DELAWARE HEALTH AND SOCIAL SERVICES (DHSS)
APPLICATION FOR FOOD BENEFITS, CASH, MEDICAL, AND CHILD CARE ASSISTANCE

Welcome to the State of Delaware Health and Social Services (DHSS)

We help Delawareans in need by providing food benefits, medical, child care, and cash assistance. We can provide information about other helpful services in your community. You can answer only the questions related to the program(s) you are applying for. If you answer ALL the questions on the Assistance Application, we can see if you are eligible for all programs. A friend or relative, or anyone that you wish, may help you complete this application.

Your application is not complete until you sign the last page. Return the application to us.

At your interview, you will need to show us:

- Proof of who you are.
- Proof of your address.
- Proof of child care costs (only for cash assistance).
- Proof of money you received in the last 30 days.

Name	**Telephone**	
Street Address		
Mailing Address (if different)		
City	**State**	**Zip Code**

If you wish to have someone else manage your case and act as your representative, please provide the information below.

Authorized Representative

I, _____ want _____
Your Name **Your Representative's Name**

to be my representative for the purpose of application and case review only. ❑ Yes ❑ No

My representative will also be issued an Electronic Benefit Transfer (EBT) card for my food benefit account and will be able to use it to purchase food. I understand that this gives the representative access to my food benefits and that any benefits spent by the representative will not be replaced. ❑ Yes ❑ No

The day we get this first page of the application with your name, address, and signature sets the date benefits may start if you sign and return the completed application to DHSS within 30 days.

_____ _____
Applicant's Signature (Required) **Date**

_____ _____
Authorized Representative's Signature **Date**

In each of the headings in this application, you will see program symbols. These symbols will help you to identify the questions you must answer for the program(s) you are requesting.

Symbols	Programs
	**Medical Assistance Programs** (doctors, hospitals, prescriptions, labs, and x-rays.)
	**Child Care Assistance** (help with the cost of child care.)
	**Cash Assistance - Temporary Assistance for Needy Families (TANF) - General Assistance (GA)**
	**Food Supplement Program** (help with monthly food expenses.)
	**Signature Required**

Terms	Definition
Alien:	A person who is not a U.S. citizen.
EBT card:	**E**lectronic **B**enefit **T**ransfer - a plastic card that you use at a store to buy food.
Eligible:	Meeting all of the guidelines to get benefits.
Household:	A person or a group of people who live together and buy food and fix meals together.
ABAWD:	Able Bodied Adult Without Dependents - An adult age 18 through 50 years old, without dependents, and physically able to work.

Nondiscrimination Statement

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

If you require this information in alternative format (Braille, large print, audiotape, etc.), contact the USDA's TARGET Center at (202) 720-2600 (Voice or TDD). If you require information about this program, activity or facility in a language other than English, contact the USDA agency responsible for the program or activity, or any USDA office.

To file a complaint alleging discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue SW, Washington, DC 20250-9410 or call, toll free, (800) 795-3272 (Voice) or (202)720-6382 (TTY). USDA is an equal opportunity provider and employer.

Delaware's Food First Electronic Benefits Transfer (EBT) Card

We issue food benefits on an EBT card. To use your food benefits, you must have an EBT card and a Personal Identification Number (PIN). When we approve your benefits, our EBT vendor will mail your card to you if you never had one before. You can also go to a card issuance site to get your card.

Delaware's Emergency Food Benefit

If your household has little or no income right now, you may be able to receive emergency food benefits within 7 days from the day we receive your completed application.

You may be able to get emergency food benefits in seven days if:

- Your household expects to receive less than $150 in income this month
- Your household does not have more than $100 in cash or bank accounts

- Your household is a migrant or seasonal farm worker household
- Your household's rent, mortgage, and utilities are more than your household's gross monthly income and liquid resources combined

Tell Us About Yourself and the People in Your Home

For which program(s) are you applying?

❑ Cash Assistance ❑ Food Supplement
❑ Medical Assistance ❑ Child Care

Name: ______________________________ Telephone Number: ____________________
Last Name, First Name and Middle Initial

Street Address: ____
Apartment Number **Development/Apartment Name**

City/State/Zip Code:____

Are you? ❑ Single ❑ Married ❑ Divorced ❑ Civil Union
❑ Separated ❑ Widowed ❑ Unmarried Partnership

Instructions

Fill in the blocks for all of the people in the household.

Race: I = American Indian/Alaskan Native
B = Black/African American
PI = Native Hawaiian/Pacific Islander
W=White
A=Asian

Ethnic Group: H=Hispanic/Latino
N=Non-Hispanic/Latino

Last Name	First Name, M.I.	Relation to you	Are you applying for this person?	Sex M/F	Birth Date	Social Security Number	Race/ Ethnic Group (optional)		U.S. Citizen	Legal Alien
		Self	❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No	❑ Yes ❑ No
			❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No	❑ Yes ❑ No
			❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No	❑ Yes ❑ No
			❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No	❑ Yes ❑ No
			❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No	❑ Yes ❑ No
			❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No	❑ Yes ❑ No
			❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No	❑ Yes ❑ No

1. Has anyone ever received cash, food, medical, or child care assistance in another state? ❑ Yes ❑ No

   What benefits? ______________ Name of state?_______________Month/Year ______________________

2. Has anyone ever been disqualified for cash or food assistance in another state? ❑ Yes ❑ No

   What benefits? _____ Name of state?_____Month/Year _____

3. Is anyone in your household in violation of probation or parole or fleeing prosecution? ❑ Yes ❑ No

4. Has anyone been convicted of a drug felony after August 22, 1996? ❑ Yes ❑ No

5. Have you or any member of your household been convicted of trading food benefits for drugs after September 22, 1996? ❑ Yes ❑ No

6. Have you or any member of your household been convicted of buying or selling food benefits over $500 after September 22, 1996? ❑ Yes ❑ No

7. Have you or any member of your household been convicted of fraudulently receiving duplicate food benefits in any State after September 22, 1996? ❑ Yes ❑ No

8. Have you or any member of your household been convicted of trading food benefits for guns, ammunitions, or explosives after September 22, 1996? ❑ Yes ❑ No

Answer the questions below if a parent(s) of any child under 18 does not live in your home.

Child's Name	Absent Parent's Name	Absent Parent's Date of Birth	Absent Parent's Social Security Number	Absent Parent's Address	Absent Parent's Employer

Tell Us About Your Health Care

Other than Medicaid does anyone in your household have health insurance or Medicare ?

❑ Yes ❑ No

If yes, provide the following information:

Name of Policy Holder	Name of Insurance	Who is Covered	Circle what is Covered	Policy Number
			Doctor | Hospital | Lab Tests | X-rays	
			Doctor | Hospital | Lab Tests | X-rays	
			Doctor | Hospital | Lab Tests | X-rays	

9. Name anyone in your household who is pregnant _____ due date _____

10. Name anyone under 19 who has a disability_____

11. Name anyone who cannot work because of medical reasons _____

12. Name anyone who has had health insurance in the last 6 months _____

    When did the insurance stop? _____ Why did it stop? _____

13. Name anyone who was injured in the last 2 years (car accident, work related injury, medical malpractice, etc.)_____

What Money Do People In Your Household Get?

Please list the person's name and the monthly amount of income. You may attach an additional sheet if needed. (Copies of income needed.)

Where does the money comes from?	Who gets the money?	How much do they get?	How often is she/he paid?
Money from work (before taxes)			
Self-employment/Babysitting/Odd Jobs			
Tips or Commissions			
Social Security			
Supplemental Security Income (SSI)			
VA Benefits, Pensions or Retirement			
Unemployment or Workers Compensation			
Child Support			
Alimony			
Work Study			
Money Earned from Interest or Dividends			
Other			

14. Has anyone in your household quit a job in the last 30 days? ❑ Yes ❑ No

If yes, employer name _____

15. Is anyone in your household a migrant or seasonal worker? ❑ Yes ❑ No

If yes, who _____

16. Is anyone in your household on strike? ❑ Yes ❑ No

If yes, who _____

Which of the Following Do You Have?

Complete this section for Cash Assistance Only

17. Does anyone in your household have any vehicles (don't include your car)?

❑ Yes ❑ No If yes, provide the following information:

Make	Model	Year	Amount Still Owed
			$
			$

18. Does anyone have or own any land, buildings, or houses other than the one you live in? ❑ Yes ❑ No

If yes, who owns it?_____

19. Does anyone receive income from these properties? ❑ Yes ❑ No

If yes, how much? $ _____

20. Does anyone in your household have any of the following?

Type of Account	Yes or No	Name on the account	Account Number	Balance
Bank or Credit Union	❑ Yes ❑ No			$
Stocks or Bonds	❑ Yes ❑ No			$
Savings Certificates	❑ Yes ❑ No			$
IRAs or Keogh	❑ Yes ❑ No			$
Trust Funds	❑ Yes ❑ No			$
Cash On Hand	❑ Yes ❑ No			$
Other	❑ Yes ❑ No			$

What Are Your Medical Expenses?

If you or anyone in your household has medical expenses and are age 60 or older, or blind, and/or receiving Federal disability benefits (SSA, SSI, VA), please list the name of the person and the amount of the medical expenses paid monthly.

Name		**Name**	
Hospitalization	$	Hospitalization	$
Prescription drugs	$	Prescription drugs	$
Doctor	$	Doctor	$
Eye Care	$	Eye Care	$
Dental	$	Dental	$
Insurance Premiums	$	Insurance Premiums	$
Transportation for medical care	$	Transportation for medical care	$
Other	$	Other	$

What Expenses Does Your Household Have?


Please tell us about your bills. (Copies of bills may be needed.)

Shelter

What are your shelter expenses (enter what you are required to pay)?

21. Rent: $_____ per month

    Is this Section 8, HUD or other rental assistance? ❑ Yes ❑ No

    Does your rent include meals (room and board)? ❑ Yes $ _____ ❑ No

    Or are you paying for meals only? ❑ Yes $ _____ ❑ No

22. Mobile Home Lot Rent $_____ per month

23. Mortgage/ Mobile Home $_____ per month

24. Second Mortgage or Home Equity Loan $_____ per month

25. Homeowner's Insurance $_____ per month

26. Property Taxes $_____ per month

27. Special Assessment $_____ per month

28. Condominium/Association Fees $_____ per month

Utilities

Check the boxes that apply and fill in the amount.

❑ Electric $_____
❑ Air Conditioning (central or window unit) $_____
❑ Heat (gas, electric, oil, propane, wood, kerosene) $_____
❑ Gas (cooking) $_____
❑ Water/Sewer $_____
❑ Trash $_____
❑ Telephone $_____
❑ HUD/WHA/DSHA (utility allowance check) $_____
❑ Excess Utilities Only $_____

Other:

29. Dependent Care Expenses? ❑ Yes $ _____ ❑ No

30. Legally-obligated Child Support Payments? ❑ Yes $ _____ ❑ No

Reporting and Verifying Expenses:

Please be sure to enter all of your expenses so that you can qualify for the full amount of food benefits that you need. If you do not put an expense down, we will not be able to count it as we decide the amount of aid to give you.

- Shelter (rent/mortgage/lot) expenses;
- Real estate taxes;
- Water and sewage expenses;
- Phone expenses;
- Dependent care expenses;
- Homeowner's Insurance;
- Utility expenses (gas/electric/oil);
- Garbage expenses;
- Medical expenses;
- Child support expenses paid to children who do not live in your home.

Do You Need Child Care?

Please tell us why you need child care?

❑ Working ❑ High School or GED completion

❑ Education/training (as part of DSS E&T Program)

❑ Health (explain):_____

❑ Other (explain): _____

Child(ren)'s Name(s) Needing Child Care	How many hours needed?	Provider name, address and phone number	Provider ID number	DHSS Provider Or Self-arranged	Date Care Began

Is Anyone in Your Household in School?

Complete this section for Cash Assistance, Food Supplement, and Child Care Only

Complete the table for anyone in your household attending school, including trade school.

Person(s) In School	Name of School	Full/Part Time	Grade	16 or Older Expected Graduation Date

Authorizations

Authorization for Receipt of Pregnancy Prevention Information

If you wish to receive information, you can call Planned Parenthood at 1-800-230-PLAN (7526).

To get teen pregnancy information, call the Alliance for Adolescent Pregnancy Prevention at 1-800-499-WAIT (9248). You can also call the Delaware Helpline at 211 or 1-800-464-4357 for the Public Health Family Planning clinic in your area.

Penalties

For the Food Supplement, Cash and Medical Assistance Programs

Although providing Social Security Numbers is voluntary, you understand that if you fail to give Social Security Numbers you or a member of your household may be denied services. Your Social Security Number will be used to determine initial and ongoing eligibility. Non-lawful aliens are not required to give a Social Security Number.

We will use your Social Security Number to check information in our records with other Federal, State, and Local agency computer matching systems. If you give us false information on purpose, we will take legal action against you.

If you receive benefits that you should not get, you will be responsible to repay those benefits during your period of eligibility and after you are no longer receiving benefits.

An individual will not be able to get food benefits or Cash Assistance if:

- he/she is fleeing to avoid prosecution, custody or confinement after a conviction that is a felony, or
- violating a condition of probation or parole imposed under a Federal or State law.

Penalties in the Food Supplement Program

If you…	You will lose food benefits…
▪ Hide information or make false statements ▪ Use EBT cards that belong to someone else ▪ Use food benefits to buy alcohol or tobacco ▪ Trade or sell benefits or EBT cards	▪ 12 months for the first offense ▪ 24 months for the second offense ▪ Permanently for the third offense
▪ Trade food benefits for controlled substances, such as drugs	▪ 24 months for the first offense ▪ Permanently for the second offense
▪ Trade food benefits for firearms, ammunition or explosives	▪ Permanently
▪ Trade, buy or sell food benefits of $500 or more	▪ Permanently

▪ Give false information about who you are and where you live so you can get extra food benefits	▪ 10 years for each offense

You can also be fined up to $250,000 or put in prison for up to 20 years or both, for doing these things. You may also be charged under Federal laws.

The information you give us will be checked to make sure your household is eligible for food benefits and Cash Assistance. Federal, State, and Local officials will check the information you give us. The information you give us may also be checked by other Federal Aid programs and Federally-Aided State programs, such as School Lunch and Medicaid. If any information given is found to be incorrect, you may be denied food benefits/Cash Assistance. If you give false information on purpose, legal action may be taken against you. You may also have to pay back the amount of benefits you should not have received.

Penalties in the Cash Assistance Program

Do Not give false information, or hide information, to get or continue to get Cash Assistance

If…	You will …
▪ Any member of your household breaks a Temporary Assistance for Needy Families (TANF) rule on purpose	▪ Lose cash assistance for 12 months for the first violation. ▪ Lose cash assistance for 24 months for the second violation. ▪ Lose cash assistance permanently for the third violation.
▪ Any applicant or recipient gives false information in order to obtain benefits	▪ Be subject to penalties that include a fine of up to $500 and imprisonment up to 6 months.
▪ Any member of your household is found guilty of misrepresenting his or her place of residence in order to get multiple benefits in two or more states for the same month from programs funded under TANF	▪ Lose cash assistance for 10 years.
▪ Any member of your household is convicted of a felony for having, using, or selling controlled substances	▪ Lose cash assistance permanently.

TANF Job Quit Penalties

If an individual quits a job without good cause the entire TANF case will close for one month or until the individual meets work and training requirements for four weeks in a row, whichever is later.

TANF Work and Training Penalties

When an individual does not comply with work and training the entire TANF case will close for one month or until the individual meets work and training requirements for four weeks in a row, whichever is later.

Medical Assistance Program

What You Need To Know About the Medical Assistance Program

I understand and agree:

- I will apply for and accept other benefits that I may be eligible to get such as Unemployment Compensation, Social Security, or Medicare.
- By law, as a condition of eligibility, I assign all rights to medical support and to payment for medical care from any third party to DHSS.
- To allow DHSS, directly or through its agents or the Diamond State Health Plan or the Delaware Healthy Children Program, to have access to all medical and school-based health and related services records of every member of my household who is eligible for Medical Assistance. This will allow DHSS to administer the medical assistance program, coordinate care, determine medical necessity, and evaluate or pay for pending or incurred medical services.

I understand and agree:

- I will automatically receive child support services from the Division of Child Support Enforcement (DCSE).
- I must cooperate with DCSE in establishing paternity and obtaining medical support for any child receiving medical assistance.
- DCSE is authorized to deduct directly from my support payments, any and all monies owed to the Division of Social Services.
- I will not be eligible for benefits if I fail to cooperate with DCSE unless a good cause is established. My child(ren) may still be eligible.
- Pregnant women are not required to cooperate in establishing paternity and obtaining medical support.

Some Medicaid programs require you to enroll in a managed care organization.

To enroll in a managed care organization (MCO), call the Health Benefits Manager at 1-800-996-9969.

Disclosure of Information

For All Programs
All information and documentation gathered for determining your Cash Assistance, Food Supplement, Child Care and Medical Assistance eligibility or other program related use is confidential. Each program provides safeguards, restricting the use and disclosure of information about you to purposes directly connected with the administration of the program.

Releasing information concerning your eligibility to anyone not authorized to receive the information is a violation of State and Federal law and may result in legal action.

We will keep your eligibility information confidential, unless you give us permission to release information to others.

Certifications and Signatures

Certification of Citizenship and Alien Status
I certify, under penalty of perjury, that I, and any other members of my household, are U.S. citizens or aliens in lawful immigration status. Non-lawful aliens may be eligible for emergency services and labor and delivery only.

Certification of Head of Household Selection
I have read and have had explained to me the provisions about selecting a head of household. I have selected the following person to be the head of household and I certify that all adult members in my household agree to this selection.

_____
(Head of Household Designee)

Certification of Understanding and Accuracy of Application Answers
I understand the questions on this application and the penalty for hiding or giving false information or breaking any of the rules listed in the penalty warning. I certify, under penalty of perjury, that all my answers are correct and complete including information about the citizenship or alien status of each household member applying for benefits. I understand and agree to provide documents to prove what I have said. I understand and agree that DHSS may contact other persons or organizations to obtain the necessary proof of my eligibility and level of benefits.

I have read, or have had read to me, all statements on this form and the information I give is true and complete to the best of my knowledge. I understand that I could be penalized if I knowingly give false information. I understand that all information I give is confidential and federal and state laws limit disclosure of information about me.

I agree to allow Delaware Health and Social Services, or its representatives, to act as my agent in recovering money spent by its medical assistance programs when other money from insurance, estates, etc. is available to pay my medical bills.

I have a right to request a Fair Hearing if I am not satisfied with any decision made about my eligibility or benefits. An attorney or any other person I choose may represent me.

I have read, or had read to me, and understand the current Rights and Responsibilities. I have received a copy of the Rights and Responsibilities from the DHSS worker.

An adult household member (age 18 or older) or an emancipated minor (under age 18) must sign this application.

Applicant's Signature	**Date**	**Witness**
Authorized Representative's Signature	**Date**	**Witness**
Spouse/Partner's Signature **(Not required for medical assistance)**	**Date**	**Witness**

For Persons Who Cannot Speak English

Translation services were offered or a family member or other person was present to translate.

Translator's Signature	**Date**	**Phone Number & Agency/Relationship**