



Assistance Application

Submit this form by mail, fax, or bring it into a local MDHHS office

Find your nearest location at
www.michigan.gov/dhs-countyoffices
or call 855-ASK-MICH

Apply online:
www.michigan.gov/mibridges

Welcome!

- **Fill out the Assistance Application**
Answer questions about you and your household.

Fill out Program Details:



Healthcare Coverage

← Refer to the Information
Booklet for details on
each program



Food Assistance Program (FAP)



Cash Assistance

Family Independence Program (FIP)
Refugee Cash Assistance (RCA)
State Disability Assistance (SDA)



Child Development + Care (CDC)



State Emergency Relief (SER)

- **Submit your application for one or more programs**
It will be sent to your local MDHHS office for review and follow-up.
You may need to interview with a MDHHS Specialist.

Receive your results

What language do you prefer?

Spoken Language

Written Language

If you do not speak English, have a hearing impairment, or have a disability, let us know how we can help you (an interpreter, sign language, TDD/TTY phone number we should call, assistance listening device, etc.) or bring your own support.

إذا كنت لا تتحدث اللغة الإنجليزية، تعاني من إعاقة سمعية، أو لديك إعاقة، أخبرنا كيف يمكننا مساعدتك (مترجم فوري، لغة الإشارة، رقم هاتف TDD/TTY يجب أن نتصل عليه، جهاز الاستماع للمساعدة، إلخ) أو أحضر أجهزة المساعدة الخاصة بك.

Si no habla inglés, tiene una discapacidad auditiva o tiene una discapacidad, háganos saber cómo podemos ayudarlo (un intérprete, un lenguaje de señas, un número de teléfono TDD / TTY al que debemos llamar, un dispositivo de asistencia auditiva, etc) o puede traer su propio apoyo.

If you are refused help, call 855-275-6424.

Michigan Department of Health and Human Services

MDHHS-1171 (1-18)

Case #:

ID#:

Applicant Registration

☐ Homeless

Legal Name (First, Middle, Last)

Household Street Address - the place where you currently live

Apt/Lot #

City

County

State

Zip Code

Mailing Address - if different from above (Street, City, County, State, ZIP Code)

Date of Birth

Social Security Number

← We need a Social Security number (SSN) for people who are requesting assistance and have an SSN or can get one. See Info Booklet (Pg 30) for more details

Cell Phone #

Home Phone #

Email

Have you received assistance in Michigan in the past (or currently)?

☐ Yes

☐ No

What programs is your household applying for today?

☐ Healthcare ☐ Food ☐ Cash ☐ Child Care ☐ State Emergency Relief

Check any that apply: (You may qualify for 7 day processing of your food assistance)

← For FAP only

☐ My monthly income is less than \$150 and I have \$100 or less in cash/accounts right now.

☐ I am a migrant or seasonal farmworker whose income has stopped and I have \$100 or less in cash/accounts right now.

☐ My household's combined monthly income and cash/accounts are less than my household's combined monthly rent/mortgage and utilities.

Sign Here

Under penalties of perjury, I state that I have reviewed this application, and to the best of my knowledge and belief, the answers I give within this application are true. If I am declaring an Authorized Representative, by signing below, I allow this person to sign my application, get official information about this application, and act for me on all future matters with this agency.

Signature of Applicant

Signature of Representative

Date

Household Members

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List everyone who lives in your home, including yourself and anyone who is not there all the time. If applying for healthcare coverage, list everyone who will be included on your federal tax return this year (note: you do not need to file taxes to receive assistance).

SSN and U.S. Citizen/National are optional for people who are not requesting assistance. See Info Booklet (Pg 30) for more details

Ethnicity/Race is optional and will not affect eligibility or benefits. See Info Booklet (Pg 34) for more details

	Relationship to you	Full Legal Name	Sex	Date of Birth	Social Security #	U.S. Citizen/ National	Married	In the Home?
1	SELF		M F			Y N	Y N	Y N
	is requesting:	HEALTHCARE	FOOD	CASH	CHILD CARE	STATE EMERGENCY RELIEF	NONE	
	Ethnicity (optional):	Race (optional):						
	Hispanic/Latino	Not Hispanic/Latino	African American/Black	American Indian/Alaska Native	Asian	Native Hawaiian/Other Pacific Islander	White	
2			M F			Y N	Y N	Y N
	is requesting:	HEALTHCARE	FOOD	CASH	CHILD CARE	STATE EMERGENCY RELIEF	NONE	
	Ethnicity (optional):	Race (optional):						
	Hispanic/Latino	Not Hispanic/Latino	African American/Black	American Indian/Alaska Native	Asian	Native Hawaiian/Other Pacific Islander	White	
3			M F			Y N	Y N	Y N
	is requesting:	HEALTHCARE	FOOD	CASH	CHILD CARE	STATE EMERGENCY RELIEF	NONE	
	Ethnicity (optional):	Race (optional):						
	Hispanic/Latino	Not Hispanic/Latino	African American/Black	American Indian/Alaska Native	Asian	Native Hawaiian/Other Pacific Islander	White	
4			M F			Y N	Y N	Y N
	is requesting:	HEALTHCARE	FOOD	CASH	CHILD CARE	STATE EMERGENCY RELIEF	NONE	
	Ethnicity (optional):	Race (optional):						
	Hispanic/Latino	Not Hispanic/Latino	African American/Black	American Indian/Alaska Native	Asian	Native Hawaiian/Other Pacific Islander	White	
5			M F			Y N	Y N	Y N
	is requesting:	HEALTHCARE	FOOD	CASH	CHILD CARE	STATE EMERGENCY RELIEF	NONE	
	Ethnicity (optional):	Race (optional):						
	Hispanic/Latino	Not Hispanic/Latino	African American/Black	American Indian/Alaska Native	Asian	Native Hawaiian/Other Pacific Islander	White	

Need more room to write? Go to notes on last page to answer these questions.

☐ Yes, I've added more notes.

Household Details

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This page is not required for
State Emergency Relief (SER)

Is anyone in your household pregnant now or were they in the last 3 months?

☐ If yes, who? ☐ No Not required for FAP

☐ # Expected End/Due Date

Does anyone in your household have a disability or a physical/emotional/mental health condition?

☐ If yes, who? ☐ No For Healthcare, only required for applicants

Do any children (under age 20) have a parent who is living outside the home?

☐ If yes, who? ☐ No

Is anyone in your household currently enrolled in college/vocational school?

☐ If yes, who? ☐ No

Is anyone temporarily absent from the home (work, military, hospital, etc.)?

☐ If yes, who? ☐ No

Has anyone in your household served in the military or armed services?

☐ If yes, who? ☐ No Not required for eligibility

Is anyone in your household a foster child, foster parent, adopted child, or non-parent caregiver?

☐ If yes, who? ☐ No

☐ Foster Child ☐ Foster Parent ☐ Adopted Child ☐ Non-parent Caregiver

Is anyone in your household currently a migrant farmworker, seasonal farmworker, refugee/asylee, victim of domestic violence, or victim of trafficking?

☐ If yes, who? ☐ No

☐ Migrant Farmworker ☐ Seasonal Farmworker ☐ Refugee/Asylee

☐ Victim of Domestic Violence ☐ Victim of Trafficking

If not a US citizen/national, does anyone have qualified immigration status?

☐ If yes, list below.

← See Info Booklet (Pg 34) for examples of qualified status. Non-applicants should skip this question

Who?	Document Type	Document Number	Date of US Entry
	Green card, etc.	#	
		#	
		#	

Need more room to write? Go to notes on last page.

☐ Yes, I've added more notes.

Assets

This page is not required for
Childcare (CDC)

Money + Accounts

Does anyone in your household have money or accounts? ☐ If yes, list below. ☐ No

☐ Checking ☐ Savings

☐ Other: 401K Retirement Plans Life Insurance Stocks Mutual Funds IRAs CDs Burial Funds
Lottery/Gambling Winnings Trusts/Annuities Payroll/Benefits Card Other

Healthcare-only applicants
should skip this page (unless
disabled or in need of long-term
care services)

Please include jointly owned
accounts and/or assets

Who?	Type of Account	Name of Bank / Institution	Amount
			\$
			\$
			\$

Vehicles

Does anyone in your household own vehicles? ☐ If yes, list below. ☐ No

☐ Car ☐ Truck ☐ Motorcycle ☐ Boat ☐ Other

Who?	Year, Make, + Model	Estimated Mileage

← Only list vehicles that are
registered in a household
member's name

Property

Does anyone in your household own property? ☐ If yes, check below. ☐ No

☐ House(s) ☐ Buildings ☐ Rental Property ☐ Land/Lot ☐ Burial Plot ☐ Other

Sales + Transfers

Has anyone sold, transferred, or given away assets in the last 5 years? ☐ If yes, explain. ☐ No

← In the last 90 days
for FAP and SER

Income

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Change in Income

Has anyone in your household had a change in employment in the last 30 days?

☐

If yes, explain.

☐

No

☐

Laid off

☐

Quit

☐

Fired

☐

On strike

☐

Voluntarily reduced hours

☐

Refused work

☐

Other

Explain

Employment (Includes Temporary/Contract Jobs)

Is anyone in your household employed?

☐

If yes, list below.

☐

No

← Include anyone who worked in the last 30 days or expects to work next month

Who?	Employer Name	Avg Hrs/Wk	Wages/Tips (Before Tax)								work next m
			\$	per	Hr	Wk	2Wks	2x/Mo	Mo	Yr	
			\$	per	Hr	Wk	2Wks	2x/Mo	Mo	Yr	

Self-Employment (Includes Odd Jobs)

Is anyone in your household self-employed?

☐

If yes, list below.

☐

No

Who?	Type of Work	Income (Before Expenses)		Expenses	
		\$	Monthly	\$	Monthly
		\$		\$	

Additional

Does anyone in your household have additional income?

☐

If yes, list below.

☐

No

← For Healthcare, only include taxable income (unemployment, pensions, social security, alimony, etc.)

☐

Unemployment

☐

Disability (SSI)

☐

Alimony

☐

Workers' Compensation

☐

Child Support

☐

Social Security (RSDI)

☐

Pension/Retirement

☐

Other: Rental Income Foster care/Adoption Subsidy Loans/Gifts Interest/Dividends Tribal Income/Benefits Net farming/fishing
Veterans Benefits/Military Allotments Refugee Resettlement/Match Grant Short Term/Long Term Disability

Who?	Type of Income	Amount Received						
		\$	per	Wk	2Wks	2x/Mo	Mo	Yr
		\$	per	Wk	2Wks	2x/Mo	Mo	Yr

Expenses

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This page is not required for
Childcare (CDC)

Dependent Care

For all expenses, only
include the amount you are
responsible to pay

Does anyone in your household pay for dependent care expenses? ☐ If yes, list below. ☐ No

☐ Childcare (day care, after school programs, etc.) ☐ Care for a child or family member with a disability ☐ Not required for Healthcare

Who pays?	Who is it for?	Amount	How Often Paid
		\$	
		\$	

Medical

Does anyone in your household pay for medical expenses? ☐ If yes, list below. ☐ No

Not required for Healthcare
(unless disabled or in need of
longterm care services)

☐ Health Insurance ☐ Prescriptions ☐ In-Home Care ☐ Hospital Bills
☐ Co-Pays ☐ Dental ☐ Transportation for Care ☐ Other

Who pays?	Type of Expense	Amount	How Often Paid
		\$	
		\$	

Court Ordered

Does anyone in your household pay for court ordered expenses? ☐ If yes, list below. ☐ No

Not required for
Healthcare

☐ Child Support ☐ Alimony/Spousal Support Paid Out

Who pays?	Who is it for?	Amount	How Often Paid
		\$	
		\$	

Student Loan Interest + Deductions

Does anyone pay for student loan interest or other tax deductible expenses? ☐ If yes, list below. ☐ No ☐ For Healthcare only

Who pays?	Type of Expense	Amount	How Often Paid
		\$	

Final Details

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Fact Check

← Not required for Healthcare

Has anyone ever been disqualified from public assistance due to welfare fraud or an intentional program violation in any state, including Michigan?

☐

If yes, who?

Name(s)

☐

No

Has anyone ever been convicted for receiving cash or food assistance from two or more states for the same time period?

☐

If yes, who?

☐

No

Has anyone ever been convicted of a drug-related felony that occurred after August 22, 1996?

☐

If yes, who?

☐

No

Convicted more than once? Y | N

Voter Registration

Would you like help registering to vote at your current address?

← See Info Booklet (Pg 35) for more details

☐

Yes, send me a voter registration application.

☐

No thanks, I am already registered/do not need a voter registration application.

Authorized Representative

Do you want someone else to act for or represent you in this case?

☐

If yes, list below.

☐

No

← If you name an authorized representative, you will give permission for a trusted person to sign your application, get information, and act for you on all future matters with MDHHS. This information can also be collected later in the process

Name of your Authorized Representative (First, Middle, Last)

Address of Representative (Street, City, State, ZIP Code)

Phone # of Representative

Email of Representative

If applying for food assistance, do you want someone else to have a Bridge Card and access your benefits to shop for you?

☐

If yes, who?

Full Name

☐

No

(This should be someone you trust)

Michigan Department of Health and Human Services

MDHHS-1171 (1-18)

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Your Signature



Sign the bottom of this page to complete your application

Anything Else?

Is there anything else you'd like for us to know about your situation?

☐ If yes, write below.

☐ No

Your Responsibilities

I have told the truth; I understand that I can be held criminally responsible for lying on this application.

I will have to provide papers that show that what I've told the department is true.

I will have to repay any benefits I should not have received, even if it is the department's error.

I will have to tell the department about any changes to the information I provided on my application.

I agree to cooperate with state or federal reviewers for an audit.

I agree to release my information for program needs.

I will use my benefits legally and will not sell, trade, or give away my benefits online or in person.

I have received, reviewed, and agree to the information provided in the Information Booklet.

← By signing this application you are agreeing to these responsibilities

Please refer to your Information Booklet to read a complete description of your rights and responsibilities

The Department's Responsibilities

If you think we, the department, made a mistake, you can ask for a hearing.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs, or disability.

Sign Here

Under penalties of perjury, I state that I have reviewed this application, and to the best of my knowledge and belief, the answers I give within this application are true, including household, citizenship and non-citizenship information, and I have listed all amounts and sources of income and property I receive/own. If I am declaring an Authorized Representative, by signing below, I allow this person to sign my application, get official information about this application, and act for me on all future matters with this agency. If I am signing as an Authorized Representative for Healthcare coverage, I attest to my agreement to meet confidentiality and act in the best interest of the beneficiary.

<div></div>	<div></div>	<div></div>
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Signature of Applicant

Signature of Representative

Date

When in-person interview completed:

<div></div>	<div></div>	<div></div>
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Signature of Applicant

Signature of Department Witness

Date

Notes



Use this page to add any additional information/notes

