LDSS-2921 DD **Statewide** (Rev. 10/18)

**DO NOT WRITE IN THE SHADED AREAS OF THIS APPLICATION**

| CENTER/ OFFICE | APPLICATION DATE | UNIT ID | WORKER ID | CASE TYPE | SERV. IND | CASE NUMBER | REGISTRY NUMBER | VERS | DISTRICT | SUFFIX | SNAP SUFFIX | CATEGORY | LANG | NUMBER REUSE INDICATOR |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | |

| CASE NAME | EFFECTIVE DATE | DISPOSITION | SERVICES TRANSACTION TYPE |
|---|---|---|---|
| | | ☐ DENIAL ☐☐☐ REASON CODE ☐ WITHDRAWAL | ☐ NEW OPENING 02 ☐ REOPEN 10 ☐ RECERTIFICATION 06 |

| ELIGIBILITY DETERMINED BY (WORKER): | DATE | ELIGIBILITY APPROVED BY (SUPERVISOR): | DATE | FORM _____ 0F _____ | SIGNATURE OF PERSON WHO OBTAINED ELIGIBILITY INFORMATION x _____ | DATE |
|---|---|---|---|---|---|---|
| | | | | | | |

| DATE RECEIVED BY AGENCY | EMPLOYED BY: ☐ SOCIAL SERVICES DISTRICT ☐ PROVIDER AGENCY SPECIFY: _____ |
|---|---|
| | |

| PA AUTHORIZATION PERIOD | | MA AUTHORIZATION PERIOD | | SNAP AUTHORIZATION PERIOD | | SERVICES AUTHORIZATION PERIOD | |
|---|---|---|---|---|---|---|---|
| FROM | TO | FROM | TO | FROM | TO | FROM | TO |
| | | | | | | | |

# NEW YORK STATE APPLICATION FOR CERTAIN BENEFITS AND SERVICES

If you are blind or seriously visually impaired and need this application in an alternative format, you may request one from your social services district. For additional information regarding the types of formats available and how you can request an application in an alternative format, see the instruction book (PUB-1301 Statewide), available at www.otda.ny.gov or https://www.health.ny.gov/.

If you are blind or seriously visually impaired, would you like to receive written notices in an alternative format? ◯ Yes ◯ No

If yes, check the type of format you would like: Large Print; Data CD; Audio CD; Braille, if you assert that none of the other alternative formats will be equally effective for you.

If you require another accommodation, please contact your social services district.

We are committed to assisting and supporting you in a professional and respectful manner. You are responsible for participating in activities, including work activities for Public Assistance and the Supplemental Nutrition Assistance Program, where required, so you can become self-sufficient. Whenever you see "Public Assistance" or "PA" on the application, it means "Family Assistance" and/or "Safety Net Assistance." We call both programs "Public Assistance." These PA programs are meant to assist you only until you can fully support yourself and your family. **Please refer to the instruction book (PUB-1301 Statewide) and "What You Should Know" Books 1, 2 and 3 (LDSS-4148A, LDSS-4148B, and LDSS-4148C) when completing this application, and contact your social services district with any questions.**

When you see "MA" on the application, it means "Medicaid." You may apply for MA using this application only if you are also applying for Public Assistance or the Supplemental Nutrition Assistance Program at the same time. If you wish to only apply for MA, you can go online at https://nystateofhealth.ny.gov/ and/or call 1-855-355-5777 for more information or to apply, or you may use the MA-only paper application - Form DOH-4220, which your worker can give you, or call MA help line at 1-800-541-2831. If you want to apply only for the Medicare Savings Program (MSP), you must apply with Form DOH-4328, which your worker can provide to you. If you have an immediate need for personal care services, you should apply for MA separately using the DOH- 4220 MA application form.

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**SECTION 1**

**CHECK EACH PROGRAM YOU OR ANY HOUSEHOLD MEMBER ARE APPLYING FOR**

Public Assistance (PA) | Child Care in lieu of PA | Supplemental Nutrition Assistance Program (SNAP) | Medicaid (MA) and SNAP
Medicaid (MA) and PA | Services (S), including Foster Care (FC) | Child Care Assistance (CC) | Emergency Assistance Only (EMRG)

**SECTION 2**

**WHAT IS YOUR PRIMARY LANGUAGE?** ○ ENGLISH ○ SPANISH ○ OTHER (specify) _____

**DO YOU WANT TO RECEIVE NOTICES IN:** ○ ENGLISH ONLY ○ ENGLISH AND SPANISH

**SECTION 3** **APPLICANT INFORMATION** **PLEASE PRINT CLEARLY**

| FIRST NAME | M.I. | LAST NAME | MARITAL STATUS | PHONE NUMBER ( ) AREA CODE |
|---|---|---|---|---|
| | | | | |

| STREET ADDRESS | APT. NO. | CITY | COUNTY | STATE | ZIP CODE |
|---|---|---|---|---|---|
| | | | | | |

IN CARE OF NAME (COMPLETE IF YOU RECEIVE YOUR MAIL IN CARE OF ANOTHER PERSON)

| MAILING ADDRESS (IF DIFFERENT FROM ABOVE) | APT. NO. | CITY | COUNTY | STATE | ZIP CODE |
|---|---|---|---|---|---|
| | | | | | |

| HOW LONG HAVE YOU LIVED AT YOUR PRESENT ADDRESS? | YEARS | MONTHS | IS THIS A SHELTER? ○ YES ○ NO | ANOTHER PHONE WHERE YOU CAN BE REACHED | NAME | PHONE NUMBER ( ) AREA CODE |
|---|---|---|---|---|---|---|
| | | | | | | |

DIRECTIONS TO CURRENT ADDRESS

| FORMER ADDRESS | APT. NO. | CITY | COUNTY | STATE | ZIP CODE |
|---|---|---|---|---|---|
| | | | | | |

IF YOU ARE CURRENTLY WITHOUT A HOME, CHECK HERE

| AGENCY HELPING APPLICANT/CONTACT PERSON | PHONE NUMBER ( ) AREA CODE |
|---|---|
| | |

DO YOU NEED THE MEDICAID PORTION OF THIS APPLICATION AND THE POTENTIAL RECEIPT OF ANY MEDICAID COVERAGE TO BE KEPT CONFIDENTIAL? ○ YES ○ NO

**SECTION 5**

**DO ANY OF THESE APPLY TO YOU?**

| | |
|---|---|
| Pregnant | 1 |
| Victim of Domestic Violence | 2 |
| Need To Establish Paternity | 3 |
| Need Child Support | 4 |
| Drug/Alcohol Problem | 5 |
| Fuel Or Utility Shutoff | 6 |
| No Place To Stay/Homeless | 7 |
| Fire Or Other Disaster | 8 |
| Have No Income | 9 |
| Serious Medical Problem | 10 |
| Pending Eviction | 11 |
| No Food | 12 |
| Need Foster Care | 13 |
| Need Child Care | 14 |
| Problems with English | 15 |
| Reasonable Accommodations | 16 |
| Other _____ | 17 |

**SECTION 4 – If You Are Applying For SNAP:** You can file an application the day you get it. In order to file a SNAP application, it must have, at minimum, your name, address (if you have one) and signature below. You must complete the application process, including signing the last page of the application and being interviewed. If eligible, you will get SNAP benefits back to the date you filed the application. You must be told, within 30 days of the date you turned in (filed) your application for SNAP benefits, if your application is approved or denied. If your household has little or no income or liquid resources, or if your rent and utility expenses are more than your income and liquid resources, you may be eligible to get SNAP benefits within five calendar days of the date you file. If you are a resident of an institution and are applying for both Supplemental Security Income (SSI) and SNAP benefits prior to leaving the institution, the filing date of the application is the date you leave the institution.

| SNAP APPLICANT/REPRESENTATIVE SIGNATURE | DATE SIGNED |
|---|---|
| x | |