may be orally or in writing. For other assistance programs, the request must be submitted to the agency in writing. Your case may be presented by a household member or a representative, such as a legal counsel, a relative, a friend or other spokesperson.
- By asking for and receiving TANF or Refugee Cash Assistance and/or Medicaid I (we) will be required to apply for and/or accept other benefits, programs, income or assets to which I (we) may be entitled. These include, but are not limited to: Social Security Disability, Child Support, annuity payments, Medicare, Unemployment Insurance, settlements, inheritance, winnings etc.
- DPHHS is authorized to match TANF and SNAP recipients' information through the National Directory of New Hires (NDNH). The results may affect your eligibility for TANF and/or SNAP Benefits.
- For SNAP the signature of the primary information person, other adult household member or an authorized representative on this application constitutes registering for work of all non-exempt household members.
- Information provided by applicants and/or recipients of financial assistance may be subject to verification via a computer matching program with the Social Security Administration. This is authorized per the Privacy Act of 1974; 5 U.S.C. 552a as amended.
- Cooperation with a random Program Compliance review is mandatory to remain eligible for continued benefits.

Required for all programs:

I understand the questions on this application and the penalty for withholding or giving false information or breaking any of the rules listed in the penalty warning. I understand and agree to provide documents to prove what I have said. I understand and agree that the Agency may contact other persons or organizations to obtain necessary verification of any statements on this application.

By signing below, I certify under penalty of perjury, that all my answers are correct and complete to the best of my knowledge, including information about the citizenship or alien status of each household member. I understand the information provided on this application can be used to establish identity for children under age 16. I have been informed my household is authorized to receive TANF Information and Referral services. I have been given the TANF Information and Referral Service brochure that has information about these services.

Your Signature	Today's Date	Witness Signature (If applicant signed with an X)
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(M, C) Signature(s) of ALL other individuals age 18 or older who live with you (if applying for TANF/Refugee Cash Assistance or Medicaid/HMK *Plus*):

Name	Relationship to Applicant	Date
Name	Relationship to Applicant	Date

COUNTY USE ONLY:

Date of Application: _____

Your interview is scheduled for: Date: _____ Time: _____

For SNAP, TANF or Refugee Cash Assistance, if you cannot keep your scheduled interview appointment, YOU MUST SCHEDULE ANOTHER APPOINTMENT.

VERIFICATION

The following is a list of possible verifications to bring to the interview or submit with your application which may speed up the application process. Social Security Number, Citizenship/alien status and identity must all be verified for all individuals requesting Medicaid/HMK *Plus*. For SNAP benefits, only the head of household needs to verify identity.

Social Security Numbers:

- You must be able to provide a Social Security number or proof that you have applied for a number for all individuals requesting assistance for any program (SNAP-**S**, Medicaid/MSP/RMA-**M**, or TANF/Refugee Cash Assistance-**C**)

Citizenship/Alien Status: (Required only for those requesting Medicaid/HMK *Plus*/RMA or TANF/Refugee Cash Assistance.) SNAP only requires verification of citizenship/alien status if questionable):

- U.S. Passport
- Official Birth Certificate
- Certificate of Naturalization
- USCIS forms
- Alien Registration Card
- Certificate of Citizenship
- Baptismal Certificate (allowed for Medicaid only if within three months of birth)

Identity: Medicaid: Required for all household members who are applying for Medicaid, HMK *Plus* or Refugee Medical benefits, and may be needed for spouses, minor children or siblings of those applying and parents of minor children who are applying. SNAP: only the head of household is required to verify their identity:

- Driver's license
- State ID card
- Military dependent ID card
- Tribal documents
- Federal or local government ID card
- Military card or draft record
- School ID with picture
- Nursery or day care records

Certain other documents may be accepted as proof of identity based on federal guidance.

Income and Resources:

- Pay stubs, pay envelopes, earnings statements from employers
- Award letters for Social Security, Supplemental Security Income, Unemployment Insurance benefits, Workers' Compensation, Veterans Administration benefits, pensions, etc.
- Child support and/or alimony stubs or payment records
- Bank statements for checking accounts and savings accounts
- Financial statements for certificates of deposit or stocks and bonds
- Federal income tax returns, bookkeeping records, expense records
- Rental income or sales contract records/ledgers
- Life insurance and/or burial policies (Not required for SNAP)
- Trust documents
- Statements of loans, gifts or contributions that you have received
- Automobile/equipment statements of loans or balance due (Not required for SNAP)
- Vehicle registrations or titles (Not required for SNAP)
- Printout or other documentation of IIM account activity

Expenses: (Providing verification of expenses is optional; however, failure to do so will result in expense not being allowed which may result in a determination of ineligibility or in fewer benefits):

- Dependent care bills and receipts
- Medical expense bills or statements (medication, doctor bills, hospital bills, insurance premiums). Include copies of Medicare and health insurance explanation of benefits/payment statements.
- Child support paid to a non-household member.

Other:

- Doctor's statements of pregnancy and due date (Not required for SNAP)
- Copy of certified divorce decree/legal separation (Not required for SNAP)
- Medicare card or information showing eligibility for Medicare Part A, B, C or D (Not required for SNAP, TANF or Refugee Cash Assistance).
- Health insurance policies (Not required for SNAP)
- Commodity release (Not required for Medicaid or TANF)
- School Enrollment (Not required for Medicaid or SNAP)