**Each Employee and their dependent MUST complete and sign the form seperately**

**Complete Legal Name:**

|  |  |  |
| --- | --- | --- |
| First: Shivansh | Middle: Rahul | Last: Gaikwad |

Have you RECEIVED since obtaining the nonimmigrant status that you seek to extend or that you seek to change, or are you CURRENTLY certified to receive, the following public benefits? (select all that apply)

**1. Yes, I have received or is currently certified to receive the following public benefits:**

|  |  |
| --- | --- |
| NO | Any Federal, State, local or tribal cash assistance for income maintenance |
| NO | Supplemental Security Income (SSI) |
| NO | Temporary Assistance for Needy Families (TANF) |
| NO | General Assistance (GA) |
| NO | Supplemental Nutrition Assistance Program (SNAP) formerly called “Food Stamps” |
| NO | Section 8 Housing Assistance under the Housing Choice Voucher Program |
| NO | Section 8 Project-Based Rental Assistance (including Moderate Rehabilitation) |
| NO | Public Housing under the Housing Act of 1937 |
| NO | Federally-Funded Medicaid |

**2.**

|  |  |
| --- | --- |
| YES | No, I have not received any of the above listed public benefits. |
| YES | No, I am not certified to receive any of the above listed public benefits. |

**If YOU have received or are currently certified to receive any of the above public benefits, provide information about the public benefits below:**

**1.**

|  |
| --- |
| Type of Benefit |
| Agency that Granted the Benefit: |
| Date you STARTED receiving the benefit or if certified, the date WILL START receiving: (mm/dd/yyyy) |
| Date Benefit Ended or Expires: (mm/dd/yyyy) |

**2.**

|  |
| --- |
| Type of Benefit |
| Agency that Granted the Benefit: |
| Date you STARTED receiving the benefit or if certified, the date WILL START receiving: (mm/dd/yyyy) |
| Date Benefit Ended or Expires: (mm/dd/yyyy) |

**3.**

|  |
| --- |
| Type of Benefit |
| Agency that Granted the Benefit: |
| Date you STARTED receiving the benefit or if certified, the date WILL START receiving: (mm/dd/yyyy) |
| Date Benefit Ended or Expires: (mm/dd/yyyy) |

**4.**

|  |
| --- |
| Type of Benefit |
| Agency that Granted the Benefit: |
| Date you STARTED receiving the benefit or if certified, the date WILL START receiving: (mm/dd/yyyy) |
| Date Benefit Ended or Expires: (mm/dd/yyyy) |

**5. If you answered YES, to Item 1, do any of the following apply to you?**

|  |  |
| --- | --- |
|  | You are enlisted in the Armed Forces or are serving in active duty or in the Ready Reserve Component of the US Armed Forces. |
|  | You are the spouse or the child of an individual who is enlisted in the Armed Forces, or who is serving in active duty or in the Ready Reserve Component of the US Armed Forces. |
|  | At the time you received the public benefits, you (or your spouse or parent) was enlisted in the Armed Forces or was serving in active duty or in the Ready Reserve Component of the US Armed Forces. |
|  | At the time you received the public benefits, you were present in the US in a status exempt from the public charge ground of inadmissibility. |
|  | At the time you received the public benefits, you were present in the US after being granted a waiver of the public charge ground of inadmissibility. |
|  | You are a child currently residing abroad who entered the US with a nonimmigrant visa to attend an N-600K, Application for Citizenship and Issuance of Certificate Under INA Section 322 interview. |
|  | None of the above statements apply to me. |

**6. Have you received, applied for, or have been certified to receive federally funded Medicaid in connection with any of the following? (select all that apply)**

|  |  |
| --- | --- |
|  | An emergency medical condition. |
|  | For a service under the Individuals with Disabilities Education Act (IDEA). |
|  | Other school-based benefits or services available up to the oldest age eligible for secondary education under State law. |
|  | While under the age of 21. |
|  | While pregnant or during the 60-day period following the last day of pregnancy. |

**7. Provide the Applicable Dates:**

|  |
| --- |
| From: (mm/dd/yyyy) |
| To:: (mm/dd/yyyy) |

Please provide any other information that may be relevant:

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|  |
| --- |
| DECLARATION |
| I declare under the penalty of perjury that I have completed, read and reviewed all the information provided below and that, to the best of my knowledge, the information contained herein is true and accurate. I understand that to knowingly furnish false information in the preparation of USCIS and/or DOL forms and any supplement thereto, or to aid and abet or counsel another to do so, is a federal offense punishable by a fine, or imprisonment up to five years, or both under 18 U.S.C. Sections 2 and 1001. Other penalties apply as well to fraud or misuse of ETA immigration documents and to perjury with respect to such documents under 18 U.S.C. Sections 1546 and 1621. |

**Shivansh Rahul Gaikwad 12/15/2020**

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**Name: Signature: Date:**

**Public Benefit Document Checklist**

* Any letter, notice, certification or agency documents that contain the following information:
  + Beneficiary’s name;
  + Name and contact information for the public benefit-granting agency;
  + Type of public benefit;
  + Date you started receiving the public benefit or, if certified, date you will start receiving the public benefit;
  + Date the benefit or coverage ended or expires (if applicable).
* If you have requested disenrollment – please provide evidence of the disenrollment or the request to disenroll if the public benefit-granting agency has not processed the request