

**STATE OF KANSAS
SOCIAL AND REHABILITATION SERVICES**



APPLICATION FOR CASH, HEALTH CARE, CHILD CARE AND FOOD STAMP BENEFITS

This application will help you provide the information needed to determine your eligibility for the following types of SRS assistance:

- **CASH FOR FAMILIES** - This temporary assistance for families is available for a limited number of months. Able-bodied adults in families applying for cash must immediately seek employment. Continued job search or other ongoing work-related activity is also required. Cooperation with the agency in establishing paternity and collecting child support is required. Families receiving cash assistance automatically receive Medicaid.
- **CASH FOR DISABLED ADULTS** - Disabled adults may be eligible for cash assistance while they await determination of federal disability benefits. A doctor's statement is required to verify the disabling condition. Disabled adults receiving cash assistance also receive limited medical coverage.
- **HEALTH CARE** - Various types of assistance are available for children, pregnant women, elderly or disabled adults to help pay medical bills and Medicare premiums. Some people may be required to be responsible for a part of their own medical bills. Medicaid benefits will be recovered from the estates of elderly and disabled adults who received assistance.
- **CHILD CARE** - This program helps adults keep working to support their families and teen parents remain in school by assisting with the costs of child care. Assistance is based upon a sliding scale which considers family income. Cooperation with the agency in establishing paternity and collecting child support is required.
- **FOOD STAMPS** - This program helps low income households buy food needed for good nutrition. You may be able to receive Food Stamps within 7 days if your household has little or no income, your rent and utility expenses are more than your income/resources or you are a migrant or seasonal farm worker.

You may apply for any or all of these programs by completing this application. You may also be required to have an interview as part of the application process. **Everyone must complete Page 1 of the application. Beginning on Page 2 there are special instructions at the top of each page which will help you complete the application for the types of assistance you are requesting.**

Your application will be processed within 30 days for child care and food stamp benefits and 45 days for cash and health care. If you are eligible, benefits will start from the date a signed application is received in our office. **To speed processing time, see the back of this page for a list of things you should bring to an interview.**

- Your interview has been scheduled on: _____
- Your interview will be with: _____
- Please call for an interview appointment: _____
- Other: _____

READ THE IMPORTANT INFORMATION ON THE BACK OF THIS PAGE.

THINGS TO BRING TO YOUR INTERVIEW (for all household members):

1. Current utility bills.
2. Proof of where you live.
3. Proof of age and identity, citizenship or alien status.
4. Child care bills and receipts.
5. Proof of Social Security numbers.
6. Proof of child support and/or alimony paid or received.
7. Proof of income: Pay stubs, earnings statements, rental property or sales contracts, Social Security, SSI, Worker's Compensation, pensions, etc.
8. Life insurance, burial plans and health insurance policies.
9. Vehicle titles or registration.
10. Rent receipt/mortgage payment (including insurance and property taxes).
11. If self-employed, federal income tax returns, bookkeeping records, sales and expenditures records.
12. Proof of medical expenses for elderly/disabled persons, such as medication, doctor bills, hospital bills, and insurance premiums.
13. Medical statement verifying pregnancy.
14. High school class schedules or proof of high school graduation or GED for *teen parents*.
15. Bank statements for checking accounts, saving accounts, or Stocks/bonds/mutual funds.

YOU HAVE A RESPONSIBILITY TO:

- Provide information needed to determine your eligibility.
- Report changes within 10 days of occurrence or on your monthly report form. (Examples of changes to report: pregnancy, baby's birth, someone leaving or moving into your house, a new job, change of income, or new address.)
- If approved for cash, turn alimony and child support payments over to SRS and cooperate with Child Support Enforcement (CSE).
- Pay a family share if you are eligible for child care benefits that require a family share.
- Use and report to SRS any resources available to pay for your family's medical expenses, such as an insurance policy, lawsuit or medical support payments.
- Cooperate with Quality Assurance staff if your case is reviewed.

YOU HAVE A RIGHT TO:

- Equal treatment regardless of race, sex, color, age, disability, religion, political belief or national origin.
- Have information given to SRS kept confidential unless directly related to the administration of SRS programs.
- Withdraw your application at any time.
- Request a fair hearing if you disagree with an SRS decision within 30 days for child care, cash and health care benefits or within 90 days for food stamp benefits.
- Have your benefits determined from the date you return this form to SRS.

SRS HAS THE RIGHT TO:

- Use your Social Security Number for computer matches with other organizations, such as banks, the IRS, the Immigration and Naturalization Service and the Social Security Administration to verify your eligibility.
- Conduct a full investigation of your eligibility including contacting employers, banks, doctors, or visiting your home.
- Deny your application or prosecute for fraud if you give false information to obtain assistance.

PENALTY WARNINGS:

NONCOOPERATION:

Families may also lose benefits for noncooperation with the following agency programs:

- Child Support Enforcement - establishing a child's paternity and collecting child support.
- Work Programs - looking for work, preparing for employment and keeping a job.

FRAUD

- **FOOD STAMP PROGRAM:** Any member of your household who breaks the following rules may not get food stamp benefits for 1 year for the first offense, 2 years for the second offense, and permanently for the third offense; may be fined up to \$250,000 or jailed up to 20 years, or both; may be barred from the Food Stamp Program for an additional 18 months if court ordered, may lose deductions; and may be prosecuted under other laws.

- Don't lie or hide information to get benefits the household should not get.
- Don't use food stamp benefits to buy non-food items, such as alcohol or cigarettes, or to pay on credit accounts.
- Don't use or have in your possession improperly obtained food stamps or Vision cards.
- Don't trade or sell Vision cards or use someone else's card.

If you buy, sell or trade more than \$500 in Food Stamp benefits you may be barred permanently from the Food Stamp Program. If a court of law finds you guilty of trading food stamp benefits for fire arms, ammunition, explosives or controlled substances, you will be subject to the following penalties:

- Loss of benefits for two years for the first offense and permanently for the second offense involving the sale of a controlled substance, and
- Permanent loss of benefits for the first offense involving the trading of firearms, ammunition, or explosives.

If you are found to have made false or misleading statements about who you are or where you live to get duplicate food stamp benefits, you may be barred from the Food Stamp Program for ten years.

- **CASH ASSISTANCE:** Anyone found guilty of obtaining or attempting to obtain cash benefits for which they are not eligible, will not receive those benefits again for 1 year for the first offense, 2 years for the second offense, and permanently for the third offense.

Your Full Legal Name: _____

Address where you live (Street Address or RR#):
 Street Address: _____

City: _____ County: _____

State: _____ Zip: _____

Is this subsidized housing (Section 8, HUD, etc.)? Yes No
 Mailing Address (if different)(Street, RR#, or P.O. Box #):
 Street Address: _____

City: _____ County: _____

State: _____ Zip: _____

Directions to your house: _____

Phone numbers where you can be reached:
 Home: _____ Work: _____
 Message/Emergency Number: _____

Has anyone in the household received cash, health care, food stamp benefits or tribally distributed Indian Commodities this month or any time in the past? Yes No If yes, list what benefits: _____

When? _____ What State? _____

AGENCY USE ONLY:

Date received in agency: _____

Worker: _____ Date Registered: _____

Case No(s): _____

Interview Date: _____

Expedited: Food Stamps Yes No, Medical Yes No
 Initial Review Added Program 30 Day Reapply

EXPEDITED SERVICES: Please complete this section for Expedited Food Stamp & Medical Benefits.

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

2. Will your household's gross income for the month be less than \$150?..... Yes No

3. Does your household have less than \$100 in cash, checking, and savings?..... Yes No

4. Is anyone in your household a migrant or seasonal farm worker?..... Yes No

5. **Shelter Expenses**
 Current Rent/Mortgage\$ _____
 Current Monthly Utilities.....+\$ _____
 Total = \$ _____

Income & Resources
 Gross income expected this month.....\$ _____
 Money in cash, checking & savings.....+\$ _____
 Total= \$ _____

Are your household's **shelter expenses** more than your household's expected gross **income and resources**? _____ Yes No

Are you affiliated with an Indian Tribe? Yes No

If yes, what tribe? _____

Do you live on an Indian Reservation? Yes No

HOUSEHOLD MEMBERS: LIST YOURSELF as person #1. List your spouse if in the home as person #2. List all other persons in your home even if you are not applying for them. If anyone is pregnant, list "unborn child". Also list anyone who is temporarily away from home. Stating your race or ethnic heritage below is optional; it will not affect your eligibility for assistance. **Check the TYPES OF ASSISTANCE wanted for each individual where indicated below:**

1.	Legal Name			Relation-ship to Person Listed in #1	Sex	Race	Date of Birth	U.S. Citizen Y/N	Social Security Number	Last Grade Completed	Cash	Food Stamps	Health Care	Child Care	None
	First	Middle	Last												
1.				SELF											
2.															
3.															
4.															
5.															
6.															
7.															
8.															

Other Names Used by Any Household Members (maiden name, prior married name, etc.): _____

Complete this page if applying for Cash, Food Stamps or Health Care Benefits.

EMERGENCY CONTACT: (Spouse, adult child or other close relative): Relationship: _____

Name: _____ Address: _____ Phone#: _____

MARITAL STATUS: Are you currently: Single, never married Married, living together (includes common-law)
 Married, but separated Divorced Widowed

ALTERNATIVE PAYEE, AUTHORIZED REPRESENTATIVE: You can designate someone to be an alternate payee. This person will have unrestricted access to your cash and food stamp benefits. Any funds missed by the alternate will not be replaced. Please complete the following if you wish to have an alternate payee and indicate which benefits will be available to the payee.

AGENCY USE ONLY

Name: _____ Cash Food Stamps

You can also authorize someone to apply for food stamp benefits for you.

Name: _____ Address: _____

DISABLED HOUSEHOLD MEMBERS: List anyone in your household who is disabled (including children): _____

Have they ever applied for disability benefits? Yes No If yes, what date: _____

PAST MEDICAL BILLS: Does anyone have unpaid medical bills for any of the 3 months just before this month? Yes No If yes, would you like eligibility for health care benefits determined for these 3 prior months? Yes No

HEALTH INSURANCE: Is anyone covered by health insurance? (Include policies held by anyone outside of the household, such as an absent parent or employer.) Yes No
 Did anyone have health insurance during the last 6 months? Yes No

If yes, to any of these questions, complete the following:

Company Name and Address	*Type of Coverage	Start/End Date	Policy Number	Group Number	Persons Covered	Monthly Premium Charge

*List type of coverage such as: Accident, Major Medical, Dental, or Other.

MEDICARE: (Complete this if you are over 65 or disabled.) Does anyone have Medicare coverage (the red, white and blue card)? Yes No If yes, complete the following:

Name	Claim Number	Part A Effective Date	Part B Effective Date

FELONY PROSECUTION AND PAROLE OR PROBATION STATUS: Has anyone in your household been convicted of a drug-related felony occurring after August 22, 1996? Yes No
 If yes, list name(s) _____

Is anyone in your household fleeing from felony prosecution or jail? Yes No
 If yes, list name(s) _____

Is anyone in your household in violation of probation or parole? Yes No
 If yes, list name(s): _____

Complete this page if applying for Cash, Food Stamps, Health Care or Child Care, for children in your household.

PARENT INFORMATION:

By law, you give SRS your rights to alimony and to child and medical support for the children for whom you receive public assistance. Will you help Child Support Enforcement (CSE) in establishing and enforcing support orders (if needed)? Yes No

If no, please explain: _____

List below the names of both parents of **each** child for whom you are requesting assistance. Also, list the names of both parents of any unborn children. If more space is needed to list parent information, use the back page of this application.

<u>Child Name</u>	<u>Mother's Name</u>	<u>Father's Name</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

AGENCY USE ONLY

ABSENT PARENT(S): At the top of each column, enter the name of any parent listed above who is absent from the household. List as much information as you know for each absent parent.

Absent Parent's Name	Child # 1		Child # 2		Child # 3		Child # 4	
Date of Birth								
Current (or last known) Address								
Social Security #								
Name of Employer or Other Source of Income								
Reason for Absence								
Date of Last Contact								
Case # and Court Where Divorce was Filed								
Paternity Established	Yes	No	Yes	No	Yes	No	Yes	No

TEEN PARENT(S): List any member of your household who is pregnant or a parent **and** under age 20.

Name _____ Expected Date Due _____

Name _____ Expected Date Due _____

HS Diploma or GED: Yes No
 HS Diploma or GED: Yes No

Complete this page if applying for Cash, Food Stamps, or Health Care Benefits

RESOURCES: Has anyone sold, traded, or given away money, vehicles, land or other property within the last 5 years?

Yes No If yes, list property transferred: _____
Date: _____ Equity Value: _____

Do you own or are you buying your own home? Yes No Value of Home: _____

Does any household member own or is anyone buying real estate other than the home? Yes No

Location of your home or other real estate property: _____

List anyone who co-owns your home or other real estate: _____

Does any household member own, or does any household member's name appear on any of the items listed below? Check yes or no for each item. If yes, complete the other columns for that item. Include any assets which are jointly-owned with someone not living with you. Include children's accounts, and if anyone is a sponsored alien, list resources of sponsor and sponsor's spouse.

Yes	No	Type of Resource	Name(s) on Account	Amount	Name of Bank, Credit Union or Company	<u>AGENCY USE ONLY</u>
		Cash on Hand				
		Checking Account # _____				
		Checking Account # _____				
		Saving Account # _____				
		Saving Account # _____				
		Credit Union Account # _____				
		Certificates of Deposit # _____				
		Stocks, Bonds or Mutual Funds				
		IRA or KEOUGH Account				
		Prepaid Burial Plan or Account				
		Livestock/Trailers				
		Life Estates/Trust Funds				
		Mineral Rights not on Home Property				
		Other _____				

Is any household member's name on the title of a car, truck, motorcycle, camper, boat, all terrain vehicle or other vehicle? Yes No If yes, complete below. Use last page to list more vehicles. _____

Year	Make	Model (include # of doors)	Tag #	Amount Owed	Name(s) on Title

Are all these vehicles registered in Kansas? Yes No If no, list state of registration: _____

Does anyone have life insurance or burial insurance? Yes No If yes, complete the following:

Name and Address of Company	Face Value	Cash Value	Owner of Policy	Name of Person Insured

Complete this page if applying for Cash, Food Stamps, Health Care, or Child Care benefits.

UNEARNED INCOME: Do any household members (including children) have any of the following income or have they applied for it? Check yes or no for each item. If yes, enter the total amount of income before deductions in the "Amount" column.

AGENCY USE ONLY

Yes	No	Date Applied	Type of Unearned Income	Name of Recipient	Amount	How Often Received
			Supplemental Security Income-SSI			
			Supplemental Security Income-SSI			
			Social Security, Claim # _____			
			Social Security, Claim # _____			
			Railroad Retirement Claim# _____			
			Veteran's Benefit Claim# _____			
			Pension/Retirement Benefit Claim# _____ Type _____			
			Worker's or Unemployment Compensation (Circle one.)			
			Child Support or Alimony Received			
			Military Allotment			
			Cash Contributions from Others			
			Contract Sale or Rental Income			
			Oil/Mineral Rights/Royalties			
			Interest/Dividend Income			
			Insurance/Lawsuit Settlement Received or Expected			
			Other _____			

SPONSOR INFORMATION: Does any legal alien/refugee living in your home have a sponsor?

Yes No Not Applicable If yes, complete the following:

Person Sponsored	Name of Sponsor	Sponsor's Address	Sponsor's Telephone Number

Complete this page if applying for Cash, Food Stamps, Health Care or Child Care benefits.

EARNED INCOME and EMPLOYMENT INFORMATION: Is any household member (including children) currently working? Yes No If yes, complete the following: (See next question for self-employment.)

AGENCY USE ONLY

Name and Job Title	Employer's Name, Phone & Address	Salary/ Hourly Wage	Amount of Tips/ Commission	Hours Per Week	How Often Paid	Day(s) of Wk/Mo Paid	Date of Next/ First Pay-check

SELF-EMPLOYMENT: Is any household member (including children) currently self-employed? Yes No If yes, complete the following:

Name	Name & Type of Business	Hours Worked Per Week	Total Monthly Gross Income	Total Monthly Business Expenses

WORK HISTORY: Has anyone in your household quit a job in the last 60 days? Yes No Complete the following information for the last twelve months starting with the most recent employment (include all household members). If needed, use last page of application to list more information.

Name	Employer's Name Address & Phone	Hourly Wage	Hours Per Week	Date Began	Date Ended	Reason for Leaving

If any household member has specialized job skills or training, please explain: _____

Complete this page if applying for Child Care benefits.

CHILD CARE: Reasons for needing child care: Employment Training/School Other
 If you are not currently using child care, what is the expected start date? _____
 List below the times child care is needed for each child.

AGENCY USE ONLY

Child's Name				
Child in School If yes, list grade and name of school.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Provider's Name and Address				

Times Child Care is needed. For Example, 3:00 p.m. to 5:15 p.m. Do not include any travel time.

Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				
Total Hours per week				
How much do you pay now for Child Care				

Complete this page if applying for Cash or Food Stamp benefits.

EXPENSES: Does your household have any of the following expenses? Check yes or no for each item and list amounts.

AGENCY USE ONLY

Current Expenses	Yes	No	Total Amount	Amount You Pay	How Often Billed
Rent/Lot Rent/Mortgage (circle one) List Name, Address and Telephone Number of person to whom you pay rent:					
Property Taxes (not included in mortgage)					
Homeowners Insurance (not included in mortgage)					
Electricity (Name of Company):					
Gas/Propane (Name of Company):					
If you pay for heating or cooling, do you wish to use the Standard Utility Allowance?					
Do you receive Low Income Energy Assistance (LIEAP)?					
Water/Sewer					
Trash					
Telephone					
Child Support/Alimony Who is the child support or alimony for?					
Child Care. List Name(s) and Address(es) of Providers:					
Medical Expenses (List only for persons who are age 60 or over or who receive disability benefits. Include health insurance premiums.)					

Does anyone help you pay the above expenses? Yes No If *yes*, please list what expenses, who is paying and how much is paid: _____

Do you (or will you) purchase and prepare meals separately from anyone else in the household?
 Yes No If *yes*, list names of those who purchase and prepare separately from you: _____

APPLICANT MUST READ & SIGN BELOW

- I understand the questions on this application and I understand the penalties for hiding or giving false information and the rights and responsibilities stated in this application and as explained by SRS staff.
- I certify under penalty of perjury that my answers are correct and complete to the best of my knowledge.
- I certify that, except for illegal aliens requesting emergency medical assistance, all members of my household for whom I am applying for assistance are U.S. citizens or are aliens in lawful immigration status.
- I understand that information needed to determine eligibility may be verified by contacting federal, state, or local officials, employers, medical providers, or other business or financial organizations.
- I understand that for food stamps, failure to report or verify any household expenses means that I will not be eligible for a deduction for those expenses.
- I understand that if I receive health care benefits after age 54 or while in an institutional or Home and Community Based Services arrangement there may be a claim against my estate to recover the medical expenditures made on my behalf. I understand that my financial institution(s) will be notified of a pending claim.
- I agree to notify the local SRS office of changes in income, resources, household composition, address or living arrangements, child care arrangements which might affect the amount of my assistance or my right to receive assistance.
- I and all persons for whom I am applying, agree to turn over to SRS all alimony and/or child support for all persons in my household receiving cash assistance.
- I and all persons for whom I am applying, agree to turn over to SRS any medical support payments for all persons receiving health care benefits.
- My signature below authorizes the use of my (our) social security number(s) to administer any program (including child support enforcement) for which I have applied.
- I understand that if required I and any other person for whom I am applying or receiving assistance, must cooperate with work requirements and failure to do so may result in ineligibility for benefits.
- I give permission for my name and the names of those in my case, our address, telephone number, and eligibility status to be given to medical providers and local health departments so that they may give me information about services they provide. Yes No

AUTHORIZATION TO RELEASE INFORMATION

My signature on this application authorizes employers, child care providers, financial institutions, insurance providers, benefit providers and other persons or agencies with knowledge of my circumstances to release to the Kansas Department of Social and Rehabilitation Services any information, including confidential information, necessary to establish my eligibility for benefits or to administer any program (including Child Support Enforcement) for which I have applied. I authorize medical providers to release medical information to the Department of SRS, the U.S. Department of Health & Human Services, insurance companies and other contracted medical providers. I also authorize SRS to share medical information for administrative purposes with other agencies and contractors. All information provided on this application is protected by state and federal confidentiality laws. This release is valid from the date set out below and shall remain valid until revoked in writing by the undersigned. A copy of this authorization is as valid as the original.

1. _____ Date _____
Signature of Applicant
2. _____ Date _____
Signature of Applicant's Spouse or Other Adult(s) in Household
3. _____ Date _____
Signature of First Witness if "X" is Used
4. _____ Date _____
Signature of Second Witness if "X" is Used
5. _____ Date _____
Signature of Court-Appointed Guardian

KANSAS VOTER REGISTRATION INFORMATION

Applying to register to vote or declining to register to vote will not affect the assistance or services that you will be provided by this agency. If you are not registered to vote where you live now, would you like to apply to register to vote here today?

YES NO Already registered where I live now.

If you do not check any box, you will be considered to have decided not to register to vote at this time. If you decline to register to vote, this fact will remain confidential. If you do register to vote, the office where your application was submitted will remain confidential and may be used only for voter registration purposes.

If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. If you complete a voter registration application, it will be forwarded to your county election officer who will tell you what precinct you are in and where you should go to vote. You may also be contacted if there are questions about your voter registration application form.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or political preference, you may file a complaint with:

Your county election officer, Secretary of State's Office, or call 1-800-262-VOTE (8683) for more information.

Applicant's Name

Signature

Date

ADDITIONAL INFORMATION

