APPLICATION FOR BENEFITS

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

PROVIDER INSTRUCTIONS

Before completing this application, access the Eligibility Verification System (EVS) using client's date of birth and social security number to determine if the client is already receiving benefits. If they are not receiving benefits, the Department encourages medical facilities to take applications so that the facility will not bear expenses for medical care for which public funds are available. Delays in applications can mean delays in payments for medical services or total denial of payment. The following forms are needed to apply for medical assistance:

PA 600 - Application for Benefits, Including the Provider Addendum
MA 314 - Eligibility Determination Form (For Inpatient Care Only)

If the PA 600 (including the Provider Addendum, when needed) contains the necessary information and verification, the CAO can determine eligibility for medical assistance and authorize either partial of full payment for medical services. If the PA 600 and Addendum are not complete, the CAO will not be able to determine eligibility until the client is interviewed. This may delay payment or result in denial.

When there is a pregnant woman or a child under the age of 21 in the household, the shorter application form, PA 600CH (Medicaid/CHIP application), may be used.

Complete the application for medical assistance benefits as follows:

1. Remove this page and complete the Addendum on the reverse side.
2. Complete the "PROVIDER USE ONLY" section on page 1 of the Application For Benefits (PA 600). Give the remaining booklet to the applicant for completion of all information.
3. After the applicant has completed the booklet, review for completeness and have the applicant sign the affidavit on page 16.
4. The applicant's signature must be witnessed by the provider or the provider's employee.
5. Complete and attach the reverse of this page to the back of this booklet.

PA 600 COMPLETION CHECKLIST

If any sections are left blank or completed inaccurately, the county assistance office cannot immediately process the request for payment for medical services, and a face-to-face interview in the CAO may be necessary.

The application should include:

Page 1	-	Name and address of applicant and signature of applicant, or someone on his/her behalf, and date.
Pages 2-13	-	As much information as possible for the applicant and other family members who are applying.
	-	Yes or No answers to all questions. If Yes, additional information should be entered.
Affidavit (Page 16)	-	The date and signature of the applicant or someone on his/her behalf.
	-	The form is signed and dated by the provider or the provider's employee.

WHO MAY APPLY

ANYONE WHO WISHES TO APPLY FOR MEDICAL ASSISTANCE (MA) MUST BE GIVEN THE OPPORTUNITY TO DO SO.

1. When a person requests an application, he or she may request medical assistance for him/herself only or for him/herself and other family members who wish to be included. The application is for all medical services covered under the MA program For this reason, the application must contain information about the applicant and all other family members who wish to apply. In addition, the CAO may use income and resource information from other family members to compute eligibility.
2. Any person, agency or institution may complete and/or submit an application form for medical assistance on behalf of an applicant. The applicant should, if at all possible, complete and sign the form. If someone else completes and signs the form, the applicant remains responsible for any fraudulent statements made on the application.
3. If another person signs for the applicant, enter the name and address of that person on the address line beneath the signature lines.
4. An application for a deceased person will be accepted if the person died during the month of application or during the 3 calendar months before the month of application. A relative, friend or official of the institution or agency which provided the service may complete and sign the application.

WHEN APPLICATION SHOULD BE MADE

When a person indicates that he/she wishes to apply for medical assistance, have the person immediately sign and date Page 1 and complete the PA 600. After the provider's representative has reviewed the form for completeness, he/she will witness the client's or representative's signature on Page 16. If the application is approved, medical assistance coverage begins on the date of the signature on the front of the booklet. Payment may be available for a service given prior to this date, if the service was given in the month of application or during the 3 calendar months before the month of application. Delay in obtaining the applicant's signature may cause the applicant to be liable for medical services that may have been covered by the MA program.

If you have any questions about the completion of the application form, phone 1-800-692-7462.

RETROACTIVE COVERAGE

The Department will pay for certain medical services provided up to three months before the calendar month of application if the applicant is eligible. If payment is being requested for medical services provided during this retroactive period, use the provider addendum to provide necessary information.

VERIFICATION

Applications must have necessary verification of income, resources, medical expenses, and any other information needed, or a county assistance office interview may be required before benefits are authorized.

PROVIDER ADDENDUM

APPLICANT INFORMATION

Name	Date

THIRD PARTY LIABILITY RESOURES INSTRUCTIONS

Complete if anyone in the applicant group (including absent spouse or parent) is covered by an HMO, or health or accident insurance. Use a second addendum if there are more than three sources. Items are self-explanatory except for the following:

Contract/Policy/Agreement Number

Enter the number as shown on the insurance card or other document. This number is often the Social Security number or HIB number of the insured person.

Group Name/Group Number

Enter the Group Name or the Group Number and any designation number (local, shop, etc.)

INCOME INSTRUCTIONS

Complete this section if anyone in the applicant group had unpaid medical expenses during the 3 calendar months before the month of application and anyone in the applicant group had income during those 3 months.

Use a separate line for each type/source of income each person received. If the income from a particular source varied during the period covered (e.g., wages often vary from pay period to pay period), use a separate line for each amount received:

Employer/Source	Enter the name of the employer or other source of income (e.g., name of union providing benefits).
Gross Amount	Enter the amount earned before deductions or the actual amount received if the income is unearned.
Begin Date	Enter the date the income started.
Date Received	Enter the last date the income was received. If the income varies, enter each date received. If the income ended, circle the date.

Attach verification of the income, if available.

THIRD PARTY LIABILITY RESOURCES

INSURANCE CARRIERS, HMO, PRIMARY CARE PHYSICIAN OF FCN	CLAIM OFFICE ADDRESS (INCLUDE CITY, STATE, ZIP CODE)	CONTRACT/POLICY/AGREEMENT NO.	GROUP NAME/GROUP NUMBER
1.			
2.			
3.			

POLICYHOLDER NAME	POLICYHOLDER SSN	POLICYHOLDER ADDRESS (IF NOT APPLICANT)
1.		
2.		
3.		

EMPLOYER NAME	EMPLOYER ADDRESS
1.	
2.	
3.	

FREQUENCY CODES

01 ONE TIME ONLY	**04** SEMI-MONTHLY	**07** QUARTERLY
02 WEEKLY	**05** MONTHLY	**08** SEMI-ANNUALLY
03 BI-WEEKLY	**06** BI-MONTHLY	**09** ANNUALLY

INCOME

NAME LAST	NAME FIRST	NAME MI	TYPE OF INCOME CODE	EMPLOYER/SOURCE	GROSS AMOUNT	FREQ CODE	BEGIN DATE	DATE REC'D

TYPE OF INCOME CODES

1 FULL-TIME EMPLOYMENT	**18** BLACK LUNG
2 PART-TIME EMPLOYMENT	**19** RAILROAD RETIREMENT
3 ROOM/BOARD OR RENT	**20** OTHER PENSIONS (FEDERAL IRA, KEOGH, ETC)
4 SELF EMPLOYMENT	**21** SICK BENEFITS
10 UNEMPLOYMENT COMPENSATION	**22** UNION BENEFITS
11 WORKER'S COMPENSATION	**23** DIVIDENDS/INTEREST
12 SOCIAL SECURITY DISABILITY	**24** COURT ORDERED SUPPORT
13 SOCIAL SECURITY SURVIVORS OR RETIREMENT	**25** SUPPORT FROM RELATIVES (LRR) LIVING IN HOUSEHOLD
14 SUPPLEMENTAL SECURITY INCOME	**26** SUPPORT FROM RELATIVES (LRR) LIVING OUTSIDE THE HOUSEHOLD
15 VETERANS COMPENSATION (DISABILITY)	**31** SCHOLARSHIPS, GRANTS, AND LOANS
16 VETERANS PENSION (RETIREMENT)	**32** VOLUNTARY SUPPORT FROM PUTATIVE FATHERS
17 UNITED MINE WORKERS BENEFITS	**99** OTHER INCOME

PENNSYLVANIA

Application for Benefits

This is an application for cash, Medical Assistance and Food Stamp benefits. If you need this application in another language or someone to interpret, please contact your local county assistance office. Language assistance will be provided free of charge.

Esta es una solicitud de efectivo/asistencia médica y beneficios de cupones para alimentos. Si necesita esta solicitud en español o necesita que alguien se la interprete en otro idioma, comuníquese con la oficina de asistencia del condado (CAO) de su localidad. El servicio de intérprete se proporciona gratuitamente.

Đây là mẫu đơn xin trợ cấp tiền mặt, Bảo Trợ Y Tế và Tem Phiếu Thực Phẩm. Nếu quí vị cần mẫu đơn bằng ngôn ngữ này hay cần người thông dịch, xin tiếp xúc với Văn Phòng Trợ Cấp Quận Hạt. Trợ giúp thông dịch sẽ được cung cấp miễn phí.

នេះជាសំបុត្រដាក់ពាក្យសុំជ្រាក់ សំបុត្រពេទ្យ និង លុយហ្វឺតស្តែម (Food Stamp)។ ប្រសិនបើលោកអ្នកត្រូវការសំបុត្រដាក់ពាក្យសុំជាភាសានេះឬត្រូវការអ្នកណាម្នាក់អោយបកប្រែ សូមទាក់ទងការិយាល័យវើលហ្វែរបស់លោកអ្នក។ ជំនួយខាងបកប្រែគឺជួយដោយឥតគិតថ្លៃ។

Настоящий документ является формой заявления на получение денежной и медицинской помощи, а также помощи продовольственными талонами (Food Stamps). Если вам нужна эта форма на русском языке или вам нужны услуги переводчика, обращайтесь в местное Бюро помощи (County Assistance Office). Помощь переводчика предоставляется бесплатно.

这是为现金、医疗协助及食物卷福利提出的申请。您如果需要使用此语言的申请或需要请人口译，请联系您的地方郡县协助办公室。语言协助免费提供。

APPLICATION FOR BENEFITS

pennsylvania
DEPARTMENT OF PUBLIC WELFARE

- **Read the entire application form.**
- **Print the requested information in the unshaded sections.**
- **If you need help completing this application, another person of your choosing can help you; you can get help from your county assistance office (CAO) or you can call the HELPLINE at 1-800-692-7462. If you are hearing impaired, call TDD 1-800-451-5886.**
- **We will accept your application during normal business hours.**

You may apply for cash, Medical Assistance and/or Food Stamp benefits using this form. If you are not eligible for cash and/or Medical Assistance benefits, you will not need to file a new application to receive or continue to receive Food Stamp benefits. If you or any of your children do not qualify for Medical Assistance, you or they may qualify for healthcare coverage through the Children's Health insurance Program (CHIP) or the adultBasic program. You will not need to file a new application. A copy of this application will be provided to the Department of Insurance or to a CHIP or adultBasic contractor.

We will start your application once you complete your name, address and signature. (Questions not marked optional must be answered before we can make a decision on your eligibility.)

You should complete the form, sign and date it. Bring it, have someone else bring it or mail it to the CAO. Medical Assistance providers or other agencies approved by our Department may submit applications for Medical Assistance. If you return your application by mail, you will receive further instructions for completing the application process. We will tell you if a face-to-face interview is needed. You must prove your identity. If necessary, the CAO can help you to obtain this proof.

We will tell you within 30 days after we receive your completed application whether or not you are eligible. Food Stamp benefit eligibility starts from the date your application is received. If eligible for cash assistance, your benefits will begin on the date we receive all the information we requested. If an interview is required, and you do not appear or contact us within 30 days of application, your application will be denied.

> **The Department issues cash and Food Stamp benefits through the Electronic Benefits Transfer (EBT) system. This system allows you to use your EBT ACCESS card to obtain your cash benefits from certain Automatic Teller Machines (ATMs) 24 hours a day, or to buy items at stores that accept the card. The Food Stamp benefits on the EBT ACCESS card can be used for buying food or seeds and plants to grow food for personal consumption.**

If you are applying for cash assistance, you and the caseworker who interviews you will complete an Agreement of Mutual Responsibility (AMR). The AMR stresses the temporary nature of cash assistance and describes the steps you agree to take that will help you support yourself and your family without welfare.

Your information is kept confidential; it is used only to administer the programs for which you may be eligible. Pages 14 and 17 of this document list your rights and responsibilities. Pages 17 and 18 will be given to you.

You can apply online at: www.compass.state.pa.us

COMPASS
CLICK. APPLY. BENEFIT.

FOOD STAMPS NOW!

- Does your household have $100 or less in available cash and bank accounts and expect to receive less than $150 in income this month?
- Are you a migrant or seasonal farm worker?
- Are your monthly gross income and cash on hand less than your rent/mortgage and utility costs for this month?

IF THE ANSWER TO ANY OF THESE QUESTIONS IS YES, YOU MAY HAVE A RIGHT TO EXPEDITED FOOD STAMPS. This means you can get Food Stamps within five calendar days. Ask for more information by contacting the local county assistance office.

FILE YOUR FOOD STAMP APPLICATION TODAY! It is **YOUR RIGHT** to file an application today at **ANY TIME** before 5 p.m. The person at the county assistance office should date-stamp your application while you watch.

If you are denied expedited food stamps, you have the right to an agency conference within two working days with a supervisor at the county assistance office.

If you believe you are being denied your rights or services, or if the county assistance office does not take your application when you hand it in, or date-stamp it while you watch, ask to talk to a supervisor or call the HELPLINE toll free at 1-800-692-7462.

YOU CAN GET FREE LEGAL HELP AT THE LOCAL LEGAL SERVICES OFFICE.

This is an equal opportunity program. If you believe you have been discriminated against because of race, color, national origin, age, sex, disability, political beliefs or religion, write:

USDA, Director, Office of Civil Rights,
1400 Independence Avenue, SW
Washington, DC 20250-9410

or call (866) 632-9992 or (202) 401-0216 (TDD).

PLEASE READ AND REMOVE THIS PAGE BEFORE COMPLETING APPLICATION

FAMILY SAFETY

Information About Your Benefits and Domestic Violence

Domestic violence happens when someone in your life harms you physically, sexually or emotionally, including:

- Physically hurting you or your children
- Threatening or trying to hurt you, your children or your property
- Forcing you to have sex
- Sexually abusing your children
- Controlling where you go and who you see
- Not allowing you or your children to have food, clothing or medical care
- Keeping you from going to work or school
- Following or stalking you

If you are or have been a victim of domestic violence or are at risk of further violence, your caseworker can:

- **Help you find local programs where you can get counseling, safety planning, shelter, legal services and other help.**

- **Excuse you from requirements for cash assistance if domestic violence prevents you from complying:** Sometimes people cannot safely follow welfare requirements because they fear that they or their children will be abused if they do so. These include:

- **Support cooperation**
- **Work (RESET)**
- **Time limits**
- **Requirements that teen parents live at home**
- **Verification**
- **Other requirements on a case-by-case basis**

If you need to be excused from welfare requirements because of domestic violence, tell your caseworker.
You can ask to speak to your caseworker in private. You may not want to share this information with your caseworker or you may decide to discuss it with your worker later. Your caseworker and the staff at the county assistance office will keep your personal information confidential. However, the Department of Public Welfare is required by law to report child abuse to the local Children and Youth Agency.

COMMONWEALTH OF PENNSYLVANIA **DEPARTMENT OF PUBLIC WELFARE**

CHECK WHICH BENEFITS YOU WANT TO RECEIVE

☐ CASH ASSISTANCE ☐ FOOD STAMP BENEFITS ☐ MEDICAL ASSISTANCE
☐ OTHER _____

☐ YES ☐ NO Do you understand English?
If no, what language do you understand? _____

☐ YES ☐ NO Are you a migrant or seasonal farm worker?

☐ YES ☐ NO Do you have a permanent home?

☐ YES ☐ NO Do you receive housing assistance? If yes, what type?
☐ Public Housing ☐ Rent (Please check one)

☐ YES ☐ NO Have you ever been disqualified or agreed to be disqualified for food stamps or cash assistance in another state?

☐ YES ☐ NO If you are applying for food stamps and are elderly, an SSI recipient or the spouse of the elderly or SSI recipient or homeless, do you want to use your food stamps to purchase meals in restaurants?

If you are applying for only food stamps, medical assistance, or for food stamps and medical assistance, provide a telephone number where you can be reached during the day for a telephone interview. _____

If you have a welfare case number in Pennsylvania - write it here _____

LAST NAME	FIRST NAME	MIDDLE INITIAL

ADDRESS		HOW LONG AT THIS ADDRESS Years	Months
CITY	STATE	ZIP CODE	PLUS 4
SCHOOL DISTRICT	TOWNSHIP (CIVIL SUBDIVISION)	TELEPHONE NUMBER	
PREVIOUS ADDRESS (Street, City, State)			

☐ YES ☐ NO Are you or anyone you are applying for currently receiving Food Stamp benefits or Medical Assistance in another state?
State_____ County _____ Record # _____

☐ YES ☐ NO Have you ever received cash benefits in another state?
If yes, complete Date: From _____ To_____

☐ YES ☐ NO Have you ever applied for benefits using a different name or social security number?
Name _____ Social Security # _____

SIGNATURE OF APPLICANT OR REPRESENTATIVE

X _____ Date _____

CHECK IF YOU ARE INTERESTED IN:

- ☐ Housing Assistance
- ☐ Receiving an application for Energy Assistance (LIHEAP)
- ☐ Food Banks
- ☐ Free or reduced cost school meals
- ☐ Employment and Training
- ☐ Special Allowance for employment or training (Clothing, etc.)
- ☐ Supplemental Security Income
- ☐ Lifeline (Reduced price phone service)
- ☐ Family Planning/ Birth Control
- ☐ Well Baby Clinic
- ☐ Women, Infants and Children Program
- ☐ Immunizations (Shots)
- ☐ Child Care
- ☐ Child Support Services
- ☐ Head Start (Kids age 3 through 6)

PROVIDER USE ONLY

PROVIDER NAME	PROVIDER NUMBER

☐ Inpatient ☐ Outpatient ☐ Emergency
☐ Non-Applicable

COUNTY ASSISTANCE OFFICE USE

☐ Mail ☐ Walk In	FILE CLEAR BY/DATE	SCREEN BY/DATE	
COUNTY / DISTRICT	APPLICATION REG #	DATE STAMP	CAT
WORKER ID / CASELOAD	RECORD NUMBER	2ND DATE	CAT
NAME			
APPOINTMENT DATE/TIME		☐ AM ☐ PM	

☐ APPLICATION ☐ ADD ON ☐ REDETERMINATION

	AUTHORIZED	NOT AUTHORIZED
DATE		
BY		
CAT		
REASON CODE		

COMPLETE THIS PAGE FOR YOURSELF AND EVERYONE WHO LIVES AT YOUR ADDRESS, EVEN IF THEY ARE NOT APPLYING

Name any person who lives with you but is temporarily staying somewhere else.
If you are applying for this person, list the person in the section below also.

*** You must provide or apply for a Social Security Number (SSN) as follows:**

If you are applying for:

- **Cash Assistance: You must provide or apply for a SSN for you or anyone for whom you are applying, and you must provide a SSN for anyone whose income or resources may affect the eligibility or benefit amount of you or anyone for whom you are applying.**
- **Food Stamp benefits: You must provide or apply for a SSN for you or anyone for whom you are applying.**
- **Medical Assistance: You must provide or apply for a SSN for you or anyone for whom you are applying unless the person is an alien seeking emergency Medical Assistance only.**

SSNs for any other individuals are not required. If you have any questions about providing a SSN, contact the county assistance office.

If you do not qualify for a SSN because of your immigration status, and you are not applying for assistance for yourself, your income and resources must still be considered in determining eligibility or benefit amount of the persons for whom you are responsible.

FOR EDUCATION

TELL US THE HIGHEST GRADE LEVEL COMPLETED BY EACH PERSON

- **01-11 = ACTUAL GRADE LEVEL COMPLETED**
- **12 = HIGH SCHOOL DIPLOMA, GED OR NEDP**
- **13 = ASSOCIATE DEGREE**
- **14 = BACHELOR'S DEGREE**
- **15 = GRADUATE DEGREE (MASTER'S OR HIGHER)**
- **16 = OTHER DEGREES, CERTIFICATES OR DIPLOMAS**
- **98 = NO FORMAL EDUCATION**

USE 98 FOR CHILDREN WHO HAVE NOT COMPLETED FIRST GRADE

PLEASE PRINT ALL INFORMATION

COUNTY OFFICE USE / LINE #	PRINT YOUR NAME FIRST: LAST NAME	FIRST NAME	MIDDLE INITIAL	JR./SR. I, II	ARE YOU APPLYING FOR THIS PERSON?	OTHER NAME, SUCH AS A MAIDEN NAME OR FORMER MARRIED NAME	BIRTH DATE MM DD YYYY	SEX M/F	* SOCIAL SECURITY NUMBER	HOW IS EACH PERSON RELATED TO YOU?	EDUCATION
					☐ YES ☐ NO					SELF	
					☐ YES ☐ NO						
					☐ YES ☐ NO						
					☐ YES ☐ NO						
					☐ YES ☐ NO						
					☐ YES ☐ NO						
					☐ YES ☐ NO						
					☐ YES ☐ NO						
					☐ YES ☐ NO						

COMPLETE THIS PAGE FOR YOURSELF AND EVERYONE WHO LIVES AT YOUR ADDRESS, EVEN IF THEY ARE NOT APPLYING

*You must sign this statement for each person for whom you are applying who is a citizen of the U.S. or an alien in satisfactory immigration status. An alien who is applying only for treatment of an emergency medical condition is not required to sign this certification or provide a Social Security Number.

By signing my name, I certify that, subject to penalties provided by law, these persons are U.S. citizens or aliens in satisfactory immigration status.

SIGNATURE | DATE

CITIZENSHIP STATUS*
Use one of the following codes:

1. U.S. Citizen
2. Perm. Alien (Qualified Alien or PRUCOL)
3. Temp. Alien
4. Refugee/Asylee/Parolee
5. Other - Not Eligible for Benefits Except for Emergency Medical Benefits
6. Unaccompanied minor

Enter number code for anyone for whom you are applying

RACE (optional)
Individuals may fit more than one group. Check all groups that apply. Your benefits will not be affected if you do not answer.

HISPANIC ORIGIN (optional)
Check this box for each person whose ethnic background is primarily Hispanic, regardless of race. Your benefits will not be affected if you do not answer

*If born in a U.S. territory, or outside the U.S., list the territory or county of birth.

CITIZENSHIP STATUS	VETERAN STATUS: VETERAN, NON-VETERAN, ACTIVE MILITARY, NATIONAL GUARD/ RESERVES	MARITAL STATUS: SINGLE, MARRIED, COMMON LAW MARRIAGE, SEPARATED, DIVORCED, WIDOWED	RACE: 1 BLACK OR AFRICAN AMERICAN	3 AM. INDIAN OR ALASKA NATIVE	4 ASIAN	5 WHITE	7 NA HAWAIIAN OR PACIFIC ISLANDER	2 HISPANIC ORIGIN	DOES THIS PERSON HAVE A PA ACCESS CARD? YES	NO	NAME ON BIRTH CERTIFICATE Last, First, MI	IF BORN OUTSIDE U.S. SPECIFY WHERE: *STATE OF BIRTH	COUNTY OF BIRTH	CITY OF BIRTH	MOTHER'S FULL MAIDEN NAME Last, First, MI	PA DRIVER'S OR STATE I.D. NUMBER

MEDICAL COVERAGE INFORMATION

☐ YES ☐ NO DO YOU OR ANYONE FOR WHOM YOU ARE APPLYING HAVE MEDICAL COVERAGE? THIS INCLUDES INSURANCE COVERAGE PROVIDED BY INDIVIDUALS LIVING IN OR OUTSIDE OF THE HOUSEHOLD. IF YES, PROVIDE THE FOLLOWING INFORMATION:

COVERAGE BY OTHER MEDICAL INSURANCE WILL NOT AFFECT YOUR ELIGIBILITY FOR BENEFITS. MEDICAL ASSISTANCE IS ALWAYS THE PAYER OF LAST RESORT.

POLICY HOLDER NAME	POLICY HOLDER ADDRESS	
INSURANCE COMPANY NAME	POLICY NUMBER	GROUP NAME/NUMBER

INSURANCE COMPANY PHONE NUMBER

INSURANCE COMPANY ADDRESS

WHO IS COVERED?

IS THIS COURT ORDERED? ☐ YES ☐ NO

INSURANCE TYPE			
MEDICARE A		DENTAL	
MEDICARE B		MAJOR MEDICAL	
VISION		BASIC HOSP / PHYSICIAN	
HOSPITAL ONLY		WORKERS' COMP	
PRESCRIPTION		HMO (INCLUDES MEDICARE)	

POLICY HOLDER NAME	POLICY HOLDER ADDRESS	
INSURANCE COMPANY NAME	POLICY NUMBER	GROUP NAME/NUMBER

INSURANCE COMPANY PHONE NUMBER

INSURANCE COMPANY ADDRESS

WHO IS COVERED?

IS THIS COURT ORDERED? ☐ YES ☐ NO

INSURANCE TYPE			
MEDICARE A		DENTAL	
MEDICARE B		MAJOR MEDICAL	
VISION		BASIC HOSP / PHYSICIAN	
HOSPITAL ONLY		WORKERS' COMP	
PRESCRIPTION		HMO (INCLUDES MEDICARE)	

POLICY HOLDER NAME	POLICY HOLDER ADDRESS	
INSURANCE COMPANY NAME	POLICY NUMBER	GROUP NAME/NUMBER

INSURANCE COMPANY PHONE NUMBER

INSURANCE COMPANY ADDRESS

WHO IS COVERED?

IS THIS COURT ORDERED? ☐ YES ☐ NO

INSURANCE TYPE			
MEDICARE A		DENTAL	
MEDICARE B		MAJOR MEDICAL	
VISION		BASIC HOSP / PHYSICIAN	
HOSPITAL ONLY		WORKERS' COMP	
PRESCRIPTION		HMO (INCLUDES MEDICARE)	

POLICY HOLDER NAME	POLICY HOLDER ADDRESS	
INSURANCE COMPANY NAME	POLICY NUMBER	GROUP NAME/NUMBER

INSURANCE COMPANY PHONE NUMBER

INSURANCE COMPANY ADDRESS

WHO IS COVERED?

IS THIS COURT ORDERED? ☐ YES ☐ NO

INSURANCE TYPE			
MEDICARE A		DENTAL	
MEDICARE B		MAJOR MEDICAL	
VISION		BASIC HOSP / PHYSICIAN	
HOSPITAL ONLY		WORKERS' COMP	
PRESCRIPTION		HMO (INCLUDES MEDICARE)	

VOTER REGISTRATION (Optional)

If you or any other adult in your household is not registered to vote where you live now, would you like to register to vote? __Yes __No
If yes, enter names below. IF YOU DO NOT CHECK 'YES' OR 'NO', you are choosing not to register to vote at this time.

To register you must: 1) Be at least age 18 on the day of the next election; 2) Be a citizen of the United States for at least one month PRIOR TO THE NEXT ELECTION; 3) Reside in Pennsylvania and the voting district at least 30 days prior to the next election.

LINE NO CAO ONLY	LAST NAME	FIRST NAME

LINE NO CAO ONLY	LAST NAME	FIRST NAME

YOUR BENEFITS WILL NOT BE AFFECTED IF YOU REGISTER OR DO NOT REGISTER.

If you need help filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. Please contact the county assistance office if you need help. If you believe that someone has interfered with your right to register to vote, 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 other political preference, you may file a complaint with the Secretary of the Commonwealth, PA Department of State, Harrisburg, PA 17120. (Toll-free telephone number 1-800-552-VOTE.)

DO NOT COMPLETE - COUNTY ASSISTANCE OFFICE USE

☐ Given to client ____/____/_____ ☐ Sent to voter registration ____/____/_____ ☐ Mailed to client ____/____/_____
☐ Declined, not interested ____/____/_____ ☐ Not a U.S. citizen ____/____/_____ ☐ Declined, already registered ____/____/_____

CRIMINAL HISTORY INQUIRY - MANY PEOPLE WITH CRIMINAL RECORDS CAN STILL GET BENEFITS, BUT WILL NEED TO BE IN COMPLIANCE WITH COURT ORDERS, PROBATION AND PAROLE AND CURRENT ON FINE PAYMENTS

If you are applying for:

- **Cash assistance or Food Stamp benefits you must answer all of the following questions for yourself and anyone for whom you are applying.**
- **Medical Assistance only, you must answer question #1 for yourself and anyone else for whom you are applying.**

If you answer "yes" to a question, name the household member(s) to whom the answer applies.

Have you or anyone for whom you are applying:

1. ☐ Yes ☐ No ever been issued a summons or warrant to appear as a defendant at criminal court? Household member(s) _____
2. ☐ Yes ☐ No ever been convicted for a felony or misdemeanor offense? Household member(s) _____
3. ☐ Yes ☐ No been convicted of a felony offense committed after Aug. 22, 1996 related to possession, distribution and/or use of a controlled substance? Household member(s) _____
4. ☐ Yes ☐ No ever been convicted of welfare fraud? Household member(s) _____
5. ☐ Yes ☐ No ever received a court order to pay fines, costs or restitution related to a criminal conviction? Household member(s) _____
6. ☐ Yes ☐ No ever been on probation or parole or in an Accelerated Rehabilitative Disposition (ARD) program? Household member(s) _____
7. ☐ Yes ☐ No ever fled or are currently fleeing from law enforcement officials? Household member(s) _____

ANSWER ALL YES AND NO QUESTIONS - FOR YES ANSWERS, COMPLETE THE UNSHADED BLOCKS

The following information will be used to determine eligibility for benefits only; it will not be released to any other parties.

☐ YES ☐ NO **Is anyone applying who is not a U.S. Citizen?** **SKIP THIS BLOCK IF THIS APPLICATION IS FOR EMERGENCY MEDICAL BENEFITS ONLY**

NAME OF PERSON WHO IS NOT A CITIZEN	DATE ENTERED THE U.S. MONTH DAY YEAR	FROM WHAT COUNTRY	ALIEN REGISTRATION NUMBER	INS SECTION

☐ YES ☐ NO **Does anyone listed above have a sponsor?**

SPONSOR NAME (Last, First, Middle)	PERSON / ORGANIZATION NAME	SPONSOR OR ORGANIZATION ADDRESS (Street, City, State, Zip Code)	
SPONSOR'S INCOME / RESOURCES	TYPE / SOURCE	HOW MUCH	HOW OFTEN

☐ YES ☐ NO **Is anyone a student? (School Type: E=Elementary, M=Middle, H=High School, C=College, T=Training, V=Vocational)** **SCH**

NAME	NAME OF SCHOOL	SCHOOL TYPE	GRADE	PART TIME FULL TIME	EXPECTED GRAD. DATE MONTH DAY YEAR
				☐ P ☐ F	
				☐ P ☐ F	
				☐ P ☐ F	

☐ YES ☐ NO **Is anyone a veteran or active in the military, national guard or reserves?** **VET/SVI**

NAME	SOCIAL SECURITY NUMBER	BRANCH OF SERVICE	DATE ENTERED MONTH DAY YEAR	DATE LEFT MONTH DAY YEAR	VETERAN CLAIM #

☐ YES ☐ NO **Is anyone a widow, parent, spouse or minor child of a veteran?**

NAME	NAME OF VETERAN	BRANCH OF SERVICE	DATE ENTERED MONTH DAY YEAR	DATE LEFT MONTH DAY YEAR	VETERAN CLAIM #

☐ YES ☐ NO **Is anyone disabled, seriously ill or in need of medical attention?**
☐ YES ☐ NO **Is anyone receiving treatment or in need of help to overcome a drug or alcohol problem?**
☐ YES ☐ NO **Does anyone require health sustaining medication?**
☐ YES ☐ NO **Has anyone applied for or received, or is anyone currently receiving RSDI (Social Security) or Supplemental Security Income (SSI)?**
☐ YES ☐ NO **Did anyone's SSI stop because of an increase in or receipt of Social Security benefits?**
☐ YES ☐ NO **Does a parent have a physical or mental disability that affects the ability to care for a child?**
☐ YES ☐ NO **Is or has anyone been a victim of domestic violence?** **DIS/INC**

NAME	DESCRIBE THE DISABILITY	DATE DISABILITY BEGAN MONTH DAY YEAR

IF YOU ARE APPLYING FOR FOOD STAMPS ONLY, SKIP PAGES 7 AND 8.

USE THIS PAGE FOR ANY PARENT AND/OR SPOUSE NOT LIVING IN YOUR HOUSEHOLD

ABS/REL

☐ YES ☐ NO **Does any unmarried child under age 21 have a mother or father who is not living with you or who is deceased?**

☐ YES ☐ NO **Does anyone have a husband or wife who is not living with you or who is deceased?**

If you answered yes to either or both questions, give the following information for each relative. Complete a separate section for each relative.

1

NAME OF RELATIVE (Last, First, Middle)	✓ IF DECEASED	SEX	RACE	BIRTHDATE (MM/DD/YYYY)	SOCIAL SECURITY NUMBER	HOW IS THIS PERSON RELATED TO YOU
		☐ M ☐ F				

ADDRESS (Street, City, State)	ZIP CODE	PHONE NUMBER

NAME OF RELATIVE'S EMPLOYER (Current or most recent)	EMPLOYER'S ADDRESS (Street, City, State)	ZIP CODE	PHONE NUMBER

NAMES FROM PAGE 2 THAT THIS PERSON IS RESPONSIBLE FOR	IF THE RELATIVE HAS MEDICAL INSURANCE FOR THESE DEPENDENTS, PROVIDE INFORMATION ON PAGE 4.

IF THIS RELATIVE PAYS SUPPORT OR IF HE SHOULD BE PAYING SUPPORT - COMPLETE THE FOLLOWING

	HOW MUCH	HOW OFTEN	LAST DATE PAID (MM/DD/YYYY)	PAID TO WHOM
FOR VOLUNTARY SUPPORT	$			

	COURT ORDER #	AMOUNT	HOW OFTEN IT IS PAID	DATE OF ORDER (MM/DD/YYYY)	WHAT ARE THE SPECIAL TERMS - IF ANY	COUNTY COURT NAME
FOR COURT ORDERED SUPPORT		$				

2

NAME OF RELATIVE (Last, First, Middle)	✓ IF DECEASED	SEX	RACE	BIRTHDATE (MM/DD/YYYY)	SOCIAL SECURITY NUMBER	HOW THIS PERSON IS RELATED TO YOU
		☐ M ☐ F				

ADDRESS (Street, City, State)	ZIP CODE	PHONE NUMBER

NAME OF RELATIVE'S EMPLOYER (Current or most recent)	EMPLOYER'S ADDRESS (Street, City, State)	ZIP CODE	PHONE NUMBER

NAMES FROM PAGE 2 THAT THIS PERSON IS RESPONSIBLE FOR	IF THE RELATIVE HAS MEDICAL INSURANCE FOR THESE DEPENDENTS, PROVIDE INFORMATION ON PAGE 4.

IF THIS RELATIVE PAYS SUPPORT OR IF HE SHOULD BE PAYING SUPPORT - COMPLETE THE FOLLOWING

	HOW MUCH	HOW OFTEN	LAST DATE PAID (MM/DD/YYYY)	PAID TO WHOM
FOR VOLUNTARY SUPPORT	$			

	COURT ORDER #	AMOUNT	HOW OFTEN IT IS PAID	DATE OF ORDER (MM/DD/YYYY)	WHAT ARE THE SPECIAL TERMS - IF ANY	COUNTY COURT NAME
FOR COURT ORDERED SUPPORT		$				

USE THIS PAGE FOR ADDITIONAL PARENTS OR A SPOUSE NOT LIVING IN YOUR HOUSEHOLD

If you answered yes to either question on page 7, give the following information for each relative. Complete a separate section for each relative.

3

NAME OF RELATIVE (Last, First, Middle)	✓ IF DECEASED	SEX	RACE	BIRTHDATE (MM/DD/YYYY)	SOCIAL SECURITY NUMBER	HOW THIS PERSON IS RELATED TO YOU
		☐ M ☐ F				

ADDRESS (Street, City, State)	ZIP CODE	PHONE NUMBER

NAME OF RELATIVE'S EMPLOYER (Current or most recent)	EMPLOYER'S ADDRESS (Street, City, State)	ZIP CODE	PHONE NUMBER

NAMES FROM PAGE 2 THAT THIS PERSON IS RESPONSIBLE FOR	IF THE RELATIVE HAS MEDICAL INSURANCE FOR THESE DEPENDENTS, PROVIDE INFORMATION ON PAGE 4.

IF THIS RELATIVE PAYS SUPPORT OR IF HE SHOULD BE PAYING SUPPORT - COMPLETE THE FOLLOWING

	HOW MUCH	HOW OFTEN	LAST DATE PAID (MM/DD/YYYY)	PAID TO WHOM
FOR VOLUNTARY SUPPORT	$			

	COURT ORDER #	AMOUNT	HOW OFTEN IT IS PAID	DATE OF ORDER (MM/DD/YYYY)	WHAT ARE THE SPECIAL TERMS - IF ANY	COUNTY COURT NAME
FOR COURT ORDERED SUPPORT		$				

4

NAME OF RELATIVE (Last, First, Middle)	✓ IF DECEASED	SEX	RACE	BIRTHDATE (MM/DD/YYYY)	SOCIAL SECURITY NUMBER	HOW THIS PERSON IS RELATED TO YOU
		☐ M ☐ F				

ADDRESS (Street, City, State)	ZIP CODE	PHONE NUMBER

NAME OF RELATIVE'S EMPLOYER (Current or most recent)	EMPLOYER'S ADDRESS (Street, City, State)	ZIP CODE	PHONE NUMBER

NAMES FROM PAGE 2 THAT THIS PERSON IS RESPONSIBLE FOR	IF THE RELATIVE HAS MEDICAL INSURANCE FOR THESE DEPENDENTS, PROVIDE INFORMATION ON PAGE 4.

IF THIS RELATIVE PAYS SUPPORT OR IF HE SHOULD BE PAYING SUPPORT - COMPLETE THE FOLLOWING

	HOW MUCH	HOW OFTEN	LAST DATE PAID (MM/DD/YYYY)	PAID TO WHOM
FOR VOLUNTARY SUPPORT	$			

	COURT ORDER #	AMOUNT	HOW OFTEN IT IS PAID	DATE OF ORDER (MM/DD/YYYY)	WHAT ARE THE SPECIAL TERMS - IF ANY	COUNTY COURT NAME
FOR COURT ORDERED SUPPORT		$				

IF YOU HAVE MORE RELATIVES TO LIST - ASK FOR AN EXTRA PAGE OR PROVIDE THE INFORMATION ON A SEPARATE SHEET OF PAPER

ANSWER ALL YES AND NO QUESTIONS - FOR YES ANSWERS, COMPLETE THE UNSHADED BLOCKS

WRK HST

☐ YES ☐ NO **Is anyone in your household working, including self-employment?**
☐ YES ☐ NO **Did you or anyone else in your household have a reduction in the number of hours worked?**
☐ YES ☐ NO **Has anyone in your household worked in the last five years?**
If you answered yes to any of the above questions, complete below.

NAME	EMPLOYER'S NAME	EMPLOYER'S ADDRESS (Street, City, State, Zip)	PHONE	START DATE MO / DAY / YR	END DATE MO / DAY / YR	# OF HOURS WORKED PER WEEK

☐ YES ☐ NO **Is anyone on strike? If yes, who?**_____ **When did the strike start? mm**_____ **dd**_____ **yyyy**_____

IF YOU ARE APPLYING FOR FOOD STAMP BENEFITS ONLY, SKIP THIS BLOCK

HIPP

☐ YES ☐ NO **If you or anyone else in your household is employed, is medical insurance available through an employer for you or anyone in your family?**
☐ YES ☐ NO **Did the loss of a job within the last 30 days cause the loss of medical insurance for anyone in your household? If yes, provide the date the coverage ended:**_____
☐ YES ☐ NO **Is there someone in your family who is pregnant?**
☐ YES ☐ NO **Is there someone in your family who is seriously ill?**

NAME	ILLNESS	PREGNANCY DUE DATE

IF YOU ARE APPLYING FOR MEDICAL ASSISTANCE ONLY AND ARE PREGNANT, UNDER AGE 21 OR HAVE A DEPENDENT CHILD UNDER AGE 21 LIVING WITH YOU, SKIP THIS BLOCK

MISC

Does anyone have any of the following resources?

☐ YES ☐ NO **Cash on hand (01)** ☐ YES ☐ NO **Savings Certificate (26)** ☐ YES ☐ NO **Trust Fund (06)**
☐ YES ☐ NO **Savings Account (02)** ☐ YES ☐ NO **U.S. Savings Bonds (05)** ☐ YES ☐ NO **Boat / Snowmobile / Camper (14)**
☐ YES ☐ NO **Checking Account (03)** ☐ YES ☐ NO **Christmas or Vacation Club (04)** ☐ YES ☐ NO **Family Savings Account (FSA)**
☐ YES ☐ NO **Certificate of Deposit (26)** ☐ YES ☐ NO **Stocks or Bonds (05)** ☐ YES ☐ NO **IRA, KEOGH or other retirement plan (27)**

NAME OF OWNER	TYPE/ACCOUNT #/LOCATION OF THE RESOURCE	CURRENT VALUE

☐ YES ☐ NO **Is anyone expecting money or any type of resource such as, but not limited to, an accident settlement, inheritance, trust fund or other resource?**
If yes, type of resource _____ **Value** _____ **When to be received, date** _____
☐ YES ☐ NO **Has anyone sold, transferred or given away a home, land, personal property or other resource in the past 36 months?**
If yes, describe the type of property _____ **Value** _____ **Date** _____

IF YOU ARE APPLYING FOR MEDICAL ASSISTANCE ONLY AND ARE PREGNANT, UNDER AGE 21 OR HAVE A DEPENDENT CHILD UNDER AGE 21 LIVING WITH YOU, SKIP THIS PAGE

ANSWER ALL YES AND NO QUESTIONS - FOR YES ANSWERS, COMPLETE THE UNSHADED BLOCKS

MV

☐ YES ☐ NO **Does anyone own or is anyone buying a car, truck or motorcycle?**
If you have a recreational vehicle such as a camper, boat or motor home, list it as a MISC. RESOURCE on page 9.

NAME(S) OF OWNER	YEAR	MAKE	MODEL	LICENSED	LICENSE PLATE NUMBER	AMOUNT OWED	MONTHLY CAR PAYMENT
				☐ YES ☐ NO			
				☐ YES ☐ NO			
				☐ YES ☐ NO			
				☐ YES ☐ NO			
				☐ YES ☐ NO			
				☐ YES ☐ NO			

INS

☐ YES ☐ NO **Does anyone have a life insurance policy?** **(IF YOU ARE APPLYING FOR FOOD STAMP BENEFITS ONLY, SKIP THIS BLOCK)**

POLICY OWNER	NAME OF INSURANCE COMPANY / POLICY NUMBER	FACE VALUE	CASH VALUE	WHO IS COVERED?
			$	
			$	
			$	

☐ YES ☐ NO **Is anyone covered by an accident policy?** **(DO NOT LIST MEDICAL OR CAR INSURANCE HERE - COMPLETE PAGE 4)**

IF YES	Insurance Company	Type of Policy (Accident, Dismemberment, Disability, etc.)

BRL

☐ YES ☐ NO **Does anyone own a burial space or plot?**

OWNER OF SPACES	NUMBER OF SPACES	VALUE	AMOUNT OWED	NAME OF CEMETERY
		$	$	
		$	$	

☐ YES ☐ NO **Does anyone have a burial agreement with a bank or funeral home?**

OWNER OF AGREEMENT	BANK / FUNERAL HOME	BANK / FUNERAL HOME ADDRESS (Street, City, State, Zip)

IF YOU ARE APPLYING FOR MEDICAL ASSISTANCE ONLY AND ARE PREGNANT, UNDER AGE 21, OR HAVE A DEPENDENT CHILD UNDER AGE 21 LIVING WITH YOU, SKIP THIS BLOCK

PROP

☐ YES ☐ NO **Does anyone own or is anyone buying a non-resident property or a non-resident mobile home? If yes, complete the unshaded blocks.**

NAME	DATE PURCHASED	MARKET VALUE	NAMES ON DEED / AGREEMENT
	MONTH DAY YEAR	$	
PROPERTY ADDRESS (Street, Township, City, State, Zip)			

NAME	DATE PURCHASED	MARKET VALUE	NAMES ON DEED / AGREEMENT
	MONTH DAY YEAR	$	
PROPERTY ADDRESS (Street, Township, City, State, Zip)			

MED EXP

List any UNPAID medical bills.

NAME OF PERSON WITH BILL	FREQUENCY	AMOUNT TO BE PAID	WHO PROVIDED SERVICE?	TYPE OF BILL (Doctor, Hospital, Prescriptions, etc.)	DATE OF SERVICE
		$			MONTH DAY YEAR

List any medical bills PAID in the last three months prior to the month of the application and/or any paid in the month of the application.

NAME OF PERSON WHO PAID BILL	FREQUENCY	AMOUNT	WHO PROVIDED SERVICE?	TYPE OF BILL (Doctor, Hospital, Prescriptions, etc.)	DATE PAID
		$			MONTH DAY YEAR

ANSWER ALL YES AND NO QUESTIONS - FOR YES ANSWERS, COMPLETE THE UNSHADED BLOCKS

EXPENSES

SHEL

☐ YES ☐ NO **Do you pay for heating or air conditioning?**
☐ YES ☐ NO **Is the bill for heating or air conditioning mailed to someone living in your household?**
☐ YES ☐ NO **Did you receive Energy Assistance (LIHEAP) since last October 1st?**
☐ YES ☐ NO **Do you have utility costs other than heating, or air conditioning, such as electric, water, sewer or phone?**
☐ YES ☐ NO **Do you live in public or subsidized housing (Section-8 or HUD)?**
☐ YES ☐ NO **Do you receive a utility allowance? If yes, list the amount. $_____**
☐ YES ☐ NO **Are your meals included in your rent?**
☐ YES ☐ NO **Do you share expenses? If yes, with whom? _____What expenses are shared (rent/utilities or both)_____.**
How much do you contribute?_____.

LIST YOUR OUT OF POCKET HOUSEHOLD EXPENSES (SEE PAGE 16 FOR ADDITIONAL INFORMATION FOR FAILURE TO VERIFY THESE EXPENSES)

EXPENSES	HOW MUCH	HOW OFTEN	EXPENSES	YES	NO	EXPENSES	YES	NO
RENT OR MORTGAGE	$		TELEPHONE			WATER		
PROPERTY TAXES (City, County, School)	$		ELECTRIC			SEWERAGE		
HOMEOWNER'S PROPERTY INSURANCE	$		GAS			GARBAGE		
OTHER SUCH AS LOT RENT, CONDO FEES, KEROSENE, ETC.	$		OIL/COAL/WOOD			UTILITY INSTALLATION		

☐ YES ☐ NO **Does anyone outside your household pay any of your expenses?**

If so, what? _____ How much? $ _____To whom? _____

INCOME

☐ YES ☐ NO **DOES ANYONE IN YOUR HOUSEHOLD HAVE ANY INCOME?**

If yes, list any income you have already received this month or expect to receive this month.

Income includes, but is not limited to:

WAGES, SELF EMPLOYMENT, BABYSITTING, ROOM AND BOARD, RENT, SOCIAL SECURITY, SSI, SUPPORT, SICK BENEFITS, UNEMPLOYMENT OR WORKER'S COMPENSATION, MONEY FOR TRAINING, DIVIDENDS OR INTEREST, PENSIONS, COMMISSIONS, UNION PAY

NAME	TYPE / SOURCE OF INCOME	HOW MUCH	HOW OFTEN	DATE RECEIVED MO / DAY / YR
		$		
		$		
		$		
		$		
		$		

INCOME AND EXPENSES

List benefits anyone has applied for but has not received such as Unemployment Compensation, Workers' Compensation, Social Security or SSI. **INCOME**

NAME	TYPE / SOURCE OF INCOME	DATE RECEIVED MO / DAY / YR	HOW MUCH	WHEN YOU EXPECT IT
			$	
			$	
			$	

List the expenses related to the care of a child or disabled adult in your household, incurred by anyone who is working, looking for work or going to school or training.

NAME OF PERSON WHO NEEDS CARE	NAME OF CARE GIVER	HOW MUCH	HOW OFTEN
		$	
		$	

List information about child support that you or another household member pays to a person who does not live with you.

NAME OF PERSON WHO PAYS	NAME OF CHILD	AMOUNT OF SUPPORT ORDER	AMOUNT ACTUALLY PAID	HOW OFTEN
		$	$	
		$	$	
		$	$	

List the expenses that you or another household member has in order to receive income, such as transportation or legal fees.

NAME	ROUND TRIP MILES TO WORK	OTHER TRANSPORTATION COSTS	LEGAL FEES	BANK OR OTHER FEES

CAO OFFICE USE ONLY

1. ☐ YES ☐ NO Is anyone in the application group receiving food stamps and not living in a certified shelter for battered women and children?
2. ☐ YES ☐ NO Is there any postponed verification from a previous expedited issuance that the household must provide?
3. ☐ YES ☐ NO Are the household liquid resources equal to or less than $100?
4. ☐ YES ☐ NO Is the countable monthly gross income less than $150?
5. ☐ YES ☐ NO Is this a migrant or seasonal farm worker household?
6. ☐ YES ☐ NO Is the household destitute?
7. ☐ YES ☐ NO Are combined monthly gross income and liquid resources less than monthly shelter expenses?

EXPEDITED REVIEW	INITIALS	DATE

☐ ELIGIBLE ☐ DENIED -- **CLIENT NOTIFIED**

REASON FOR DENIAL:

REGISTERED FOR CATEGORIES

CLIENT'S RIGHTS

RIGHT TO NONDISCRIMINATION

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political beliefs, or disability.

To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (866) 632-9992 or (202) 401-0216 (TDD). USDA is an equal opportunity provider and employer.

RIGHT TO APPEAL

You have the right to ask for a Pennsylvania Department of Public Welfare hearing to appeal a decision of or failure to act by the Department which affects your benefits or that you believe is unfair or incorrect. You may file the appeal at the county assistance office (CAO). At the appeal hearing, you may represent yourself, or someone else, such as a lawyer, friend or relative may represent you.

RIGHT TO AN AGENCY CONFERENCE

If you appeal, you may have an agency conference before the hearing. If you appeal because the Department decided that you are not eligible for expedited Food Stamp service, you have a right to an agency conference with a supervisor within two work days.

RIGHT TO A WRITTEN NOTICE

We will give you a written notice explaining your benefits. If we deny, change, suspend or stop benefits, we will explain the reason on the notice. You have 30 days (90 days for food stamps) from the mailing date of the notice to ask for a hearing if you disagree with the action taken and/or the reasons given.

RIGHT TO A CERTIFICATE OF CREDITABLE COVERAGE

You have the right to ask the Department to provide you with a Certificate of Creditable Coverage to verify your Medical Assistance coverage. Federal law limits when health coverage may be denied or limited for a pre-existing condition. If you enroll in a group health plan that excludes treatment for a pre-existing condition, you can be credited for the time you received Medical Assistance. You may request a certificate to verify your Medical Assistance coverage. Contact your case worker to request this certificate

RIGHT TO CONFIDENTIALITY

We keep information you give confidential and use it only to administer the programs you apply for and/or may be eligible for, such as the school lunch program, the Children's Health Insurance Program (CHIP) or adultBasic. Any person knowingly violating any of the rules and regulations of this Department shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay a fine, not exceeding one hundred dollars ($100), or to undergo imprisonment, not exceeding six months, or both (62 P.S. Section 483). The CAO, when requested, must provide federal, state and local law enforcement officials with the address, Social Security Number and photograph (if available) of an individual who is fleeing to avoid prosecution, custody or confinement for a felony or violating probation or parole.

RIGHT TO CLAIM GOOD CAUSE

The law requires you to cooperate in establishing paternity for any child born out of marriage and get any support owed to you and/or any child(ren) for whom you want cash and/or Medical Assistance. The Department will excuse you from cooperating with the support requirements if you prove that it would not be in the best interest of you or the child(ren) for whom assistance is claimed. If you are not exempt from employment and training requirements, you must comply unless you have good cause. You must meet Semiannual Reporting requirements unless you have good cause.

CLIENT RESPONSIBILITIES

RESPONSIBILITY TO ACKNOWLEDGE LIABILITY OF REAL OR PERSONAL PROPERTY

If you are applying for cash assistance and have non-resident real property and/or personal property, we may require you to sign an agreement to repay benefits that you, your spouse and your children have received.

If you are age 55 or older and receive Medical Assistance to pay for nursing facility services, home and community-based waiver services and any related hospital and prescription drug service, you will be required to repay the cost of these services from your probate estate.

RESPONSIBILITY TO PROVIDE INFORMATION

You must give true, correct and complete information. You must cooperate in documenting or proving the information you give. Cash assistance may be denied if you fail to provide certain verification. If you cannot provide proof, you should ask the CAO to help. You must cooperate fully with persons or investigators of the Department or the Office of Inspector General conducting investigations.

RESPONSIBILITY TO REPORT CHANGES

For cash assistance and Medical Assistance, you must report changes in: the number of people in your household, address, new unearned income, real property or other resources (such as bank accounts or life insurance). However, for Medical Assistance, if you are pregnant, under 21 years of age or have a dependent child under 21 years of age living with you, you are not required to report changes in resources. You must report any plans to leave the state, even temporarily. If you have no earned income, you must report new employment or new income from self-employment. If you have earned income, you must report if your gross monthly earned income increases by more than $100 than the estimated gross monthly earned income used to determine your benefit. If you have unearned income, you must report if your gross monthly unearned income increases by more than $50 than the amount used to determine your benefit. You must report changes within the first 10 days of the month following the month of the change.

For Food Stamp households that are not participating in Semiannual Reporting (SAR), you must report changes as described for cash assistance with three exceptions. If you have unearned income, you must report increases or decreases in gross monthly unearned income of more than $50. Additionally, changes in life insurance and temporary absences from the state or county do not need to be reported.

For Food Stamp households that are participating in SAR, you must report if your household's total gross monthly income exceeds 130 percent of the Federal Income Poverty Guidelines (FPIGs) for your household size. The report must be made within 10 calendar days from the end of the month in which the gross monthly income exceeds the 130 percent FPIGs. Your caseworker will explain your specific income reporting requirement.

In addition, for Food Stamp households that contain an Able-Bodied Adult Without Dependents (ABAWD) that are participants in SAR, the household must report if the ABAWD work hours fall below an average of 20 hours weekly. An ABAWD means that you are able to work, you are age 18 through 49 and you have no children under age 18 who live with you.

If you are proven to have failed, without good cause, to report earned income in a timely manner, you may not receive an earned income deduction on the unreported income. This may reduce the amount of cash assistance and/or Food Stamps to which you are entitled and increase the amount of the overpayment claim.

You can report changes to the CAO in person, by telephone, by fax or by mail.

RESPONSIBILITY TO USE THE PA ACCESS CARD LAWFULLY

You may use the PA ACCESS card for services only during the period you are eligible. You must use the card only for the person who is eligible and you may get only the services that are needed and reasonable.

RESPONSIBILITY TO PROVIDE SOCIAL SECURITY NUMBERS

For cash, Medical Assistance and/or Food Stamp benefits, you must provide a Social Security Number (SSN) for each person for whom you are applying. If you do not have an SSN you must apply for one. Refusal or failure to provide an SSN may result in disqualification. For cash benefits, we will also ask you to supply an SSN for anyone else whose income and/or resources affect your eligibility or amount of benefits. Your SSN is used to verify your identity and to prevent duplication of state and federal benefits. Your SSN is used for computer matches to verify income and resources that may affect your eligibility and/or benefits. An alien who is applying for emergency Medical Assistance only, is not required to provide an SSN. (42 U.S.C. §1320b-7).

PROHIBITIONS AND PENALTIES

You must **not:**

- give false, incorrect or incomplete information;
- trade, sell or alter your Electronic Benefit Transfer (EBT) Card or your PA ACCESS Card;
- use someone else's EBT or PA ACCESS Card;
- use your Food Stamp benefits to buy ineligible items such as alcoholic drinks or tobacco;
- use your Food Stamp benefits to buy drugs or controlled substances, firearms, ammunition or explosives; **or**
- use your Food Stamp benefits to pay for food already received, or use your Food Stamp benefits to purchase food on credit.

Any member of your household who is found guilty by a court or an Administrative Disqualification hearing of breaking any of the above rules or who signs a voluntary disqualification consent agreement or waiver of Administrative Disqualification hearing will be barred from getting cash assistance or Food Stamp benefits for up to:

- 12 months for the first violation;
- 24 months for the second violation; **and**
- permanently for the third violation.

Any household member found guilty by a court of using Food Stamp benefits to buy controlled substances will be disqualified for:

- 24 months for the first violation, **and**
- permanently for the second violation.

Any household member found guilty by a court of buying or selling Food Stamp benefits or other benefit instruments for cash or consideration other than food for the exchange of firearms, ammunition, explosives or controlled substances in the amount of $500 or more in Food Stamp benefits will be disqualified permanently.

Any household member found by a court or an Administrative Disqualification hearing of misrepresenting his identity or residence to receive multiple Food Stamps will be disqualified for 10 years.

Any household member fleeing to avoid prosecution, custody or confinement for a felony or attempted felony, or violating a condition of probation or parole will be ineligible for cash assistance and Food Stamps until the situation is rectified.

Any individual who has been sentenced for a felony or a misdemeanor offense and who has not satisfied the penalty imposed by the court is ineligible for cash assistance.

An individual is ineligible for cash assistance for a period of 10 years if he is convicted of fraudulent misrepresentation of residence for the purpose of receiving additional benefits in two or more states.

Cash assistance will be reduced by amounts received by cashing an assistance check at a gambling casino, race track, bingo hall or other establishment that derives more than 50 percent of its gross revenues from gambling.

If you do not report changes as required, your benefits may be reduced or stopped. If you purposely fail to give correct information or report changes, you may be tried and if found guilty, fined and/or be put in jail for theft by deception. Improper use of the PA ACCESS Card for medical services and/or cash and Food Stamp electronic benefit transfers may result in a fine or imprisonment, or both.

If you are found guilty of violating these rules, or committing fraud, you also may be:

- fined up to $250,000 for Food Stamps and up to $15,000 for cash;
- jailed up to 20 years for Food Stamps and up to seven years for cash; **and/or**
- required to repay the benefits you received.

FOOD STAMP WORK REQUIREMENTS/SANCTIONS

If you are physically and mentally fit, over 15 years of age and under 60 years of age, and not otherwise exempt, you may not refuse to register for employment; participate in an approved employment and training program unless you have good cause; accept employment unless you have good cause; provide sufficient information to your county assistance office about your employment status and job availability unless you have good cause or comply with workfare. Additionally, you must not voluntarily and without good cause quit your job or reduce the number of hours you work if, after the reduction, you are employed less than 30 hours per week.

If you or another member of your household violates any of the above work requirements, you or that person may be disqualified from receiving Food Stamps. Before a disqualification is imposed, you will receive a notice and will have the right to appeal and have a fair hearing.

The minimum disqualification periods are as follows: for the first violation, one month and thereafter until the failure to comply ceases; the second violation is three months and thereafter until the failure to comply ceases; and for the third and subsequent violations, six months and thereafter until the failure to comply ceases.

CASH ASSISTANCE WORK REQUIREMENTS/PENALTIES

A mandatory participant who fails to cooperate with the work requirement, accept a bona fide offer of employment; or who terminates employment, reduces earnings or fails to apply for work, without good cause, is ineligible for cash assistance.

The period of the penalty is:

First occurrence - 30 days or until the failure to comply ceases, whichever is longer.

Second occurrence - 60 days or until the failure to comply ceases, whichever is longer.

Third occurrence - permanently.

If an individual fails to report for an initial appointment with a contracted work activity, or fails to complete a partial determiniation related to non-cooperation with a work activity, the entire assistance group is ineligible.

If the reason for the penalty occurs in the first 24 months of receipt of cash assistance, whether consecutive or interrupted, the penalty applies only to the individual.

If the reason for penalty occurs after the first 24 months of receipt of cash assistance, whether consecutive or interrupted, the sanction applies to the entire assistance group.

In place of the penalties above, if an employed individual voluntarily, without good cause, reduces his earnings by not fulfilling the work requirement, the cash grant is reduced by the dollar value of the income that would have been earned if the recipient would have fulfilled his work requirement, until the requirement is met.

AFFIDAVIT

WHEN I SIGN THIS FORM I AGREE THAT:

- I have read this application in full or someone has read it to me, and I understand the questions asked.
- I received a copy of my rights and responsibilities, and have read them or someone has read them to me; I understand, and agree to abide by them.
- I will provide or cooperate in getting any information needed to prove my statements.
- I must report any changes in my circumstances within the first 10 calendar days of the month following the month of the change, unless I am in Semiannual reporting for Food Stamp benefits.
- I will cooperate with the requirements of the child support enforcement program as directed by the Department of Public Welfare (DPW).
- If I receive cash and/or Medical Assistance benefits, I give the state and/or the Domestic Relations Section the right to pursue and collect cash and/or medical support for me and others for whom I am applying.
- If I receive a check for my cash benefits, the worker has read the certification on the back of the check; and every time I sign a check, I am signing the certification.
- I am responsible for any fraudulent statements made on this application even if the application is submitted by someone acting on my behalf.
- I consent to, and will fully cooperate in the finger, photo and signature imaging process. I understand that refusal to cooperate may result in the denial of benefits.
- I certify that, subject to penalties provided by law, the information I gave is true, correct and complete to the best of my knowledge
- I am authorizing the DPW to release to the appropriate agency, information regarding my receipt of cash assistance, Food Stamp benefits and/or Medical Assistance as necessary to qualify my employer to receive federal and/or state Tax Credits.
- If I receive cash assistance, I will be required to sign an Agreement of Mutual Responsibility which defines my plan to achieve self sufficiency.
- If contacted by Quality Control about information I provided on this application, I will cooperate with their inquiry.

WHEN I SIGN THIS FORM I UNDERSTAND THAT:

- The Office of Inspector General may visit my residence within 7 to 10 days from the date I signed the application for benefits to confirm information I provided to the County Assistance Office.
- The state operates a fraud control program under which local, state and federal officials may verify the information I have given. Verification will include confirmation through the Pennsylvania State Police Criminal Record Files, the Administrative Office of Pennsylvania Court files and other records that are available.
- The state may obtain information about my circumstances from other sources, including computer matches and the U.S. Citizenship and Immigration Services except for persons applying for emergency Medical Assistance only.
- I must report changes in my circumstances within the first 10 calendar days of the month following the month of the change, unless I am in Semiannual reporting for Food Stamp benefits. (See pages 17 and 18 for reporting requirements.)
- My benefits may be reduced or terminated or I can be penalized (including charged with fraud) for giving false or misleading information or for not reporting changes that would affect my benefits.
- I am giving the state the right to seek, with or without legal action, payment from private or public health insurance or liable third party. The amount recovered will not exceed the amount paid by Medical Assistance.
- The state Domestic Relations Section has the right to review all records of medical services paid for by Medical Assistance.
- Payment for medical services will be made directly to the provider, not to me. This includes payments from Medical Assistance.
- The law provides for automatic assignment of support rights for myself and others for whom I am accepting cash assistance and/or Medical Assistance to the state.
- If I receive cash benefits, all support including arrears will be paid to the state. When cash benefits stop, arrears may be paid to the state to repay the amount of cash and other reimbursable assistance that I received for my family. The amount of arrears paid to the state will not exceed the arrears assigned to the state or the total reimbursable assistance I received for my family, whichever is less. The total amount of reimbursement from child support and other sources will not exceed the total amount of reimbursable assistance received. If I receive medical benefits, medical support may be paid to the state. Medical support retained by the state will not be more than the amount paid under the Medical Assistance program.
- **Failure to report or provide proof of household expenses** will be regarded as my statement that I do not want to receive a deduction for unreported or unproven expenses (Authority; U.S. Department of Agriculture, Food and Nutrition Service, Mid-Atlantic region, Administrative Note 6-99, issued Jan. 4, 1999). I understand that I have the right to receive credit for household expenses at the time I report and that I may be asked to provide proof of them at any time during my food stamp certification period.

CLIENT OR AUTHORIZED REPRESENTATIVE SIGNATURES	DATE	ID	EMPLOYEE/WITNESS SIGNATURES	DATE

ADDRESS OF REPRESENTATIVE (Street, City, Zip)	PHONE NUMBER

SECOND WITNESS IF AN (X) IS SIGNED ABOVE	ADDRESS OF WITNESS	DATE

CLIENT RIGHTS

RIGHT TO NONDISCRIMINATION

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political beliefs, or disability.

To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (866) 632-9992 or (202) 401-0216 (TDD). USDA is an equal opportunity provider and employer.

RIGHT TO APPEAL

You have the right to ask for a Pennsylvania Department of Public Welfare hearing to appeal a decision of or failure to act by the Department which affects your benefits or that you believe is unfair or incorrect. You may file the appeal at the county assistance office (CAO). At the appeal hearing, you may represent yourself, or someone else, such as a lawyer, friend or relative may represent you.

RIGHT TO AN AGENCY CONFERENCE

If you appeal, you may have an agency conference before the hearing. If you appeal because the Department decided that you are not eligible for expedited Food Stamp service, you have a right to an agency conference with a supervisor within 2 work days.

RIGHT TO A WRITTEN NOTICE

We will give you a written notice explaining your benefits. If we deny, change, suspend, or stop benefits, we will explain the reason on the notice. You have 30 days (90 days for Food Stamps) from the mailing date of the notice to ask for a hearing if you disagree with the action taken and/or the reasons given.

RIGHT TO A CERTIFICATE OF CREDITABLE COVERAGE

You have the right to ask the Department to provide you with a Certificate of Creditable Coverage to verify your medical assistance coverage. Federal law limits when health coverage may be denied or limited for a pre-existing condition. If you enroll in a group health plan that excludes treatment for a pre-existing condition, you can be credited for the time you received Medical Assistance. You may request a certificate to verify your medical assistance coverage. Contact your case worker to request this certificate

RIGHT TO CONFIDENTIALITY

We keep information you give confidential and use it only to administer the programs you apply for and/or may be eligible for, such as the school lunch program, the Children's Health Insurance Program (CHIP) or adultBasic. Any person knowingly violating any of the rules and regulations of this Department shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay a fine, not exceeding one hundred dollars ($100), or to undergo imprisonment, not exceeding six months, or both (62 P.S. Section 483). The CAO, when requested, must provide federal, state and local law enforcement officials with the address, Social Security Number and photograph (if available) of an individual who is fleeing to avoid prosecution, custody or confinement for a felony or violating probation or parole.

RIGHT TO CLAIM GOOD CAUSE

The law requires you to cooperate in establishing paternity for any child born out of marriage and get any support owed to you and/or any child(ren) for whom you want cash and/or Medical Assistance. The Department will excuse you from cooperating with the support requirements if you prove that it would not be in the best interest of you or the child(ren) for whom assistance is claimed. If you are not exempt from employment and training requirements, you must comply unless you have good cause. You must meet Semiannual Reporting requirements unless you have good cause.

CLIENT RESPONSIBILITIES

RESPONSIBILITY TO ACKNOWLEDGE LIABILITY OF REAL OR PERSONAL PROPERTY

If you are applying for cash assistance and have non-resident real property and/or personal property, we may require you to sign an agreement to repay benefits that you, your spouse and your children have received.

If you are age 55 or older and receive Medical Assistance to pay for nursing facility services, home and community-based waiver services and any related hospital and prescription drug service, you will be required to repay the cost of these services from your probate estate.

RESPONSIBILITY TO PROVIDE INFORMATION

You must give true, correct and complete information. You must cooperate in documenting or proving the information you give. Cash assistance may be denied if you fail to provide certain verification. If you cannot provide proof, you should ask the CAO to help. You must cooperate fully with persons or investigators of the Department or the Office of Inspector General conducting investigations.

RESPONSIBILITY TO REPORT CHANGES

For cash assistance and Medical Assistance, you must report changes in: the number of people in your household, address, new unearned income, real property or other resources (such as bank accounts or life insurance). However, for Medical Assistance, if you are pregnant, under 21 years of age or have a dependent child under 21 years of age living with you, you are not required to report changes in resources. You must report any plans to leave the state, even temporarily. If you have no earned income, you must report new employment or new income from self-employment. If you have earned income, you must report if your gross monthly earned income increases by more than $100 than the estimated gross monthly earned income used to determine your benefit. If you have unearned income, you must report if your gross monthly unearned income increases by more than $50 than the amount used to determine your benefit. You must report changes within the first 10 days of the month following the month of the change.

For Food Stamp households that are not participating in Semiannual Reporting (SAR), you must report changes as described for cash assistance with three exceptions. If you have unearned income, you must report increases or decreases in gross monthly unearned income of more than $50. Additionally, changes in life insurance and temporary absences from the state or county do not need to be reported.

For Food Stamp households that are participating in SAR, you must report if your household's total gross monthly income exceeds 130 percent of the Federal Income Poverty Guidelines (FPIGs) for your household size. The report must be made within 10 calendar days from the end of the month in which the gross monthly income exceeds the 130 percent FPIGs. Your caseworker will explain your specific income reporting requirement.

In addition, for Food Stamp households that contain an Able-Bodied Adult Without Dependents (ABAWD) that are participants in SAR, the household must report if the ABAWD work hours fall below an average of 20 hours weekly. An ABAWD means that you are able to work, you are age 18 through 49 and you have no children under age 18 who live with you.

If you are proven to have failed, without good cause, to report earned income in a timely manner, you may not receive an earned income deduction on the unreported income. This may reduce the amount of cash assistance and/or Food Stamps to which you are entitled and increase the amount of the overpayment claim.

You can report changes to the CAO in person, by telephone, by fax or by mail.

RESPONSIBILITY TO USE THE PA ACCESS CARD LAWFULLY

You may use the PA ACCESS card for services only during the period you are eligible. You must use the card only for the person who is eligible and you may get only the services that are needed and reasonable.

RESPONSIBILITY TO PROVIDE SOCIAL SECURITY NUMBERS

For cash, Medical Assistance and/or Food Stamp benefits, you must provide a Social Security Number (SSN) for each person for whom you are applying. If you do not have an SSN you must apply for one. Refusal or failure to provide an SSN may result in disqualification. For cash benefits, we will also ask you to supply an SSN for anyone else whose income and/or resources affect your eligibility or amount of benefits. Your SSN is used to verify your identity and to prevent duplication of state and federal benefits. Your SSN is used for computer matches to verify income and resources that may affect your eligibility and/or benefits. An alien who is applying for emergency Medical Assistance only, is not required to provide an SSN. (42 U.S.C. §1320b-7).

AFFIDAVIT - CLIENT'S COPY

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- I will cooperate with the requirements of the child support enforcement program as directed by the Department of Public Welfare (DPW).
- If I receive cash and/or Medical Assistance benefits, I give the state and/or the Domestic Relations Section the right to pursue and collect cash and/or medical support for me and others for whom I am applying.
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- I certify that, subject to penalties provided by law, the information I gave is true, correct and complete to the best of my knowledge
- I am authorizing the DPW to release to the appropriate agency, information regarding my receipt of cash assistance, Food Stamp benefits and/or Medical Assistance as necessary to qualify my employer to receive federal and/or state Tax Credits.
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- The state may obtain information about my circumstances from employers and other sources, including computer matches and the U.S. Citizenship and Immigration Services except for persons applying for emergency Medical Assistance only.
- I must report changes in my circumstances within the first 10 calendar days of the month following the month of the change, unless I am in Semiannual reporting for Food Stamp benefits. (See pages 16 and 17 for reporting requirements.)
- My benefits may be reduced or terminated or I can be penalized (including charged with fraud) for giving false or misleading information or for not reporting changes that would affect my benefits.
- I am giving the state the right to seek, with or without legal action, payment from private or public health insurance or liable third party. The amount recovered will not exceed the amount paid by Medical Assistance.
- The state Domestic Relations Section has the right to review all records of medical services paid for by Medical Assistance.
- Payment for medical services will be made directly to the provider, not to me. This includes payments from Medical Assistance.
- The law provides for automatic assignment of support rights for myself and others for whom I am accepting cash assistance and/or Medical Assistance to the state.
- If I receive cash benefits, all support including arrears will be paid to the state. When cash benefits stop, arrears may be paid to the state to repay the amount of cash and other reimbursable assistance that I received for my family. The amount of arrears paid to the state will not exceed the arrears assigned to the state or the total reimbursable assistance I received for my family, whichever is less. The total amount of reimbursement from child support and other sources will not exceed the total amount of reimbursable assistance received. If I receive medical benefits, medical support may be paid to the state. Medical support retained by the state will not be more than the amount paid under the Medical Assistance program.
- **Failure to report or provide proof of household expenses** will be regarded as my statement that I do not want to receive a deduction for unreported or unproven expenses (Authority; U.S. Department of Agriculture, Food and Nutrition Service, Mid-Atlantic region, Administrative Note 6-99, issued Jan. 4, 1999). I understand that I have the right to receive credit for household expenses at the time I report and that I may be asked to provide proof of them at any time during my food stamp certification period.

You must **not:**

- give false, incorrect or incomplete information;
- trade, sell or alter your Electronic Benefit Transfer (EBT) Card or your PA ACCESS Card;
- use someone else's EBT or PA ACCESS Card;
- use your Food Stamp benefits to buy ineligible items such as alcoholic drinks or tobacco;
- use your Food Stamp benefits to buy drugs or controlled substances, firearms, ammunition or explosives; **or**
- use your Food Stamp benefits to pay for food already received, or use your Food Stamp benefits to purchase food on credit.

Any member of your household who is found guilty by a court or an Administrative Disqualification hearing of breaking any of the above rules or who signs a voluntary disqualification consent agreement or waiver of Administrative Disqualification hearing will be barred from getting cash assistance or Food Stamp benefits for up to:

- 12 months for the first violation;
- 24 months for the second violation; **and**
- permanently for the third violation.

Any household member found guilty by a court of using Food Stamp benefits to buy controlled substances will be disqualified for:

- 24 months for the first violation, **and**
- permanently for the second violation.

Any household member found guilty by a court of buying or selling Food Stamp benefits or other benefit instruments for cash or consideration other than food for the exchange of firearms, ammunition, explosives or controlled substances in the amount of $500 or more in Food Stamp benefits will be disqualified permanently.

Any household member found by a court or an Administrative Disqualification hearing of misrepresenting his identity or residence to receive multiple Food Stamps will be disqualified for 10 years.

Any household member fleeing to avoid prosecution, custody or confinement for a felony or attempted felony, or violating a condition of probation or parole will be ineligible for cash assistance and Food Stamps until the situation is rectified.

Any individual who has been sentenced for a felony or a misdemeanor offense and who has not satisfied the penalty imposed by the court is ineligible for cash assistance.

An individual is ineligible for cash assistance for a period of 10 years if he is convicted of fraudulent misrepresentation of residence for the purpose of receiving additional benefits in two or more states.

Cash assistance will be reduced by amounts received by cashing an assistance check at a gambling casino, race track, bingo hall or other establishment that derives more than 50 percent of its gross revenues from gambling.

If you do not report changes as required, your benefits may be reduced or stopped. If you purposely fail to give correct information or report changes, you may be tried and if found guilty, fined and/or be put in jail for theft by deception. Improper use of the PA ACCESS Card for medical services and/or cash and Food Stamp electronic benefit transfers may result in a fine or imprisonment, or both.

If you are found guilty of violating these rules, or committing fraud, you also may be:

- fined up to $250,000 for Food Stamps and up to $15,000 for cash;
- jailed up to 20 years for Food Stamps and up to seven years for cash; **and/or**
- required to repay the benefits you received.

FOOD STAMP WORK REQUIREMENTS/SANCTIONS - If you are physically and mentally fit, over 15 years of age and under 60 years of age, and not otherwise exempt, you may not refuse to register for employment; participate in an approved employment and training program unless you have good cause; accept employment unless you have good cause; provide sufficient information to your county assistance office about your employment status and job availability unless you have good cause or comply with workfare. Additionally, you must not voluntarily and without good cause quit your job or reduce the number of hours you work if, after the reduction, you are employed less than 30 hours per week.

If you or another member of your household violates any of the above work requirements, you or that person may be disqualified from receiving Food Stamps. Before a disqualification is imposed, you will receive a notice and will have the right to appeal and have a fair hearing.

The minimum disqualification periods are as follows: for the first violation, one month and thereafter until the failure to comply ceases; the second violation is three months and thereafter until the failure to comply ceases; and for the third and subsequent violations, six months and thereafter until the failure to comply ceases.

CASH ASSISTANCE WORK REQUIREMENTS/PENALTIES

A mandatory participant who fails to cooperate with the work activity requirement, accept a bona fide offer of employment; or who terminates employment, reduces earnings or fails to apply for work, without good cause, is ineligible for cash assistance.

The period of the penalty is:

First occurrence - 30 days or until the failure to comply ceases, whichever is longer.

Second occurrence - 60 days or until the failure to comply ceases, whichever is longer.

Third occurrence - permanently.

If an individual fails to report for an initial appointment with a contracted work activity, or fails to complete a partial determination related to non-cooperation with a work activity, the entire assistance group is ineligible.

If the reason for the penalty occurs in the first 24 months of receipt of cash assistance, whether consecutive or interrupted, the penalty applies only to the individual.

If the reason for penalty occurs after the first 24 months of receipt of cash assistance, whether consecutive or interrupted, the penalty applies to the entire assistance group.

In place of the penalties above, if an employed individual voluntarily, without good cause, reduces his earnings by not fulfilling the work requirement, the cash grant is reduced by the dollar value of the income that would have been earned if the recipient would have fulfilled his work requirement, until the requirement is met.