Department of Social Services
W1E General Application Instructions

What do I need to do to get benefits?

1. **Fill out the application.** You can use this application for SNAP, cash and certain types of medical help. For faster service, fill out an on-line application at www.connect.ct.gov

If you need help filling out this application because of a disability or impairment, or if you need a translator, call the Benefit Center at 1-855-626-6632.

- You can start by writing your name and address on page 1, signing page 2 and sending these pages of the application to DSS. **But before we can tell if you are eligible for any help you must answer all of the questions for the help you want to get.**

Programs

Supplemental Nutrition Assistance Program (SNAP): Help to buy food.

If applying for only SNAP, fill out pages 1–11 stop after completing question 34. Skip to page 15 complete questions 1-7 under "Federal Data Collection Standards". Read pages 15-17 stop at "for State Supplement". Skip to page 19, read "Certifications and Signatures" and sign below. Skip to page 20, start at the "Non-Discrimination Statement" and read through to page 22.

- **Emergency Food Help**

  We may be able to give you emergency food help within seven days of when you apply. You must prove your identity be ready to show that
  - your household's total income is less than $150 a month.
  - your household's cash and bank accounts total less than $100.
  - the total of your household's income, cash, and bank accounts are less than your total housing and utility cost for a month.
  - there is a migrant or seasonal farm worker in your household.

- **Cash and medical:** Fill out all pages of the application.

If you are eligible for SNAP, medical, or cash we will give you benefits back to the date of your application.

Getting Medical Help

Use this application to apply for health insurance only if you are:

- 65 years old or older; or
- receiving Medicare; or
- determined disabled by DSS and are working

Do not use this application to apply for health insurance if you are not one of the three groups listed above. If you want to apply for health insurance for a child in your care, you can apply on-line at www.accesshealthCT.com or you can apply by phone by calling Access Health CT at 1-855-805-4325.You can get a paper application by calling Access Health CT at 1-855-805-4325.You can also apply this way if you are a pregnant woman or an adult between the ages of 19-64.

If you want to apply for **Long-Term Care (LTC) or Home Based Care (medical care services in your home)** use form **W1-LTC**. You can apply on-line or you can get the W1-LTC paper application at www.connect.ct.gov or call the DSS Benefit Center at 1-855-626-6632 and ask for a paper application.

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2. **Turn in the application.** You can mail it to DSS ConneCT Scanning Center, P.O. Box 1320, **Manchester, Connecticut 06045-**1320 or drop it at any DSS office.

DSS makes Medicaid eligibility decisions based on disability within 90 days from the date of application. DSS will make all other Medicaid eligibility decisions within 45 days from the date of application, except in unusual circumstances. For SNAP applicants who are not eligible for emergency seven-day processing and who complete the application process, DSS will make decisions about SNAP no later than 30 days after the application is filed. If the SNAP applicant is in an institution and applying for SNAP and Supplemental Security Income (SSI) at the same time, the filing date is the date of release from the institution. All SNAP applications are processed in accordance with SNAP procedures, even if you apply for SNAP and other programs. You must have an interview and show proof of some of the information given on the application. You may not be denied SNAP solely because you may be denied benefits from other programs.

When filling out this application, please note the following:

- **Social Security numbers (SSN) and citizenship:** We need to know the SSN and citizenship status only for people applying for help. If you are applying for someone else, and not for yourself, we may not need your SSN or citizenship status. People who are not U.S. citizens may still be eligible for some help. If you do not have a SSN yourself, other family members who do have SSNs may still be eligible.
- **Ethnicity and Racial Heritage:** You can choose not to give your ethnic group and racial heritage information. It will not affect your eligibility. This information helps us follow Title VI of the Civil Rights Act of 1964, as updated by the Affordable Care Act.

Please keep these instruction pages for your records. Do not send it with your application.

THIS INFORMATION IS AVALABLE IN ALTERNATE FORMATS. Call (800) 842-1508 or TDD: 1-800-842-4524.

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What is the zip code where you live?	**If you have a client ID, write it here:**
	0 0

What is your first name?

What is your last name?

Make a clear, dark mark ● in each circle that applies to you and the people you are applying for.

Who are you applying for?

- ◯ Only myself
- ◯ Myself and my spouse
- ◯ Myself and my family
- ◯ Only children under 19 in my care

What are you applying for?

- ◯ SNAP (Supplemental Nutritional Assistance Program)
- ◯ Health Insurance for individuals who are:
  - 65 years old or older; or
  - receiving Medicare; or
  - determined disabled by DSS and are working.

  Do not use this application to apply for health insurance if you are not in one of the three groups listed above. If you want to apply for long- term care or home-based services, use form **W-1LTC**. For all other health insurance applications, contact Access Health CT at 1-855-805-4325.
- ◯ Cash

Are you pregnant?	◯ Yes	◯ No
Do you live in a licensed residential care facility (boarding home)?	◯ Yes	◯ No

Answer the following questions if you are applying for SNAP:

Is your household's total income less than $150 a month?	◯ Yes	◯ No
Do your household's cash and bank accounts total less than $100?	◯ Yes	◯ No
Is the total of your household's monthly income, cash and bank accounts less than your total housing and utility costs for a month?	◯ Yes	◯ No
Is anyone in your household a migrant or seasonal farm worker?	◯ Yes	◯ No

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Tell Us about the Head of Household

Full Name *(first, middle initial, last)*		Maiden (*or other names used)*
Date of Birth	Best Phone Number	What language do you speak best?
Do you need a translator to assist you with your application? ☐ Yes ☐ No		
Do you need our help filling out this application because of a disability or impairment? ☐ Yes ☐ No If yes, call the Benefit Center at 855-626-6632.		

Home Address	City	State	Zip Code
Mailing Address *(if different)*	City	State	Zip Code

1. Do you need a reasonable accommodation because of a disability or impairment? ☐ Yes ☐ No
   If yes, what kind do you need?_____
   _____
   _____
2. Are you blind or do you have trouble seeing, even when wearing glasses? ☐ Yes ☐ No
3. Are you deaf or are you hard of hearing? ☐ Yes ☐ No

I certify that all of the statements made above are true and complete to the best of my knowledge. If I knowingly give wrong information, I may be subject to penalties for false statements under sections 53a-122 and 53a-123 of the Connecticut General Statutes. I may also be subject to penalties for perjury under federal law.

_____ _____

Applicant's Signature Date Authorized Representative's Signature Date

_____ _____

Helper's Signature Date Interpreter's Signature Date

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Authorized Representative

You may appoint people to help you with your application and also for other purposes relating to your eligibility for DSS programs. Check those that apply to you.

☐ **General authorized representative /responsible person** to help me apply for all DSS programs (SNAP, medical, cash) and to assist me with all aspects of the application and eligibility process, which includes reporting changes and getting notices on my behalf. This person knows my circumstances well enough to answer questions and will act in my best interest.

This person is my: ☐ Power of Attorney ☐ Conservator ☐ Legal Guardian ☐ Other _____

_____

Name Address Telephone Number

SNAP ONLY

☐ **Shopper** (A person to shop for you)

_____

Name Address Telephone Number

☐ **Medical authorized representative just** to help me fill out my application for medical assistance to pay for my hospital bill and ask for a hearing if medical assistance is denied.

_____

Name Address Telephone Number

Tell us about the people in your household

Please answer below for the members of your household STARTING WITH YOURSELF:

Check the help you want to apply for: ☐ None ☐ Food ☐ Cash
☐ Medical for 65 and older or receiving Medicare or determined disabled by DSS and working

Your Full Name *(first, middle initial, last)*

Sex ☐ Male ☐ Female	Social Security Number	Last grade completed in school

Marital status: ☐ Never married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Ethnicity: If Hispanic/Latino ethnicity ☐ Mexican, Mexican American, Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic/Latino/a or Spanish

Racial heritage: ☐ White ☐ Black or African American ☐ American Indian/Alaska Native
☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian
☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander

Place of birth *(City/state or country)*	Are you a U.S. citizen? ☐ Yes ☐ No

If he or she is not a U.S. citizen and is applying for help, complete the following:

What date did you enter the United States?	What date did you move to Connecticut?	List your I-94 number if you have one.

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Tell us about household member number 2

Check the help you want to apply for: ☐ None ☐ Food ☐ Cash
☐ Medical for 65 and older or receiving Medicare or determined disabled by DSS and working

Full Name *(first, middle initial, last)*			Relationship to you
Sex: ☐ Male ☐ Female	Date of Birth	Social Security Number	Last grade completed in school

Marital status: ☐ Never married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Ethnicity: If Hispanic/Latino ethnicity ☐ Mexican, Mexican American, Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic/Latino/a or Spanish

Racial heritage: ☐ White ☐ Black or African American ☐ American Indian/Alaska Native
☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian
☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander

Place of birth *(City/state or country)*	Is he or she a U.S. citizen? ☐ Yes ☐ No

If he or she is not a U.S. citizen and is applying for help, complete the following:

What date did he or she enter the United States?	What date did he or she move to Connecticut?	List his or her I-94 number if he or she has one.

Tell us about household member number 3

Check the help you want to apply for: ☐ None ☐ Food ☐ Cash
☐ Medical for 65 and older or receiving Medicare or determined disabled by DSS and working

Full Name *(first, middle initial, last)*			Relationship to you
Sex: ☐ Male ☐ Female	Date of Birth	Social Security Number	Last grade completed in school

Marital status ☐ Never married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Ethnicity: If Hispanic/Latino ethnicity ☐ Mexican, Mexican American, Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic/Latino/a or Spanish

Racial heritage: ☐ White ☐ Black or African American ☐ American Indian/Alaska Native
☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian
☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander

Place of birth *(City/state or country)*	Is he or she a U.S. citizen? ☐ Yes ☐ No

If he or she is not a U.S. citizen and is applying for help, complete the following:

What date did he or she enter the United States?	What date did he or she move to Connecticut?	List his or her I-94 number if he or she has one.

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Tell us about household member number 4

Check the help you want to apply for: ☐ None ☐ Food ☐ Cash
☐ Medical for 65 and older or receiving Medicare or determined disabled by DSS and working

Full Name *(first, middle initial, last)*			Relationship to you
Sex: ☐ Male ☐ Female	Date of Birth	Social Security Number	Last grade completed in school

Marital status ☐ Never married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Ethnicity: If Hispanic/Latino ethnicity ☐ Mexican, Mexican American, Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic/Latino/a or Spanish

Racial heritage: ☐ White ☐ Black or African American ☐ American Indian/Alaska Native
☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian
☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander

Place of birth *(City/state or country)*	Is he or she a U.S. citizen? ☐ Yes ☐ No

If he or she is not a U.S. citizen and is applying for help, complete the following:

What date did he or she enter the United States?	What date did he or she move to Connecticut?	List his or her I-94 number if he or she has one.

Tell us about household member number 5

Check the help you want to apply for: ☐ None ☐ Food ☐ Cash
☐ Medical for 65 and older or receiving Medicare or determined disabled by DSS and working

Full Name *(first, middle initial, last)*			Relationship to you
Sex: ☐ Male ☐ Female	Date of Birth	Social Security Number	Last grade completed in school

Marital status: ☐ Never married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Ethnicity: If Hispanic/Latino ethnicity ☐ Mexican, Mexican American, Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic/Latino/a or Spanish

Racial heritage: ☐ White ☐ Black or African American ☐ American Indian/Alaska Native
☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian
☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander

Place of birth *(City/state or country)*	Is he or she a U.S. citizen? ☐ Yes ☐ No

If he or she is not a U.S. citizen and is applying for help, complete the following:

What date did he or she enter the United States?	What date did he or she move to Connecticut?	List his or her I-94 number if he or she has one.

Please make copies of this page or attach another sheet if you need to add more people. Make sure you answer all of the questions.

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Answer for all members of your household including yourself:

1. Is anyone in your household pregnant? ☐ Yes ☐ No If yes, who?_____

   Due Date:_____

2. Is anyone in your household a foster child or foster adult? If yes, who?_____

3. If you are applying for food or cash benefits, do you or does anyone in your household have an outstanding arrest warrant or is anyone in your household violating parole or on probation?

   ☐ Yes ☐ No If yes, who?_____

4. Have you or has any member of your household been convicted of

   a) a felony under federal or state law for possession, use or distribution of a controlled drug substance (felony drug conviction) after August 22, 1996? ☐ Yes ☐ No

   b) trading SNAP benefits for drugs after September 22, 1996? ☐ Yes ☐ No

   c) buying or selling SNAP benefits over $500 after September 22, 1996? ☐ Yes ☐ No

   d) fraudulently receiving duplicate SNAP benefits in any state after September 22, 1996? ☐ Yes ☐ No

   e) trading SNAP benefits for guns, ammunitions or explosives after September 22, 1996? ☐ Yes ☐ No

5. Do you, or does anyone in your household, who is not citizen, have a sponsor? ☐ Yes ☐ No
If yes, please complete the following:

Household member being sponsored	Relationship to Sponsor	Sponsor's name	Sponsor's address

6. Has anyone in your household received cash, medical, or food help within the last 90 days?

   ☐ Yes ☐ No If yes, date last received: _____ From which state?_____

7. Do you usually buy and cook food with everyone you live with? ☐ Yes ☐ No

   If no, who buys and cooks food separately? _____

8. Is anyone in the household renting a room with meals included? ☐ Yes ☐ No

   If yes, who and how much does each person pay for room and board?

   _____

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9. Has anyone in your household or his or her spouse ever served in the military? ☐ Yes ☐ No
If yes, complete the following:

1. Name of person in military	Relationship to person in military	Household member's name if spouse is in the military
Military service number or social security number	Have you been rated with a service related disability? ☐ Yes ☐	Military status
2. Name of person in military	Relationship to person in military	Household member's name if spouse is in the military
Military service number or social security number	Have you been rated with a service related disability? ☐ Yes ☐	Military status

10. List anyone in your household who is a student:

Name	Student 1	Student 2	Student 3	Student 4
Name of school/training program:				
Type of student:	☐ High school ☐ GED ☐ College ☐ Vocational	☐ High school ☐ GED ☐ College ☐ Vocational	☐ High school ☐ GED ☐ College ☐ Vocational	☐ High school ☐ GED ☐ College ☐ Vocational
Are you a full-time student?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Are you getting financial aid?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Tell us about your household's income:

11. Does anyone in your household have any income from work? Income from work means wages, salaries, tips and commissions from jobs. It also means self-employment income such as money you get from your own business or for doing odd jobs or any other work you do for money. ☐ Yes ☐ No
If yes, complete the following:

Please provide proof of your income. Examples of proof are your last 4 weeks of paystubs or, if self-employed, your most recent business records.			
Person working			
Employer's name			
Employer's phone			
Hourly pay:	**$**	**$**	**$**
Hours *(per week)*:			
How often paid *(weekly, monthly)*:			
Gross monthly income	**$**	**$**	**$**

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12. If any income has recently changed, please tell us why and the date it changed:

_____

_____

_____

13. Is anyone in your household currently on strike from his or her job? ☐ Yes ☐ No

14. Has anyone in your household reduced his or her work hours in the last 90 days? ☐ Yes ☐ No

If yes, who_____ Why?_____

_____

15. Have you or anyone in your household lost or quit a job within the last 90 days? ☐ Yes ☐ No

If yes, who?_____ Date of job loss/quit: _____Date of last pay:_____

Reason for job loss or for quitting:_____

_____

16. **Does anyone in your household get money from places other than work?** ☐ Yes ☐ No
If yes, tell us about this month's income for anyone in your home who is listed on this application.
Examples of unearned income are the following:

- Rent paid to you
- Loans repaid to you
- TFA or TANF *(Temporary Assistance for Needy Families)*
- Retirement pension
- Military benefits
- Disability benefits
- Child or spousal support
- Guardian or foster care payments
- Social Security benefits
- Supplemental Security Income (SSI)
- Dividends or interest on investments
- Worker's compensation
- Tribal payments
- Unemployment compensation
- Educational income (such as financial aid)

Person receiving the money	**Source of money**	**Amount received**	**How often received *(weekly, monthly)***	**Expected to continue**
		$		☐ **Yes** ☐ **No**
		$		☐ **Yes** ☐ **No**
		$		☐ **Yes** ☐ **No**
		$		☐ **Yes** ☐ **No**
		$		☐ **Yes** ☐ **No**
		$		☐ **Yes** ☐ **No**

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Tell us about your household's expenses

Housing expenses

17. Do you or anyone in your household pay housing expenses? ☐ Yes ☐ No

If yes: ☐ Rent ☐ Mortgage What is the total rent/mortgage? _____

How much do you pay of the total rent?	Fire/hazard insurance, if separate:	Property tax, if separate:
$_____ per ☐ Week ☐ Month ☐ Year	$_____ per ☐ Week ☐ Month ☐ Year	$_____ per ☐ Week ☐ Month ☐ Year
Person or company you pay rent/mortgage to:		
Address and phone number of person or company you pay rent to:		

18. Do you get help paying for housing? ☐ Yes ☐ No If yes, please complete the following:

Who pays?	Who is it paid to?	Amount paid:
		$
		$

19. If you reported that your income is less than your housing expenses, how do you pay these expenses?

_____

_____

Utility expenses

20. Do you pay for heat separately from your rent or mortgage? ☐ Yes ☐ No

21. How do you heat your home? _____

22. Do you pay for cooling separately from your rent or mortgage? ☐ Yes ☐ No

23. What other utilities do you pay? ☐ Water/sewer ☐ Garbage ☐ Electric ☐ Gas ☐ Phone ☐ Other: _____

24. Did you receive a check from the energy assistance program during the past year at this address? ☐ Yes ☐ No

25. Do you plan to apply for energy assistance program this year? ☐ Yes ☐ No

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Dependent care expenses

26. Does anyone in your household pay for child care or care for an adult with a disability? ☐ Yes ☐ No
If yes, who pays? _____ **$** _____ a month and complete the following:

1. Name of person who gets daycare	Amount you pay per week $	Total Cost per Week $
Name of provider	Address and phone number	
2. Name of person who gets daycare	Amount you pay per week $	Total Cost per Week $
Name of provider	Address and phone number	
3. Name of person who gets daycare	Amount you pay per week $	Total Cost per Week $
Name of provider	Address and phone number	

27. Does the state pay for your dependent care (for example, Care 4 Kids)? ☐ Yes ☐ No

Court-ordered child support expenses

28. Does anyone in your home pay court-ordered child support? ☐ Yes ☐ No
If yes, complete the following:

Person who pays support	For which child(ren)	Amount paid	How often?
		$	
		$	
		$	
		$	
		$	
		$	
		$	

Medical expenses

29. Does anyone in your household have medical bills from the last 3 months? ☐ Yes ☐ No

30. Does anyone outside your household help pay medical expenses? ☐ Yes ☐ No

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31. Does anyone in your household who is 60 years old or older or a person with a SSI/SSD disability have medical expenses such as medical insurance (premiums, deductibles and co-pays), transportation cost for medical appointments or dental bills? ☐ Yes ☐ No If yes, list these expenses.

Person with medical expenses					
Amount paid/owed					

Tell us about your household's resources.

32. Do you or does anyone in your household have cash that is not in the bank? ☐ Yes ☐ No if yes, how much?_____

33. Do you or does anyone in your household own or have stocks, bonds, IRAs, 401ks, trust funds?
☐ Yes ☐ No If yes, to question complete the following:

Belongs to	Type	Name of bank/company	Current balance/value

34. Does anyone in your household own real estate, land or property? ☐ Yes ☐ No

If yes, who?_____ Address of property:_____

If you are applying for food help only skip to page 15 complete questions 1-7 under "Federal Data Collection Standards". Read pages 15-17 stop at "for State Supplement". Skip to page 19, read "Certifications and Signatures" and sign below. Skip to page 20, start at the "Non -Discrimination Statement" and read through to page 22. To apply for cash or medical benefits, please continue.

35. Does anyone in your household have any items of value? (examples: cars, trucks, boats)
☐ Yes ☐ No If yes, complete the following:

Belongs to	Type	Year make model

36. Do you or does anyone in your household own or have checking, savings, CDs, money markets, and credit union account(s)? ☐ Yes ☐ No If yes, complete the following:

Belongs to	Type	Name of bank/company

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37. Have you or has anyone in your household filed a lawsuit that is still pending? ☐ Yes ☐ No
If yes, complete the following:

Person with lawsuit	Attorney's name and address

38. Do you or does anyone in your household expect to receive an inheritance? ☐ Yes ☐ No

If yes**,** when? _____ Please complete the following:

Person expecting inheritance	**Attorney's name and address**

39. Do you or does anyone in your household have a life insurance policy? ☐ Yes ☐ No
If yes, complete the following:

Life insurance owner	**Insurance Company Name and address**	**Cash Surrender Value**

40. Have you or has anyone in your household sold or transferred ownership of any motor vehicles, bank accounts, property of any kind, stocks, bonds, mutual funds or cash within the last 24 months?
☐ Yes ☐ No If yes, complete the following**:**
Note: For SNAP, DSS considers only the last three months.

Who	**Type**	**Date**

41. Does anyone in your household have a long- term care policy? ☐ Yes ☐ No

42. Does anyone in your household have a prepaid funeral contract? ☐ Yes ☐ No
If yes, to question 41-42, complete the following:

insurance/contract owner	**Company Name and address**

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Child support

Important – By applying for medical or cash help, you are letting us pursue health care coverage and child support from parents not living in your household, unless you think this parent might harm you or the child.

43. Do any of the children's parents live outside the child's home? ☐ Yes ☐ No If yes, please list the parent(s) below, Also if you are under 18 and not living with your parents, list them. **Please give as much information as possible. If you need more space, please copy this page or attach another sheet and answer all the questions.**

Child Name		**Child Name**	
Name of Parent not living in home		**Name of Parent not living in home**	
Address		Address	
Sex: ☐ Female ☐ Male	Date of Birth	Sex: ☐ Female ☐ Male	Date of Birth
Social Security Number	Amount of child support	Social Security Number	Amount of child support

Adult legally liable relatives

If you are married and your spouse is not living with you, complete the following section giving as much information as possible.

Spouse's Name		
Address		
Sex: ☐ Female ☐ Male	Date of Birth	Social Security Number

44. Did anyone in your household receive cash from the TFA/Temporary Assistance for Needy Families (TANF) program since 1996? ☐ Yes ☐ No If yes, complete the following:

Person	State

Your ability to work

45. Does anyone in the household have a medical condition that makes him or her unable to work? ☐ Yes ☐ No If yes, who_____

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46. Is anyone in your household unable to work because he or she is caring for a disabled child or adult?

☐ Yes ☐ No If yes, who is providing the care?_____

Who needs the care?_____

47. Has anyone in your household applied for disability benefits through the Social Security Administration (SSA)? ☐ Yes ☐ No If yes, complete the following:

Date of your application *(month, year)*	When did you get a decision letter *(month, year)*	Your application was: ☐ Approved ☐ Denied
If your application was denied, did you appeal? ☐ Yes ☐ No	If yes, what was the appeal date *(month, year)*:	

Date of your application *(month, year)*	When did you get a decision letter *(month, year)*	Your application was: ☐ Approved ☐ Denied
If your application was denied, did you appeal? ☐ Yes ☐ No	If yes, what was the appeal date *(month, year)*:	

48. If you are applying for cash and you are blind, disabled or 65 years old or older, do you eat at least one meal at a restaurant each day? ☐ Yes ☐ No

49. If you are applying for cash and you are blind, disabled or 65 years old or older, do you have a special diet? ☐ Yes ☐ No
If yes, explain:_____

_____

Tell us about your household's medical insurance

Please answer the following questions for you and anyone in household:

50. Do you or does anyone in your household have Medicare. ☐ Yes ☐ No

If yes, complete the following:

Person on Medicare	Medicare Number

51. Does anyone in your household have other medical insurance? ☐ Yes ☐ No
If yes, complete the following:

Person	Name and of medical insurance

Please provide a copy of the front and back of insurance cards for current coverage or for coverage that has ended in the past three months.

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Federal Data Collection Standards

Please answer the following questions, which we are required to ask you by federal law:

1. Are you, or is anyone in your household, deaf or hard of hearing? ☐ Yes ☐ No
2. Are you, or is anyone in your household, blind or does anyone have trouble seeing, even when wearing glasses? ☐ Yes ☐ No
3. Because of a physical, mental or emotional condition, do you or does anyone in your household (5 years old or older) have trouble concentrating, remembering or making decisions? ☐ Yes ☐ No
4. Do you or does anyone in your household (15 years old or older) have trouble doing errands alone, such as going to a doctor's office or shopping? ☐ Yes ☐ No
5. Do you or does anyone in your household (5 years old or older) have serious trouble walking or climbing stairs? ☐ Yes ☐ No
6. Do you or does anyone in your household (5 years old or older) have trouble getting dressed or bathing/showering? ☐ Yes ☐ No
7. How well do you (5 years or older) speak English? ☐ Very well ☐ Well ☐ Not well ☐ Not at all

READ CAREFULLY FOR ALL PROGRAMS

I understand and agree to the following:

- For all programs, except SNAP, I will notify the Department of Social Services (DSS) within 10 days of any change in income, assets or living arrangements.
- I may request a hearing if I disagree with an action taken on my case. Hearing requests must be in writing for all programs, except SNAP. Requests for SNAP hearing may also be made by telephone. You may represent yourself at a hearing, or you may have a lawyer, relative, friend of someone else represent you.
- **All information given on this form is subject to verification by federal, state and local officials. I will cooperate with these officials by providing authorizations, documents and other proof to prove what I have said. I authorize DSS to verify any information given on this form.**
- **If I make a false or misleading statement, I may be subject to civil or criminal penalties.**
- All information given on this form, including Social Security numbers, is confidential, except as permitted or required by court order, state or federal law. With certain exceptions, it will be used only to administer DSS programs. If DSS believes that there is imminent danger to a child's or family's health, safety or welfare, DSS will provide the child's address and telephone number to the Department of Children and Families. For all programs, except Medicaid, DSS will give your address to a law enforcement official to locate you if you are fleeing to avoid prosecution or custody for certain crimes or for violating a condition of probation for certain crimes or if you have information that a law enforcement official needs to do his or her job concerning certain crimes.
- DSS may disclose information about me and others in my family or household who are receiving benefits for purposes directly connected with the administration of DSS programs. Purposes directly connected with the administration of DSS' programs include, but are not limited to: establishing eligibility, determining the amount of help, providing services, and for investigations, prosecutions, or civil proceedings related to the administration of DSS programs.
- DSS may disclose to its contractors confidential information from the Department of Labor concerning unemployment compensation benefit and quarterly wage information pertaining to individuals who have

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signed this application only as necessary to determine and review eligibility for medical assistance, SNAP, SAGA, TFA and State Supplement.

- I authorize DSS to verify any information regarding anyone's non-citizen status with the U.S. Citizenship and Immigration Services (USCIS). I understand that DSS will not share the information given on this form with USCIS. I also understand that USCIS CANNOT use this application to deny admission to the U.S., harm permanent resident status or deport me or anyone I am applying for.
- Any information I give on this form, including Social Security numbers, will be used to verify identity and eligibility for those people in my household who are going to receive benefits. People who live with me who are not going to receive benefits do not need to give their Social Security numbers. If they wish to do so, it may be easier to verify their income and speed up the application process. Social Security numbers will be cross-matched against federal, state and local government files by computers. DSS is allowed to request Social Security numbers based on the following statutes: for SNAP, the Food and Nutrition Act of 2008 (formerly the Food Stamp Act), 7 USC §§ 2011-2036; 7 USC § 2025(e)(1) and 42 USC §§ 1320b-7(a)(1) and (b)(4); for TFA, 42 USC §§ 1320b-7(a)(1) and (b)(1); for Medicaid, 42 USC §§1320b-7(a)(1) and (b)(2); for State Supplement to the Aged, Blind and Disabled, 42 USC §§ 1320b-7(a)(1) and (b)(5); for SAGA, the Tax Reform Act of 1976, 42 USC § 405(c)(2)(C)(i); for all programs except SAGA, Conn. Gen. Stat. § 17b-77.
- If a SNAP claim arises against your household, the information on this application, including all Social Security numbers, may be referred to federal and state agencies, as well as private claims collection agencies for claims collection action
- The State will use information available to it through the Income and Eligibility Verification System (IEVS) and through the National Directory of New Hires (for the Temporary Family Assistance program) to process my request for help. This information will come from the Labor Department, the Social Security Administration, the Internal Revenue Service and other agencies when allowed by law. DSS may verify (check) the information it receives from these sources directly with other sources, such as banks and employers. These results may affect my household's eligibility and level of benefits.
- The State may verify (check) information it gets about child support payments, which are made to the State on behalf of my child, with the Bureau of Child Support Enforcement (BCSE).
- Giving the information asked for on this application is voluntary. If I do not give certain information, however, my application will be denied. For SNAP, if you fail to report or verify any of the listed expenses, DSS will treat this as a statement that you do not want to receive a deduction for the unreported expense.
- I will cooperate with state and federal personnel in Quality Control Reviews.

FOR THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

I understand and agree to the following:

- **If I break any of the rules on purpose I can be barred from SNAP for one year to permanently, fined up to $250,000, imprisoned up to 20 years or both. I may also be subject to prosecution under any other applicable federal and state laws and I may also be barred from SN AP for an additional 18 months if court ordered.**
- **My application/recertification for and receipt of my SNAP benefits is a registration for work for myself and all members of my SNAP assistance unit who are required to register. I further understand that I and all other members of the SNAP assistance unit who are required to do so must participate in Employment and Training services unless there is good cause not to participate.**
- I will notify the Department of Social Services (DSS) by the 10th day of the month following the month when my income increases above 130% of the federal poverty level for my family size.

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- I will notify the DSS by the 10th day of the month following the month when anyone in my household who is considered an Able Bodied Without Dependents works less than 20 hours per week or participates in an Employment and Training activity less than 20 hours per week.
- **If I break a SNAP rule on purpose, I am ineligible to get SNAP. The first time I break a rule I will not be able to get SNAP for one year. The second time I will not be able to get SNAP for two years. The third time I will not be able to get SNAP ever again.**
- **If I am found guilty of trafficking SNAP benefits of $500 or more, I cannot get SNAP ever again. Trafficking in SNAP means selling them instead of using them to buy food.**
- **If I am found guilty of buying a product with SNAP that has a container with a return deposit with the intent of getting cash by dumping the product out and returning the container for cash, the first time I break this rule I will not be able to get SNAP for 12 months, the second time I will not be able to get SNAP for 24 months, the third time I will not be able to get SNAP ever again.**
- **If I am found guilty of buying or trading a controlled substance or receiving SNAP benefits as payment for a controlled substance, the first time I break this rule I cannot get SNAP for 24 months and the second time I will not be able to get SNAP ever again.**
- **If I am found guilty of buying or trading firearms, ammunition or explosives or receiving SNAP benefits as payment for firearms, ammunition or explosives, I will not be able to get SNAP ever again.**
- **If I intentionally misuse an Electronic Benefit Transfer (EBT) card, I may no longer get SNAP. I may also be fined up to $250,000 or sent to jail for up to 20 years or both. Misuse of an EBT card means altering, selling, or trading a card, using someone else's card without permission or exchanging benefits.**
- **It is an intentional misuse of an EBT card and you are not allowed to buy nonfood items, such as alcohol or cigarettes, or to buy food on credit. This could result in a disqualification.**
- **If I make a false statement about the identity or address of myself or household members to get more than one SNAP benefit for the same time period, I will not be able to get SNAP for 10 years.**

FOR STATE SUPPLEMENT CASH

I understand and agree to the following: If money is due to me because of an inheritance, settlement of a pending or future lawsuit, lottery winnings, the sale of property or from many other sources, this money will go (be assigned) to the State. The State may recover from that money an amount up to the total amount of benefits paid to me or anyone for whom I receive benefits.

- The State will place a lien against my home and my spouse's property and any non-home property either or us owns in the State in the amount of benefits I receive.
- I will give DSS a security mortgage on all non-home property outside of the State that I or my spouse owns.
- The State will recover money from my estate after I die.
- My legally liable relative may be billed to repay the State for cash the State paid to me.

FOR SAGA CASH

I understand and agree to the following:

- If money is due to me because of an inheritance, settlement of a pending or future lawsuit, lottery winnings, the sale of property or from many other sources, this money will go (be assigned) to the State. The State may recover from that money an amount up to the total amount of benefits paid to me or anyone for whom I receive benefits.
- The State will place a lien against my home and my spouse's property and any non-home property that either of us owns in the State in the amount of benefits I receive. The State will also place a lien against the property of the parent(s) of children under 18 years old who live in my household.

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- I will give DSS a security mortgage on all non-home property outside of the State that I or my spouse owns.
- I must cooperate with the State in getting support from my spouse and from parents of children under 18 years old who live in my household.
- If a member of my household has a substance abuse problem, he or she may be required to be in treatment in order to receive SAGA cash benefits.
- If I make false or misleading statements when I apply for SAGA, this is breaking the law and I may not be able to get SAGA for up to a year.

FOR JOBS FIRST/TFA CASH

I understand and agree to the following:

- The State will place a lien against my home and my spouse's property and any non-home property that either of us owns in the State in the amount of benefits I receive. The State will also place a lien against the property of the parents of children under 18 years old who live in my household. I and all other members of the Jobs First/TFA household who are required to do so must participate in Employment Services, unless there is an exemption for that person.
- If money is due to me from an inheritance or from the settlement of a pending or future lawsuit, lottery winnings, the sale of property or from any other sources, this money will go (be assigned) to the State. The State may recover from that money an amount up to the total amount of benefits paid to me or anyone for whom I receive benefits.
- I will give DSS a security mortgage on the non-home property outside of the State that I or my spouse own.
- If I knowingly give false (wrong) information to DSS about myself or someone I am applying for in order to get Jobs First/TFA benefits or get the wrong amount of money, I will not get the benefits for **6 months** the first time this happens and **12 months** the second time. If it happens a third time, I will never again be able to get Jobs First/TFA benefits.
- I will not use my EBT card to conduct electronic benefit transfer transactions in a liquor store, an adult-oriented entertainment establishment or casino, gambling casino or gaming establishment.
- DSS may conduct an unscheduled home visit.
- The State recovers money it paid to me from my estate when I die. My legally liable relative may be billed to repay the State for cash paid to me.

FOR MEDICAL ASSISTANCE

I understand and agree to the following:

- Money from a pending or future lawsuit will go (be assigned) to the State to recover any medical expenses paid by the State related to the lawsuit.
- If I knowingly give false (wrong) or misleading information to DSS about myself of someone I am applying for, I am breaking federal law and I may be fined up to $25,000 or put in prison for 5 years or both.
- By applying for medical assistance, I give (assign) my right of support from third parties to DSS (section 1912 of the Social Security Act).
- If I am in a nursing facility or if I am applying for home and community-based services, and I want to assign my support rights against my spouse, I must sign an additional assignment of support (section 1924 of the Social Security Act).
- By receiving medical assistance, I allow the State to recover the cost of my medical bills that are covered by a third party, such as other insurance, directly from that third party.
- The State recovers money from my estate if I receive long-term care services and also if I am at least 55 years old when I receive community medical assistance benefits and I do not have a living spouse or child who is under 21 years old or blind or disabled.
- The State may place a lien on my home, under certain conditions, if I enter a nursing facility and I will not be returning to my home in the community.

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- DSS or its representative may apply for Medicare on my behalf if DSS thinks I am eligible for Medicare. DSS or its representative may also file Medicare claims and appeals on my behalf.
- DSS or any other health insurer or provider may release information about me and my family as necessary for the delivery of medical and program services, as permitted by federal and state law.
- I will not alter (change), trade, sell or use someone else's medical services identification card.
- The State may bill my legally liable relative to repay it for the costs of my medical care.

CHILD SUPPORT ASSIGNMENT AND COOPERATION

I understand and agree to the following:

- By making this application for help from the State, I assign (give) to the State all the rights I have to current support from any person for any family member included in this application.
- For as long as I am getting help from the State, I must fully cooperate with the State in order to get other responsible persons to contribute to my family's support.
- The State will keep child support due to me while I am receiving cash help, which means that I will not collect it during that time.
- When my TFA cash help ends, all current child support will come to me. Any unpaid child support that was due to me during the time I was receiving TFA cash help is owed to the State.
- The State will continue to enforce my child support order after I stop receiving help, unless I notify the State that I do not want this service.

CERTIFICATIONS AND SIGNATURES

I have read this form or have had it read to me in a language that I understand.

I certify that all of the information given on this form is true and complete to the best of my knowledge. I certify that I have specific knowledge of the identity of all children for whom I am asking for help on this form and that the information I gave about these children is accurate to the best of my knowledge. I also declare and certify that I and everyone for whom I am applying for help is either a United States citizen or a non-citizen for whom I have provided true and accurate (correct) information.

If I have knowingly given incorrect information, I may be subject to penalties for false statement as specified in sections 53a-157b and 17b-97 of the Connecticut General Statutes; to penalties for larceny as specified in sections 53a-122 and 53a-123 of the Connecticut General Statutes; and to other criminal and civil penalties under state and federal law. I may also be subject to penalties for perjury under federal law. I authorize the Department of Social Services to verify any information given on this form.

If someone helped you complete this form or completed this form for you, that person must also sign this form.

Applicant's Signature	Date	Spouse's Signature	Date
Helper's Signature and relationship to you	Date	Representative Signature	Date
Witness's Signature (if applicant signed with X)	Date	Interpreter's Signature	Date

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Authorization To Disclose Application Status: I_____, hereby authorize the Department of Social Services to share information regarding the status of this application for assistance with the following individuals, agencies or institutions.

Name	Address	Telephone Number

Applicant's or Authorized Representative's signature	Date

FOR HOSPITAL AND SUBSTANCE ABUSE TREATMENT FACILITY REPRESENTATIVES: I certify that the applicant was informed of his/her responsibility to complete this application; and that his/her signature could not be obtained for the following reason(s):_____

_____

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

The U.S. Department of Agriculture (USDA) also 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 with USDA, complete the USDA 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 by 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).

For any other information dealing with the 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 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).

USDA and HHS are equal opportunity providers and employers.

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You may also file discrimination complaints or request reasonable accommodations as follows:

You have the right to make a discrimination complaint if you think we have taken action against you because of your race, color, religion, sex, gender identity or expression, marital status, age, national origin, ancestry, political beliefs, sexual orientation, intellectual disability, mental disability, learning disability, or physical disability, including, but not limited to, blindness.

An individual with a disability may request and receive a reasonable accommodation or special help from the Department of Social Services when it is necessary to allow the individual to have an equal and meaningful opportunity to participate in programs administered by the Department.

If you asked for an accommodation or special help and we refused to provide it, you may make a complaint to the Department's Affirmative Action Division Director or any of the agencies listed below:

Commissioner of Social Services
Attention: Affirmative Action Division Director/ADA Coordinator
25 Sigourney Street
Hartford, CT 06106-5033
Telephone: 1-860-424-5040, toll free: 1-800-842-1508, TDD: 1-800-842-4524
Fax: 1-860-424-4948

Connecticut Commission on Human Rights and Opportunities
25 Sigourney Street
Hartford, CT 06106
Telephone: 1-860-541-3400, toll free: 1-800-477-5737, TDD: 1-860-541-3459
Fax: 1-860-246-5265
Web: http://www.ct.gov/chro/site/default.asp

U.S. Department of Health and Human Services
Office for Civil Rights
JFK Federal Building, Room 1875
Boston, MA 02203
Telephone: 1-617-565-1340, toll free: 1-800-368-1019, TDD: 1-800-537-7697
Fax: 1-617-565-3809
Web: http://www.hhs.gov/ocr/office/file/index.html

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DO YOU WANT TO REGISTER TO VOTE?

Federal and state laws require the Department of Social Services (DSS) to give you the chance to register to vote. Please answer the questions below and print and sign your name in the space provided.

Are you registered to vote? ☐ Yes I am already registered ☐ No

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.

Applying to register or declining to register to vote will **not** affect the amount of assistance that you will be provided by this agency.
If you would like help in 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.

To register, complete a voter registration application form and leave it at DSS or mail it in. The form is included with DSS applications that we mail to you, and you can also get one at all DSS offices. You can mail your completed form to DSS in the enclosed envelope or send it directly to your Town Hall. If you need help, please call **1-855-626-6632**.

_____ _____ _____
Print Your Name Your Signature Date

Address_____
Number Street City State

For Worker's Use Only

Date_____ ☐ No check boxes checked ☐ Voter Registration Card Sent

Worker Name_____ Worker DMC Number_____

(Tear Here and Keep)

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 you own political party or other political preferences, you may file a complaint with: State Elections Enforcement Commission, 20 Trinity Street, Hartford, CT 06106; 860-256-2940, toll-free 866-733-2463, TDD: 1-800-842-9710;SEEC@ct.gov.