

**Louisiana Department of Social Services
Office of Family Support**

Application for Assistance

FOOD STAMPS: To begin to apply and establish an application date for Food Stamp Benefits, fill in your name, address, and signature (below), tear off this page, and give it to us today.

Print your name		Social Security Number	
Address: Street/RR	City	State	Zip Code
Mailing Address, if different from above			
Signature		Date	
Telephone Number			

EXPEDITED SERVICES: If your household meets any of the conditions listed below and if you are eligible, you will receive food stamp benefits within seven (7) days of the date you apply, provided that you have completed the application process within the seven day time period.

- The money you have gotten or expect to receive this month is less than \$150 and your liquid resources (such as cash on hand, checking or savings accounts, etc.) are less than \$100; or
- Your income and resources are not enough to cover your shelter costs; or
- Your household includes migrant or seasonal farm workers who are destitute and your resources are \$100 or less.

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<p>All applications are considered without regard to race, color, national origin, sex, age, disability or religious or political belief.</p> <p>I want to apply for:</p> <p><input type="checkbox"/> Food Stamp Benefits</p> <p><input type="checkbox"/> Family Independence Temporary Assistance Program (FITAP)</p> <p><input type="checkbox"/> Refugee Medical Assistance (RMA)</p> <p><input type="checkbox"/> Kinship Care Subsidy Program (KCSP)</p>	<p style="text-align: center;">Local Office Use Only</p> <p>Date Mailed _____ Date Rec'd _____</p> <p>Worker No. _____ Caseload No. _____</p> <p>I.D. Number _____</p> <p>Other I.D. Number _____</p> <p>Screened By _____</p> <p>Eligible for Expedited Services for Food Stamp Benefits <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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The Office of Family Support offers programs to help meet food and money needs. This application can be used to apply for: Food Stamps, the Family Independence Temporary Assistance Program (FITAP), the Kinship Care Subsidy Program (KCSP), and Refugee Medical Assistance (RMA). Every application must be followed by an interview. A worker will ask you about your household circumstances and ask you to provide proof of the information you give. One application may be completed for both financial assistance and food stamp benefits. If you are eligible for assistance, benefits will be provided from the date of application.

NON-DISCRIMINATION: In accordance with Federal law and U. S. Department of Agriculture (USDA) and U. S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited on the basis of religious or political beliefs.

To file a complaint of discrimination, contact USDA or HHS. Write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). USDA and HHS are equal opportunity providers and employers.

FOOD STAMPS - Food stamp benefits help low-income households buy food needed for good health. If you do not qualify for expedited services, eligibility for food stamp benefits will be determined and if you are found eligible, benefits will be received within 30 days of the date you apply. If you are a resident of an institution and are applying for SSI/food stamp benefits, action on your case will be taken within 30 days of the date of your release from the institution.

FITAP- Eligible families with children can get cash and may also receive medical assistance. If you are eligible, you will receive your first cash benefits within 30 days. If you are eligible for medical help you will also receive medical cards. If your eligibility for Medicaid cannot be determined from information provided on this application form, you may have to complete a separate application. If you are certified, the Office of Family Support will assist you to regain your independence through employment and increased collection of child support for your children.

If approved for **cash assistance**, the amount received could cause your food stamp benefits to be terminated or lowered. You will not receive advance notice of the change in your food stamp benefits. Members of your household who are required to register for work may be required to participate in employment and training programs by attending an orientation session, looking for and accepting employment, going to school or completing some other work-related activity. **Food stamp household members** who are required to register for work are automatically registered by this application. Members of your food stamp household who are age 18 to 50 and have no dependent children are required to work an average of 20 hours per week or participate in a job training program at least 20 hours each week or they will be eligible for food stamps for only 3 months in a 36 month period unless they meet certain exemptions.

VOTER REGISTRATION: Voter eligibility requirements are found on the Voter Registration Application Form. If you are not registered to vote where you now live, would you like to apply to register to vote here today? **Yes** **No** **Already Registered.** **IF YOU DO NOT CHECK A BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO APPLY TO REGISTER TO VOTE AT THIS TIME.** If you do register to vote, the location where your application was submitted will remain confidential. If you decline to register to vote, this fact will remain confidential.

If you would like help in filling out the voter registration form, help is available. The decision to seek or accept help is yours. You may fill out the application form in private. **Yes, I would like help.** **No, I do not want help.** If you believe that someone has interfered with your right to register or to decline to register to vote, or 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 other political preference, you may file a complaint with: **The Commissioner of Elections, P. O. Box 94125, Baton Rouge, LA 70804-9125. The toll free telephone number is: 1-800-825-3805.** Applying to register or declining to register to vote will be used for voter registration purposes only and will not affect the amount of assistance that you may be provided by this agency.

1. Name of Applicant: (Last) _____ Title: Sr., Jr., III, etc (First) _____ MI _____ Maiden _____

2. Mailing Address (St. Address or Rural Route) _____ Apt. No/Lot No. _____

City _____ State _____ Zip Code _____

Residence Address (if different than mailing) _____ Parish _____

3. Home Telephone Number _____ Work or Other Phone (Whose) _____

4. Do you want to authorize someone to apply for you? Yes No If yes, who _____

5. **Household members - Fill in all blanks for each person who lives in your house (even if you are not applying for them), including yourself.** If any item is unknown, write "unknown" in the column. Under **DOB**, indicate the date of birth of the person listed. Under **ED** (educational level) indicate the highest grade of school completed.

****You are not required to provide information regarding race/ethnicity, and it will in no way affect consideration of your application. Title VI of the Civil Rights Act of 1964 authorizes the State to ask.**

RACE CODES (list as many as apply to each person.) **AA**-Alaskan Native/American Indian; **AS**-Asian; **HI**-Hispanic/Latino; **NH**-Native Hawaiian/Other Pacific Islander; **WH**-White; **B**-Black/African American.

ETHNICITY CODES: (Choose only one Ethnic Code) **H**-Hispanic/Latino or **NH** - Non-Hispanic/Non-Latino

Last Name	First Name and Middle Initial	Relationship to Head of HH	Race	Ethnicity Code	DOB	SSN	ED	Sex
		Self						

5a. Are you applying for assistance for everyone listed above? Yes No If no, explain: _____

5b. Do all persons listed above purchase and prepare meals together? Yes No If no, who does not: _____

5c. Does anyone in your household pay someone for room and meals? Yes No If yes, who: _____

5d. List any household members who are pregnant: _____ Due Date _____

5e. Are immunizations current on all children? Yes No

6. If you are not the parent of the child(ren) for whom you are applying, do you have legal custody? Yes No

7. Have you or anyone in your household received cash assistance or food stamp benefits from another Louisiana parish or another state? Yes No If yes, who _____ When _____

City/Parish/State _____

VERIFICATION/DOCUMENTATION (LOCAL OFFICE USE ONLY)

Identity:

Residency:

Enumeration:

Marital Status:

Living with qualified relative:

Age/Relationship:

Legal Custody:

Parenting Skills Training:

Immunization:

If everyone listed on page 2 is not included in certification, explain:

Is an EBT card needed? Yes No

8. a. Has anyone in your household ever been disqualified or had their benefits reduced or stopped for breaking the rules of a program such as food stamps, cash assistance, SSI?
 Yes No If yes, give name _____
- b. Is any member of your household a fleeing felon or in violation of his probation or parole or been convicted of a felony involving the possession, use, or distribution of a controlled substance? Yes No If yes, give name _____

DO NOT WRITE IN SHADED AREA

9. Is everyone in your household a U.S. citizen or a non-citizen national?
 Yes No

If no, complete OFS 4 Addendum AS. If non-citizen national, record verification.

10. a. Do you (or anyone living with you) have cash money on hand, in a bank account, or anywhere else? Yes No How much? _____
- b. Do you (or anyone living with you) own or are you paying for a home, lot, land, or other things? Yes No
- c. Did you (or anyone living with you) sell, trade, or give away any cash or property within the last three months? Yes No
- d. Do or did you or any member of your household receive or expect to receive any lump sum of money such as an insurance settlement, lawsuit settlement, inheritance, retroactive social security payment, SSI payment, oil royalty, or other? Yes No

If yes to 10, complete OFS 4 Addendum R.

11. List all persons in your household who attend school

Name of Person in School	Name of School	Part Time Or Full Time	Expected Date Of Graduation

Food Stamp cases: If student is age 18-49 and enrolled in school other than elementary or high school, complete OFS 4 Addendum ST.

12. a. Do you, or anyone living with you, receive or expect to receive **money** from **work** (including self-employment, odd jobs) or job training? **Yes** **No**
- b. When did you or anyone in your household last work? _____
Who worked? _____
Where did he/she work? _____
- c. Has anyone in your household quit a job or refused to accept employment in the last 60 days? **Yes** **No** If yes, who _____ When _____
- d. Are you or anyone in your household on strike? **Yes** **No**
- e. Do you (or anyone living with you) get any other money, cash, or checks? (Include child support, alimony, pension or retirement, unemployment, state or government checks.)
 Yes **No**

DO NOT WRITE IN SHADED AREA. Local Office Use Only.

If yes to 12. a.-d. or 12. f., complete OFS 4 Addendum I.

Name of Person Who Has Applied for/Receives Income	Source of Income	How Often Received	Amount Received

- f. Do you (or anyone living with you) get other types of income (income from rent property, money from roomer/boarder, HUD or Energy checks, military allotment or military reserves, training allowance, interest income), cash, gifts, loans, or contributions from parents, relatives, friends, or others? **Yes** **No** How much? _____ How often? _____

Where are checks cashed?

13. Do you or anyone in your household pay someone to care for a child, or a disabled or elderly adult, so that a household member can work, attend training or school, or look for work?
 Yes **No** If yes, how much? _____ How often? _____
To whom? _____ Name _____ Telephone# _____

Explore CCAP benefits

14. a. **Shelter Expenses:** Do you have shelter expenses (rent, mortgage, utilities)? **Yes** **No**
Do you live in public housing or receive a rent subsidy? **Yes** **No**

If yes to 14.a. or 14.b., complete OFS 4 Addendum SD/M.

- b. **Medical Expenses:** If you are applying for food stamp benefits, is there a member of your household who is age 60 or over, or eligible for or receiving SSI, Social Security Disability Benefits, VA Benefits, Railroad Retirement Disability Benefits, or any government disability benefits? **Yes** **No** Does this person have any medical expenses? **Yes** **No**

Your application can be completed without verification of medical expenses. However, if you wish to receive a deduction for a medical expense, it must be verified. Please check below to indicate your choice.

- I do **NOT** wish to verify and receive a medical deduction.
 I will provide verification of medical expenses and insurance reimbursement.

- c. **Support Payments to Anyone Outside the Household:** Is a member of your household paying legally obligated child support or alimony (including payments such as medical insurance, rent, etc.) to someone outside your home? **Yes** **No**

If yes to 14.c., complete OFS 4 Addendum CSP.

Do expenses exceed income? **Yes** **No** Complete OFS 4MW if management is questionable

15. Work Registration: List the name and age of all persons in the household age 16 and over.

Name	Age	Reason for Exemption	
		FITAP	FS

IF YOU ARE APPLYING FOR FOOD STAMP BENEFITS ONLY, SKIP QUESTIONS 16 THROUGH 20 AND ANSWER QUESTION 21.

16. Information on a parent not living in the home: complete the following for the absent parent of each child living in the home. If the child's natural father and legal father are not the same person, give the requested information for both fathers.

Names of children: _____

Absent Parent's Name: _____

Names of children: _____

Absent Parent's Name: _____

VERIFICATION/DOCUMENTATION

Absent Parent information: Complete or review OFS 4AP.

AP's Last Known Address and Phone No.:

17. If you are applying for cash assistance, is anyone in your household, including yourself, covered by any type of medical insurance? (Include policies through work, military, or owned by someone outside your household.) Yes No

If yes to item 17, complete form 117-1.

18. Is Group Health Insurance available to you at the place where you or your spouse work? Yes No If yes, I have been given the BHSF Flyer LaHIPP (Louisiana Health Insurance Premium Payment Program) and a referral has been made to the BHSF LaHIPP Program.

19. I understand that by accepting FITAP or KCSP I have assigned to the Louisiana Department of Social Services (DSS) my rights and the rights of anyone included in the certification to support from any other person. I have also consented to let DSS be named the payee of a court order for support, and to let the Support Enforcement Director act as my attorney-in-fact.

20. If you are applying for or receiving cash benefits, are you or have you ever been a victim of domestic violence? Yes No **Although you are not required to answer this question, under P.L. 104-193 Louisiana is authorized to ask.**

21. **Do you expect changes in your circumstances or in any information you have reported on this form?** Yes No
If yes, explain: _____

By signing this application, I consent to the release of information to the Louisiana Office of Family Support by any persons or agencies who have knowledge of my circumstances.

I certify under penalty of perjury that the information I have given in this application, as well as any information I will provide during my interview, is and will be true, complete, and correct to the best of my knowledge, including the information I have given regarding the U. S. citizenship or immigration status of all household members. I understand that I will be subject to prosecution for fraud if I knowingly give false, incorrect, or incomplete information in order to obtain or try to obtain, or help someone else obtain or try to obtain, financial or food assistance. In addition to the penalties listed on the form OFS 4RR (Rights, Responsibilities, and Penalties), my household will also be subject to prosecution and/or disqualification under other applicable federal or state laws. I further understand that I will be required to repay any benefits received improperly for any person in my household.

Sign and date here	Your Signature (or Mark) _____	Date Signed _____
	Signature (or mark) of your wife or husband (when applicable) _____	
	Signature of Minor Unmarried Mother (when applicable) _____	

If you, or your wife or husband, sign with an "X" mark, ask two people to witness the mark; if applicant is blind, ask three people to witness.

Witness	Witness	Witness
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Signature of Person Who Helped You Fill in this Form and His or Her Relationship to You

Signature

Relationship

I have read and explained the fraud penalty rules to the client.

I have read and explained rights and responsibilities and provided a copy of the form OFS 4RR (Rights, Responsibilities and Penalties) to the client.

KIDMED services have been explained to the client, advising that any KIDMED eligible children under age 21 in the household may receive those services.

The availability of all medical services, including transportation, has been explained to the client. Information about medical services covered by the Medicaid Program has been provided. WIC services have been explained. It was explained that pregnant women until six months after the pregnancy ends, or if breast-feeding, until the baby's first birthday, and children under age five who are eligible for FITAP, KCSP, or Food Stamps are income eligible for WIC.

As the worker and representative of the Office of Family Support, I certify that all agreements have been explained to the client. I have explained the client's responsibility to report changes, appeal rights, the confidential nature of the records, and penalties for fraudulent statements.

Signature of Agency Representative

Date

I want to withdraw my _____ application because _____

Signature

Date