APPLICATION FOR ASSISTANCE

Welcome to the Department of Health & Human Services (DHHS),
Bureau of Family Assistance (BFA)

To apply for the programs and services we offer, you must fill out this *Application for Assistance*, then have an interview, and give us proof of your household circumstances. Please read all of the information given to you, and answer all of the questions as best as you can. ***Do not answer anything that you do not understand***. If you need help in filling out this *Application,* tell us. ***You have the right to immediately file your Application as long as it contains the applicant's name and address and the signature of a responsible household member or the household's authorized representative.*** However, we will be able to more quickly figure out if you can get benefits if you complete the entire *Application*. If you only want Supplemental Nutrition Assistance Program (SNAP) benefits and are completing the full *Application*, please complete every Section except Section I.

BFA assistance is based on your income. Some BFA programs may also look at the cash value of things that you own (your assets) when figuring out if you qualify for a program we offer.

SNAP Benefits

The Supplemental Nutrition Assistance Program (SNAP) helps low-income people buy the food they need for good health. You will need to have an interview with a DHHS worker to see if you are eligible for this program. Your SNAP benefits are based on the date of application, which is the date your completed application is received by the District Office. If you are a resident of an institution who is jointly applying for SSI and SNAP benefits prior to leaving the institution, the filing date of your application is your date of release from the institution. With identification, you may get emergency SNAP benefits within 7 calendar days if:

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

Social Security Numbers (SSN)

The Federal Privacy Act of 1974 as amended, requires that we tell you the laws that allow us to ask for the SSN of each person requesting assistance, whether you are required to give them to us, and what we will do with them. SSNs are required for the following programs. After each program is the law or regulation that requires us to ask for these SSNs:

- FANF: 42 USC 405(c)(2); 45 CFR 205.52; RSA 167:4-c; & RSA 167:79,iii(h).
- SNAP: RSA 167:4-c; Food and Nutrition Act of 2008, as amended, 7 USC 2011-2036; 7 CFR 273.2(b)(4)(i); & 7 CFR 273.6.
- Medical Assistance and other financial assistance: RSA 167:4-c; Section 2651 of PL 98-369; 42 CFR 435.910; 42 CFR 435.920; & 42 USC 1320b-7.

Each person who wants assistance from the above programs must provide an SSN or apply for an SSN at the Social Security Administration (SSA). Members of your household who do not want to apply for benefits do not need to provide an SSN. Giving us an SSN is optional for persons who are not applying for assistance. Giving us an SSN can save you time and money getting needed verifications.

If you are applying only for some members of your family, such as a parent applying for Medical Assistance just for a child, you only have to give us the child's SSN or apply for an SSN for your child. Your child's eligibility for medical coverage will not be affected if you only give us your child's SSN.

If an SSN is not provided for each person who is applying for the listed programs, your application may be denied or you may get less benefits. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY: 1-800-325-0778.

Applicants who only want Child Care assistance do not have to provide a SSN, but if SSNs are provided, it may help shorten the eligibility verification process.

We ask for SSNs so we can verify identity, other benefits received, earned and unearned income, and resource information you give us. It will be shared and verified with:

- federal, state, and local entities;
- offices within DHHS as allowed by federal law;
- employment and unemployment databases;
- the Internal Revenue Service and SSA;
- contracted third parties;
- financial entities; and
- other computer matching programs.

The information will be used:

- to figure out if you are eligible or continue to be eligible for the assistance you requested;
- to figure out the amount of your benefits or errors in your eligibility or benefits; and
- in an investigation of suspected abuse of program law or rules.

It may be disclosed to Federal and State agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to

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avoid the law. If a SNAP claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action.
We do not give SSNs or any other information regarding non-applicants to the US Citizenship and Immigration Services (USCIS), or any other agency not directly connected with programs and/or services offered by DHHS.

Emergency Medicaid for Non-Citizens

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

Citizenship & Identity

You must declare and prove the citizenship or non-citizenship status of each household member applying for assistance. Non-citizens applying for assistance, except Emergency Medicaid, must provide USCIS documentation of qualified alien status. USCIS documentation will be verified and non-citizen status of applicant household members will be subject to verification through the submission of information from the application to USCIS, and the submitted information received from USCIS may affect eligibility and benefits.

Third Party Insurance or Medical Payments

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

Benefits Received in Error

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

Financial or Medical Child Support

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

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

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

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

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

Begin Date for Medicaid Eligibility

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

AGENCY USE ONLY

This is your record of application and will be filled out by a Department of Health and Human Services worker and returned to you. BFA has received:

a completed application for _____ from _____ on _____

_____ _____

District Office Signature of Worker

KEEP THIS PAGE FOR YOUR RECORDS

APPLICATION FOR ASSISTANCE

A. Please tell us about who you are and where you live.

Full Legal Name: _____ Primary Language: _____

Current Place of Residence: ☐ Own home ☐ Nursing Facility ☐ Adult Family Home ☐ Assisted Living
☐ Rental ☐ Homeless ☐ Hospital ☐ Hotel/Motel ☐ Residential Care Facility ☐ Other

Street Address: _____ Mailing Address: _____ (if different)

City/State/Zip: _____

Home Phone: _____ Work Phone: _____ Cell/Message: _____

E-Mail Address: _____ ☐ I do not have an E-Mail address

Does anyone in your family have Medicare Part A or B? ☐ Y ☐ N

Why do you need our help? _____

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

B. Please tell us about the people you live with. Start with yourself and list ALL of the people living with you.

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

Full Legal Name	SSN	DOB	Relation to you	U.S. Citizen?	Student (Yes or No. If Yes, put grade too)	RID (BFA Use Only)
1.			SELF	☐ Y ☐ N		
2.				☐ Y ☐ N		
3.				☐ Y ☐ N		
4.				☐ Y ☐ N		
5.				☐ Y ☐ N		
6.				☐ Y ☐ N		

C. I want to apply for: (TYPES OF ASSISTANCE REQUESTED)

☐ All Programs ☐ Cash ☐ SNAP ☐ Child Care ☐ Medicare Savings Programs (MSP) [QMB/QWDI/SLMB/SLMB135]
☐ Medical Assistance – if you need Medical Assistance for a child, pregnant women, or parent/caretaker relative of a child, you must also complete the insert entitled *Medical Assistance for Children, Pregnant Women, and Parent/Caretaker Relatives Insert*

☐ Home and Community-Based Care (HCBC) *Which HCBC program? use check boxes below:*

☐ Acquired Brain Disorder ☐ Choices For Independence ☐ Developmental Disability ☐ In Home Supports

☐ Nursing Facility (NF) Services - Facility Name:

D. *The following information is collected to be sure that everyone is served fairly without regard to race, color, or national origin. Your answers are voluntary. The information provided will not affect your eligibility or benefit amount. For ethnicity, please select one response. For race, please select all that apply.*

Ethnicity: Are you Hispanic or Latino? ☐ Yes ☐ No

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

AGENCY USE ONLY:

RFA#		Case #			Forms Given: 725	177
Cash: _____	OPEN	CLOSE	DENY	DATE: _____	DO:	
SNAP	OPEN	CLOSE	DENY	DATE: _____	DO:	
MA: _____	OPEN	CLOSE	DENY	DATE: _____	DO:	
CM/MCPW	OPEN	CLOSE	DENY	DATE: _____	DO:	
Child Care	OPEN	CLOSE	DENY	DATE:	DO:	
EBT Card Status:	None	Active	Bad Address		Deactivated/Cancelled	Undelivered

E. Please tell us about all income for everyone in your home.

Your Wages: $ ☐ Weekly ☐ Bi-Weekly ☐ Monthly

Other Wages: $ ☐ Weekly ☐ Bi-Weekly ☐ Monthly

Other Wages $ ☐ Weekly ☐ Bi-Weekly ☐ Monthly

Has anyone recently lost a job? ☐ Yes ☐ No

If yes, who?_ When?___/___/___

SSA/SSDI: $ Spousal Support: $

SSI: $ Unemployment: $

VA: $ Child Support: $

Pension: $ Other: $

F. Please tell us about all assets for everyone in your home.

Checking/Savings: $ Other Chk/Save: $

Stocks/Bonds/CD's: $ IRA: $

Your or Your Spouse's Annuity: $ Other Assets: $

Trusts: $ Life Insurance: $

Vehicle (Yr/Mdl): Vehicle (Yr/Mdl):

G. Your Expenses:

Rent (monthly): $

Mortgage (monthly): $

Lot Rent/Condo Fee (monthly): $

Taxes (yearly): $

Dependent Care: $

Medical Expenses: $

Cost of doing business: $

Have you gotten more than $20 in fuel assistance in this or the past 12 months? ☐ Yes ☐ No

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

Heating/Cooling (A/C): ☐ Yes ☐ No

Phone: ☐ Yes ☐ No

Electric: ☐ Yes ☐ No

Other: ☐ Yes ☐ No

Internet(including mobile): ☐ Yes ☐ No

H. Please answer all questions.

1. Are you a migrant or seasonal farm worker? ☐ Yes ☐ No
2. Have you or anyone in your household received SNAP assistance for this month? ☐ Yes ☐ No
3. Are you currently living in a shelter for battered individuals? ☐ Yes ☐ No
4. Is anyone in your household blind or disabled? ☐ Yes ☐ No
5. Have you sold or transferred property in the last 5 years? ☐ Yes ☐ No
6. Is anyone in your household currently receiving assistance from another State? ☐ Yes ☐ No
   If yes, which State? What kind of assistance?

I. Do you only want SNAP? If so, you can skip to Section J now. If you want cash, medical or child care help, please answer all questions in this Section before proceeding to Section J.

1. Is anyone in your household pregnant or has anyone given birth in the last 3 months? ☐ Yes ☐ No
2. Do you have any unpaid medical bills from the past 3 months that you would like help paying? ☐ Yes ☐ No
3. If you are applying for Financial Assistance to Needy Families (FANF), is the father's name blank or "not stated" on the birth certificate for any of your children? ☐ Yes ☐ No
4. If applying for FANF, how many absent parents?
5. Do you or any other household member have health insurance other than Medicaid? ☐ Yes ☐ No
   If yes, name of Insurer? Policy Number:
6. Was anyone in your household in foster care at age 18 or older? ☐ Yes ☐ No
   If yes, who? State: Date Foster Care Ended: / /

J. Signatures

I CERTIFY, UNDER PENALTY OF PERJURY, THAT I HAVE REVIEWED THE INFORMATION ON THIS APPLICATION, INCLUDING ANY INFORMATION INDICATED ON THE INSERT; IT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE, INCLUDING THE INFORMATION CONCERNING CITIZENSHIP AND ALIEN STATUS OF THE MEMBERS APPLYING FOR ASSISTANCE. I UNDERSTAND A FULL FINANCIAL AND MEDICAL ELIGIBILITY INTERVIEW MAY NEED TO BE CONDUCTED BEFORE MY ELIGIBILITY CAN BE DETERMINED.

Applicant Signature **Date**

Printed Name and Signature of Person Helping the Applicant **Date** **Relationship to Applicant**

I withdraw my application for: ☐ Cash ☐ Medical Assistance ☐ SNAP ☐ Child Care ☐ HCBC/NF ☐ MSP

Signature **Date**

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

Printed Name & Signature **Title/Agency** **Date**

Time Limits

You can only receive Financial Assistance to Needy Families for 60-months in your lifetime. Months you received this assistance while you were a child do not count towards the lifetime limit. Your time limit begins when you receive benefits as an adult. **There is no time limit on State Supplement Program, Medical Assistance, SNAP benefits, or child care assistance.**

Administrative Appeal

You or someone representing you may request an Administrative Appeal if you are not satisfied with any eligibility decision made by DHHS. You may be represented by an attorney, yourself, or another person, such as a relative or friend, at an Administrative Appeal. DHHS will not pay for the cost of any legal services, but there are free and reduced cost legal services available in NH. An Administrative Appeal may be requested either verbally or in writing by contacting a District Office or DHHS, 105 Pleasant Street, Concord, NH 03301-6521. Telephone (603) 271-4292 or 1-800-852-3345 ext 14292; TDD Access: Relay NH 1-800-735-2964 or 711.

Quality Control

Your case may be selected for a quality control or other governmental review. Such a review entails an in-depth investigation into your household's financial or medical situation, living arrangements and other circumstances. We may be contacting banks, employers, companies, merchants, child care providers, and other appropriate sources, concerning your household and statements you made to DHHS. **Failure to cooperate in these reviews could result in the loss of your benefits**.

Reporting Changes

You will be required to periodically complete a review of your circumstances. Your cash, child care, and SNAP case could be closed, and/or your eligibility for Medical Assistance may be affected, if you do not completely fill out the form and return it by the due date and participate in a personal interview, if required.

If you only get SNAP benefits and you have a 4, 5, or 6-month eligibility period, you only need to report those changes in household circumstances that would place your household's income above 130% of the poverty level.

If you receive cash, child care, Medical Assistance, or if your SNAP eligibility period is not 4, 5, or 6 months, then you must notify the Department within 10 calendar days after the change happens for changes in factors that affect eligibility, such as:

- source of income;
- hours worked by a household member;
- amount of income of any member in your household;
- all household changes, such as marriage, divorce, new baby, child leaves, etc.;
- child care provider;
- resources (e.g., cash, stocks, bonds, or money in a bank or savings account);
- receipt of any lump sum payment or settlement;
- residence, or shelter costs; or
- dependent care costs, child support payments or medical deductions, or other changes that may affect the amount of your household's benefits.

Protection of Medical Assistance for Social Security Beneficiaries

If you are receiving cash assistance under the OAA, ANB, or APTD program, and a Social Security cost-of-living increase or this increase combined with an increase in other income makes you ineligible for financial assistance, you may still be entitled to Medical Assistance under the Pickle Amendment policy.

Once you begin receiving Medical Assistance under the Pickle Amendment, future Social Security cost-of-living increases will not affect your eligibility. However, other changes in your circumstances can still make you ineligible for Medical Assistance.

If you are eligible to receive cash assistance under one of the above programs, but choose not to receive a payment, you will **NOT** be entitled to this protection of your Medical Assistance under the Pickle Amendment.

Notice to Immigrant Families

If you get help with health care or SNAP, it will not affect your immigration status. If you or members of your family used or received Medicaid or SNAP, it will not affect your or your family members' ability to become U.S. citizens.

However, if you get cash assistance such as TANF or help with the cost of nursing home care, it might create problems with becoming a U.S. citizen, especially if the benefits are your family's only income. Before you apply, you may want to talk with an agency that helps immigrants with legal questions or contact the US Citizenship and Immigration Services (USCIS).

ATTENTION!

Anything you tell or give to us will be verified:

- **at the federal, state and local levels; and also**
- **through collateral contacts and/or computer matching with other electronic verification tools such as, but not limited to, USCIS, IEVS, Vital Records, SSA, financial institutions, & employment databases.**

We do this to confirm your eligibility for our programs and determine your benefits. If any information we get from using these sources doesn't match the information you provided to us, you may be denied assistance, your benefits may change, and you may be subject to criminal prosecution for knowingly providing false information. Any member of your household who breaks any of these rules on purpose can be prohibited from participating in the cash assistance, child care assistance, and SNAP programs for periods ranging from one year to permanently. For SNAP, you can also be fined up to $250,000, imprisoned up to 20 years, or both, and will be subject to prosecution under the applicable state and federal laws for violations of the Food and Nutrition Act. If you are convicted, the court may also bar you from participating in the program for another 18 months, in addition to the sentence you receive.

DO NOT

- **Do not** give false information or hide information to get or continue to get benefits.
- **Do not** trade or sell SNAP benefits to anyone who is not authorized to use them for your household.
- **Do not** use SNAP benefits to buy ineligible items.
- **Do not** use any benefits your household was not entitled to receive.
- **Do not** give your EBT Card PIN out to anyone.
- **Do not** use child care services paid for by DHHS, for employment-related activities not approved by DHHS.
- **Do not** use your EBT card or cash from your EBT card at stores in which more than 50% of visible inventory is alcohol, or that primarily engage in body piercing, branding, or tattooing, gaming establishments, cigar, pipe, smoke, or tobacco stores/stands/shops, most marijuana dispensaries, or businesses in which more than 50% of visible inventory being sold or rented is adult-oriented entertainment.
- **Do not** try to buy food with your SNAP benefits unless you have your EBT card with you at the time you buy the food. You may not buy food on 1 day and pay for it with your EBT SNAP benefits on another day.

Identity & Residence

An individual who DHHS has determined has made or is convicted of having made a fraudulent statement or representation with respect to their identity or place of residence in order to receive multiple benefits at the same time will be ineligible for financial assistance and SNAP benefits for 10 years.

Trafficking SNAP Benefits

Any person who is found guilty in a court of law:

- Of trading of a controlled substance in exchange for SNAP benefits, will be prohibited from participating in SNAP for 24 months for the 1st offense and permanently for the 2nd offense.
- For the trading of ammunition, firearms, or explosives in exchange for SNAP benefits, or of any trafficking in SNAP benefits of more than $500, will become permanently ineligible for SNAP benefits.
- For buying or selling SNAP benefits will be suspended from SNAP for 1 year for the 1st offense, 2 years for the 2nd offense, and permanently for the 3rd.

Medical Assistance Fraud

Section 1128B of the Social Security Act provides federal penalties for fraudulent acts and false reporting in connection with your application for or receipt of Medical Assistance benefits.

A person may be prosecuted in Federal Court for deliberate statements that are known to be false and which affect eligibility for any benefit or payment under the Medical Assistance program.

A person may also be prosecuted for concealing or failing to disclose any event that affects their right to any benefit or payment, or its conversion to a use other than intended. The law also provides a penalty for a kickback, bribe, or rebate in connection with the furnishing of Medical Assistance.

Conviction of an offense could result in loss of Medical Assistance benefits for a period not to exceed 1 year. Penalties are fines up to $25,000 or imprisonment for not more than 5 years, or both.

Intentional False Statements/Program Violations (IPV)

Any person who intentionally makes a false statement or misrepresents their circumstances or intentionally fails to disclose the receipt of property, wages, income or resources or any change in circumstances that would affect their initial or continued eligibility for assistance may be found guilty of violating state law. The penalties are: a class A felony where the value of the monetary award or goods or services exceeds $1,000; a class B felony where the value exceeds $100; and a misdemeanor where the value does not exceed $100. RSA 167:17-b and 17-c.

Anyone who commits an intentional program violation (IPV) in SNAP cannot get these benefits for 12 months for the 1st violation, 24 months for the 2nd violation, and permanently for a 3rd IPV.

STATEMENTS OF UNDERSTANDING

All Programs — INITIALS

I certify that I have read and understand "Your Rights and Responsibilities". _____

I understand that DHHS will keep my eligibility and case information confidential and only persons involved in administering DHHS' programs or as otherwise permitted by Federal regulations or State law will review it. _____

I understand that despite other rules of confidentiality, names of children in SNAP and/or FANF households are required to be released to schools so that they may be determined automatically eligible for Free and Reduced School Meals. _____

I understand that I must provide proof of: my household situation, what I have written on the application, and what I have told DHHS. _____

I understand that the information I have provided will be verified by collateral contacts and/or Federal, State, and local officials and that if any information is found to be incorrect or false, or if I have deliberately withheld information related to my receipt of assistance, now or in the future, I may lose my benefits and may be prosecuted for fraud. _____

I understand that my signature below and/or on the application authorizes DHHS and any contracted third party to obtain verification that I or anyone in my household meet the eligibility requirements for assistance, and authorizes release of such information to DHHS. My authorization to release information to DHHS remains in effect for as long as I or anyone in my household receives any kind of DHHS assistance. _____

I understand that my signature below **and/or** on the application permits DHHS and any contracted third party entity to verify my income, identity, and assets, and the income, identity, and assets of any other person whose income, identity, and assets are required to determine eligibility for the assistance I am requesting. Failure to give permission to conduct these verifications or revoking permission to conduct these verifications will result in denial or termination of assistance. _____

I understand that if I am required to have an interview, I will be sent an Eligibility Interview Summary (EIS) after my interview. I agree to review this EIS and will notify DHHS within 10 days if any of the information is incorrect or has changed. _____

Cash & SNAP Programs

I certify that if I applied for FANF, the Domestic Violence Option has been explained to me, and I understand it. _____

I certify that if I applied for FANF, I got written information about the treatment of lump sum income. _____

I understand that my receipt of TANF cash assistance is an assignment to DHHS of each recipient's rights to child and spousal support. _____

I understand that if I get cash assistance from DHHS, the cash I get could cause my SNAP benefits to end or be reduced. I also understand that if this happens, I will not get advance notice of this change. _____

I understand that to get a cash payment from any BFA program, I must be eligible to get that cash every day of the entire payment period. If I am not eligible for cash at any time during that payment period, I understand that a cash payment will not be issued to me. _____

I understand that in NH, if anyone in my household is fleeing to avoid prosecution of a felony crime, or is violating conditions of probation or parole, that person will be ineligible to get cash or SNAP benefits until that individual has satisfied his/her legal obligations with respect to the felony crime or probation or parole violations. My signature below is my sworn statement that I will notify DHHS if anyone in my household is fleeing felony prosecution or violating conditions of probation or parole. _____

I understand that if anyone in my household has been convicted, as an adult, of a crime of aggravated sexual abuse, murder, sexual exploitation and other abuse of children, a Federal or State offense involving sexual assault, or an offense under State law determined by the Attorney General to be substantially similar to such offence, after February 7, 2014, and is out of compliance with terms of the sentence, that person will be ineligible to get cash or SNAP benefits. My signature below is my sworn statement that I will notify DHHS if anyone in my household has been convicted of such crime and is out of compliance with the terms of their sentence. _____

I understand that the use of my Electronic Benefits Transfer (EBT) card for SNAP or cash benefits is controlled by my 4-digit Personal Identification Number (PIN), that I am responsible for the security of my EBT card and PIN, and that EBT benefits will not be replaced if someone else uses my card after I have activated it. _____

PLEASE INITIAL AND SIGN THE BACK!

Cash & SNAP Programs Con't

INITIALS

I understand that my EBT card or cash from my EBT card cannot be used at stores in which more than 50% of visible inventory is alcohol, or that primarily engage in body piercing, branding, or tattooing, gaming establishments, or cigar, pipe, smoke, or tobacco stores/stands/shops, most marijuana dispensaries, or businesses in which more than 50% of visible inventory being sold or rented is material considered adult-oriented entertainment per RSA 650:1,III, and that if I use my EBT card or cash from my EBT card at one of these places, I will be sanctioned with a cash penalty, per RSA 167:7-b and He-W PART 608. _____

I understand that if I do not use my SNAP benefits on my EBT card for 274 days in a row, I will lose those benefits and not get them back. If I do not use my cash benefits for 90 days in a row, I will lose those benefits and not get them back. I understand that I will be disqualified from the SNAP Program and may be prosecuted if I use my EBT card for illegal purposes. These illegal activities include selling my card and my PIN for cash, drugs, or other items, or exchanging SNAP benefits for cash at a retailer. _____

I understand that for SNAP benefits, to get a deduction for child care expenses, rent or mortgage payments, utility or other shelter expenses, child support paid to a non-household member, or medical expenses (only for the elderly or disabled), I **must** tell DHHS about these expenses and then provide proof of them. Failure to report or verify any of the above listed expenses, or of receipt of fuel assistance, could mean that I will get less SNAP benefits each month, and will be seen as my statement that my household does not want to get a deduction for the unreported or unverified expense. _____

I certify that I have reviewed BFA Form 215 *Reporting Requirements* and BFA Form 216 *Are You An ABAWD?* and understand the requirements that have been explained to me. _____

I understand that my receipt of SNAP requires that I comply with SNAP work requirements. **I certify** that I have read and understand BFA Form 213, *SNAP Work Requirements*. _____

Medical Assistance

I understand that my receipt of medical assistance is an assignment to DHHS of my rights to all third party medical insurance or payments, including medical child support. _____

I understand that my receipt of medical assistance means DHHS must be able to obtain medical records from medical providers. My signature below and/or on the application authorizes my family's medical providers to release any records to DHHS. _____

I understand that, if I am in a nursing home, DHHS must be able to exchange eligibility information with the nursing home to best administer the program. My signature below and/or on the application authorizes that exchange and remains in effect for as long as I receive DHHS assistance for my nursing home care. _____

I understand that for long-term care services (Nursing Facility or Home and Community-Based Care), I am required to disclose to DHHS any interest that my spouse or I have in any annuity. _____

I understand that if either my spouse or I are requesting long-term care services, any annuity purchased or modified by my spouse or me on or after February 8, 2006 will be considered a transfer of assets for less than fair market value unless the State is named the beneficiary for at least the amount of Medicaid paid for long-term care services. _____

NH Child Care Scholarship

I understand that I must only use child care services paid for by DHHS for those employment-related activities approved by DHHS. I may have to reimburse DHHS for those payments made for times I was involved in other, non-approved activities. _____

Signatures

I certify, under penalty of perjury that I have reviewed the above information and it is true and complete to the best of my knowledge.

_____ _____
Applicant Signature Date

_____ _____ _____
Printed Name and Signature of Person Helping the Applicant Date Relationship to Applicant

I certify that I have given the above signed individual(s) the opportunity to review this document, and that I have completely explained and given them a copy of the Rights and Responsibilities Notice. I also certify that I have given them a copy of this page, if it was requested.

_____ _____ _____
Printed Name & Signature Title/Agency Date

NONDISCRIMINATION STATEMENT

Do Not Send Applications Here

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, etc.), 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.

CIVIL RIGHTS COMPLAINTS INVOLVING USDA PROGRAMS

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 USDA Program Discrimination Complaint Form, (AD-3027), found online at: How to File a Complaint, 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:

(1) mail:
Food and Nutrition Service, USDA
1320 Braddock Place, Room 334, Alexandria, VA 22314; or
(2) fax: (833) 256-1665 or (202) 690-7442; or

(3) 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.

CIVIL RIGHTS COMPLAINTS INVOLVING HHS PROGRAMS

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 on line 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. For faster processing, we encourage you to use the OCR online portal to file complaints rather than filing via mail. 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. We also provide alternative formats (such as Braille and large print), auxiliary aids and language assistance services free of charge for filing a complaint.

This institution is an equal opportunity provider.

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COMMUNITY RESOURCES

When you are struggling to make ends meet, it is hard to remember that you are not alone. There are many groups and services that can help you. The programs listed here may be helpful to you. We've listed contact information for most of them, but if you need help finding one of the programs, or if you have any questions, call 1-844-275-3447 (1-844-ASK-DHHS).

MEDICAL

NH Medication Bridge Program - Helps people get needed medications. 603-225-0900
http://www.healthynh.com/medication-bridge.html

HAVEN – Services for victims of domestic and sexual violence.
1-603-994-SAFE (7233) [24-hour confidential hotline] www.havennh.org

HOUSING

NH Housing Finance Authority Assisted Housing Division - Helps find affordable housing in NH.
800-640-7239 **TDD Line for the Hearing Impaired:** (603) 472-8623 www.nhhfa.org/

Homeless Outreach Intervention
800-852-3345 ext. 9196 **TDD Access Relay** (800) 735-2964
https://www.dhhs.nh.gov/programs-services/housing-services/homeless-assistance-prevention-services

NH Department of Energy – Helps pay for heat and electric.
603-271-3670 https://www.energy.nh.gov/energy-information/programs-initiatives

LEGAL AID

NH Legal Assistance – Offers low- or no-cost legal help to low-income families and seniors.
www.nhla.org/

Berlin	Portsmouth	Concord	Manchester	Claremont
800-698-8969	800-562-3994	800-921-1115	800-562-3174	800-562-3994

EMPLOYMENT

NH Employment Security – Helping people find work and file for benefits.
800-852-3400 TDD Access: Relay NH 1-800-735-2964 www.nh.gov/nhes

OTHER RESOURCES

2-1-1 NH – Connects people for free to services available in their community.
In state, dial toll-free **2-1-1** or 866-444-4211 **TTY Number**: 603-634-3388
www.211nh.org

Al-Anon / Alateen
603-369-6930
www.nhal-anon.org

Alcoholics Anonymous
800-593-3330
www.nhaa.net

Child Care Aware of NH – Educates and supports families about child care.
855-393-1731 or 603-578-1386
https://www.nh-connections.org

Consumer Credit Counseling Services – Helps individuals manage money, pay bills, and save.
800-550-1961 https://www.greenpath.com/

Domestic Violence Hotline – Serving victims of domestic violence.
866-644-3574 https://www.nhcadsv.org/member-programs.html

Food Pantries – Provides food to needy families and individuals.
603-669-9725 http://www.nhfoodbank.org

Meals On Wheels – Delivers meals to homebound individuals. 1-888-998-6325
http://mealsonwheelsamerica.org

Narcotics Anonymous – Focuses on addiction and recovery.
888-624-3578 http://gsana.org

NH Community Loan Fund – Helps low-income individuals save for a home, college, or to start a business.
603-224-6669 or http://www.communityloanfund.org/

State of NH Division of Veterans Services – Helps veterans and dependents get benefits.
800-622-9230 TDD Access: Relay NH 1-800-735-2964
https://www.dmavs.nh.gov/veterans-services

Office of Health Equity Provides refugee resettlement assistance services. 603-271-3986
https://www.dhhs.nh.gov/programs-services/diversity-culture-inclusion

Pet Neutering Referrals – Helps low-income pet owners with the costs of spaying or neutering their pet.
(603) 271-3697

Relay Services for the Hearing Impaired
800-735-2964 or 711

Service Link – Help for elders, adults with disabilities, and their families.
866-634-9412 www.servicelink.nh.gov/index.htm

Social Security Administration (SSA) Provides benefits to disabled, retired, and surviving family members.
800-772-1213 TTY: 800-325-0778 www.ssa.gov/

School Breakfast & Lunch Program Provides free or reduced breakfast and lunch to children at school.
Department of Education 603-271-3494 or info@doe.nh.gov
SNAP-Ed Provides nutrition education to SNAP recipients. 603-255-3612
https://extension.unh.edu/health-well-being/programs/nutrition-connections

Waypoint Provides help for families and children.
800-640-6486 https://waypointnh.org

Women, Infants & Children (WIC) – Provides education and food to pregnant women, mothers, & children.
800-942-4321 **TDD Access Relay** (800) 735-2964
https://www.dhhs.nh.gov/programs-services/population-health/women-infants-children-nutrition-program

NH Commodity Supplemental Food Program NH-CSFP
Provides healthy food to supplement food budget for adults age 60 or older.
800-942-4321
www.dhhs.nh.gov/programs-services/adult-aging-caresupplemental-food-seniors