KEEP THIS BOOKLET FOR YOUR RECORDS

Assistance Application

Information Booklet

Welcome to the State of Michigan Department of Health and Human Services (MDHHS)

We have programs to help you and/or your household (everyone living in your home) with food, child care, cash and emergencies. We can also tell you about other programs and resources that may help meet your needs. We look forward to helping you and/or your household.

If you need help with reading, writing, hearing, etc., please tell us. If you need an interpreter, we will provide one or you may bring your own.

Did you consume water from the Flint Water System and live, work or receive childcare or education at an address that was served by the Flint Water System from April 2014 through present day? If yes, you may wish to apply for health care coverage at www.michigan.gov/mibridges or request a DCH-1426, Application for Health Coverage & Help Paying Costs.

Steps to Assistance

1 - **Apply online for assistance programs at *www.michigan.gov/mibridges*.** You may bring, mail or fax your assistance application to the MDHHS office in your area. You can find the address and phone number to the office in your area in your phone book under the state government section, or online at *www.michigan.gov/dhs-countyoffices*.

2 - **Read this booklet and keep it.** It tells you about our programs and has important information. **When you sign the assistance application, you agree to the rules in this booklet.**

3 - **Answer the questions on the assistance application.** We need your answers to decide what help you may receive. You can apply for all or some of our programs.

4 - **For some programs we may need to ask for more information (proof).** We will let you know what we need.

5 - **We will send you a letter** in the mail telling you if you are approved or denied. **Keep this letter.** It has important information, including the name, phone number and email address of your MDHHS specialist.

You have the right to apply for help today. The date MDHHS receives your assistance application or filing form may affect the date your benefits start. **Exception:** If you are applying for Supplemental Security Income and food assistance benefits before being released from an institution, the filing date for your benefits will be the date you get out of the facility.

If you cannot finish the whole assistance application today, you may either complete the **filing form** (on pages 9 and 10 or online at *www.michigan.gov/dhs-forms*) or you may turn in your incomplete assistance application. It must have your: name, date of birth (not needed for food assistance), address (unless homeless), and signature or your representative's signature (someone filing for you).

Before you can be approved for help, you must complete the assistance application.

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.

El Michigan Department of Health and Human Services (MDHHS) no discrimina contra ningún individuo o grupo a causa de su raza, religión, edad, origen nacional, color de piel, estatura, peso, estado matrimonial, información genética, sexo, orientación sexual, identidad de sexo o expresión, creencias políticas o incapacidad.

Michigan Department of Health and Human Services لن تمييز ادارة الخدمات الصحية و الانسانية لولاية ميشيغان (MDHHS) ضد أي فرد أو مجموعة بسبب العرق، أو الديانة، أو العمر، أو الأصل الوطني، أو اللون، أو الطول، أو الوزن، أو الحالة الزوجية، أو المعلومات الجينية، أو الجنس، أو التوجه الجنسي ،أوالهوية الجنسية أو التعبير، أو المعتقدات السياسية، أو الإعاقة.

Local office address

MDHHS specialist name, phone number and email address

Read this information booklet before you sign the assistance application.

Timely Decisions

We must make timely decisions to approve or deny your application for assistance. Below are the program standards we follow:

Program Symbols	MDHHS Programs	Standards
	Food Assistance Program (FAP)	
	• Expedited (seven-day processing)	7 days
	• Food Assistance Program	30 days
	Child Development and Care (CDC)	30 days
	Cash Assistance	
	• Family Independence Program (FIP)	45 days
	• Refugee Cash Assistance (RCA)	30 days
	• State Disability Assistance (SDA)	60 days

Expedited Food Assistance Program (Seven-Day Processing)

Your household may qualify for seven-day processing of your food assistance application if:

- You have less than $150 in monthly gross income and $100 or less in liquid assets (cash on hand, checking or savings accounts, savings certificates), **or**
- Your combined gross income and liquid assets are less than your monthly rent and/or mortgage payment plus heat and utilities, **or**
- You are a **destitute*** migrant or seasonal farmworker with $100 or less in liquid assets.

If your household qualifies for seven-day processing you must:

- Participate in an interview, **and**
- Provide proof of your identity, **and**
- Complete the entire application form.

To continue receiving food assistance benefits, you will be asked to provide proof of other information (like income, residency, etc.). If you provide the proof when you apply, you may be given a longer food assistance benefit period.

*** Destitute** means that your income **stopped** before the date you applied, or your income **has started** but you expect to receive no more than $25 within the next 10 days.

Food Assistance Program (FAP) Interviews

Most FAP interviews are held by telephone. However, you may request an in-person interview.

If you are also applying for cash assistance, you may be scheduled for an in-person interview.

We May Need Proof

For most programs, MDHHS will need proof of your household's income. If you have proof, send or bring it with your assistance application. Some ways to prove income are:

- ☐ Check stubs
- ☐ Child support receipts
- ☐ Social Security award letter
- ☐ Self-employment records of income and expenses
- ☐ Tax Return

If we need proof, we will send you a list of what we need.

For some programs, we **MAY** need proof of:

- ☐ Age and/or identity
- ☐ Immigration status
- ☐ U.S. citizenship
- ☐ Pregnancy
- ☐ Relationship
- ☐ School enrollment, anyone ages 6-49
- ☐ Income that recently started or stopped
- ☐ Assets (for example, cash on hand, checking/ savings accounts, credit union accounts, etc.)

If you need help getting proof, ask your MDHHS specialist.

Read this information booklet before you sign the assistance application.

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Read this information booklet before you sign the assistance application.

Programs

Food Assistance Program (FAP)

FAP provides benefits that can be used to buy food (including seeds and plants to grow your own food) for your household. People of all ages may receive FAP.

You may be eligible for FAP benefits if you have either:

- Low/no income.
- Low/no assets.

Income

FAP eligibility and benefit amounts are based on your household income and the number of people in your FAP group. When we look at your income, we make some **deductions** and consider **allowable expenses** (see below).

Deductions from countable income:

- 20 percent of earned income, and
- A standard deduction based on the number of people in your FAP group.

Allowable expenses:

- Medical expenses over $35 a month not paid by a third party (for persons age 60 or older, veteran with a disability or a person with a disability).
- Some housing and utility costs.
- Some child care costs and costs for care of persons with disabilities.
- Court-ordered child support paid to a non-household member.

Failure to report or verify any listed expenses will be seen as a statement by you that you do not want to receive a deduction for the unreported or unverified expenses. Verifications must be received within 10 days.

Tell us on your assistance application if you have received the Home Heating Credit or a Michigan Energy Assistance Program Payment in an amount greater than $20 in the month of application or within the past 12 months and your heat is included in your rent. If you do not tell us about the credit, we will assume you do **not** want to receive a deduction for heat expenses.

Program requirements:

- **Follow Work Rules and Penalties** - see page 12.
- **Child Support Services** - see page 7.
- **Child Support Actions** - see pages 11, 12.

Resident County Hospitalization (RCH)

RCH helps individuals with low income who cannot pay for medical care when they are in the hospital overnight.

You may be eligible for RCH if you:

- Have low income, and
- Are not eligible for Medicaid, and
- Do not have other insurance to pay for inpatient hospital care.

Each county sets its own financial eligibility rules.

For more information, contact the MDHHS office in your area.

Child Development and Care (CDC)

CDC helps pay for the cost of child care. You may be eligible if you are:

- A family with low income.
- A licensed foster parent requesting care for foster children.
- A member of a MDHHS protective services case participating in a treatment plan.
- A FIP or Supplemental Security Income (SSI) recipient.
- A FIP applicant doing a required work participation program activity.

Read this information booklet before you sign the assistance application.

Child Development and Care (CDC) (continued)

You must have a child care need at application because of:

- Work.
- High school completion classes (including General Educational Development (GED), adult basic education and English as a second language).
- Approved education or training.
- Approved treatment activities for a health or social condition.

The child care must be provided in Michigan by a:

- Licensed child care center.
- Licensed group child care home.
- Registered family child care home.
- Michigan Department of Education (MDE) enrolled unlicensed child care provider who has completed the Great Start to Quality Orientation and:
  - provides care in the child's home, or
  - is related by blood, marriage or adoption as a grandparent/great-grandparent, aunt/great-aunt, uncle/great-uncle, or sibling and provides care in his/her own home.

  To apply to be an unlicensed provider, complete the application at *www.michigan.gov/childcare* and follow the instructions listed on the application.

  Enrollment is not allowed if the provider, or an adult household member age 18 and older living with the provider, is convicted of certain crimes or on the central registry for child abuse or neglect.

What does the department pay?

CDC Payment

The actual CDC payment amount may not cover all child care expenses. The department pays part of the cost of child care for approved families.

Current reimbursement rates and the income eligibility scale can be found at *www.michigan.gov/childcare.*

You are responsible for any child care costs not covered by the CDC program.

Program requirements:

- **Child Support Services** - see page 7.
- **Child Support Actions** - see pages 11, 12.

Resources:

- More information about the CDC program may be obtained online at *www.michigan.gov/childcare.*
- If you need help finding an eligible child care provider, contact your Great Start to Quality Resource Center at 877-614-7328 or visit *www.greatstarttoquality.org*.

Family Independence Program (FIP)
Refugee Cash Assistance (RCA)

The main goal of cash assistance programs is to help families become self-supporting and independent.

- **FIP** is temporary cash assistance for low-income families with minor children or pregnant women.
- **RCA** is temporary cash assistance for persons recently admitted into the U.S. as refugees or someone treated as a refugee.

To qualify for FIP or RCA, you must have:

- Low income, **and**
- Cash assets less than $3,000 and property assets less than $200,000.

You may be eligible for FIP if you are not receiving cash benefits from another state and you are either:

- Pregnant.
- A parent, legal guardian, or relative acting as a parent for a child under the age of 18 (or a high school student age 18). Children ages 6-18 must attend school full time.

FIP time limit:

You cannot receive FIP for more than the federal 60-month time limit or the state's 48-month lifetime limit unless you qualify for an exception or exemption month. This includes any cash assistance you may have received in another state.

It is prohibited to use FIP or RCA to purchase lottery tickets, alcohol, tobacco, or for gambling, illegal activities, massage parlors, spas, tattoo shops, bail-bond activities, adult entertainment, cruise ships or other nonessential items.

You may be eligible for RCA if you are:

- A refugee (or someone treated as a refugee) as determined by the United States Citizenship and Immigration Services (USCIS).
- Within eight months of date of entry to the U.S., and
- Not eligible for FIP.

The FIP or RCA grant amount is based on:

- Number of people in your household group.
- Court-ordered child support expenses paid by your household.
- Total income.

Child support payments. Each month you are on FIP, current support we collect on your order is kept by the state. If you get support in a month when you are getting FIP, you must report it to your local MDHHS office, and you may need to repay it. If the support we collect is more than your FIP grant for at least two months, we may close your FIP case so you can get the child support payments directly.

Program requirements:

- **Follow Work Rules and Penalties** - see pages 12, 13, 14.
- **Child Support Services** - see page 7.
- **Child Support Actions** - see pages 11, 12.
- **Immunize Children Under Age 6 - Get Shots (FIP)** - see page 11.

State Disability Assistance (SDA)

SDA provides cash assistance to meet the basic needs of a person with a disability, a person caring for a person with a disability or persons in a special living arrangement.

It is prohibited to use SDA to purchase lottery tickets, alcohol, tobacco, or for gambling, illegal activities, massage parlors, spas, tattoo shops, bail-bond activities, adult entertainment, cruise ships or other nonessential items.

An individual may be considered disabled for the following reasons (reasons for disability may change):

- Age 65 or older.
- Unable to work for 90 days or more because of a medical condition.
- Receiving Supplemental Security Income (SSI) or Social Security disability benefits.
- Receiving medical assistance based on disability or blindness.
- Receiving special education services.
- Receiving Michigan Rehabilitation Services.
- Diagnosed as having AIDS.
- Living in an adult foster care home, a home for the aged, a county infirmary or a substance abuse treatment center.

You may be eligible for SDA if you are not eligible for FIP and you are any of the following (reasons for disability may change):

- 65 or older.
- Permanently or temporarily **disabled**.
- Taking care of a person with a disability who lives with you.

AND you have:

- Cash assets less than $3,000 and property assets less than $200,000 **and**
- Low income (different limits for single and married persons).

Read this information booklet before you sign the assistance application.

State Emergency Relief (SER)

SER provides limited help to households with low income who have an emergency. SER helps prevent serious harm to individuals and families who have an emergency that threatens their health or safety.

You may be eligible for SER if:

- You have low income and limited assets.
- The emergency situation is not likely to happen again (example: for help with rent or house payments, you must show you have enough income to pay your housing costs in the future).
- You have made certain required payments on your shelter, heat, electric and/or utility bills.
- The amount you need is within our limits.

Covered services include:

- Relocation payments to avoid or eliminate homelessness.*****
- Mortgage, insurance and/or property tax payment, to stop forfeiture, foreclosure or tax sale.*****
- Limited home repairs.
- Home heating, electric and utility bills.
- Burial costs.

***** *MDHHS works with the Salvation Army to provide emergency shelter statewide.*

The amount of help you may receive depends on the number of people in your household, income, assets, type of service requested and other factors.

To apply for SER, complete the DHS-1514 or apply online at *www.michigan.gov/mibridges*.

Child Support Services

FAP, CDC, and Cash Assistance:

The Office of Child Support (OCS) is part of MDHHS and is responsible for the child support program in Michigan. OCS works with the prosecuting attorney (PA), friend of the court (FOC) and agencies in other states.

The goal of OCS is to ensure that children are supported by their parents. Child support may include:

- Cash for everyday living.
- Health and/or educational benefits.
- Payment for child care costs.

Child support services can help:

- Locate a child's parent(s).
- Establish a child's legal father by:
  - Voluntary paternity papers.
  - Court action for paternity.
- Establish and enforce a court order to support the child's financial and medical needs.

You must cooperate with child support services if:

- One or both of the child's parents do not live in the home with the child; and
- You receive child care services, food or cash assistance from MDHHS.

OCS will send a letter asking you to complete an online form or to call OCS. Follow the directions in the letter.

Child Support for Non-Assistance Families:

You do not have to receive assistance from MDHHS to apply for child support services.

To apply for services, complete the *IV-D Child Support Services Application/Referral* (DHS-1201) by:

- Applying online at *www.michigan.gov/michildsupport*;
- Printing a DHS-1201 from the MDHHS public website at *www.michigan.gov/dhs-forms*.
- Calling OCS at **866-540-0008**; or
- Sending a written request to:

Office of Child Support
Case Management Unit
PO Box 30750
Lansing, MI 48909-8250

If you complete an application online, it will be automatically sent to the Office of Child Support. Otherwise, return the completed DHS-1201 to the MDHHS in your area, the local PA or FOC or the address above.

Early On®

Early On coordinates services for families who have a child ages 0 (birth) to 3 with a disability, developmental delay, or a related medical condition.

To find out if your child is eligible, call *Early On* at **800-*EarlyOn (327-5966)*** or online at *www.1800earlyon.org.* An *Early On* coordinator in your county will:

- Let you know if your child is eligible.
- Help you decide if you want *Early On* services for your child.

There is no cost for an evaluation of *Early On* eligibility.

***Early On* services can include:** assessment services, audiology, diagnostic medical services, early identification, family skills training, health services, home visits, nursing services, nutritional counseling, occupational therapy, pathology, psychological services, screening, service coordination, social work services, special equipment, special instruction, speech, transportation, counseling (family, group, individual) and vision services.

Read this information booklet before you sign the assistance application.

Low Income Home Energy Assistance Program (LIHEAP)

LIHEAP consists of federal money given to each state to help low-income individuals and families with heating costs. In Michigan, this money is used for the following programs:

- Home Heating Credit (HHC).
- State Emergency Relief (SER) - see page 7.
- Weatherization Assistance Program (WAP).

Home Heating Credit (HHC)

The HHC is available to **all** low-income households including those with rent that includes heat. The Michigan Department of Treasury determines eligibility and makes the payments.

Applications for the HHC are available at the Michigan Department of Treasury and wherever tax forms are available (*www.michigan.gov/treasury*, select Income Tax Forms from the Treasury Quick List on the home page). You do not need to file a state income tax return to receive the HHC. Eligibility is based on income, number of tax exemptions and household heating costs.

Weatherization Assistance Program (WAP)

WAP is a federally funded, low-income residential energy conservation program available to low-income Michigan homeowners and renters. These services reduce energy use and lower utility bills. Services may include:

- Attic insulation and ventilation.
- Wall insulation.
- Foundation insulation.
- Smoke detectors.
- Dryer venting.
- Air leakage reduction.

Applications for WAP are available at your local weatherization operator.

Resources:

- **LIHEAP** - call the toll-free MDHHS Assistance hotline at 855-275-6424 (855-ASK-MICH).
- **HHC** - *www.michigan.gov/heatingassistance* or call the Michigan Department of Treasury at 517-636-4486.
- **Weatherization** - *www.michigan.gov/heatingassistance.*

Things You Must Do

By signing the assistance application, you agree to do these things:

Give Correct Information and Report Changes (All Programs)

Correct information. You must give MDHHS correct and complete information about you and everyone in your household.

If you give us incorrect or incomplete information on purpose, or you do not report a change, you **may** be prosecuted for perjury or fraud, or denied benefits. (See "Penalties for Intentional Program Violation Or Fraud" on page 14 for more information.)

Reporting changes. Tell your MDHHS specialist about changes or report changes online within **10 days** of the change.* If you have any doubt about whether to report a change, contact your MDHHS specialist. Your MDHHS specialist will tell you if different reporting rules apply to you, such as simplified reporters.

The types of changes you must report are:

- Employment starts, stops (within 10 days of receiving your first/last payment) or changes.
- Change in rate of pay (within 10 days of receiving the first payment reflecting the change).
- Bank accounts (opening/changes/closures), sale/purchase of property, etc.
- Change of hours worked by more than five hours per week, if it will last more than one month.
- Unearned income starts or stops (like Social Security, unemployment or retirement benefits, etc.).
- Unearned income changes by more than **$50 per month for most programs.**
- Change in assets.
- Change of address.
- Housing or utility cost stops, starts or changes.
- Anyone moving in or out of your home.
- Changes in child care need, cost or provider.
- Changes in child support amount paid out or received.
- Health or medical insurance premiums or change in coverage.
- Changes in a child's school attendance.

If you file for bankruptcy, you shall send a copy of the official bankruptcy notice to:
MDHHS, Legal Services, PO Box 30037, Lansing, MI 48909.

*Exception: For FIP only, you must report a child leaving your home within five days of the date you know he or she will be absent for 30 days or more.

Read this information booklet before you sign the assistance application.

Filing Form

Michigan Department of Health and Human Services (MDHHS)

You have the right to apply for help today. If you cannot finish the entire assistance application today, you may complete this filing form and return it to the MDHHS office in your area to protect your application date.* If applying for only FAP, you must fill in your name, address (unless homeless) and signature or your representative's signature. The date MDHHS receives your filing form may affect the date your benefits start. MDHHS will still need to receive your completed assistance application before any benefits can be approved.

**Exception: If you are applying for SSI and FAP benefits before being released from an institution, the filing date for your benefits will be the date you get out of the facility.*

If you need help filling out this application, MDHHS must help you. If you are refused help, you may call 855-275-6424.

If you do not speak English or you have a disability, how can we help you?

☐ Interpreter ☐ Sign language ☐ Assisted listening device (ALD) ☐ Other _____

If you do not speak English, what language do you speak? _____

1. I received help from Michigan in the past. ☐ **Yes** **Case/recipient number** _____ (if known) ☐ **No**

2. I am applying for:

☑ **Food Assistance Program (FAP)** (seven-day processing may begin today if you complete the back of this form **and** your household qualifies).

☐ **Child Development and Care (CDC)** (help with child care costs).

☐ **Cash Assistance (FIP- Family Independence Program, RCA - Refugee Cash Assistance, SDA - State Disability Assistance)** (help with cash for pregnant women, families with children, refugees, adults with disabilities, live-in caretakers of adults with disabilities or residents of special living arrangements).

3. Legal name (first, middle, last; birth name, if different)

RJD2

Required for FAP

4. ☐ Male ☐ Female

5. Date of birth 07 / 27 / 1967

6. Social Security number** ___ – ___ – ____

7. Phone number ___ – ___ – ____

8. Message number ___ – ___ – ____

***Voluntary if applying ONLY for child care or emergency medical. Not required for FAP.*

9. Address where you live (number, street, rural route, apartment/lot number) *** ☐ Homeless

123 Main St.

City	County	State	ZIP code
Flint	Genesee	MI	48501

10. Mailing address (if different from above or PO box) ***

City	County	State	ZIP code

**** Required for FAP*

Signature

Under penalties of perjury, I swear or affirm that this filing form has been examined by or read to me, and, to the best of my knowledge, the facts are true and complete. If I am a third party applying on behalf of another person, I swear that this filing form has been examined by or read to the applicant, and, to the best of my knowledge, the facts are true and complete.

Signature of client or representative	**Date**
Chiu Baka	2017-07-27 00:00:00 UTC

Required for FAP

Expedited Food Assistance Program Seven-Day Processing

1. Does everyone in the household usually buy and fix food together? ☐ Yes ☐ No
   If no, list who does not _____
2. How much are the total cash assets belonging to your household?
   (Include cash, savings, checking, savings bonds, etc.) $ _____
3. How much is the total monthly gross income (before any deductions such as taxes) for your household?
   (Include earnings, unemployment benefits, child support, Social Security benefits, etc.) $ _____
4. Does anyone in your household receive tribal food distribution benefits? ☐ Yes ☐ No
   If yes, list who _____
5. What is the total amount you pay for your monthly rent and/or mortgage payment, property taxes, homeowners insurance, etc.? $ _____
6. Do you pay for heat? ☐ Yes ☐ No
7. Do you pay for cooling (including room air conditioner)? ☐ Yes ☐ No
8. If you do not pay for heating or cooling, check which utilities you pay: ☐ Non-heat electric ☐ Water/sewer ☐ Telephone ☐ Cooking fuel ☐ Garbage/trash

9. Is anyone in your household a ☐ migrant or ☐ seasonal farmworker?
☐ Yes ▸ *Complete the table below.* ☐ No

Has anyone received any income from the same grower within 30 days before the application date?	☐ Yes ▸ Name of person(s): ☐ No	Date	Gross pay amount
Does anyone expect to receive more income this month?	☐ Yes ▸ Name of person(s): ☐ No		
Has anyone received a travel advance?	☐ Yes ▸ Name of person(s): ☐ No		
Has anyone recently lost their only source of income?	☐ Yes ▸ Name of person(s): ☐ No	Last pay date	Gross pay amount

10. Names of all household members	Birth date	Social Security number
	__/__/____	___-__-____
	__/__/____	___-__-____
	__/__/____	___-__-____
	__/__/____	___-__-____
	__/__/____	___-__-____

11. Do you need more pages? ☐ Yes ☐ No

For office use only Date application received in local office	Case name	
	Application number	Case number
	Specialist name	
	Specialist phone	Fax
	Specialist email	

Assistance Application

Michigan Department of Health and Human Services (MDHHS)

Instructions

Check ALL programs you are applying for. *The program symbols below will appear in each section of questions on the application. These symbols tell you which questions you must answer for each program. For more information about programs, see the* ***Information Booklet****.*

☐ **Food Assistance Program (FAP).**

☐ **Child Development and Care (CDC)** (help with child care costs).

☐ **Cash Assistance (FIP - Family Independence Program, RCA - Refugee Cash Assistance, SDA - State Disability Assistance)** (help with cash for pregnant women, families with children, refugees, adults with disabilities, live-in caretakers of adults with disabilities or residents of special living arrangements).

If you answer all the questions on the assistance application, we can determine if you are eligible for the program(s) you selected above.

Please print your answers.

If you cannot complete this application now, you may complete the filing form on the previous page of this information booklet or online at *www.michigan.gov/mibridges* or download the form at *www.michigan.gov/dhs-forms*. The date MDHHS receives your assistance application or filing form may affect the date your benefits start. MDHHS will still need to receive your completed assistance application before any benefits can be approved.

If you need help filling out this application, MDHHS must help you. If you are refused help, you may call 855-275-6424.

1. If you do not speak English or you have a disability, how can we help you?
   ☐ Interpreter ☐ Sign language ☐ Assisted listening device (ALD) ☐ Other _____
2. If you do not speak English, what language do you speak? _____

Si usted necesita ayuda llenando esta solicitud, MDHHS debe ayudarle. Si ellos se niegan ayuda, usted puede llamar al 855-275-6424.

1. ¿Si usted no habla inglés o tiene una incapacidad, como podemos ayudarle?
   ☐ Intérprete ☐ Lengua de señas ☐ Dispositivo de ayuda auditiva (ALD) ☐ Otro _____
2. ¿Si usted no habla inglés, qué idioma habla? _____

إن كنت بحاجة الى مساعدة في ملء هذا الطلب فيجب على **MDHHS** تقديم المساعدة لك ، فيمكنك الاتصال بالرقم التالي : **855-275-6424**

١ إن كنت لا تتكلم اللغة الإنكليزية أو تعاني من اعاقة ، فكيف يمكننا مساعدتك؟

☐ مترجم شفهي ☐ لغة الاشارة ☐ اجهزة مساعدة للسمع **(ALD)** ☐ غير ذلك _____

٢. إن كنت لا تتكلم اللغة الإنكليزية ، فما هي اللغة التي تتكلمها ؟ _____

For office use only Date application received in local office

Case name	
Application number	Case number
Specialist name	
Specialist phone	Fax
Specialist email	

This form is issued under authority of the Code of Federal Regulations (CFR) 42 CFR 435.907; 7 CFR 273.2(d); and Sections 25 and 59 of Act 280 of the Public Acts of 1939, as amended, and Public Act 280 of 1939. You must complete this form if you want the department to consider your application for financial or food assistance or for child care services.

A. Address Information

1. **Check where you live:** ☐ House/apartment/mobile home* ☐ Homeless ☐ Other _____

   *Do you share this house/apartment/mobile home with others? For CDC only ☐ Yes ☐ No

   If you live in a facility or special living arrangement, or have lived in one in the last three months, check what type below:

   ☐ Home for the aged
   ☐ Children's group home
   ☐ Adult foster care home
   ☐ Commercial boarding house
   ☐ Hospital
   ☐ County infirmary
   ☐ Nursing facility
   ☐ Mental health or psychiatric facility
   ☐ Jail/prison
   ☐ Emergency housing/shelter
   ☐ Drug or alcohol treatment center
   ☐ Juvenile residential facility
   ☐ Community justice center
   ☐ Domestic violence shelter
   ☐ Halfway house
   ☐ Assisted living

   What date do you expect to leave, or what date did you leave the facility? __/__/____ ☐ Date unknown ☐ Does not apply

   Name of facility _____

2. **Address where you live, or address of facility** (number, street, rural route, apartment/lot number)

   City | State | ZIP code | County

3. **Mailing address** (if different from above, or PO Box)

   City | State | ZIP code | County

4. Home phone ___-___-____ Cell phone ___-___-____ Work phone ___-___-____

   Phone number where we can leave a message ___-___-____ Whose number is it? (name/relationship)

   Telephone Typewriter (TTY) number ___-___-____ Email address

5. Have you moved from, or received assistance from, another state any time after August 1996? ☐ Yes ☐ No

   If yes, what state? _____ What county? _____

   Date(s) received assistance from another state _____ What type of assistance? _____

   Date you moved to Michigan (MI) __/__/____ What was your caseworker's name? _____ Caseworker phone number ___-___-____

6. Do you and your household intend to remain in MI? ☐ Yes ☐ No
7. Did you or someone in your household come to MI with a job commitment or looking for work? ☐ Yes ☐ No
8. If you are a migrant or seasonal farmworker, list your permanent mailing address below.

   Permanent mailing address (number, street, rural route, apartment/lot number, PO Box)

   City | State | ZIP code | County

B. Food Assistance Information

1. Does everyone in the household usually buy and fix food together? ☐ Yes ☐ No
   If no, list who does not _____
2. How much are the total cash assets belonging to your household?
   (Include cash, savings, checking, savings bonds, etc.) $ _____
3. How much is the total monthly gross income (before any deductions) for your household?
   (Include earnings, unemployment benefits, child support, Social Security benefits, etc.) $ _____
4. Does anyone in your household receive tribal food distribution benefits? ☐ Yes ☐ No
   If yes, list who _____
5. If attending college, university, etc., do you live in a dorm or have a meal plan? ☐ Yes ☐ No

C. Information About You and Your Household

- ***Answer for ALL persons in your household (everyone living in your home). Include persons who are not there all the time, even if you are not applying for them. LIST YOURSELF FIRST.***
- ***If you are an alien with a sponsor who has agreed to financially support you, even if (s)he is not doing so, include your sponsor's information in one of the boxes below.***
- ***Spaces for five more persons in your household are available on the next five pages. Do you need more household pages? ☐ Yes ☐ No***

Answer for person 1. Check all boxes that apply.

1. Name (first, middle initial, last; birth name, if different) _____ 2. Date of birth _____ 3. Relationship to you SELF

4. ☐ Male ☐ Female 5. Social Security number* ___-___-____

6. Marital status ☐ Married ☐ Never married ☐ Divorced ☐ Widowed ☐ Separated

7. Is this person a U.S. citizen? ☐ Yes ☐ No **If no, and you are a documented alien, what is your date of entry: _____
   Mother's Maiden Name _____ Place of Birth _____ (county, city, state)

8. Pregnant now/last two months ☐ Yes ☐ No If yes, ▸ Due date/pregnancy end date __/__/____
   Number expected/had ☐ One ☐ Twins ☐ Triplets ☐ Other _____

9. Highest grade completed in school _____ ☐ Received GED

10. In school now? ☐ Yes ☐ No If yes, ▸ School name _____ ☐ Full-time ☐ Half-time ☐ Less than half-time
    ☐ K-12 ☐ GED ☐ College ☐ Trade school ☐ University ☐ Vocational ☐ Other

11. Ethnicity (optional) ☐ Hispanic/Latino ☐ Not Hispanic/Latino

12. Race (optional) ☐ American Indian/Alaska Native – Enter tribe name _____
    ☐ Asian ☐ Black/African American
    ☐ Native Hawaiian/Other Pacific Islander ☐ White

13. Is this person any of the following? (check all that apply) ☐ Refugee or Asylee ☐ Sponsor of an alien
    ☐ Migrant farmworker ☐ Foster child ☐ Foster parent ☐ Temporarily absent (college, military, etc.)
    ☐ Seasonal farmworker ☐ Adopted child ☐ Non-parent caregiver ☐ Victim of Trafficking

14. If this person is currently away from the home ▸ Why? _____ Expected return date _____

15. How many days each month does this person stay at the application address? ____ at another address? ____
    Other address _____ (number, street, rural route, apartment/lot number, city, state, zip code)

16. What kind of help does this person need? ☐ Food
    ☐ Child care ☐ Cash assistance ☐ None (not applying)

* Optional if applying ONLY for child care. **Applies to FIP, RCA and FAP applicants only.
*/**For FAP, see pages 11 and 16 of this booklet.

Answer for person 2. Check all boxes that apply.

1. Name (first, middle initial, last; birth name, if different) _____ 2. Date of birth _____ 3. Relationship to you _____

4. ☐ Male ☐ Female 5. Social Security number* ___-___-____

6. Marital status ☐ Married ☐ Never married ☐ Divorced ☐ Widowed ☐ Separated

7. Is this person a U.S. citizen? ☐ Yes ☐ No **If no, and you are a documented alien, what is your date of entry: _____
Mother's Maiden Name _____ Place of Birth _____ (county, city, state)

8. Pregnant now/last two months ☐ Yes ☐ No If yes, ▸ Due date/pregnancy end date __/__/____
Number expected/had ☐ One ☐ Twins ☐ Triplets ☐ Other _____

9. Highest grade completed in school_____ ☐ Received GED ☐ Full-time ☐ Half-time ☐ Less than half-time

10. In school now? ☐ Yes ☐ No If yes, ▸ School name _____
☐ K-12 ☐ GED ☐ College ☐ Trade school ☐ University ☐ Vocational ☐ Other

11. Ethnicity (optional) ☐ Hispanic/Latino ☐ Not Hispanic/Latino

12. Race (optional) ☐ American Indian/Alaska Native – Enter tribe name _____
☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African American ☐ White

13. Is this person any of the following? (check all that apply) ☐ Refugee or Asylee ☐ Sponsor of an alien
☐ Migrant farmworker ☐ Foster child ☐ Foster parent ☐ Temporarily absent (college, military, etc.)
☐ Seasonal farmworker ☐ Adopted child ☐ Non-parent caregiver ☐ Victim of Trafficking

14. If this person is currently away from the home ▸ Why?_____ Expected return date _____

15. How many days each month does this person stay at the application address? _____ at another address? _____
Other address?_____ (number, street, rural route, apartment/lot number, city, state, zip code)

16. What kind of help does this person need? ☐ Food
☐ Child care ☐ Cash Assistance ☐ None (not applying)

17. If this person is under 22, complete this section:
Who paid for this child's birth expenses ☐ State ☐ Parents ☐ Another person
What was the marital status of the mother while pregnant with this child? _____
If Married or Divorced: Marriage Date __/__/____ Separation Date __/__/____ Divorce Date __/__/____
Order/County/State: _____ Order/County/State: _____
If single, this child's Conception Date __/__/____ City: _____ State ____ Country _____
Has an Affidavit of Parentage (AOP) or a court order named someone as the father? ☐ Yes ☐ No
If Yes, Order/AOP# _____ Date __/__/____ City: _____ State ____ Country _____
If No, is there more than one possible father? ☐ Yes ☐ No, If Yes, **Stop**
If not directed to stop, complete the following for each parent:

Father

Name (first, mi, last) Birthdate SSN
_____ __/__/____ _____
Approximate age (if Birthdate not known): _____
Is he in the home? ☐ Yes ☐ No
Is he deceased? ☐ Yes ☐ No
Is he the same father described for a previous child?
☐ Yes, name: _____ ☐ No
Is he a single-parent adopter? ☐ Yes ☐ No
Has the court terminated his rights? ☐ Yes ☐ No
If Yes to any of the above, **stop**. Otherwise:
Is there a support order naming him for this child?
Order # _____ County_____State_____Country_____
Last known employer & address _____
Month/year last worked __/____
Height ___ Weight ___ Hair color ____ Eye Color ____
Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Race: ☐ American Indian/Alaska Native (Tribe _____)
☐ Asian ☐ Hawaiian Native/Pacific Islander
☐ Black/African American ☐ White
Father's health insurance covering this child:
Carrier _____ Policy # _____

Mother

Name (first, mi, last) Birthdate SSN
_____ __/__/____ _____
Approximate age (if Birthdate not known): _____
Is she in the home? ☐ Yes ☐ No
Is she deceased? ☐ Yes ☐ No
Is she the same mother described for a previous child?
☐ Yes, name: _____ ☐ No
Is she a single-parent adopter? ☐ Yes ☐ No
Has the court terminated her rights? ☐ Yes ☐ No
If Yes to any of the above, **stop**. Otherwise:
Is there a support order naming her for this child?
Order #_____County_____State_____Country_____
Last known employer & address _____
Month/year last worked __/____
Height ___ Weight ___ Hair color ____ Eye Color ____
Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Race: ☐ American Indian/Alaska Native (Tribe _____)
☐ Asian ☐ Hawaiian Native/Pacific Islander
☐ Black/African American ☐ White
Mother's health insurance covering this child:
Carrier _____ Policy # _____

* Optional if applying ONLY for child care. **Applies to FIP, RCA and FAP applicants only.
*/**For FAP, see pages 11 and 16 of this booklet.

Answer for person 3. Check all boxes that apply.

1. Name (first, middle initial, last; birth name, if different) _____ 2. Date of birth _____ 3. Relationship to you _____

4. ☐ Male ☐ Female 5. Social Security number* ___-___-____

6. Marital status ☐ Married ☐ Never married ☐ Divorced ☐ Widowed ☐ Separated

7. Is this person a U.S. citizen? ☐ Yes ☐ No **If no, and you are a documented alien, what is your date of entry: _____
Mother's Maiden Name _____ Place of Birth _____ (county, city, state)

8. Pregnant now/last two months ☐ Yes ☐ No If yes, ▸ Due date/pregnancy end date __/__/____
Number expected/had ☐ One ☐ Twins ☐ Triplets ☐ Other _____

9. Highest grade completed in school_____ ☐ Received GED ☐ Full-time ☐ Half-time

10. In school now? ☐ Yes ☐ No If yes, ▸ School name _____ ☐ Less than half-time
☐ K-12 ☐ GED ☐ College ☐ Trade school ☐ University ☐ Vocational ☐ Other

11. Ethnicity (optional) ☐ Hispanic/Latino ☐ Not Hispanic/Latino

12. Race (optional) ☐ American Indian/Alaska Native – Enter tribe name _____
☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African American ☐ White

13. Is this person any of the following? (check all that apply) ☐ Refugee or Asylee ☐ Sponsor of an alien
☐ Migrant farmworker ☐ Foster child ☐ Foster parent ☐ Temporarily absent (college, military, etc.)
☐ Seasonal farmworker ☐ Adopted child ☐ Non-parent caregiver ☐ Victim of Trafficking

14. If this person is currently away from the home ▸ Why?_____ Expected return date _____

15. How many days each month does this person stay at the application address? _____ at another address? ____
Other address?_____ (number, street, rural route, apartment/lot number, city, state, zip code)

16. What kind of help does this person need? ☐ Food
☐ Child care ☐ Cash Assistance ☐ None (not applying)

17. If this person is under 22, complete this section:
Who paid for this child's birth expenses ☐ State ☐ Parents ☐ Another person
What was the marital status of the mother while pregnant with this child? _____
If Married or Divorced: Marriage Date __/__/____ Separation Date __/__/____ Divorce Date __/__/____
Order/County/State: _____ Order/County/State: _____
If single, this child's Conception Date __/__/____ City: _____ State ____ Country _____
Has an Affidavit of Parentage (AOP) or a court order named someone as the father? ☐ Yes ☐ No
If Yes, Order/AOP# _____ Date __/__/____ City: _____ State ____ Country _____
If No, is there more than one possible father? ☐ Yes ☐ No, If Yes, **Stop**
If not directed to stop, complete the following for each parent:

Father	**Mother**
Name (first, mi, last) Birthdate SSN	Name (first, mi, last) Birthdate SSN
_____ __/__/____ _____	_____ __/__/____ _____
Approximate age (if Birthdate not known): _____	Approximate age (if Birthdate not known): _____
Is he in the home? ☐ Yes ☐ No	Is she in the home? ☐ Yes ☐ No
Is he deceased? ☐ Yes ☐ No	Is she deceased? ☐ Yes ☐ No
Is he the same father described for a previous child? ☐ Yes, name: _____ ☐ No	Is she the same mother described for a previous child? ☐ Yes, name: _____ ☐ No
Is he a single-parent adopter? ☐ Yes ☐ No	Is she a single-parent adopter? ☐ Yes ☐ No
Has the court terminated his rights? ☐ Yes ☐ No	Has the court terminated her rights? ☐ Yes ☐ No
If Yes to any of the above, **stop**. Otherwise:	If Yes to any of the above, **stop**. Otherwise:
Is there a support order naming him for this child?	Is there a support order naming her for this child?
Order # _____ County_____State_____Country_____	Order #_____County_____State_____Country_____
Last known employer & address _____	Last known employer & address _____
Month/year last worked __/____	Month/year last worked __/____
Height ___ Weight ___ Hair color ____ Eye Color ____	Height ___ Weight ___ Hair color ____ Eye Color ____
Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino	Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Race: ☐ American Indian/Alaska Native (Tribe _____)	Race: ☐ American Indian/Alaska Native (Tribe _____)
☐ Asian ☐ Hawaiian Native/Pacific Islander	☐ Asian ☐ Hawaiian Native/Pacific Islander
☐ Black/African American ☐ White	☐ Black/African American ☐ White
Father's health insurance covering this child:	Mother's health insurance covering this child:
Carrier _____ Policy # _____	Carrier _____ Policy # _____

* Optional if applying ONLY for child care. **Applies to FIP, RCA and FAP applicants only.
*/**For FAP, see pages 11 and 16 of this booklet.

Answer for person 4. Check all boxes that apply.

1. Name (first, middle initial, last; birth name, if different) _____ 2. Date of birth _____ 3. Relationship to you _____

4. ☐ Male ☐ Female 5. Social Security number* ___-___-____

6. Marital status ☐ Married ☐ Never married ☐ Divorced ☐ Widowed ☐ Separated

7. Is this person a U.S. citizen? ☐ Yes ☐ No **If no, and you are a documented alien, what is your date of entry: _____
Mother's Maiden Name _____ Place of Birth _____ (county, city, state)

8. Pregnant now/last two months ☐ Yes ☐ No If yes, ▸ Due date/pregnancy end date __/__/____
Number expected/had ☐ One ☐ Twins ☐ Triplets ☐ Other _____

9. Highest grade completed in school_____ ☐ Received GED ☐ Full-time ☐ Half-time

10. In school now? ☐ Yes ☐ No If yes, ▸ School name _____ ☐ Less than half-time
☐ K-12 ☐ GED ☐ College ☐ Trade school ☐ University ☐ Vocational ☐ Other

11. Ethnicity (optional) ☐ Hispanic/Latino ☐ Not Hispanic/Latino

12. Race (optional) ☐ American Indian/Alaska Native – Enter tribe name _____
☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African American ☐ White

13. Is this person any of the following? (check all that apply) ☐ Refugee or Asylee ☐ Sponsor of an alien
☐ Migrant farmworker ☐ Foster child ☐ Foster parent ☐ Temporarily absent (college, military, etc.)
☐ Seasonal farmworker ☐ Adopted child ☐ Non-parent caregiver ☐ Victim of Trafficking

14. If this person is currently away from the home ▸ Why?_____ Expected return date _____

15. How many days each month does this person stay at the application address? _____ at another address? _____
Other address?_____ (number, street, rural route, apartment/lot number, city, state, zip code)

16. What kind of help does this person need? ☐ Food
☐ Child care ☐ Cash Assistance ☐ None (not applying)

17. If this person is under 22, complete this section:
Who paid for this child's birth expenses ☐ State ☐ Parents ☐ Another person
What was the marital status of the mother while pregnant with this child? _____
If Married or Divorced: Marriage Date __/__/____ Separation Date __/__/____ Divorce Date __/__/____
Order/County/State: _____ Order/County/State: _____
If single, this child's Conception Date __/__/____ City: _____ State ____ Country _____
Has an Affidavit of Parentage (AOP) or a court order named someone as the father? ☐ Yes ☐ No
If Yes, Order/AOP# _____ Date __/__/____ City: _____ State ____ Country _____
If No, is there more than one possible father? ☐ Yes ☐ No, If Yes, **Stop**
If not directed to stop, complete the following for each parent:

Father	**Mother**
Name (first, mi, last) Birthdate SSN _____ __/__/____ _____	Name (first, mi, last) Birthdate SSN _____ __/__/____ _____
Approximate age (if Birthdate not known): _____	Approximate age (if Birthdate not known): _____
Is he in the home? ☐ Yes ☐ No	Is she in the home? ☐ Yes ☐ No
Is he deceased? ☐ Yes ☐ No	Is she deceased? ☐ Yes ☐ No
Is he the same father described for a previous child? ☐ Yes, name: _____ ☐ No	Is she the same mother described for a previous child? ☐ Yes, name: _____ ☐ No
Is he a single-parent adopter? ☐ Yes ☐ No	Is she a single-parent adopter? ☐ Yes ☐ No
Has the court terminated his rights? ☐ Yes ☐ No	Has the court terminated her rights? ☐ Yes ☐ No
If Yes to any of the above, **stop**. Otherwise:	If Yes to any of the above, **stop**. Otherwise:
Is there a support order naming him for this child?	Is there a support order naming her for this child?
Order # _____ County_____State_____Country_____	Order #_____County_____State_____Country_____
Last known employer & address _____	Last known employer & address _____
Month/year last worked __/____	Month/year last worked __/____
Height ___ Weight ___ Hair color ____ Eye Color ____	Height ___ Weight ___ Hair color ____ Eye Color ____
Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino	Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Race: ☐ American Indian/Alaska Native (Tribe _____) ☐ Asian ☐ Hawaiian Native/Pacific Islander ☐ Black/African American ☐ White	Race: ☐ American Indian/Alaska Native (Tribe _____) ☐ Asian ☐ Hawaiian Native/Pacific Islander ☐ Black/African American ☐ White
Father's health insurance covering this child: Carrier _____ Policy # _____	Mother's health insurance covering this child: Carrier _____ Policy # _____

* Optional if applying ONLY for child care. **Applies to FIP, RCA and FAP applicants only.
*/**For FAP, see pages 11 and 16 of this booklet.

Answer for person 5. Check all boxes that apply.

1. Name (first, middle initial, last; birth name, if different) _____ 2. Date of birth _____ 3. Relationship to you _____

4. ☐ Male ☐ Female 5. Social Security number* ___-___-____

6. Marital status ☐ Married ☐ Never married ☐ Divorced ☐ Widowed ☐ Separated

7. Is this person a U.S. citizen? ☐ Yes ☐ No **If no, and you are a documented alien, what is your date of entry: _____
Mother's Maiden Name _____ Place of Birth _____ (county, city, state)

8. Pregnant now/last two months ☐ Yes ☐ No If yes, ▸ Due date/pregnancy end date __/__/____
Number expected/had ☐ One ☐ Twins ☐ Triplets ☐ Other _____

9. Highest grade completed in school _____ ☐ Received GED ☐ Full-time ☐ Half-time ☐ Less than half-time

10. In school now? ☐ Yes ☐ No If yes, ▸ School name _____
☐ K-12 ☐ GED ☐ College ☐ Trade school ☐ University ☐ Vocational ☐ Other

11. Ethnicity (optional) ☐ Hispanic/Latino ☐ Not Hispanic/Latino

12. Race (optional) ☐ American Indian/Alaska Native – Enter tribe name _____
☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African American ☐ White

13. Is this person any of the following? (check all that apply) ☐ Refugee or Asylee ☐ Sponsor of an alien
☐ Migrant farmworker ☐ Foster child ☐ Foster parent ☐ Temporarily absent (college, military, etc.)
☐ Seasonal farmworker ☐ Adopted child ☐ Non-parent caregiver ☐ Victim of Trafficking

14. If this person is currently away from the home ▸ Why? _____ Expected return date _____

15. How many days each month does this person stay at the application address? _____ at another address? ____
Other address? _____ (number, street, rural route, apartment/lot number, city, state, zip code)

16. What kind of help does this person need? ☐ Food
☐ Child care ☐ Cash Assistance ☐ None (not applying)

17. If this person is under 22, complete this section:
Who paid for this child's birth expenses ☐ State ☐ Parents ☐ Another person
What was the marital status of the mother while pregnant with this child? _____
If Married or Divorced: Marriage Date __/__/____ Separation Date __/__/____ Divorce Date __/__/____
Order/County/State: _____ Order/County/State: _____
If single, this child's Conception Date __/__/____ City: _____ State ____ Country _____
Has an Affidavit of Parentage (AOP) or a court order named someone as the father? ☐ Yes ☐ No
If Yes, Order/AOP# _____ Date __/__/____ City: _____ State ____ Country _____
If No, is there more than one possible father? ☐ Yes ☐ No, If Yes, **Stop**
If not directed to stop, complete the following for each parent:

Father

Name (first, mi, last) Birthdate SSN
_____ __/__/____ _____
Approximate age (if Birthdate not known): _____
Is he in the home? ☐ Yes ☐ No
Is he deceased? ☐ Yes ☐ No
Is he the same father described for a previous child?
☐ Yes, name: _____ ☐ No
Is he a single-parent adopter? ☐ Yes ☐ No
Has the court terminated his rights? ☐ Yes ☐ No
If Yes to any of the above, **stop**. Otherwise:
Is there a support order naming him for this child?
Order # _____ County_____State_____Country_____
Last known employer & address _____
Month/year last worked __/____
Height ___ Weight ___ Hair color ____ Eye Color ____
Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Race: ☐ American Indian/Alaska Native (Tribe _____)
☐ Asian ☐ Hawaiian Native/Pacific Islander
☐ Black/African American ☐ White
Father's health insurance covering this child:
Carrier _____ Policy # _____

Mother

Name (first, mi, last) Birthdate SSN
_____ __/__/____ _____
Approximate age (if Birthdate not known): _____
Is she in the home? ☐ Yes ☐ No
Is she deceased? ☐ Yes ☐ No
Is she the same mother described for a previous child?
☐ Yes, name: _____ ☐ No
Is she a single-parent adopter? ☐ Yes ☐ No
Has the court terminated her rights? ☐ Yes ☐ No
If Yes to any of the above, **stop**. Otherwise:
Is there a support order naming her for this child?
Order #_____County_____State_____Country_____
Last known employer & address _____
Month/year last worked __/____
Height ___ Weight ___ Hair color ____ Eye Color ____
Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Race: ☐ American Indian/Alaska Native (Tribe _____)
☐ Asian ☐ Hawaiian Native/Pacific Islander
☐ Black/African American ☐ White
Mother's health insurance covering this child:
Carrier _____ Policy # _____

* Optional if applying ONLY for child care. **Applies to FIP, RCA and FAP applicants only.
*/**For FAP, see pages 11 and 16 of this booklet.

Answer for person 6. Check all boxes that apply.

1. Name (first, middle initial, last; birth name, if different) _____ 2. Date of birth _____ 3. Relationship to you _____

4. ☐ Male ☐ Female 5. Social Security number* ___-___-____

6. Marital status ☐ Married ☐ Never married ☐ Divorced ☐ Widowed ☐ Separated

7. Is this person a U.S. citizen? ☐ Yes ☐ No **If no, and you are a documented alien, what is your date of entry: _____
Mother's Maiden Name _____ Place of Birth _____ (county, city, state)

8. Pregnant now/last two months ☐ Yes ☐ No If yes, ▸ Due date/pregnancy end date __/__/____
Number expected/had ☐ One ☐ Twins ☐ Triplets ☐ Other _____

9. Highest grade completed in school_____ ☐ Received GED ☐ Full-time ☐ Half-time

10. In school now? ☐ Yes ☐ No If yes, ▸ School name _____ ☐ Less than half-time
☐ K-12 ☐ GED ☐ College ☐ Trade school ☐ University ☐ Vocational ☐ Other

11. Ethnicity (optional) ☐ Hispanic/Latino ☐ Not Hispanic/Latino

12. Race (optional) ☐ American Indian/Alaska Native – Enter tribe name _____
☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African American ☐ White

13. Is this person any of the following? (check all that apply) ☐ Refugee or Asylee ☐ Sponsor of an alien
☐ Migrant farmworker ☐ Foster child ☐ Foster parent ☐ Temporarily absent (college, military, etc.)
☐ Seasonal farmworker ☐ Adopted child ☐ Non-parent caregiver ☐ Victim of Trafficking

14. If this person is currently away from the home ▸ Why?_____ Expected return date _____

15. How many days each month does this person stay at the application address? _____ at another address? ____
Other address?_____ (number, street, rural route, apartment/lot number, city, state, zip code)

16. What kind of help does this person need? ☐ Food
☐ Child care ☐ Cash Assistance ☐ None (not applying)

17. If this person is under 22, complete this section:
Who paid for this child's birth expenses ☐ State ☐ Parents ☐ Another person
What was the marital status of the mother while pregnant with this child? _____
If Married or Divorced: Marriage Date __/__/____ Separation Date __/__/____ Divorce Date __/__/____
Order/County/State: _____ Order/County/State: _____
If single, this child's Conception Date __/__/____ City: _____ State ____ Country _____
Has an Affidavit of Parentage (AOP) or a court order named someone as the father? ☐ Yes ☐ No
If Yes, Order/AOP# _____ Date __/__/____ City: _____ State ____ Country _____
If No, is there more than one possible father? ☐ Yes ☐ No, If Yes, **Stop**
If not directed to stop, complete the following for each parent:

Father

Name (first, mi, last) Birthdate SSN
_____ __/__/____ _____
Approximate age (if Birthdate not known): _____
Is he in the home? ☐ Yes ☐ No
Is he deceased? ☐ Yes ☐ No
Is he the same father described for a previous child?
☐ Yes, name: _____ ☐ No
Is he a single-parent adopter? ☐ Yes ☐ No
Has the court terminated his rights? ☐ Yes ☐ No
If Yes to any of the above, **stop**. Otherwise:
Is there a support order naming him for this child?
Order # _____ County_____State_____Country_____
Last known employer & address _____
Month/year last worked __/____
Height ___ Weight ___ Hair color ____ Eye Color ____
Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Race: ☐ American Indian/Alaska Native (Tribe _____)
☐ Asian ☐ Hawaiian Native/Pacific Islander
☐ Black/African American ☐ White
Father's health insurance covering this child:
Carrier _____ Policy # _____

Mother

Name (first, mi, last) Birthdate SSN
_____ __/__/____ _____
Approximate age (if Birthdate not known): _____
Is she in the home? ☐ Yes ☐ No
Is she deceased? ☐ Yes ☐ No
Is she the same mother described for a previous child?
☐ Yes, name: _____ ☐ No
Is she a single-parent adopter? ☐ Yes ☐ No
Has the court terminated her rights? ☐ Yes ☐ No
If Yes to any of the above, **stop**. Otherwise:
Is there a support order naming her for this child?
Order #_____County_____State_____Country_____
Last known employer & address _____
Month/year last worked __/____
Height ___ Weight ___ Hair color ____ Eye Color ____
Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Race: ☐ American Indian/Alaska Native (Tribe _____)
☐ Asian ☐ Hawaiian Native/Pacific Islander
☐ Black/African American ☐ White
Mother's health insurance covering this child:
Carrier _____ Policy # _____

* Optional if applying ONLY for child care. **Applies to FIP, RCA and FAP applicants only.
*/**For FAP, see pages 11 and 16 of this booklet.

D. Household Members Under Age 22

Do you need more pages? ☐ *Yes* ☐ *No*

List person(s) under age 22 in the household	List name of mother/father (first, middle, last)	Check if parent is deceased	If person under age 22 does not live with a parent, who does he/she live with?	Check box(es) below if: • Parents were ever married to each other. • Paternity was legally established. • Support is court-ordered.
	Mother	☐ Yes	Name	☐ Married ☐ Paternity ☐ Support Order # ______
	Father	☐ Yes	Relationship	
	Mother	☐ Yes	Name	☐ Married ☐ Paternity ☐ Support Order # ______
	Father	☐ Yes	Relationship	
	Mother	☐ Yes	Name	☐ Married ☐ Paternity ☐ Support Order # ______
	Father	☐ Yes	Relationship	
	Mother	☐ Yes	Name	☐ Married ☐ Paternity ☐ Support Order # ______
	Father	☐ Yes	Relationship	
	Mother	☐ Yes	Name	☐ Married ☐ Paternity ☐ Support Order # ______
	Father	☐ Yes	Relationship	
	Mother	☐ Yes	Name	☐ Married ☐ Paternity ☐ Support Order # ______
	Father	☐ Yes	Relationship	
	Mother	☐ Yes	Name	☐ Married ☐ Paternity ☐ Support Order # ______
	Father	☐ Yes	Relationship	
	Mother	☐ Yes	Name	☐ Married ☐ Paternity ☐ Support Order # ______
	Father	☐ Yes	Relationship	
	Mother	☐ Yes	Name	☐ Married ☐ Paternity ☐ Support Order # ______
	Father	☐ Yes	Relationship	
	Mother	☐ Yes	Name	☐ Married ☐ Paternity ☐ Support Order # ______
	Father	☐ Yes	Relationship	

E. Child Development and Care (CDC) Information

Do you need more pages? ☐ *Yes* ☐ *No*

1. Do you need help paying for child care? ☐ **Yes** ☐ **No**

Why do you need help paying for child care? **Check all that apply.**

☐ Work ☐ High school or GED ☐ Education/training approved by MDHHS or the work participation program.

☐ Treatment for health or social condition (explain) _____

If you checked "High school or GED" or "Education/training approved by MDHHS or the work participation program" above, do you need child care for study time? ☐ Yes ☐ No

If yes, please indicate the number of hours of child care per week needed for study time _____

Name of child needing care	Provider name	Provider ID number (if known)

2. Does the family have total assets that exceed one million dollars? ☐ **Yes** ☐ **No**

F. Medical Information

Do you need more pages? ☐ *Yes* ☐ *No*

FAP applicants need to only answer questions 5, 7, 8, and 9.

1. List anyone in your household who is a victim of domestic violence _____ ☐ None
2. List any children under 6 years of age who are not up-to-date on their immunizations (shots) _____ ☐ None
3. List any children in an *Early On* program _____ ☐ None

   Name and phone number of *Early On* coordinator _____
4. List anyone who is now or has ever been in a special education class _____ ☐ None

   Name and phone number of school _____
5. List anyone going to an alcohol or drug treatment program _____ ☐ None
6. List anyone working with Michigan Rehabilitation Services _____ ☐ None

   Name and phone number of Michigan Rehabilitation counselor _____
7. List anyone caring for a child, spouse, or other person with a disability in the home _____ ☐ None
8. Is the caregiver able and available to work in addition to caring for someone? ☐ Yes ☐ No
9. List anyone applying for assistance who is physically or mentally unable to work full time. ☐ None

Person	Medical condition	Is this person able to work?
		☐ **Yes** ☐ **No**
		☐ **Yes** ☐ **No**
		☐ **Yes** ☐ **No**

G. Medical Coverage

Does anyone in your household have, or expect to have, medical coverage?

☐ **Yes** ▸ ***Check which type of coverage and complete the table below.*** ☐ **No**

☐ Health/hospital insurance (employer, parent, etc.)
☐ Medicare
☐ Accident (home or car insurance, etc.)
☐ MIChild
☐ Plan/contract (life care contract, etc.)
☐ Workers' compensation
☐ Health savings account
☐ Other _____

Person covered	Name and address of insurance company	Claim, contract/group numbers, effective date

H. Asset Information

Do you need more pages? ☐ *Yes* ☐ *No*

1. Does anyone in your household have any assets (include assets owned with another person)?

☐ **Yes** ▸ ***Check all types of assets your household has and complete the table below.*** ☐ **No**

☐ Checking/savings accounts
☐ Certificates of deposit (CD)
☐ Cash on hand/in safe deposit box
☐ Trust or annuities
☐ Life estate
☐ Life insurance
☐ Burial trust/funeral contract(s)
☐ Money market accounts
☐ Christmas club accounts
☐ Savings bonds, stocks or mutual funds
☐ Land contract, mortgage, or other notes payable to household member
☐ Burial plot(s), casket, etc.
☐ Patient trust fund
☐ IRA, KEOGH, 401K, or deferred compensation account(s)
☐ Real estate/property
☐ Real estate/property (not including place you live)
☐ Tools/equipment/livestock/crops
☐ Lottery/gambling winnings
☐ Other (mineral rights, any other accounts, funds, resources, in-kind benefits, etc.)
☐ Credit union accounts

Owner of asset	Type of asset	Balance (amount or value)	Name and address (bank, insurance company, etc.)	Account or policy number, etc.

2. Has anyone in your household:

- Sold/given away property, land, stocks, bonds, vehicles, savings, checking or credit union accounts, income, cash, etc., or closed any accounts or removed or added a name to any asset within the last 60 months (5 years) or (within the last 3 months for FAP)? ☐Yes ☐No
  If yes, ▸ Who? _____ ▸ What? _____
  ▸ Date ☐☐/☐☐/☐☐☐☐ ▸ How much? $ _____
- Filed a lawsuit which may bring money, property, etc. ? ☐ Yes ☐ No
  If yes, ▸ Who? _____ ▸ What? _____
  ▸ Date ☐☐/☐☐/☐☐☐☐ ▸ How much? $ _____
- Received a one-time payment (such as workers' compensation, lottery winnings, insurance settlement lawsuit award, etc.) within the last 60 months (5 years) or (within the last 3 months for FAP)? ☐ Yes ☐ No
  If yes, ▸ Who? _____ ▸ What? _____
  ▸ Date ☐☐/☐☐/☐☐☐☐ ▸ How much? $ _____
- Acting for another household member, put any money, lawsuit settlement, income or assets in a trust, annuity or similar legal device within the last 60 months (5 years) or (within the last 3 months for FAP)? ☐ Yes ☐ No
  If yes, ▸ Who? _____ ▸ What? _____
  ▸ Date ☐☐/☐☐/☐☐☐☐ ▸ How much? $ _____
- Has anyone in your household received a federal tax refund in the last 12 months? ☐ Yes ☐ No
  If yes, ▸ Who? _____ ▸ When? _____
  ▸ Date ☐☐/☐☐/☐☐☐☐ ▸ How much? $ _____

I. Vehicle Information

Do you need more pages? ☐ *Yes* ☐ *No*

Does anyone in your household have any vehicles?

☐ **Yes** ▸ ***Check all that apply and complete the table below.*** ☐ **No**

☐ Car ☐ Truck ☐ Boat ☐ Camper/trailer ☐ Motorcycle ☐ RV ☐ Other vehicles

Owner(s) on vehicle title or registration	Year	Make / Model	Mileage	Amount owed

J. Migrant or Seasonal Farmworker Income

Do you need more pages? ☐ *Yes* ☐ *No*

Is anyone in your household a ☐ **migrant or** ☐ **seasonal farmworker?**
☐ **Yes** ▶ ***Complete the table below.*** ☐ **No**

		Date	Gross pay amount
Has anyone received any income from the same grower within 30 days before the application date?	☐ Yes ▶ Name of person(s): ☐ No		
Does anyone expect to receive more income this month?	☐ Yes ▶ Name of person(s): ☐ No		
Has anyone received a travel advance?	☐ Yes ▶ Name of person(s): ☐ No		
Has anyone recently lost their only source of income?	☐ Yes ▶ Name of person(s): ☐ No	Last pay date	Gross pay amount

K. Employment Changes

Do you need more pages? ☐ *Yes* ☐ *No*

Did anyone in your household have changes in employment in the last 30 days?
☐ **Yes** ▶ ***Check all that apply and complete the table below.*** ☐ **No**

Check all that apply	Name of person(s)	Name and address of employer	Date of change	Date and gross amount of final pay
☐ Refused work Reason _____				
☐ Voluntarily reduced hours worked Reason _____				
☐ Quit a job Reason _____				
☐ Was laid off Reason _____				
☐ Was fired Reason _____				
☐ Is participating in a strike Reason _____				

L. Self-Employment Income (including odd jobs)

Do you need more pages? ☐ *Yes* ☐ *No*

1. Is anyone in your household self-employed or will anyone be self-employed before the end of the next calendar month? ☐ **Yes** ▶ ***Complete the table below.*** ☐ **No**

Self-employed person	Type of work or business and date business started	Business name and address	Gross monthly income (amount before any expenses)	Monthly self-employment expenses
	☐☐/☐☐/☐☐☐☐			
	☐☐/☐☐/☐☐☐☐			

M. Employment Income

Do you need more pages? ☐ *Yes* ☐ *No*

Is anyone in your household working for wages or salary or will anyone begin working before the end of the next calendar month? ☐ **Yes** ▸ ***Complete the information below for each working person.*** ☐ **No**

Name of working person _____ Start date ☐☐/☐☐/☐☐☐☐

Employer name/address/phone number _____

Type of work _____ Job title _____

If new job, first paycheck date ☐☐/☐☐/☐☐☐☐ Will employment continue? ☐ Yes ☐ No

Day of week pay is received _____ Most recent or last paycheck date ☐☐/☐☐/☐☐☐☐

Average # of hours expected to work _____ per ☐ Week ☐ Pay period Rate of pay $ _____ ☐ Hourly ☐ Salary ☐ Other _____

How often paid: ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Other _____

Do you receive a ☐ Bonus ☐ Commission or ☐ Overtime? ☐ Yes ☐ No

▸ If yes, amount $ _____ How often? _____

Do you receive tips not included in your check? ☐ Yes ☐ No

▸ If yes, average tips not included $ _____ per ☐ Week ☐ Pay period ☐ Other _____

Name of working person _____ Start date ☐☐/☐☐/☐☐☐☐

Employer name/address/phone number _____

Type of work _____ Job title _____

If new job, first paycheck date ☐☐/☐☐/☐☐☐☐ Will employment continue? ☐ Yes ☐ No

Day of week pay is received _____ Most recent or last paycheck date ☐☐/☐☐/☐☐☐☐

Average # of hours expected to work _____ per ☐ Week ☐ Pay period Rate of pay $ _____ ☐ Hourly ☐ Salary ☐ Other _____

How often paid: ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Other _____

Do you receive a ☐ Bonus ☐ Commission or ☐ Overtime? ☐ Yes ☐ No

▸ If yes, amount $ _____ How often? _____

Do you receive tips not included in your check? ☐ Yes ☐ No

▸ If yes, average tips not included $ _____ per ☐ Week ☐ Pay period ☐ Other _____

N. Other Income

Do you need more pages? ☐ *Yes* ☐ *No*

1. Does anyone in your household receive, or expect to receive (has applied for), any income other than earnings?

☐ **Yes** ▸ ***Check all boxes that apply and complete the table below.*** ☐ **No**

☐ Social Security benefits (RSDI) ☐ Supplemental Security Income (SSI) ☐ Disability benefits

☐ Pension/retirement benefits ☐ Refugee Resettlement Income (FAP only) ☐ Unemployment benefits

☐ Railroad retirement benefits ☐ Workers' compensation ☐ Rental income

☐ Veterans benefits ☐ Money from friends or relatives, etc. ☐ Room and/or board income

☐ Military allotments ☐ Interest/dividend income ☐ Refugee matching grant

☐ Land contract, mortgage, or other notes payable to a household member

☐ Income/payments from a tribe (tribal general assistance, land claims, casino profit sharing, per capita, etc.)

☐ Other (tax refund, mineral rights, in-kind monies/benefits, etc.)

☐ Child support/court order docket # _____

Person receiving/ expecting money	Income source/type	How often received	Amount received	Expected to continue?	Date expecting if not yet received
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

2. If anyone in your household receives Social Security (RSDI) or Railroad Retirement benefits, list the claim number(s) _____

3. Has anyone in your household served in the military or the armed services? ☐ Yes ☐ No

If yes, _____

☐ **Does anyone who served in the military or armed services have a disability?**

Who? _____

☐ **Is anyone a widow(er) or child of a deceased person who served in the military or armed services?**

Who? _____

☐ **Is anyone a spouse or child with a disability of a person with a disability who served in the military or armed services?**

Who? _____

☐ **Is anyone in the household active duty in the US military?**

Who? _____

☐ **Is anyone in the household active duty in the National Guard or Reserve?**

Who? _____

☐ **None of these.**

O. Disability Benefits

Do you need more pages? ☐ *Yes* ☐ *No*

1. Has anyone in your household, who is not receiving disability benefits, applied for or been denied disability benefits? ☐ **Yes** ▸ ***Check all disability benefits that apply and complete the table below.*** ☐ **No**

Person	Type of benefit	Benefit status	Date of action (if known)
	☐ Social Security Claim # ______ ☐ Self ☐ Spouse ☐ Parent ☐ Supplemental Security Income (SSI) ☐ Other______	☐ Applied for benefits. ☐ Denied benefits.* ☐ Appealed the denial. ☐ Requested a hearing.	
	☐ Social Security Claim # ______ ☐ Self ☐ Spouse ☐ Parent ☐ Supplemental Security Income (SSI) ☐ Other______	☐ Applied for benefits. ☐ Denied benefits.* ☐ Appealed the denial. ☐ Requested a hearing.	
	☐ Social Security Claim # ______ ☐ Self ☐ Spouse ☐ Parent ☐ Supplemental Security Income (SSI) ☐ Other______	☐ Applied for benefits. ☐ Denied benefits.* ☐ Appealed the denial. ☐ Requested a hearing.	

* *Social Security Administration has decided he/she is not disabled.*

2. If benefits were denied, have the person's health problem(s) changed? ☐ **Yes** ☐ **No**

If yes, ▸ **List who** ______ **Date of change** ______

☐ **Health problem is worse** ☐ **New health problem** ☐ **Has more than one health problem**

P. Dependent Care Expenses and Court-Ordered Support

Do you need more pages? ☐ *Yes* ☐ *No*

1. Does anyone in work, school, or training pay for the care of a ☐ **child,** ☐ **family member with disabilities?**

☐ **Yes** ▸ ***Complete the table below (DO NOT include amounts paid by MDHHS or anyone else).*** ☐ **No**

Person paying	Amount paid	How often	Name of person(s) receiving care
	$______	☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Other	
	$______	☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Other	
	$______	☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Other	

2. Does anyone in your household pay court-ordered ☐ **child support** ☐ **spousal support/alimony?**

☐ **Yes** ▸ ***If either of the boxes are checked above, complete the table below.*** ☐ **No**

Person paying	Court-order/docket number and county of order	Order amount	Amount paid per	For whom
		$______	$______ ☐ Week ☐ Month ☐ Other	
		$______	$______ ☐ Week ☐ Month ☐ Other	
		$______	$______ ☐ Week ☐ Month ☐ Other	

Q. Medical Expenses

Do you need more pages? ☐ *Yes* ☐ *No*

1. List anyone who has paid or unpaid medical expenses for services provided in the last three months:

▸ Who?_____ What months?_____

List anyone who has paid medical premiums in the last three months:

▸ Who?_____ What months?_____

2. Does anyone in your household have ongoing medical expenses?

☐ **Yes** ▸ ***Check all expenses that apply and complete the table below.*** ☐ **No**

☐ Medical care
☐ Dental care
☐ Hospitalization
☐ Transportation for medical care
☐ Emergency room
☐ Nursing facility
☐ Prescribed over-the-counter drugs
☐ Prescription drugs
☐ Dentures
☐ Eyeglasses
☐ Hearing aids
☐ Prosthetics
☐ Service animal
☐ Guardian/conservator fees
☐ Health insurance premium
☐ Medicare premium
☐ Medical equipment/supplies
☐ Personal care/chore services
☐ Other

Person with expense	Medical expense (checked above)	Amount person pays	How often (monthly, yearly, etc.)

R. Shelter Expenses

Check the boxes that apply and fill in the amount.

1. ☐ Rent $ _____ (list ONLY the amount **you** pay, **NOT** the amount paid by HUD, Housing Choice Voucher (Section 8), MSHDA, etc.)
   ☐ Weekly ☐ Monthly ☐ Other
2. Does anyone pay for:
   Rent that includes meals (room/board) ☐ Yes ▸ $ _____ ☐ Weekly ☐ Monthly ☐ Other ☐ No
   Meals only (board) ☐ Yes ▸ $ _____ ☐ Weekly ☐ Monthly ☐ Other ☐ No
3. ☐ Mobile home lot rent? $ _____ ☐ Weekly ☐ Monthly ☐ Other
4. ☐ Mortgage/mobile home/land contract $ _____ ☐ Weekly ☐ Monthly ☐ Other
5. ☐ Second mortgage or home equity loan $ _____ ☐ Weekly ☐ Monthly ☐ Other
6. Shelter expenses billed separately from rent or mortgage: ☐ Fuel Type (Ex. wood, gas, propane)
   ☐ Heat (gas, electric, propane, wood, etc.)
   ☐ Cooling (including room air conditioner)
   ☐ Electricity (non-heat)
   ☐ Water/sewer
   ☐ Cooking fuel
   ☐ Garbage/trash pick-up
   ☐ Telephone
   ☐ Homeowner's insurance $ _____ per year
   ☐ Property taxes $ _____ per year
   ☐ Special assessments $_____per_____
   ☐ Mortgage guarantee insurance $ _____ per _____
   ☐ Cooperative/condominium/association fee $_____
   ☐ Excess cooling costs when non-heat electric is included in rent $ _____
   ☐ Other_____ $ _____
7. Has anyone in your household who is applying for FAP received the Home Heating Credit (HHC) in an amount greater than $20 for this month or within the past 12 months? ☐ **Yes** ☐ **No**
8. Has anyone in your household who is applying for FAP received a energy related State Emergency Relief (SER) payment or Michigan Energy Assistance Program (MEAP) payment in an amount greater than $20 for this month or within the past 12 months? ☐ **Yes** ☐ **No**

S. Receipt of Benefits

1. Did anyone in your household ever apply for or receive benefits from Michigan in the past? ☐ Yes ☐ No
   - If yes, under what name(s)? _____
     (maiden name, alias, former spouse, etc.)
   - If yes, list Social Security number benefits received under. _____
   - If yes, have you ever received a Bridge card? ☐ Yes ☐ No
     If yes, who? _____
2. Does anyone in your household receive Women, Infants, Children (WIC) benefits? ☐ Yes ☐ No
   - If yes, who? _____
3. Does anyone in your household receive tribal TANF (cash) benefits? ☐ Yes ☐ No
   - If yes, who? _____
4. Does anyone in your household receive Adoption subsidy/Guardianship Assistance Payments? ☐ Yes ☐ No
   - If yes, who? _____
5. If attending college, university, etc., are you enrolled in/paying for a meal plan? ☐ Yes ☐ No
   - If yes, how many meals per week are included in the plan? _____

T. Information MDHHS Needs to Know

Answer for everyone in your household.

- Has anyone ever been disqualified or had their benefits reduced or stopped because they did not follow program rules in any state, including Michigan? ☐ Yes ☐ No
  - If yes, who? _____
  - If yes, what state? _____
- Has anyone ever been convicted of fraud or signed a recoupment agreement and/or disqualification paperwork for receiving cash or food assistance from two or more states for the same time period? ☐ Yes ☐ No
  - If yes, who? _____ What program(s)? _____
    What state(s)? _____
- Is anyone fleeing from felony prosecution, an outstanding felony warrant or jail? ☐ Yes ☐ No
  - If yes, who? _____
- Has anyone ever been convicted of a drug-related felony that occurred after August 22, 1996? ☐ Yes ☐ No
  - If yes, who? _____ Convicted more than once? ☐ Yes ☐ No
- Is anyone in violation of probation or parole? ☐ Yes ☐ No
  - If yes, who? _____

U. Offer of State of Michigan Voter Registration Application

If you are not already registered to vote at your current address, would you like to register to vote? ☐ Yes ☐ No

NOTE: Checking 'yes' does not register you to vote. If you check 'yes' or do not respond, a voter registration application will be forwarded to you.

Applying or declining to register to vote will not affect the amount of help you will be provided by this department. If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration application form in private.

If you believe someone has interfered with your right to:

- Register to vote.
- Decline to register to vote.
- Privacy in deciding whether to register or in applying to register to vote.
- Choose your own political party or other political preference.

You may file a complaint with:

Secretary of State
PO Box 20126
Lansing, MI 48901-0726

V. Representative, Guardian, Conservator or Person Helping with Application

1. If you are eligible for food assistance, do you want someone else to have a Bridge card and access to your food benefits to shop for you? This person should be someone you trust. Yes ☐ No

   If yes, enter his/her full name _____
   (This person will be your authorized representative.)

2. Are you filling this application out for someone else? ☐ Yes ☐ No
   Are you representing the person applying? ☐ Yes ☐ No
   Check one or both.

   ▸ ***If Yes is checked for one or both questions above, complete the following information:***

Name | Phone number ___-___-____

Street address (number, street, rural route, apartment/lot number, PO Box)

City | State | ZIP code

Representative's relationship to applicant *(check all that apply)*
☐ Guardian ☐ Relative (*specify*) _____
☐ Conservator ☐ Other (*specify*) _____

If you are under age 18, are you married?
☐ Yes ☐ No

W. Affidavit

IMPORTANT: Before you sign this application, READ the affidavit.

Under penalties of perjury, I swear or affirm that this application has been examined by or read to me, and, to the best of my knowledge, the facts are true and complete including the information concerning citizenship and alien status of the members applying for benefits. If I am a third party applying on behalf of another person, I swear this application has been examined by or read to the applicant, and, to the best of my knowledge, the facts are true and complete.

I certify I have received a copy, reviewed and agree with the sections in the assistance application **Information Booklet** explaining how to apply for and receive help: Programs, Things You Must Do, Important Things to Know, Repay Agreements, and Information About Your Household That Will Be Shared.

I certify, under penalty of perjury, that all the information I have written on this form or told my MDHHS specialist or my representative is true. I understand I can be prosecuted for perjury if I have intentionally given false or misleading information, misrepresented, hidden, or withheld facts that may cause me to receive assistance I should not receive or more assistance than I should receive. I can be prosecuted for fraud and/or be required to repay the amount wrongfully received. I understand I may be asked to show proof of any information I have given.

	When in-person interview completed:
Signature of client or representative Date	Signature of department witness/migrant recruiter Date

Notes

Notes

Things You Must Do (continued)

Repay Extra Benefits (All Programs)

If you or anyone in your household receives benefits they are not eligible for, the adults in the household must repay the extra benefits. The benefits must be repaid even if there was no fraud. If MDHHS makes an error, the adults in the household must repay the extra benefits.

For FAP, an authorized representative (someone with access to your food benefits who can shop for you) may also be responsible for repayment of any extra FAP benefits.

Recoupment. MDHHS may keep part of your future benefits as repayment for extra benefits you received.

Trafficking. FAP benefits that are sold or traded are treated as extra benefits and must be repaid.

Release of information. If you or anyone in your household received extra benefits, the information on your assistance application, including Social Security numbers, may be given to federal, state and private agencies to help with collection.

*Provide Social Security Numbers (Most Programs)

For most programs, under federal law 42 USC 1320b-7, you must provide Social Security numbers for everyone **applying**.

Exceptions include:

- When applying for child care **only**, you do not have to provide a Social Security number for adults or children who do not need child care.
- When applying for FAP, you do not have to provide a social security number for anyone not applying.
- FAP clients are excused from providing and obtaining a Social Security number based on religious grounds.

MDHHS will help you apply for Social Security numbers. Give MDHHS the Social Security number as soon as you receive it. If you do not, your benefits may be reduced or denied. You may have to repay an overpayment.

MDHHS will use Social Security numbers to check whether you are eligible and receiving the correct benefits. MDHHS uses Social Security numbers to check information with other agencies. (See “Information About Your Household That Will Be Shared.”)

Pursue Other Benefits (Most Programs)

You must apply for other benefits you may qualify for, such as:

- Unemployment benefits.
- Social Security and Supplemental Security Income (SSI) benefits.
- Veterans Administration benefits.

MDHHS will tell you if you need to apply for benefits.

If you do not pursue benefits when required, your MDHHS benefits may be reduced, closed or denied.

Immunize Children Under Age 6 - Get Shots (FIP)

Children under age 6 must be immunized as recommended by the Michigan Department of Health and Human Services.

Your cash benefits may be reduced by $25 per month until your children are up-to-date on their immunizations.

A child is exempt from the immunization requirement if:

- (S)he is under two months of age.
- Immunizations are medically inappropriate for the child.
- Immunizations are against the family’s religious beliefs.

Child Support Actions (Most Programs)

You will receive a letter about the child support program if:

- You receive FIP, FAP or CDC; and
- One or more of the child’s parents do not live with the child.

Read and follow the directions in the letter. You will need to provide more information about yourself, the minor child(ren) in your home and the parents of the minor child(ren). The letter will tell you to complete an online form or to call OCS.

While you receive benefits from FIP, FAP or CDC, you must keep working with the Office of Child Support, the prosecuting attorney, and friend of the court to pursue paternity and/or support.

Good cause. MDHHS will not require you to pursue paternity or support if you have good cause.

To claim good cause, speak to your MDHHS specialist and ask for the “Claim of Good Cause” (DHS-2168) form. You may be asked to provide proof.

If you do not cooperate with child support actions when required, and do not have a good cause reason, MDHHS will do all of the following for at least one month:

- Remove the food assistance benefits of the person not cooperating.
- Deny or stop your child care benefits.
- Deny or stop cash assistance for your entire household.
- Deny SER for failure to comply with a requirement of FIP.

*See pages D-H of this booklet.

Read this information booklet before you sign the assistance application.

Child Support Actions (Most Programs) (continued)

When you get a FIP grant, you give (assign) to MDHHS any current support for you (spousal support) or minor children in your home (child support). This means when you get FIP, some of the spousal or child support you get from someone else may go to MDHHS to pay back some of the FIP grant.

You may get a child support payment that is owed to you while on FIP. If you do get a child support payment, call your local MDHHS office to find out if you can keep it. If your MDHHS specialist tells you the payment was sent to you in error, you must return the money. If you do not return the money, you may lose your FIP grant or your grant may be reduced.

If the amount of support MDHHS collects is more than your FIP grant for at least two months, MDHHS may close your FIP case so you can receive support payments directly.

Follow Work Rules and Penalties (FIP or RCA and FAP)

Your work rules will depend on whether you receive FIP or RCA cash assistance, FAP benefits with no cash assistance, or time-limited FAP benefits.

FIP or RCA cash assistance work rules.
Your family must complete a Family Automated Screening Tool (FAST) and develop a Family Self-Sufficiency Plan (FSSP). The FAST and FSSP requirements are for FIP only. The FSSP will list the work activities that you must do up to 40 hours per week to receive FIP. You design this plan with your MDHHS specialist and the work participation program. For RCA only, you must develop a Refugee Family Self-Sufficiency Plan (RFSSP).

- Complete the FAST (FIP only).
- Help make and comply with a FSSP (FIP only) or RFSSP (RCA only).
- Not quit, refuse work or reduce work hours.
- Not get fired from a job due to misconduct or missing work.
- Comply with assigned employment and/or self-sufficiency activities.

Penalties for breaking FIP or RCA work rules. If you break the FIP or RCA work rules without good cause (see "Good Cause" on page 13), MDHHS will:

- Deny your application (you may reapply).
- Stop FIP for your whole family for three months for the first time, six months for the second time and permanently for the third time.
- Count all penalty months toward your state 48-month lifetime limit (FIP only).
- Stop RCA for you for at least three months (but the rest of your household might be eligible).
- If you receive both FIP and FAP, we may:
  - Stop or reduce your FAP benefits for at least one month if you are not excused from FAP work rules.
  - Count your FIP grant amount as income.

FAP work rules. All group members not meeting deferral criteria will be registered for work and may be required to perform specific work incuding cooperation with employment and training activities. (NOTE: If you receive both cash and food benefits, you must follow FIP work rules.)

- **If you are working, you may not:**
  - Quit a job of 30 hours or more per week.
  - Voluntarily reduce work hours below 30 hours per week without good cause.
- **If you are not working, or you work less than 30 hours per week, you may not:**
  - Refuse a job offer.
  - Refuse to participate in required employment-related activities that must be done to receive FAP.

Penalties for breaking FAP work rules. If you receive FAP and you break the work rules without good cause, your benefits will stop or be reduced for:

- At least one month for the first time, and
- Six months for any other time after the first time.

Time-limited food assistance rules. (NOTE: Time limits are not always in effect, so check with your MDHHS specialist.)

Special time limits and work requirements might apply to you if you are:

- A person without a disability,
- At least 18 years old but under the age of 50; and
- Living in a household with no children under age 18 (related or unrelated).

Work Rule Deferrals and Good Cause (FIP or RCA and FAP)

Work rule deferrals (excused). Some people who receive cash or food assistance may be excused from work rules. If you receive FIP and are excused from the work rules, you may have to do other activities. If you think you should be excused from work rules, talk to your MDHHS specialist.

NOTE: Reasons for being excused may change.

You may be excused from FIP or RCA work rules if you are:

- Age 65 or older.
- A parent of a baby less than 2 months old. You may be assigned to family strengthening activities once the baby is 6 weeks old.
- Working 40 hours per week.
- Caring for a child or spouse with a disability (depending on the person's needs and the child's school attendance).
- A person with a disability or medical limitations.
- Experiencing a domestic violence situation (determined by MDHHS).

You may be excused from FAP work rules if you are:

- Age 60 or older.
- Personally caring for a child under the age of 6 who is receiving FAP on your case.
- Working 30 hours per week or earning at least minimum wage times 30 hours per week.
- Attending high school, adult education or a GED program at least half-time.
- Injured, ill or personally caring for a household member with a disability.
- Pregnant with medical complications.
- Applying for FAP at a Social Security office.
- In substance abuse treatment or rehabilitation.
- Applying for or receiving unemployment benefits.
- Appealing the denial of unemployment benefits.

Good cause. You have the right to claim good cause if you believe you should be excused from the FIP, RCA and/or FAP work rules. If you think you have a good cause reason, contact your MDHHS specialist right away. NOTE: Reasons for good cause may change.

FIP or RCA or FAP - Reasons for good cause:

- An unplanned event or factor that does not allow you to meet the work rules (for example, domestic violence, religion, health or safety risk, or homelessness).
- Illness or injury.
- You requested child care that was not provided.
- You requested transportation services that were not provided.
- Long commute (more than two hours per day or more than three hours per day with child care).
- You quit a job to take a comparable job.
- Your job required you to commit illegal activities.
- You are physically or mentally unable to do the job.
- Your employer discriminated against you based on age, race, religion, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability.
- You are working 40 hours per week for at least the state minimum wage.
- Reasonable accommodation was not provided.

FAP only - You may have a good cause reason if you/your:

- Are deferred.
- Moved due to another household member's job or education/training.
- Have a job that requires you to retire or to join, resign from or refrain from joining a labor union or organization.
- Have a job that is on strike or at a lockout site.
- Have unreasonable work conditions.
- Have been offered a job that is outside of your work experience during the **first 30 days** as a mandatory FAP work participant.
- Employer is not able to keep the promise of work.

Important Things To Know

Penalties, Intentional Program Violation or Fraud (FAP, FIP, SDA, CDC)

Call 800-222-8558 to report suspected welfare fraud.

Intentional Program Violation (IPV) is when you make a false or misleading statement, hide, misrepresent or withhold facts on purpose to receive or continue to receive extra benefits.

Fraud/IPV - If we think you committed fraud/IPV, we may hold an administrative hearing, bring criminal charges or ask you to voluntarily sign a disqualification agreement.

FAP Trafficking - You may also be guilty of fraud/IPV if you trade, attempt to trade or sell your FAP benefits or Bridge card online or in person. You may not use or attempt to use FAP benefits or Bridge cards that belong to another household for your household. You may not use FAP benefits or Bridge cards to purchase **o**r attempt to purchase anything other than food, seeds, and plants to grow your own food for your household.

If it is proven in court that you are guilty of **fraud:**

- You are subject to criminal penalties (for example, fines up to $250,000, jail/prison time up to 20 years, or both). You may be charged under other federal laws and a court may prevent you from receiving benefits for an additional 18 months; **and**
- You must repay any extra benefits you received because of the fraud/IPV; **and**
- You will be disqualified from receiving FIP/SDA and/or FAP benefits - see the table below.

If it is proven in an administrative hearing you are guilty of **IPV** or you voluntarily sign a disqualification:

- You will be disqualified from receiving FIP/SDA and/or FAP benefits - see the table below, **and**
- You will have to repay the extra benefits you received because of the fraud/IPV.

CDC Penalties - Violation of program rules may result in a disqualification of 6 months, 12 months or a lifetime.

If you do any of the following:	**You will lose FIP/SDA and/or FAP benefits for:**
• Make a false or misleading statement. • Hide, misrepresent or withhold facts to receive or continue to receive benefits. • Trade, attempt to trade, or sell less than $500 in FAP benefits or Bridge cards online or in person. • Use or attempt to use FAP or cash benefits to buy ineligible items such as alcoholic drinks or tobacco. • Purchase beverages with FAP benefits then immediately empty the contents and return the container for the cash. • Use or attempt to use FAP benefits or Bridge cards that belong to someone else for your household.	• One year for the first violation. • Two years for the second violation. • Life for the third violation.
If you are:	**You will lose FAP benefits for:**
• Found by a court or an administrative hearing to have lied about your identity or where you live to receive benefits on two or more cases at the same time.	• 10 years.
If you are:	**You will lose FIP benefits for:**
• Convicted in court of lying about your identity or where you live to receive benefits* in two or more cases at the same time. *Benefits include programs funded under Title IV-A of the Social Security Act, Medicaid and Supplemental Security Income.	• 10 years.
If any member of the household is found guilty in court of:	**You will lose FAP benefits for:**
• Trading FAP benefits for drugs.	• Two years for the first offense. • Life for the second offense.
If any member of the household is found guilty in court of:	**You will lose FAP benefits for:**
• Trading or attempting to trade FAP benefits for firearms, ammunition, or explosives. • Trading, buying or selling or attempting to trade, buy or sell FAP benefits of $500 or more for anything other than food online or in person. • Paying or attempting to pay for food purchased on credit with FAP.	• Life.

Read this information booklet before you sign the assistance application.

Important Things To Know (continued)

General Complaints

Clients have the right to make general complaints about matters other than the right to apply, non-discrimination or hearing issues. Written complaints can be sent to:

Michigan Department of Health and Human Services
Specialized Action Center
235 S. Grand Avenue
PO Box 30037
Lansing, MI 48909
or call 855-275-6424 or 855-ASK-MICH.

Hearing Rights

If you do not agree with a decision MDHHS makes to deny, reduce, or terminate benefits, or for failure to act with reasonable promptness, you have the right to request a hearing.

Food Assistance Program hearings may be requested by phone to your Specialist. Hearings for all other programs must be requested in writing. The request should include your name, address, and case number. Attach a copy of the notice, if possible. Go to *www.michigan.gov/documents/FIA-Pub18_14356_7.pdf* to download a form to use, or contact your specialist to request a form.

- Mail the signed and dated request to the hearings coordinator at your local Department of Health and Human Services office.
- Keep a copy of the request and any other document you attach for yourself.
- At the hearing you can explain why you think the action is wrong and present evidence.
- MDHHS must receive your request for appeal within 90 days of the mailing date of this notice or a hearing will not be granted.
- MDHHS must receive your request for an appeal within 10 days of the mailing date of the notice to continue receiving your benefits.

You may be required to repay any assistance that you receive while your appeal is pending if: (1) the Department's proposed action is upheld in the hearing decision, or (2) your request for appeal is withdrawn, or (3) you or your authorized representative do not attend this hearing.

You may choose anyone to represent you. If that person is not a lawyer or is not appointed by a court, you must give us your signed authorization and the person you wish to represent you must also sign the request. Attach a copy of the court's order if the person is court-appointed to help you. The Michigan Administrative Hearing System will deny the request for an administrative hearing made by the representative if you do not provide proof of authorization.

If You Think We Discriminate

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: *http://www.ascr.usda.gov/complaint_filing_cust.html,* and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call 866-632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

(2) fax: 202-690-7442; or

(3) email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at 800-221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: *http://www.fns.usda.gov/snap/contact_info/hotlines.htm.*

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call 202-619-0403 (voice) or 800-537-7697 (TTY).

This institution is an equal opportunity provider.

Read this information booklet before you sign the assistance application.

Important Things To Know (continued)

Persons With Disabilities

You do not have to tell us about disabilities, but some help is only available to persons with disabilities. If you or someone in your household has a disability, we can make exceptions or give you special help.

Tell your MDHHS specialist if you need help.

If you do not tell us about a disability now, you can tell us about it later.

If you are denied special help or an exception you need because of a disability, and you think the denial was wrong, you may file a complaint of discrimination with:

USDA - See address in previous section.

You may file electronically via: *http://www.michigan.gov/disabilityresources/0,4563,7-223-74971-352839--,00.html*

Or

This form may be printed and sent to:

MDHHS, Americans with Disabilities Act Coordinator
PO Box 30037, Suite 708
Lansing, MI 48909
855-275-6424

**Citizens and Non-Citizens/Social Security Numbers

Social Security numbers and immigration papers are NOT required for a person who is:

- Not applying for help.
- Only applying for child care. (You must give a Social Security number for the child and the child must be a U.S. citizen or show immigration papers.)

Other eligible members of your household will still be able to receive help.

You may have to provide information about income and assets of all persons in your household, even if they are not applying.

Receiving food or emergency assistance will **not** affect your immigration status. If you are here illegally, it may affect your ability to stay in the U.S.

For some programs, **persons claiming U.S. citizenship** must provide proof of citizenship and identity. Acceptable proof of citizenship includes, but is not limited to, a U.S. passport, a certificate of naturalization, or a U.S. public birth record showing birth in the U.S. or U.S. territories.

Persons receiving SSI, Social Security, Medicare, or adoption assistance, foster children and newborn "safe delivery," babies are not required to provide proof of U.S. citizenship for MDHHS programs.

Race and Ethnicity

Answering questions about race and ethnicity is voluntary. If you do not answer these questions, your eligibility or benefit levels will not be affected.* The information is collected to ensure that program benefits are distributed without regard to race, color or national origin.

** If you choose not to answer these questions, your MDHHS specialist may choose an answer for you.*

Domestic Violence

We may be able to waive some program requirements (such as working, looking for a job, pursuing child support or going to school) if participating would:

- Put you or a family member in danger of physical or emotional harm.
- Subject you to sexual abuse.
- Otherwise be unfair to you.

You are authorized to receive domestic violence comprehensive services. Contact the MDHHS office in your area or your MDHHS specialist for more information or to access these services.

Resources:

- Online at: *www.michigan.gov/domesticviolence.*
- DHS-Pub-859, Is Someone Hurting You or Your Children? (also available in Spanish) - online at: *www.michigan.gov/dhs-publications*.

If You Receive Tribal Benefits

You cannot receive food benefits from the tribal food distribution program and the food assistance program at the same time.

You cannot receive tribal TANF (cash) from a tribe and FIP cash benefits from MDHHS at the same time.

Tribal organizations may receive LIHEAP funds from the federal government. Payments are limited to the highest amount available from either MDHHS or the tribal organization. MDHHS will ask you to prove any tribal LIHEAP payment you receive.

**See pages D-H of this booklet.

Read this information booklet before you sign the assistance application.

Bridge Card

Cash and/or food benefits are accessed by using a debit card. This debit card is called the Bridge card or Electronic Benefit Transfer (EBT) card.

Call EBT Customer Service toll-free at 888-678-8914 to:

- Report a lost, stolen or damaged card.
- Request a replacement card (after your first replacement card, your benefits may be reduced to cover the cost of replacing any additional cards).

This same replacement card policy applies if you have one or both of the following individuals:

  - Someone who has access to your cash benefits (protective payee), or
  - For FAP, someone who you approved to purchase food for your household (authorized representative).
- Establish/change your personal ID number (PIN).
- Find out your balance.

Repay Agreements

By signing the assistance application, you agree to do these things:

Lump Sums and Accumulated Benefits (SDA, State-Funded FIP)

If you receive SDA, you agree to repay MDHHS if you receive:

- Lump sum payments such as an inheritance, insurance settlement, etc., or
- Accumulated benefits paid retroactively such as unemployment benefits or workers' compensation.

If you receive SDA or state-funded FIP, you agree to repay MDHHS if you receive retroactive SSI.

You agree to allow the Social Security Administration to pay MDHHS the amount of state-funded assistance you received while your SSI claim was pending.

If the first accumulated benefit payment is sent to you, you agree to pay MDHHS right away for the state-funded assistance you received while the claim was pending.

If you disagree with the amount MDHHS keeps, see "Hearing Rights."

Information About Your Household That Will Be Shared

By signing the assistance application, you agree that MDHHS can share information about you and your household with others, and that other agencies or people can give us information about you, as stated below:

Information MDHHS Will Get From Others

Social Security Administration information (all programs) - You agree the Social Security Administration may give MDHHS all information needed to determine your eligibility.

Quality Control (QC) and/or Office of Inspector General (OIG) Investigations - MDHHS might choose your case for a quality control review or a complete investigation. If your case is chosen, MDHHS will contact you, other people, employers and/or agencies for proof of the information provided on your assistance application.

Law enforcement check (FAP, FIP, SER) - MDHHS may give or receive information from law enforcement officials for the purpose of catching persons fleeing to avoid the law.

Child care billing information (CDC) - Information submitted by your child care provider will be used in determining payment amounts.

Computer cross-checking (all programs) - MDHHS will check with federal, state and private agencies to make sure the information you provide on the assistance application is correct. Verification of the information you provide may affect your household's eligibility and level of benefits. MDHHS may check wages, income, assets, unemployment benefits, income tax refunds, Social Security benefits and numbers, child support, immigration status, etc.

If you give any information that does not match, MDHHS will check to find out what is correct. You may be asked for permission to contact employers, banks, or other people.

MDHHS will check records from other states. You may be denied benefits in Michigan if you or other household members were disqualified in another state.

Information MDHHS Will Give To Others

Eligibility information (FAP) - MDHHS sends food assistance program (FAP) eligibility information to schools. This information allows your child(ren) to receive free or reduced-cost meals.

CDC - Notice will be sent to your child care provider when:

- Your CDC has been approved and authorized.
- Changes occur that impact your CDC eligibility.
- Your CDC eligibility has ended.

Undocumented Aliens - MDHHS may send information about certain undocumented aliens to the Department of Homeland Security.

Survey Information - You may be contacted for survey information to help evaluate MDHHS' quality of programs and customer service.

Website References

- **Career Education and Workforce Programs:** *www.michigan.gov/mdcd*
- **Earned Income Tax Credit:** *www.michiganeic.org*
- **Energy Assistance Programs:** *www.michigan.gov/heatingassistance*
- **Family Automated Screening Tool (FAST):** *www.michigan.gov/fast*
- **Michigan Department of Education Child Development and Care:** *www.michigan.gov/childcare*
- **Michigan Department of Health and Human Services:** *www.michigan.gov/mdhhs*
  - **Applying for Assistance** *www.michigan.gov/dhs-applicationprocess*
  - **Cash Assistance** *www.michigan.gov/dhs-cash*
  - **Child Support** *www.michigan.gov/childsupport*
  - **Child Support Application & Case Information** *www.michigan.gov/michildsupport*
  - **Emergency Services** *www.michigan.gov/dhs-ser*
  - **Food Assistance** *www.michigan.gov/foodstamps*
  - **MDHHS County Offices** *www.michigan.gov/dhs-countyoffices*
  - **MDHHS Forms & Applications** *www.michigan.gov/dhs-forms*
  - **MDHHS Policy and Procedural Manuals** *www.michigan.gov/dhs-manuals*
  - **Office of Services to the Aging:** *www.michigan.gov/osa*
  - **Women, Infants and Children (WIC) program:** *www.michigan.gov/wic*
- **Michigan Disability Resources:** *www.michigan.gov/disabilityresources*

Publications

Ask your MDHHS specialist if you would like any of these publications. The following publications are available online at: *www.michigan.gov/dhs-publications*. Some are also available in Spanish (Sp).

- **Child Support**
  - Understanding Child Support: A Handbook for Parents (DHS-Pub-748) (Sp)
  - What Every Parent Should Know About Establishing Paternity (DHS-Pub-780) (Sp)
  - Fatherhood: Taking Responsibility for Your Child (DHS-Pub-806)
  - DNA Paternity Testing: Questions and Answers (DHS-Pub-865) (Sp)
- **Home Heating Credit**
  - Notice to Potential Home Heating Credit Recipients (DHS-Pub-788) (Sp)
- **State Emergency Relief**
  - You and Your Energy Bills (DHS-Pub-631)
  - MDHHS Can Help With Temporary Assistance (DHS-Pub-783)

Read this information booklet before you sign the assistance application.