Request for Assistance

Maryland Department of Human Services

Office Use Only
Date:

This form is used for the first three programs listed below. Your caseworker can tell you how to apply.

Supplemental Nutrition Assistance Program (SNAP)

SNAP helps low-income households buy the food they need for good health.

Medical Assistance

Medical Assistance (MA) is a comprehensive health care insurance program for families and individuals providing access to health care services for many of the State's low-income residents. Individuals may be eligible for services depending upon income and other factors.

Maryland Children's Health Program (MCHP) gives full health benefits for children up to age 19, and pregnant women of any age who meet the income guidelines. Your caseworker can discuss the income guidelines with you.

Cash Assistance

Temporary Cash Assistance (TCA) provides cash assistance to needy families with children when the family's income and resources do not meet their needs. People applying for and receiving TCA participate in work activities.

Emergency Assistance to Families with Children (EAFC) provides cash assistance to families facing a crisis, such as eviction or other emergencies.

Temporary Disability Assistance Program (TDAP) provides cash assistance for disabled adults who cannot work.

Child Care Services

The Purchase of Child Care (POC) program helps eligible families pay for childcare through vouchers. Vouchers can be used to purchase care from any licensed childcare center or home. Vouchers can also be used to pay approved family members who provide childcare. Your case manager will tell you how to apply for this assistance.

Energy Assistance

The Office of Home Energy Programs (OHEP) helps families pay their utility bills, minimize heating crises, and make energy costs more affordable through the Maryland Energy Assistance program and the Electric Universal Service Program. Your case manager will tell you how to apply for this assistance.

This section is for office use only					
Cat.	**AU#**	**Status**	**WOMIS Screen**	**Case Reassign Needed**	
				From:	Clearer:
				To:	Screener:

General Information

About SNAP

You have the right to file for SNAP immediately by filling out your name, address, and signing the front of this Request for Assistance Form.
If you are eligible, we will provide benefits from the date we receive the signed form.

You may get SNAP right away if you give us proof of your identity and one of the following applies to you:

- 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 checking or savings accounts, are $100 or less.
- Your household is a migrant or seasonal farmworker household.

If you qualify to get SNAP right away, we will act on your application within 7 days from the date you sign this form.

Do not complete the following questions. This is for office use only.

Expedited SNAP

Applicants meeting the expedited standards below are eligible to receive SNAP benefits within 7 days. Households must complete and sign the Request for Assistance and provide proof of identity before you approve benefits.

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

a. Household's monthly rent or mortgage amount $_____
b. Appropriate utility standard $_____ Total $_____
c. Approximate monthly income $_____
d. Household cash/savings for all members $_____ Total $_____

2. Do total shelter costs exceed monthly income and resources? ☐ Yes ☐ No

3. Are the household members destitute migrant or seasonal workers whose cash and savings are over $100 or less? ☐ Yes ☐ No

4. If the answer to any questions 1-3 is yes, then expedite. Expedited Eligible? ☐ Yes ☐ No

I certify that I screened this applicant for expedited SNAP, verified the applicant's identity, and determined that the household was ☐ was not ☐ potentially eligible for expedited issuance at this time.

Signature of Screener	**Date**

Step 1: Tell Us About You

To request assistance, complete this section and sign your name. We can help you more quickly if you fill out the whole form.

Full Name (last, first, middle initial) **Email Address**

Home Address (number and street) City State Zip Code

Mailing Address (number and street or P.O. Box) City State Zip Code

Home Phone **Work Phone** **Cell Phone**

Your Signature **Today's Date**

Authorized Representative:

You may choose a person to represent you. 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 SNAP benefits ❑ Receive your Medical Assistance card

Step 2: Tell Us How We Can Help You

1. **What kind of assistance do you need now?** (Check all that apply)

   ❑ SNAP ❑ Cash Assistance ❑ Medical Assistance
   ❑ Referral to Child Care Services ❑ Referral to Energy Assistance

2. **Do you have any unpaid medical bills from the last 3 months?** ❑Yes ❑ No

3. **Do you have any of these problems?**

   ❑ Utility shut off ❑ Eviction or Foreclosure ❑ No Food
   ❑ No Heat ❑ No Place to Stay ❑ Can't Afford Child Care
   ❑ Other _____

4. **What kind of assistance do you or anyone who lives with you get now?**

Kind of Assistance	Person Receiving Assistance

5. **Have you or anyone who lives with you received assistance from a state other than Maryland?** (if yes, please fill in the blanks below) ❑ Yes ❑ No

State Received _____ When Received _____ Kind of Assistance _____

6. **Does anyone applying for Maryland Children's Health Program have employee-based health insurance** (insurance you get on the job)**?** ❑Yes ❑ No

7. **Has anyone applying for Maryland Children's Health Program dropped employee-based insurance in the past 6 months?** ❑Yes ❑ No

Step 3: Tell Us About the People In Your Household

8. **Tell us about the people who live with you.**
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.

Yourself | Client ID#

_____ **Full Name** (last, first, middle initial) | **Self** **Relation to You** | _____ **Race** | ❑ Male ❑Female

_____ **Date of Birth** (mm/dd/yyyy) | _____ **Social Security Number** | _____ **Marital Status**

Applying ❑Yes ❑ No **Disabled?** ❑Yes ❑ No **U.S. Citizen** ❑Yes ❑ No

Additional Household Member | Client ID#

_____ **Full Name** (last, first, middle initial) | _____ **Relation to You** | _____ **Race** | ❑ Male ❑Female

_____ **Date of Birth** (mm/dd/yyyy) | _____ **Social Security Number** | _____ **Marital Status**

Applying ❑Yes ❑ No **Disabled?** ❑Yes ❑ No **U.S. Citizen** ❑Yes ❑ No

Additional Household Member | Client ID#

_____ **Full Name** (last, first, middle initial) | _____ **Relation to You** | _____ **Race** | ❑ Male ❑Female

_____ **Date of Birth** (mm/dd/yyyy) | _____ **Social Security Number** | _____ **Marital Status**

Applying ❑Yes ❑ No **Disabled?** ❑Yes ❑ No **U.S. Citizen** ❑Yes ❑ No

Additional Household Member	Client ID#

Full Name (last, first, middle initial) **Relation to You** **Race** ❑ Male ❑Female

Date of Birth (mm/dd/yyyy) **Social Security Number** **Marital Status**

Applying ❑Yes ❑ No **Disabled?** ❑Yes ❑ No **U.S. Citizen** ❑Yes ❑ No

Additional Household Member	Client ID#

Full Name (last, first, middle initial) **Relation to You** **Race** ❑ Male ❑Female

Date of Birth (mm/dd/yyyy) **Social Security Number** **Marital Status**

Applying ❑Yes ❑ No **Disabled?** ❑Yes ❑ No **U.S. Citizen** ❑Yes ❑ No

Additional Household Member	Client ID#

Full Name (last, first, middle initial) **Relation to You** **Race** ❑ Male ❑Female

Date of Birth (mm/dd/yyyy) **Social Security Number** **Marital Status**

Applying ❑Yes ❑ No **Disabled?** ❑Yes ❑ No **U.S. Citizen** ❑Yes ❑ No

Additional Household Member	Client ID#

Full Name (last, first, middle initial) **Relation to You** **Race** ❑ Male ❑Female

Date of Birth (mm/dd/yyyy) **Social Security Number** **Marital Status**

Applying ❑Yes ❑ No **Disabled?** ❑Yes ❑ No **U.S. Citizen** ❑Yes ❑ No

9. Is anyone in your household pregnant?

Full Name (last, first, middle initial) **Expected Due Date**

10. List any absent parents of children in your household.
A child's parent who does not live with you is an absent parent. Also, list your spouse if he or she does not live with you. Enter what you know about the person.

Name (last, first, initial)	**Date of Birth**	**Address**	**Social Security #**	**Client ID#**

Step 4: Tell Us About Your Income

11. In this section tell us about all the money that members of your household get each month, both earned and unearned.
We need this information so we can give you the correct benefit. List all income before deductions. Give the type and amount of income. (Types of income include full or part-time earnings, self-employment, babysitting, odd jobs, day's work, roomer/boarder payments, social security benefits, pensions, alimony, child support, Temporary Cash Assistance and any other earned or unearned income.)

Name of Person with Income	Type of Income	Name and Address of Employer	Amount of Income	How Often Received
			$	
			$	
			$	

12. If you are not working now, when did your job end?

_____
Name and Address of Employer

_____ _____ _____
Date Job Ended **Reason Job Ended** **Date Last Paycheck Received**

Step 5: Tell Us About Your Assets

13. Please tell us about your assets, including the money you have and things you own.
Examples of assets include bank accounts, certificates of deposit, investments, stocks, bonds, property you do not live in.

Type of Bank Account or Asset	Amount in Account or Value of Asset	Name of Person with Account/Asset
	$	
	$	
	$	

Step 6: Tell Us About Your Expenses

Only answer these questions below if you are applying for SNAP Benefits.

14. In this section tell us about your costs for where you live and other expenses.

Expense	Amount	How Often?	Name of Person that Pays
Rent or Mortgage	$		
Tax and Insurance	$		
Co-op or Condo Fees or Ground Rent	$		
Water, Sewer, Garbage	$		
Gas, Electric	$		
Telephone	$		
Child or Adult Care Costs (babysitting)	$		
Medical Costs for Elderly or Disabled	$		
Legally Obligated Child Support	$		

15. Is heat included in your rent? ❑Yes ❑ No
If heat is not included in the rent, how do you heat your home?

_____
How do you heat your home?

16. Do you pay for air conditioning? ❑Yes ❑ No

_____
Name of your utility company or person you pay

17. Does someone help you with your shelter costs? ❑Yes ❑ No

_____
Full Name of Person That Helps (last, first, middle initial)

18. Are you sharing any of your shelter costs listed above? ❑Yes ❑ No

_____ _____
Full Name of Person Sharing Shelter Costs (last, first, initial) Your Share

19. Do you live in public housing, Section 8 housing, or Farmers Home Administration (FMHA) Section 515 housing? ❑Yes ❑ No

20. Did you get Energy Assistance (State help with heating or electric bills) at your current address within the past 12 months? ❑Yes ❑ No

HOUSEHOLD'S DECLARATION INQUIRY – Complete if you are applying for Temporary Cash Assistance or Supplemental Nutritional Assistance Program

1. Has anyone in your household been convicted of:
a. A drug kingpin felony on or after August 22, 1996?
(Drug kingpin-An organizer, supervisor, financier, or manager who acts as a co-conspirator in a conspiracy to manufacture, distribute, dispense, transport in, or bring into the State a controlled dangerous substance).
□ YES □ NO If yes, who? _____
b. A volume dealer drug felony on or after August 22, 1996?
(Volume dealer - An individual, who manufactures, distributes, dispenses, or possesses certain quantities of a controlled dangerous substance).
□ YES □ NO If yes, who? _____
2. Has anyone in your household been convicted after February 7, 2014, of aggravated sexual abuse, murder, sexual exploitation and other abuse of children, sexual assault as defined in the Violence Against Women Act of 1994, or a similar state law, **and** is also not in compliance with the terms of their sentence?
□ YES □ NO If yes, who? _____
3. Is anyone in your household currently violating parole or probation or fleeing from the police or the courts?
□ YES □ NO If yes, who? _____
4. 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 to receive SNAP benefits or cash assistance from more than one place in the same month?
□ YES □ NO If yes, who? _____
5. Has a court convicted any member of your household for trading or trafficking SNAP benefits of $500 or more?
□ YES □ NO If yes, who? _____
6. 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? _____

Customer Rights

In accordance with federal civil rights laws and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Programs that receive federal financial assistance from the U.S. Department of Health and Human Services (HHS), such as Temporary Assistance for Needy Families (TANF), and programs HHS directly operates are also prohibited from discrimination under federal civil rights laws and HHS regulations.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or who have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

USDA provides federal financial assistance for many food security and hunger reduction programs such as the Supplemental Nutrition Assistance Program (SNAP), the Food Distribution Program on Indian Reservations (FDPIR) and others. To file a program complaint of discrimination, complete the Program Discrimination Complaint Form, (AD-3027) found online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by mail: Food and Nutrition Service, USDA,1320 Braddock Place, Room 334, Alexandria, VA 22314; or fax: (833) 256-1665 or (202) 690-7442; or phone: (833) 620-1071; or email: FNSCIVILRIGHTSCOMPLAINTS@usda.gov.

For any other information regarding SNAP issues, persons should either contact the USDA SNAP hotline number at (800) 221-5689, which is also in Spanish, or call the state information/hotline numbers (click the link for a listing of hotline numbers by state); found online at: SNAP hotline.

HHS provides federal financial assistance for many programs to enhance health and well-being, including TANF, Head Start, the Low Income Home Energy Assistance Program (LIHEAP), and others. If you believe that you have been discriminated against because of your race, color, national origin, disability, age, sex (including pregnancy, sexual orientation, and gender identity), or religion in programs or activities that HHS directly operates or to which HHS provides federal financial assistance, you may file a complaint with the Office for Civil Rights (OCR) for yourself or for someone else

To file a complaint of discrimination for yourself or someone else regarding a program receiving federal financial assistance through HHS, complete the form online through OCR's Complaint Portal at https://ocrportal.hhs.gov/ocr/. You may also contact OCR via mail at: Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201; fax: (202) 619-3818; or email: OCRmail@hhs.gov. Persons who need assistance with filing a civil rights complaint can email OCR at OCRMail@hhs.gov or call OCR toll-free at 1-800-368-1019, TDD 1-800-537-7697. For persons who are deaf, hard of hearing, or have speech difficulties, please dial 7-1-1 to access telecommunications relay services.

This institution is an equal opportunity provider.

I certify, under penalty of perjury, that all the information I gave in this form is true, correct, and complete to the best of my ability, belief, and knowledge, including the information on the citizenship and alien status of those applying for benefits. 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.

Your Signature **Today's Date**

Signature of Authorized Representative (if any) **Today's Date**

Additional Information

If you need space to write information that does not fit on another page, add it here: