APPLICATION FOR ASSISTANCE

Welcome to the Department of Health & Human Services (DHHS), Division of Family Assistance (DFA)

This is your application for the programs and services we offer. Please read all of the information given to you, and answer all of the questions as best as you can. ***Do not answer anything that you do not understand***. If you need help in filling out this application, tell us. ***We will accept your application even if you only fill in your name, address, signature, and program(s) requested.*** DFA assistance is based on your income. Some DFA programs may also look at the cash value of things that you own, your "resources," when figuring out if you qualify for a program DFA offers. Some resources, such as the home where you live, are not counted. Your Family Services Specialist (FSS) will explain which resources are counted.

Food Stamps

The Food Stamp Program helps low-income people buy the food they need for good health. You will need to complete an interview with an FSS to see if you are eligible for this program. ***Your benefits are based on the date you give us an application.*** The resource limits for this program are:

- $2,000 per household; or
- $3,000 if one member of the household is at least 60 years old, or disabled.

With identification, you may get emergency food stamps within 7 calendar days if:

- you have less than $150 in monthly gross income and no more than $100 in liquid resources;
- you have shelter costs that are higher than your gross income and liquid resources; or
- you are a migrant or seasonal farm worker who is destitute as defined in 7 CFR 273.10(e)(3).

Social Security Numbers (SSN)

The Federal Privacy Act of 1974 requires that we tell you the laws that allow us to ask for the Social Security Numbers (SSN) of each person requesting assistance, whether you are required to give them to us, and what we will do with them. SSNs are required for the following programs. After each program is the Public Law that requires us to ask for these SSNs.

- NHEP/FAP: Section 137 of Federal Public Law 92-603.
- Food Stamps: Section 4 of Federal Public Law 96-58.
- Medical Assistance and other financial assistance: Section 2651 of Federal Public Law 98-369.

Each person who wants assistance from the above programs, must provide an SSN or apply for a number at the Social Security Administration. If you are applying only for some members of your family, such as a parent applying for Medical Assistance just for a child, you only have to give us the child's number or apply for one for your child. Your child's eligibility for medical coverage will not be affected if you don't give us your SSN.

If an SSN is not provided for each person who is applying for the listed programs, your application may be denied or you may get less benefits.

Applicants for Healthy Kids Silver Premium Program do not have to provide an SSN.

We ask for SSNs so we can share earned and unearned income and resource information between DHHS and:

- the Social Security Administration;
- New Hampshire Employment Security;
- the Internal Revenue Service;
- financial institutions; and
- other computer matching programs.

This information may be shared with various offices within DHHS as allowed by federal law, used to identify or verify any errors in your eligibility and benefits, and used in an investigation of suspected abuse of program law or rules.

We do not give SSNs or any other information regarding non-applicants to the Bureau of Citizenship and Immigration Services (BCIS), formerly known as INS, or any other agency not directly connected with programs and/or services offered by DHHS.

Emergency Medicaid for Non-Citizens

Emergency Medicaid is available to non-citizens, regardless of their immigration status, to cover some emergency services, including labor and delivery. ***Social Security Numbers are not needed to apply for Emergency Medicaid.***

Citizenship

You must declare the citizenship or non-citizenship status of each household member applying for assistance. Non-citizens applying for assistance, except Emergency Medicaid, must provide BCIS documentation of qualified alien status. BCIS documentation will be verified.

Third Party Medical Payments

If you are applying for Medical Assistance or Healthy Kids Gold, receipt of such assistance is an assignment to DHHS of your rights to all third party medical payments without anyone having to sign any other form. All available parties must be billed and all resulting payments must be applied to the cost of medical care before DHHS will pay. Also, if you receive a settlement or an award from a liable third party, you must pay DHHS back for related medical services we paid. RSA 167:14-a.

Benefits Received in Error

You are required to pay back any benefits or services received in error, regardless of whether we made a mistake in processing your case or you made a mistake in the information you provided, or failed to provide, to us.

Financial or Medical Child Support

If you are applying for TANF cash payments, your receipt of such assistance is an assignment to DHHS of your rights to financial child support. Without signing any other form, you give DHHS the right to collect and keep financial child support payments made on behalf of your children who receive assistance. RSA 161-C:22

DHHS collects and keeps the support to partially offset the amount of cash assistance paid to you. If support payments are equal to or more than the amount we give you, your cash assistance case will be closed and the support payments sent to you.

Receipt of Medical Assistance for children is an assignment of medical child support rights. This means that you must cooperate with DHHS to establish and enforce medical child support for your children. Medical child support usually means health insurance provided by the absent parent, but can also be an ongoing dollar amount paid by the other parent to allow you to buy health insurance for your children.

If you receive money to purchase insurance, this money will be kept by the State while you receive Medicaid and will be used to pay back the state and federal governments. If paternity is not established for any of your children who are getting Medicaid, you must also cooperate with DHHS to legally establish paternity.

The assignment of support rights is a requirement. Your rights and responsibilities and the penalty for refusal without a good reason, will be explained to you when you meet with your Family Services Specialist.

Begin Date for Medicaid Eligibility

Your Medicaid eligibility generally begins on the day that you meet all the requirements for the program you applied for, including the resource limit.

AGENCY USE ONLY

This is your record of application and will be filled out by a Department of Health and Human Services worker and returned to you. DFA has received a completed application for _____ from _____ on _____

District Office | Signature of Worker

State of New Hampshire
Department of Health and Human Services
Division of Family Assistance

800
7/04

Referred for XFS ☐ Yes ☐ No
Initials:_____

A. APPLICANT

Name: _____ **Mailing Address:** _____
Street Address: _____ **(if different)** _____
City/State/Zip: _____ **Primary Language:** _____
Phone: _____
Does anyone in your family have Medicare Part A or B? ☐ Y ☐ N **Are You Homeless?** ☐ Y ☐ N

Why are you applying for assistance? _____

Information Supplier: _____
(if different from applicant) **Name** **Address** **Phone #**

B. INDIVIDUAL HOUSEHOLD MEMBERS Please list ALL of the people living in your household (including yourself).

You do not have to give the Social Security Number or immigration status of any individual who is not applying for assistance.

Name:	U.S. Citizen?	SSN:	Date of Birth:	Relation to you:	RID (Agency Use Only)
1.	☐ Y ☐ N			SELF	
2.	☐ Y ☐ N				
3.	☐ Y ☐ N				
4.	☐ Y ☐ N				
5.	☐ Y ☐ N				
6.	☐ Y ☐ N				

C. I WANT TO APPLY FOR: (TYPES OF ASSISTANCE REQUESTED)

☐ **Nursing Home Care**

THE FOLLOWING PROGRAMS:

☐ **All programs** ☐ **Cash** ☐ **Medical Assistance**
☐ **Food Stamps** ☐ **Child Care** ☐ **Medicare Buy-In Programs (QMB/SLMB)**

D. GROSS INCOME (everyone in household)

Your Wages: $ _____ ☐ Weekly ☐ Bi-Weekly ☐ Monthly
Other Wages: $ _____ ☐ Weekly ☐ Bi-Weekly ☐ Monthly
Other Wages: $ _____ ☐ Weekly ☐ Bi-Weekly ☐ Monthly
Has anyone recently lost a job? ☐ Yes ☐ No
If yes, who? _____ When? ___/___/___

SSA/SSDI: $ _____ Spousal Support: $ _____
SSI: $ _____ Unemployment: $ _____
VA: $ _____ Child Support: $ _____
Pension: $ _____ Other: $ _____

E. RESOURCES (everyone in household)

Your Checking/Savings: $ _____ Other Chk/Save: $ _____
Your Stocks/Bonds/CD's: $ _____ Other Stk/Bnd/CD: $ _____
Your IRA: $ _____ Other IRA: $ _____
Other Resources: $ _____ Other Resources: $ _____
Vehicle (Yr/Mdl) _____ Vehicle (Yr/Mdl) _____

F. HOUSEHOLD EXPENSES

Rent (monthly): $ _____
Mortgage (monthly): $ _____
Lot Rent/Condo Fee (monthly): $ _____
Taxes (yearly): $ _____
Home Ins. (yearly): $ _____
Dependent Care: $ _____
Medical Expenses: $ _____

Do you pay for the following utilities separate from your rent or mortgage?

Heat: ☐ **Yes** ☐ **No**
Phone: ☐ **Yes** ☐ **No**
Electric: ☐ **Yes** ☐ **No**
Other: ☐ **Yes** ☐ **No**

PLEASE COMPLETE THE BACK

AGENCY USE ONLY:

RFA:					**Date Received:**		
Forms Given:	**725**	**177**	**AW9**	**253**	**Other Forms:**		
NHEP/FAP AP	**OPEN**	**CLOSE**		**DENY**	**DATE:**	**DO:**	
NHEP/FAP MA	**OPEN**	**CLOSE**		**DENY**	**DATE:**	**DO:**	
ADULT AP	**OPEN**	**CLOSE**		**DENY**	**DATE:**	**DO:**	
QMB/SLMB	**OPEN**	**CLOSE**		**DENY**	**DATE:**	**DO:**	
FOOD STAMPS	**OPEN**	**CLOSE**		**DENY**	**DATE:**	**DO:**	
HKG/HKS/MCPW	**OPEN**	**CLOSE**		**DENY**	**DATE:**	**DO:**	
CHILD CARE	**OPEN**	**CLOSE**		**DENY**	**DATE:**	**DO:**	
EBT Card Status:	**None**		**Active**		**Deactivated**	**Cancelled**	

G. POTENTIAL ELIGIBILITY QUESTIONNAIRE

1. Are you a migrant or seasonal farm worker? ☐ Yes ☐ No
2. **Have you or anyone in your household received Food Stamp assistance for this month?** ☐ **Yes** ☐ **No**
3. Are you currently living in a shelter for battered individuals? ☐ Yes ☐ No
4. **Is anyone in your household blind or disabled?** ☐ **Yes** ☐ **No**
5. Have you sold or transferred property in the last 5 years? ☐ Yes ☐ No
6. **Is anyone in your household currently receiving assistance from another State?** ☐ **Yes** ☐ **No**
   If yes, which State? _____ **What kind of assistance?** _____
7. Is anyone in your household pregnant or has anyone given birth in the last 3 months? ☐ Yes ☐ No
8. **Do you have any unpaid medical bills from the past 3 months that you would like help paying?** ☐ **Yes** ☐ **No**
9. If you are applying for cash assistance for dependent children, is the father's name blank or "not stated" on the birth certificate for any of your children? ☐ Yes ☐ No
10. **If applying for cash for your family, how many absent parents?** _____

H. *The following information is collected to be sure that everyone is served fairly. Your answers are voluntary. The information provided will not affect your eligibility or benefit amount.*

Are you Hispanic or Latino? ☐ **Yes** ☐ **No**

Are you: **White?** ☐ **Y** ☐ **N** **Black or African American?** ☐ **Y** ☐ **N** **Asian?** ☐ **Y** ☐ **N**
Native Hawaiian or Other Pacific Islander? ☐ **Y** ☐ **N** **American Indian or Alaskan Native?** ☐ **Y** ☐ **N**

I. SIGNATURES

I certify, under penalty of perjury, that I have reviewed this information; it is true and complete to the best of my knowledge, including the information concerning citizenship and alien status. I understand a full eligibility interview may be conducted before my eligibility can be determined.

Applicant: _____
Signature **Date**

Other: _____ _____
Signature **Date** **Relationship to Applicant**

I withdraw my application for:
☐ **Cash** ☐ **Medical Assistance** ☐ **Child Care**
☐ **Food Stamps** ☐ **Medicare Buy-In Programs** ☐ **Nursing Home Care**

_____
Signature **Date**

I certify that I have given the above individual(s) the opportunity to review this application. I also certify that I have provided a copy of this form, if one was requested.

_____
Family Services Specialist Signature **Date**