FACTS YOU SHOULD KNOW ABOUT APPLYING FOR TEMPORARY CASH ASSISTANCE, FOOD SUPPLEMENT PROGRAM (FORMERLY FOOD STAMPS) AND MEDICAL ASSISTANCE

Social Security Numbers

- You must give us a social security number for each family member who wants benefits.
- If a person who wants benefits does not have a social security number, that person must apply for a number. We can help applicants get their numbers.
- If a family member has applied for a social security number, we will not delay your application while you wait for the number.
- We use social security numbers to prove income. We do not give numbers to other agencies like Immigration and Naturalization.

Citizenship and Immigration Status

- You must tell us about the citizenship and immigration status for each family member who wants benefits.

Information

- If a family member will not tell us about citizenship, immigration status or social security number, that person will not get benefits.
- They must still give us proof of income, expenses and other things.
- The other family members who give us their information will get benefits if they meet the rules.

Emergency Medical Assistance

- Immigrants who are not eligible for other kinds of medical assistance and apply only for emergency medical assistance do not have to tell us their social security number, immigration or citizenship status.

Time Limits

- Temporary Cash Assistance has time limits.
- The Food Supplement Program (formerly Food Stamps) and Medical Assistance do not have a time limit.
- When Temporary Cash Assistance ends because of time limits, earnings or other reasons, you may still get Food Supplement benefits and Medical Assistance.

Interviews

- You, a responsible family member or someone you choose to represent you must come into our office for an interview.
- If you have a serious problem, or if you are working, and you cannot come to our office for an interview, we can interview you by telephone.
- You must give or send us the proof we ask for at your interview.

If you need help:

Applying for benefits, or
Have questions about information you must give us
Want to know what will happen to your benefits
Do not speak English and need free translation services
Call your case manager or call 1-800-332-6347

Si necesita ayuda para llenar el formulario favor de llamar al 1-800-332-6347.

Date Received (Agency use only)

MARYLAND DEPARTMENT OF HUMAN RESOURCES
FAMILY INVESTMENT ADMINISTRATION
APPLICATION FOR ASSISTANCE

Your Name (Last, First, Middle)	Home Telephone		Work Telephone	
Where do you live? (Number and Street)	Apt. #	City	State	Zip Code
Mailing Address (If different from home)			Cell Telephone	

What language do you speak? □ English □ Spanish □ Other _____

If you do not speak English and need free translation services, call your case manager or call 1-800-332-6347.

What type of assistance do you need now? (Check all that you need)

□ Cash Assistance □ Child Care Services □ Food Supplement Program (Food Stamps)

□ Medical Assistance - Do you have any unpaid medical bills from the past 3 months? □ Yes □ No

Do you have any of these problems?

□ Utility shut off □ Eviction or foreclosure □ No place to stay □ No heat □ No food □ Cannot afford child care □ other:_____

Are you or anyone in your household pregnant? □ Yes □ No If yes, who?_____ Due Date_____

Are you or anyone in your household disabled? □ Yes □ No If yes, who? _____ Disability?_____

What type of assistance do you or any household members receive now or in the past? (Check Now if you are currently receiving this assistance)		**Under what name?**
Now	1.	1.
Now	2.	2.
Now	3.	3.

If you are applying for the Food Supplement Program (FSP) you can complete all of the form and give it to us now. You may also fill in your name, address, sign this page and give the page to us. You can then finish the rest of the application at home and bring or mail it back to the office. You will not get any benefits until we receive the entire form and interview you.

Your Food Supplement benefit is based on the date you sign this application and give it to the department of social services.

You may get Food Supplement benefits right away if you meet one of the following conditions:

- Your household's monthly rent or mortgage and utilities are more than your household's income and resources.
- Your household's gross monthly income is less than $150, and your resources, such as bank accounts, are $100 or less.
- Your household is a migrant or seasonal farm worker household.

If you qualify to get Food Supplement benefits right away, you will receive them within 7 days from the date you sign the form; however, you will not get expedited Food Supplement benefits, if eligible, until we get a completed application form and interview you.

YOUR SIGNATURE	**DATE**

Go to page 2

FOR AGENCY USE ONLY

LDSS Office	Programs applied for or receiving	AU ID #s
Case Manager's Name		
Application/Redetermination Date		MA #s

EXPEDITED SERVICE FOR FSP BENEFITS (CUSTOMERS SHOULD NOT WRITE IN THIS AREA – FOR AGENCY USE ONLY)

Applicants who meet the standards below are eligible to receive Food Supplement benefits within 7 days. The customer must be interviewed, either in person or by telephone, in order to determine eligibility for expedited service. The application must be complete, signed, and identity verified before expedited benefits can be issued.

1. Is the total household income this month, before deductions, less than $150 AND household cash/savings $100 or less? □ **Yes** □ **No**

   Estimated self-reported income for this month = $_____ Household's monthly rent or mortgage amount = $_____

   Household cash and savings for all members = $_____ Appropriate utility standard (SUA, LUA or actual) = $_____

   A. Total income and liquid resources = $_____ **B. Total shelter costs** = $_____

2. Is the total amount for **B. (Total shelter costs)** greater than the total for **A. (Total income and liquid resources)**? □ **Yes** □ **No**
3. Are the household members destitute migrant or seasonal farm workers whose cash and savings are $100 or less? □ **Yes** □ **No**

   If the answer to any of the above questions is yes, this household is potentially eligible for Expedited FSP.
4. If there is another reason why this household should NOT be expedited, list it here: _____

I certify that I screened this applicant for expedited Food Supplement benefits and determined that the household □ **was** □ **was not** eligible for expedited issuance at this time.

Signature of Case Manager	**Date**

A. HOUSEHOLD MEMBERS

Fill in the blanks for everyone that lives with you. List your own name first. Social Security number and Citizenship are optional for members not applying for benefits. Use the codes below to complete the Citizenship, Race and Ethnicity columns. Enter each code that applies, using at least one code for each person.

Ethnicity Codes: 1= Hispanic or Latino, 2=Not Hispanic/Latino

Race Codes: you can choose one or more race code - 1=American Indian/Alaskan Native, 2=Asian, 3=Black/African American, 4=Native Hawaiian/Pacific Islander, 5=White

Citizenship/Immigration Code: 1=United States Citizen, 2=Permanent Resident, 3=Asylee, 4=Alien granted conditional entry, 5=Parolee 1 year or more, 6=Alien whose deportation is withheld, 7=Refugee, 8=Battered alien spouse, child, or parent of child(ren)

Note: You do not have to give information about your race or ethnicity. If you do, it will help show how we obey the Federal Civil Rights Law. We will not use this information to decide if you are eligible. If you do not give us your race, it will not affect your application. The case manager will enter a race code for statistical purposes only. Title VI of the Civil Rights Act of 1964 allows us to ask for this information.

Only Answer the questions **below for each person who↓ wants benefits ↓**

APPLYING FOR (Yes or No)	NAME (Last, First, Middle)	How are they related to you?	DATE OF BIRTH	SEX	ETHNICITY	RACE	IN SCHOOL (Yes or No)	LAST GRADE COMPLETED	U.S. CITIZEN (Yes or No)	SOCIAL SECURITY NUMBER
		Self								

Are any of the household members a roomer or boarder? □ Yes □ No If yes, who?_____

B. CITIZENSHIP/ IMMIGRATION STATUS

If anyone for whom you are applying is not a United States citizen, fill in this section. ONLY ANSWER THESE QUESTIONS FOR EACH PERSON WHO WANTS BENEFITS. **If you are not eligible for other kinds of Medical Assistance and you are applying only for Emergency Medicaid, you do not have to fill-in this section**.

Household member	INS Status	Sponsored Immigrant? □ Yes □ No	Country of origin
	US Entry date:	INS Number:	
Household member	INS Status	Sponsored Immigrant? □ Yes □ No	Country of origin
	US Entry date:	INS Number:	
Household member	INS Status	Sponsored Immigrant? □ Yes □ No	Country of origin
	US Entry date:	INS Number:	
Household member	INS Status	Sponsored Immigrant? □ Yes □ No	Country of origin
	US Entry date:	INS Number:	
Household member	INS Status	Sponsored Immigrant? □ Yes □ No	Country of origin
	US Entry date:	INS Number:	

C. AUTHORIZED REPRESENTATIVE:

You may choose a person to apply for you. You may also choose a person to get your benefits through your Independence Card. This person can use your benefits the same way you do. If you choose someone to help you, give us the following information about the person and check what you want this person to do.

Name (Last, First , Middle)	Relationship	Telephone Number	
Number, Street	City	State	Zip Code

Check what you want the representative to do:

□ Complete interview for you □ Use your Independence Card (cash) □ Receive your notices
□ Sign your application □ Use your Food Supplement benefits □ Receive your Medical Assistance card

D. STUDENTS

Are any household members between ages 18-50 attending a school for higher education (college, vocational or technical school)?

□ Yes □ No Name of student _____

School_____

Is the student employed? □ Yes □ No

Is the student getting educational grants, scholarships, or loans? □ Yes □ No Amount $_____

Amount of tuition $_____ Books $_____ Fees $_____ Transportation $_____

E. RESOURCES/ASSETS

Does anyone in your household have any resources or assets such as a checking or savings account, stocks, bonds, cash on hand, property other than where you live, prepaid burial plan, trust fund, IRA or KEOGH account? □ Yes □ No If yes, list below:

NAME OF OWNER (Specify if self-employed)	TYPE OF RESOURCE/ASSET	BALANCE/VALUE	LOCATION (Name of Bank, at home, etc.)

F. TRANSFER OF ASSETS

Has anyone in your household sold, traded or given away any property, stocks, bonds, cash or other assets in the past 36 months? (60 months if a trust is involved)

Former Owner	Transfer Date	Who Received the Asset?	Type of asset

Fair Market Value $	Amount Received $	Reason for Transfer

G. EARNED INCOME

Dose anyone in your household receive any income from employment? □ Yes □ No If yes, list all gross income **before deductions** (such as full or part-time employment, self-employment, baby-sitting, odd jobs, day work, roomer/boarder payments, etc.)

NAME	NAME OF EMPLOYER (INCLUDE ADDRESS AND PHONE NUMBER)	RATE OF PAY	NUMBER OF HOURS WORKED	AMOUNT PER PAY PERIOD	HOW OFTEN RECEIVED

H. DEPENDENT CARE

If anyone in your household pays someone to care for a child or disabled adult, fill in this section:

Name of Care Provider	Telephone	Name of Care Provider	Telephone
Number Street		Number Street	
City State Zip code		City State Zip code	
Household Member Receiving Care	Under 2 years old? □ Yes □ No	Household Member Receiving Care	Under 2 years old? □ Yes □ No
Who Pays?	Cost $	Who Pays?	Cost $
Household Member Receiving Care	Under 2 years old? □ Yes □ No	Household Member Receiving Care	Under 2 years old? □ Yes □ No
Who Pays?	Cost $	Who Pays?	Cost $

I. CHILD SUPPORT/ALIMONY EXPENSE

Does any household member pay court ordered child support to a **NON-HOUSEHOLD** member? □ Yes □ No If yes, who? (Includes current payments, arrearages, health insurance)

DEPENDENT'S NAME, ADDRESS AND PHONE NUMBER	AMOUNT PAID	PERSON OR AGENCY PAID	HOW OFTEN PAID

J. OTHER INCOME AND BENEFITS

If anyone in your household receives, applied for or was denied any benefit listed below, place a check in the box next to the benefit

□ Alimony □ Child Support □ Social Security □ SSI
□ Railroad Retirement □ Veteran's Pension/Benefit □ Unemployment Benefits □ Education Grants or Loans
□ Worker's Compensation □ Pension or Retirement □ Union Benefits □ Disability, Sick or Maternity Benefits
□ Military Allotment □ Money from Rental Income □ Black Lung Benefits □ Money from Friends or Relatives
□ Lump Sum Cash Amounts □ Civil Service Annuity □ Temporary Cash Assistance □ TDAP
□ Social Security Disability □ Interest Dividends from Stocks, Bonds, Savings or Other Investments
□ Other _____

Do you agree to apply for all benefits you may be entitled to receive? □ Yes □ No

If you checked yes to receiving, applying for or being denied any benefits, fill in below:

HOUSEHOLD MEMBER	TYPE OF BENEFIT	Applied		CLAIM NUMBER	Received		Amount
		yes	no		yes	no	
		yes	no		yes	no	
		yes	no		yes	no	
		yes	no		yes	no	
		yes	no		yes	no	

K. SHELTER COSTS – Complete if you are applying for Food Supplement Program Benefits

Is anyone in your household paying for any of the following? Check all those paid and answer the questions.

√	Expenses	Amount	How Often?	Who Pays?	√	Expenses	Amount	How Often?	Who Pays?
	Rent					Water			
	Mortgage					Sewer			
	Electric					Garbage			
	Gas					Wood/Coal			
	Oil					Property Tax			
	Coop/Condo / Assoc. fees					Homeowner's insurance			
	Telephone					Other			

Do you live in: □ Public Housing □ Section 8 Housing □ FMHA 515 Housing □ Private Housing

Is heat included in your rent? □ Yes □ No Do you pay an electric bill for lights or cooking? □ Yes □ No

If heat is not included in the rent, what is your source of heat? _____

Do you pay for air conditioning? □ Yes □ No

Does someone help you with your utility costs? □ Yes □ No If yes, who?_____

Are you sharing any of the shelter costs listed above? □ Yes □ No If yes, with whom? _____

Your share? _____

Have you received Energy Assistance at your current address within the past 12 months? □ Yes □ No

L. MEDICAL EXPENSES – Complete Appropriate Section if Applying for Medical Assistance or Food Supplement Benefits

Medical Assistance – Do you or any household members pay medical expenses? □ Yes □ No If yes, check the appropriate box

Food Supplement Benefits – Do you or any household members pay medical expenses for any person age 60 or over, or any person receiving disability benefits? □ Yes □ No If yes, check the appropriate box and list the monthly amount you pay.

DISCUSS THESE EXPENSES WITH YOUR CASE MANAGER.

□ Health/Medicare Insurance	$_____	□ Medical/Dental Insurance	$_____	Others _____
□ Dentures/Glasses/Hearing Aids	$_____	□ Transportation Costs	$_____	_____
□ Hospital	$_____	□ Nursing	$_____	_____
□ Attendant Care	$_____	□ Pharmacy Expense	$_____	_____

M. HOUSEHOLD'S DECLARATION INQUIRY – Complete if you are applying for Temporary Cash Assistance or Food Supplement Benefits

1. Has anyone in your household ever been convicted of a felony committed on or after August 22, 1996 that involved drugs?
   □ YES □ NO If yes, who? _____
2. Is anyone in your household currently violating parole or probation or fleeing from the police or the courts?
   □ YES □ NO If yes, who? _____
3. Has anyone in your household been convicted since August 22, 1996 in a Federal or State Court for not telling the truth about where they lived or their identity in order to receive Food Supplement benefits or cash assistance from more than one place in the same month?
   □ YES □ NO If yes, who? _____
4. Has a court convicted any member of your household for trafficking Food Supplement benefits of $500 or more?
   □ YES □ NO If yes, who?_____
5. Is anyone in your household receiving benefits under another identity or as a member of another household or in another State?
   □ YES □ NO If yes, who?_____

N. MEDICAL INSURANCE – Complete if you are applying for Medical Assistance or Temporary Cash Assistance

1. Has anyone applying dropped health insurance coverage in the past six months? □ YES □ NO
2. Does anyone applying have any health insurance? □ YES □ NO If you answered yes to question 2, fill in the section below.

HEALTH INSURANCE POLICY NUMBER 1

POLICY HOLDER NAME	POLICY NUMBER	GROUP NUMBER

HOUSEHOLD MEMBER(S) COVERED BY POLICY	RELATIONSHIP OF MEMBER TO POLICY HOLDER	HOUSEHOLD MEMBER(S) COVERED BY POLICY	RELATIONSHIP OF MEMBER TO POLICY HOLDER

POLICY HOLDER ADDRESS

Number	Street	City	State	Zip Code	Telephone

INSURANCE COMPANY/UNION

Insurance Company Name

Number	Street	City	State	Zip Code	Telephone

HEALTH INSURANCE POLICY NUMBER 2

POLICY HOLDER NAME	POLICY NUMBER	GROUP NUMBER

HOUSEHOLD MEMBER(S) COVERED BY POLICY	RELATIONSHIP OF MEMBER TO POLICY HOLDER	HOUSEHOLD MEMBER(S) COVERED BY POLICY	RELATIONSHIP OF MEMBER TO POLICY HOLDER

POLICY HOLDER ADDRESS

Number	Street	City	State	Zip Code	Telephone

INSURANCE COMPANY/UNION

Insurance Company Name

Number	Street	City	State	Zip Code	Telephone

0. LIFE INSURANCE, FUNERAL PLANS or BURIAL FUNDS – Complete if you are applying for Medical Assistance or Temporary Cash Assistance

NAME OF PERSON INSURED	NAME OF PERSON WHO PAYS	FACE VALUE OR VALUE OF PLAN	CASH VALUE	POLICY NUMBER OR ACCOUNT NUMBER	COMPANY, FUNERAL HOME OR BANK NAME

PLEASE USE THIS SPACE IF YOU NEED TO GIVE US MORE INFORMATION ABOUT ANY APPLICATION QUESTION.

If you need more space, ask for the 9701- Application for Assistance Addendum.

P. CHILD SUPPORT INFORMATION – Complete this section if you want TEMPORARY CASH ASSISTANCE OR MEDICAL ASSISTANCE for a child who has an absent or deceased parent. Fill in a separate section for each absent or deceased parent.

#1 ABSENT PARENT (AP) INFORMATION

Name of Absent Parent (First, Middle, Last)	Relationship of absent parent to you.	Check one: □ Absent □ Deceased

CHILD'S NAME	MARITAL STATUS OF CHILD'S PARENTS AT BIRTH
	□ Married □ Divorced □ Unknown □ Separated □ Never Married
	□ Married □ Divorced □ Unknown □ Separated □ Never Married
	□ Married □ Divorced □ Unknown □ Separated □ Never Married
	□ Married □ Divorced □ Unknown □ Separated □ Never Married

Social Security Number	Other Name	Date of Birth	Age	Race	Sex □ Male □ Female

AP's Last Known Address	Number Street	City	State	Zip Code	Telephone	
AP's Parent's Address	Number Street	City	State	Zip Code	Telephone	

Driver's License State	Birth Place (City, State)	
Current or Prior Military **Dates:** From: To:	Paying Military Allotment? □ Yes □ No If yes, To whom?	Military Branch

Incarcerated □ Currently □ Previously □ Never	Institution Name

ABSENT PARENT INCOME INFORMATION

Last Known Employer	Name, Address & Telephone
Second Employer	Name, Address & Telephone

Other Income/Benefits: □ Social Security □ SSI □ Veteran's Pension □ Unemployment □ Worker's Compensation □ Pension/Retirement □ Union Benefits □ Other, list_____

ABSENT PARENT COURT ORDER INFORMATION

Paying Support? □ YES □ NO	To Whom?	Last Date Paid	Payment Amount
Court Ordered? □ YES □ NO	If yes, where was the court order issued?		Can you give us a copy? □ YES □ NO

#2 ABSENT PARENT (AP) INFORMATION

Name of Absent Parent (First, Middle, Last)	Relationship of absent parent to you.	Check one: □ Absent □ Deceased

CHILD'S NAME	MARITAL STATUS OF CHILD'S PARENTS AT BIRTH
	□ Married □ Divorced □ Unknown □ Separated □ Never Married
	□ Married □ Divorced □ Unknown □ Separated □ Never Married
	□ Married □ Divorced □ Unknown □ Separated □ Never Married
	□ Married □ Divorced □ Unknown □ Separated □ Never Married

Social Security Number	Other Name	Date of Birth	Age	Race	Sex □ Male □ Female

AP's Last Known Address	Number Street	City	State	Zip Code	Telephone	
AP's Parent's Address	Number Street	City	State	Zip Code	Telephone	

Driver's License State	Birth Place (City, State)	
Current or Prior Military **Dates:** From: To:	Paying Military Allotment? □ Yes □ No If yes, To whom?	Military Branch

Incarcerated □ Currently □ Previously □ Never	Institution Name

ABSENT PARENT INCOME INFORMATION

Last Known Employer	Name & Address: Number Street	City	State	Zip Code	Telephone	
Second Employer	Name & Address: Number Street	City	State	Zip Code	Telephone	

Other Income/Benefits: □ Social Security □ SSI □ Veteran's Pension □ Unemployment □ Worker's Compensation □ Pension/Retirement □ Union Benefit □ Other, list_____

ABSENT PARENT COURT ORDER INFORMATION

Paying Support? □ YES □ NO	To Whom?	Last Date Paid	Payment Amount
Court Ordered? □ YES □ NO	If yes, where was the court order issued?		Can you give us a copy? □ YES □ NO

YOU HAVE THE FOLLOWING RIGHTS

RIGHT TO WRITTEN NOTICE – We must always give you a written notice explaining your benefits when we approve your case. We must always give you written notice when we change your benefits, deny or close your case. You have 90 days from the notice date to ask for a hearing. If you ask for a hearing within 10 days, you may be able to keep getting benefits while you wait for the hearing.

RIGHT TO APPEAL – Ask for a hearing if you disagree with the Department's decision. Your case manager can help you write your appeal. At the hearing, you can speak for yourself or bring a lawyer, friend or relative to speak for you.

EQUAL RIGHTS – Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy state we cannot discriminate against you because of race, color, national origin, sex, age, or disability. Under the Food and Nutrition Act and USDA policy, we also cannot discriminate against you because of religion, political beliefs or retaliation.

If you think we have discriminated against you contact USDA or HHS. To contact USDA write USDA, Director, Office of Civil Rights, 1400 Independence Avenue SW, Washington, DC 20250-9410. You may also call toll free, 1-866-632-9992 (voice). TDD users can contact USDA through local relay or the Federal Relay at 1-800-877-8339 (TDD) or 1-866-377-8642 (relay voice users). To contact HHS, write Office for Civil Rights, Health and Human Services, 150 S. Independence Mall West – Suite 372, Philadelphia, PA 19106-3499. You may also call HHS toll free at 1-800-368-1019 (voice) or 1-800-537-7697 (TDD). You may also send an email to OCRMail@hhs.gov. USDA and HHS are equal opportunity providers and employers.

For the Food Supplement Program, if you need this information in a different format (Braille, large print, audiotape, etc.), contact the USDA's TARGET Center at 202-720-2600 (Voice or TDD). If you need information about this program, activity or facility in a language other than English, contact the USDA agency responsible for the program or activity, or any USDA office.

RIGHT TO PRIVACY – You are giving personal information in the application. We use the information to see if you are eligible for benefits. If you do not give the information, we may deny your application. You have a right to review, change, or correct any information. We will not show your information or give it to others unless you give us permission or federal and state law allows us to do so.

RIGHT TO CLAIM GOOD CAUSE – If you want Temporary Cash Assistance (TCA), you must help the Department get child support. You may not have to help if it puts your or your family in danger.

RIGHT TO REFUSE HELP – You do not have to accept help from a religious organization if it is against your religious beliefs.

RIGHT TO TIMELY APPLICATION PROCESSING – If you are eligible for expedited Food Supplement Program benefits we must give you your benefits within 7 days. For the regular Food Supplement Program and other programs, except for certain Medical Assistance programs, we must process your application within 30 days. There are times when there is a delay in processing. If there is a delay, we will send you a letter to tell you why there is delay in processing your application.

YOU HAVE THE FOLLOWING RESPONSIBILITIES

PROVIDE INFORMATION – You must give true and complete information. You may need to give us proof of this information. We will keep this information private. Any delay in providing proof may result in your case being delayed or denied.

Collecting application information, including the social security number of each household member, is authorized under the Food and Nutrition Act of 2008, U.S.C.2011-2036, Social Security Act §1137(f) and 42 U.S.C. §1320b-7(d). We use the information to find out if your household is eligible. We check this information by matching computer programs.

We also use the information to see if you meet program rules. We may contact your employer, bank or other party. We may also contact local, state or federal agencies to make sure the information is correct. We can give your information to other federal or State agencies for official use and to law enforcement officers who need it to find persons fleeing to avoid the law.

If you get too much in benefits:

- You may have to repay the money for the benefits, and
- We may give the application information, including social security numbers, to federal or state agencies, as well as private claims collections agencies, for action.

Giving information is voluntary. If you do not give us information such as social security numbers for everyone who wants help, we may deny benefits for each person who does not give a social security number. If you do not have a social security number, we will help you get one.

REPORT CHANGES - You must report all changes within ten days unless you are part of the Food Supplement Program simplified reporting group and are not receiving Cash Assistance or Medical Assistance. If you want to know if you are part of this group, ask your case manager. You may tell us about any changes in person, by telephone, or by mail to the Department.

Warning – We may deny, lower or stop your benefits if you give us wrong information or do not report changes. A judge may fine and/or imprison you if you deliberately give wrong information or do not report changes.

AUTHORIZED REPRESENTATIVES – In most instances, if your authorized representative gives us wrong information, you will have to pay back any amount you are overpaid.
If your authorized representative knowingly gives us the wrong information or does not use your benefits properly, we may disqualify the person from being an authorized representative.
If a drug and alcohol treatment center or a group living arrangement acts as your authorized representative for your food benefits and they willfully give us wrong information about your situation, we may prosecute the person under applicable State or federal law.

FOOD SUPPLEMENT PROGRAM PENALTIES

Do not:

- Give false information or withhold information to get or continue to get Food Supplement Program (FSP) benefits
- Trade or sell FSP benefits, or electronic benefit cards.
- Use FSP benefits to buy items not allowed, such as alcohol and tobacco.
- Use someone else's FSP benefits.
- Use someone else's Electronic Benefits Card without authorization.

Your Food Supplement Program benefits will not increase if your cash assistance case is reduced or closed because you did not follow the rules.

If a household member deliberately breaks the rules, we may bar the person from the Food Supplement Program.

- We may bar this person for **one year** after the first violation.

- We may bar this person for **two years**:
  * After the second violation, or
  * After the first time a court finds this person guilty of buying illegal drugs with Food Supplement Program benefits.

- We may bar this person **permanently**:
  * After the third violation, or
  * After the second time a court finds a person guilty of buying illegal drugs with FSP benefits, or
  * After the first time a court finds this person guilty of buying guns, bullets, or explosives, with FSP benefits.
  * After a court finds this person guilty of trafficking FSP benefits of $500 or more.

- We may bar this person for **ten years** if found guilty of making a false statement about the person's identity in order to receive multiple benefits at the same time.

- **A judge can also fine this person up to $250,000, imprison the person for up to 20 years, or both. A judge can also bar this person for an additional 18 months. The person may also have to face further prosecution under other federal laws.**

TCA PENALTY – If an assistance unit member is convicted of an Intentional Program Violation (IPV), everyone in your family will lose their benefits.

- The first time, you will lose benefits for **6 months** or until you repay all of the money.
- The second time, you will lose benefits for **12 months** or until you repay all of the money.
- The third time, **you cannot get TCA benefits again**.

MEDICAID WARNING AND PENALTY - Only use Medical Assistance cards if you are eligible.

Every person convicted of "Medicaid Fraud" with a value of **$500** or more in money, services, or goods is guilty of a felony, and shall:

1. Pay back money, services or goods; or the value of those services or goods unlawfully received;
2. Be subject to a fine of no more than $10,000, imprisoned for no longer than five years, or both.

Every person convicted of "Medicaid Fraud" with a value of less than $500 in money, services or goods is guilty of a misdemeanor, and shall:

1. Pay back money, services or goods; or the value of those services or goods unlawfully received;
2. Be fined no more than $1,000 and imprisoned for no longer than three years or both.

READ BEFORE SIGNING:

I understand that it is important to give true information and if I do not, I am breaking the law.

I understand that I can be fined, imprisoned or have my benefits reduced for making false statements or for pretending to be another person.

I know I can be punished for not reporting changes that may affect my eligibility or benefit amount.

I understand that if I get more Food Supplement benefits than I should, all adult members of my household are liable for repaying the debt.

I know the Department can use the application against me in a court of law for fraud prosecution.

I know that failing to report or verify shelter, medical, or dependent care expenses or child support payments is the same as saying I do not want a deduction for the expenses I did not verify or report.

I understand that the Department may check the information on this form to see if it is correct and may select my case for a spot check, such as for a Quality Control Review.

I agree to allow someone from the Department to visit me at home. I will help them get all needed proofs from any source.

I understand by signing this application:

- I accept cash assistance and/or medical assistance.
- I agree that Medicare Part B will make payments directly to doctors and medical suppliers.
- I give the Department the right to seek payment from private or public health insurance and any liable third party. I understand that I must cooperate with the department in securing such payments. The Department may seek payment without legal action, as long as it does not keep more than the amount Medical Assistance paid.
- I give the Department the right to inspect, review and copy all medical records for services received through the Medical Assistance Program.

I understand that when a person is deceased who was at least 55 years old when receiving Medical Assistance the state may take money from the estate to repay payments made on behalf of that person. The program may take the money only if there is no surviving spouse, unmarried child younger than 21, or blind or disabled child (married or unmarried) of any age.

SIGNATURE SECTION

I understand that, as required by Maryland law, certain law enforcement agencies that investigate fraud can obtain information about my application, income, benefits and other documentation as part of their investigation. While access to my application and benefit information is normally limited (under Md. Code Ann. Human Resources Article § 1-201), these limits do not apply to these investigative agencies. Such agencies include the Department of Human Resources' Office of the Inspector General. I understand that I do not need to provide consent to these agencies in order for them to investigate any allegations of fraud against me. Any information found as a result of the investigation may be used against me if an allegation of fraud is prosecuted.

I have read or someone has read and explained the entire application to me. I swear or affirm under penalty of perjury, that all the information I gave is true, correct, and complete to the best of my ability, belief and knowledge. I received a copy of my rights and responsibilities. I authorize any person, partnership, corporation, association, or governmental agency that knows the facts about my eligibility to give that information to the Department. I also authorize the Department to contact any person, partnership, corporation, association, or governmental agency that has given proof of my eligibility for benefits. I certify, under penalty of perjury, that by signing my name below, all persons for whom I am applying are U.S. citizens, lawfully admitted immigrants or individuals in satisfactory immigration status.

Signature of Applicant / Recipient		Date
Signature of Witness (If you Signed an X)		Date
Signature of Spouse (If Applicable)		Date
Signature of Authorized Representative (If Applicable)		Date
Signature of Case Manager		Date

I withdraw my application for: □ Cash Assistance □ Food Supplement Program □ Medical Assistance

Signature of Applicant, Recipient, Authorized Representative		Date

ASSIGNMENT OF SUPPORT RIGHTS FOR TEMPORARY CASH ASSISTANCE

- I assign to the State of Maryland all rights, titles, and interest in support that I may have for myself or for any person receiving TCA.
- This includes any overdue support that has not been collected.
- I agree to have the child support agency collect any support owed to me and to keep up to the amount of TCA paid to me.
- I agree to send to the State of Maryland any support I receive. If I do not turn over this support, I will have to repay this amount to the State of Maryland. I may also be prosecuted for fraud.

When I am eligible for Medical Assistance:

- I assign all rights, title, and interest in medical support and health insurance payments I may have for myself or any person receiving Medical Assistance. This includes overdue medical support or health insurance payments that have not been collected.
- I agree to have the child support agency collect medical support payments owed to me and to keep up to the amount of Medical Assistance payments that were made for me.
- I agree to give the State of Maryland any medical support or health insurance payments I receive.

- I will cooperate to the best of my ability and knowledge with the child support agency while I am receiving TCA and Medical Assistance
- If I do not cooperate with the child support agency, I may lose all my benefits and my case may be closed

I HAVE READ THESE STATEMENTS OR SOMEONE READ THEM TO ME. I UNDERSTAND WHAT THEY MEAN. BY SIGNING MY NAME BELOW, I AGREE TO FOLLOW WHAT THEY SAY.

Signature	**Date**