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	FS SUFFIX	CATEGORY	LANG	NUMBER REUSE INDICATOR

CASE NAME | EFFECTIVE DATE | DISPOSITION ☐ DENIAL ☐☐☐ REASON CODE ☐ WITHDRAWAL | SERVICES TRANSACTION TYPE ☐ 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

I CONSENT TO WITHDRAW MY APPLICATION. I UNDERSTAND THAT I MAY REAPPLY AT ANY TIME.

Signature x_____ Date _____

DATE RECEIVED BY AGENCY

EMPLOYED BY: ☐ SOCIAL SERVICES DISTRICT

PROVIDER AGENCY SPECIFY: _____

TA AUTHORIZATION PERIOD		MA AUTHORIZATION PERIOD		FS AUTHORIZATION PERIOD		SERVICES AUTHORIZATION PERIOD	
FROM	TO	FROM	TO	FROM	TO	FROM	TO

NEW YORK STATE

APPLICATION FOR: TEMPORARY ASSISTANCE (TA) - MEDICAL ASSISTANCE (MA) - MEDICARE SAVINGS PROGRAM (MSP) - FOOD STAMP BENEFITS (FS) - SERVICES (S), including Foster Care (FC) - CHILD CARE ASSISTANCE (CC)

We are committed to assisting and supporting you in a professional and respectful manner with your goal of achieving self-sufficiency. You, in turn, must be committed to becoming self-sufficient and must be responsible for participating in activities to reach self-sufficiency including work activities. Whenever you see "Temporary Assistance" or "TA" on the application, it means "Family Assistance" and "Safety Net Assistance". We call both Public Assistance Programs "Temporary Assistance". These TA Programs are meant to assist you only until you can fully support yourself and your family.

Please refer to the "How to Complete" instruction book (Pub-1301 Statewide) when completing this application.

CHECK EACH PROGRAM YOU OR ANY HOUSEHOLD MEMBER ARE APPLYING FOR

1

☐ Temporary Assistance And Medical Assistance ☐ Temporary Assistance ☐ Medical Assistance

☐ Medicare Savings Program ☐ Food Stamp Benefits ☐ Services, including Foster Care ☐ Child Care Assistance

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

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

2

APPLICANT INFORMATION — PLEASE PRINT CLEARLY

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

3

HOUSE NO.	STREET ADDRESS	APT. NO.	CITY	COUNTY	STATE	ZIP CODE

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

AGENCY HELPING APPLICANT/CONTACT PERSON — PHONE NUMBER ( ) AREA 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 HOME

FORMER ADDRESS	APT. NO.	CITY	COUNTY	STATE	ZIP CODE

If You Are Applying For Food Stamp Benefits (FS), you have the right to turn in (file) this application the same day you get it. It must have at least your Name, Address (if you have one) and Signature below when you turn it in. If you are eligible, you will get FS back to the date you filed. You may be able to get FS quicker if you have little or no income or liquid resources, or if your rent and utility expenses are more than your income and liquid resources. Talk to your worker if you have questions about this.

4

FS APPLICANT/REPRESENTATIVE SIGNATURE — DATE SIGNED

x

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
- ☐ Urgent Personal Or Family Problem 8
- ☐ Fire Or Other Disaster 9
- ☐ Have No Job 10
- ☐ Serious Medical Problem 11
- ☐ Recently Lost Income 12
- ☐ Pending Eviction 13
- ☐ No Food 14
- ☐ Need Foster Care 15
- ☐ Need Child Care 16
- ☐ Other _____ 17

5

LIST EVERYBODY WHO LIVES WITH YOU, EVEN IF THEY ARE NOT APPLYING WITH YOU. LIST YOURSELF ON THE FIRST LINE. *PLEASE PRINT.*

RI	LN	FIRST NAME	(Middle Initial) M.I.	LAST NAME	THIS PERSON IS APPLYING FOR: TA	FS	MA	MSP	CC	FC	S	DATE OF BIRTH Month	Day	Year	SEX M OR F	RELATIONSHIP TO YOU	SOCIAL SECURITY NUMBER OF APPLYING MEMBERS *(See "How to Complete" instruction book Pub-1301 Statewide, **or** talk to your worker)*	HIGHEST SCHOOL GRADE COMPLETED	DOES THIS PERSON (INCLUDING YOUR MINOR CHILDREN) BUY FOOD OR PREPARE MEALS WITH YOU? YES	NO
	01															**SELF**				
	02																			
	03			6																
	04																			
	05																			
	06																			
	07																			
	08																			

PLEASE LIST MAIDEN OR OTHER NAMES BY WHICH YOU OR ANYONE IN YOUR HOUSEHOLD HAS BEEN KNOWN

Line No.	ONC	FIRST NAME	M.I.	LAST NAME
		7		

IS ANYONE SANCTIONED? ☐ YES ☐ NO

IF YES, WHO	REASON	END DATE

DO NOT WRITE IN SHADED AREAS

NON-APPLICANT INFORMATION

LN	FIRST NAME	LAST NAME	LEGALLY RESPONSIBLE YES	NO	FOR WHOM?	CONTRIBUTION/ DEEMED INCOME	CHECK IF MEMBER OF FS HOUSEHOLD

ALIEN INFORMATION

LN	ALIEN STATUS	STATUS ADJUSTED YES	NO	DATE OF ENTRY/STATUS MONTH	DAY	YEAR	APPLIED FOR CITIZENSHIP YES	NO	SPONSORED YES	NO

INDIVIDUAL EDUCATION

LN	DEGREE RECEIVED	LN	DEGREE RECEIVED
01		05	
02		06	
03		07	
04		08	

RACE/ETHNIC AFFILIATION CODES

H Hispanic or Latino(a)
I Native American or Alaskan Native
A Asian
B Black or African American
P Native Hawaiian **or** Pacific Islander
W White

LN	ENTER Y (YES) OR N (NO) IF HISPANIC OR LATINO	ENTER Y (YES) OR N (NO) FOR EACH RACE AFFILIATION					CLIENT IDENTIFICATION NUMBER	ENTER APPROPRIATE CODES								
	H	I	A	B	P	W		REL	SSN	SFUI	MS	SI	LA	EM	CI	EL
01																
02																
03																
04																
05																
06																
07																
08																

ANTICIPATED FUTURE ACTION			CASE TYPE	RELATED CASE NUMBERS
LINE NO.	CODE	DATE		

SERVICE ELIGIBILITY PROCESS CODE			
SFUI	CODE	SFUI	CODE
SFUI	CODE	SFUI	CODE

NEEDED	REFERRALS	COMPLETED
	CAP	
	Services	
	SSA	
	Legal	

CONSIDER

- ✓ Relationship
- ✓ Filing Unit
- ✓ Legally Responsible Relative
- ✓ Single Economic Unit
- ✓ FS Household Composition
- ✓ FS Aged/Disabled Individual
- ✓ Photo ID/AFIS
- ✓ CBIC/PIN
- ✓ RFI/OCA
- ✓ Health Insurance

REQUESTED	DOCUMENTATION	IN FILE
	Photo I.D.	
	Birth Verification	
	Marriage License	
	Social Security Card	
	Code 9 Resolution	
	Alien Status	
	Multi-Suffix/Co-op Case Notice (Single Economic Unit Questionnaire)	

CITIZENSHIP/ALIEN STATUS INFORMATION

Please read the entire page carefully before completing. If you have questions see the "How to Complete" instruction book or talk to your worker.

SECTION 8

LIST EVERYONE WHO IS APPLYING OR WHO IS REQUIRED TO APPLY.

IF YOU HAVE QUESTIONS, SEE THE "HOW TO COMPLETE" INSTRUCTION BOOK (PUB-1301 Statewide) OR TALK TO YOUR WORKER.

You **do not** have to fill out Section 8 or 9 if you are applying for MA **only** and:

- You are pregnant, or
- You are applying **only** for coverage for the treatment of an **emergency** medical condition.

You **do** have to fill out Sections 8 and 9 if you are:

- Applying for MA **only,** but you do not have to include people who do not want MA.
- Applying for Child Care Assistance **only**, but you need to fill out the information only for the children who would be receiving Child Care Assistance.
- Applying for Foster Care **only**, but you need to fill out the information only for children who would be receiving Foster Care.
- Applying for other Services under certain circumstances.

SECTION 9 - CERTIFICATION

Some social services programs require that you certify that you are a U.S. citizen or national, or an alien with satisfactory immigration status. Other programs do not. If you are an alien and do not know if you have satisfactory immigration status, see the "How To Complete" instruction book or talk to your worker.

You MUST sign the Certification below only if you are a U.S. citizen or national, or an alien with satisfactory immigration status, **and** you are applying for:

- Temporary Assistance (where there are children in the household or a member of the household is pregnant), or
- Food Stamp Benefits, or
- Medical Assistance (except if the applicant is pregnant), or
- Medicare Savings Program, or
- Child Care Assistance (certification is needed for the children **only**), or
- Foster Care (certification is needed for the children **only)**, or
- Other services under certain circumstances.

An adult household member or authorized representative may sign for all household members. Example: A *parent* without satisfactory status may sign for his/her *child* who has satisfactory status.

An application for FS must list all persons living in the FS household. An application for TA must list all children for whom you are applying, their brothers and sisters and all parents of those children who live together. If you do not check whether a listed person is a U. S. citizen or national, or an alien, or provide an alien number for an alien, that person will not be given assistance, and the remaining members of the household will receive reduced benefits.

SIGN* AND DATE THE BOX BELOW FOR EACH APPLICANT.

IN THE CASE OF AN APPLYING ALIEN, CHECK (✓) THE PROGRAM(S) FOR WHICH EACH APPLYING ALIEN HAS SATISFACTORY IMMIGRATION STATUS. (SEE "HOW TO COMPLETE" INSTRUCTION BOOK, PUB-1301 STATEWIDE.)

LN	FIRST NAME	MI	LAST NAME	Check **either "CITIZEN/ NATIONAL" or "ALIEN" for** each person.		*Alien Number (If Applicable)*	**CERTIFICATION**	Date	TA	FS	MA	MSP	CC	FC	S
01				☐ CITIZEN/ NATIONAL	☐ ALIEN	A	Sign Name X								
02				☐ CITIZEN/ NATIONAL	☐ ALIEN	A	Sign Name X								
03				☐ CITIZEN/ NATIONAL	☐ ALIEN	A	Sign Name X								
04				☐ CITIZEN/ NATIONAL	☐ ALIEN	A	Sign Name X								
05				☐ CITIZEN/ NATIONAL	☐ ALIEN	A	Sign Name X								
06				☐ CITIZEN/ NATIONAL	☐ ALIEN	A	Sign Name X								
07				☐ CITIZEN/ NATIONAL	☐ ALIEN	A	Sign Name X								
08				☐ CITIZEN/ NATIONAL	☐ ALIEN	A	Sign Name X								

8

9

By checking a box above and by signing the certification in Section 9, I hereby certify, under penalty of perjury, that I, and/or the persons for whom I am signing, am a United States citizen or national, or an alien with a satisfactory immigration status.

I understand that signing this Certification may result in information about applying members of my household being submitted to the Immigration and Naturalization Service (INS) for verification of immigration status, if applicable.
The use or disclosure of the information above is restricted to persons and organizations directly connected with the verification of immigration status and the administration or enforcement of the provisions of the Temporary Assistance (TA), Food Stamp Benefits (FS), Medical Assistance (MA), Medicare Savings Program (MSP), Child Care Assistance (CC), Foster Care (FC) and Services (S) Programs.

*** A person who wishes to sign the Certification but cannot write may make an "X" on the line in front of a witness. The witness must sign below.**

I witnessed the marks made in lines: _____,_____,_____,_____,_____,_____ Signature of witness: _____ Date Signed: _____

NON-CUSTODIAL PARENT/CHILD SUPPORT/MEDICAL SUPPORT INFORMATION

DO NOT WRITE IN SHADED AREAS

If you are applying for Temporary Assistance, you must help us obtain child support/medical support for you and your children. If you are applying for Medical Assistance **only**, you may have to help us obtain medical support for yourself and your applying children. If you are applying for Child Care Assistance and/or Foster Care, you may have to help us obtain child support for the children for whom you are applying. If you have questions, see the "How to Complete" instruction book (PUB-1301 Statewide). List the names of everyone under 21 whose parent is not in the household, and write down any information you currently have about that person's non-custodial parent. If **you** are under 21, write down the information about **your** non-custodial parent who is not in the household.

NAME OF PERSON UNDER 21	NON-CUSTODIAL PARENT'S NAME AND ADDRESS	NON-CUSTODIAL PARENT'S DATE OF BIRTH MONTH	DAY	YEAR	SOCIAL SECURITY NUMBER
A.					
B.					
C.	10				
D.					
E.					

Do you or does anyone who lives with you get money from child support payments? ☐ Yes ☐ No

If yes, list below:

WHO	AMOUNT RECEIVED	HOW OFTEN	FROM WHOM
	$		
	$		
	$		
	$		

Circle whichever arrangement applies:

Is there JOINT/SHARED/SPLIT custody? ☐ Yes ☐ No

If Yes, how was it determined? ☐ court order ☐ agreement of the parties

ABSENT/DECEASED SPOUSE INFORMATION - If the husband or wife of anyone applying lives someplace else or is deceased, please indicate below.

FIRST NAME	M.I.	LAST NAME	DATE OF BIRTH	DATE OF DEATH	SOCIAL SECURITY NUMBER
		11			

ADDRESS	CITY	COUNTY	STATE	ZIP CODE

ABSENT CHILD INFORMATION - If anyone applying has a child under 18 living someplace else, please indicate below.

NAME OF PERSON APPLYING	NAME OF ABSENT CHILD	DATE OF BIRTH	ADDRESS *(Street, City, County, State and Zip Code)*	PATERNITY ESTABLISHED? Yes	No	DO YOU PAY CHILD SUPPORT? Yes	No
		12					

REQUESTED	DOCUMENTATION	IN FILE
	Paternity Acknowledgement	
	Child Support Order	
	Good Cause Form (LDSS-4279)	
	IV-D Attestation (LDSS-4281)	
	LRR Letter/Questionnaire	
	Other Support	
	Death Certificate	
	Divorce Decree	
	VA Benefits	
	Order of Filiation/Paternity	

NEEDED	REFERRALS	COMPLETED
	CTHP	
	CAP	
	CSS Application (LDSS-2521)	
	IV-D (LDSS-2860)	
	Paternity	

CONSIDER

- ✓ Health Insurance of Non-Custodial Parent/Absent Spouse
- ✓ Child Health Plus
- ✓ TASA
- ✓ Petition to Family Court
- ✓ SSI/SSA

TEEN PARENT INFORMATION

Is there a teen parent under age 18 in the household? ☐ Yes ☐ No 13

Who _____

Does the teen parent's child live in the household? ☐ Yes ☐ No

Name of teen parent's child _____

TEEN PARENT:

LN NO. _____ Marital Status _____

High School Diploma? _____

LN NO. _____ Marital Status _____

High School Diploma? _____

TEEN PARENT CHILDREN

LN NO. _____ LN NO. _____

INCOME INFORMATION:

DO NOT WRITE IN SHADED AREAS

Indicate if you or anyone who lives with you receives money from:		YES	NO	WHO	AMOUNT/VALUE	WHO	AMOUNT/VALUE	CD
Wages, Salary, Including Overtime, Commissions, Training Programs, Tips	1							01
Self-Employment	2							20
Unemployment Insurance Benefits	3							49
Supplemental Security Income (SSI) Benefits	4							45
Social Security Disability Benefits	5							42
Social Security Dependent Benefits	6							
Social Security Survivor's Benefits	7							43
Social Security Retirement Benefits	8							44
Railroad Retirement Benefits	9							38
Retirement Benefits (Pensions)	10							39
Dividends/Interest from Stocks, Bonds, Savings, etc.	11							03
Workers' Compensation	12							59
NYS Disability Benefits	13							33
Veteran's Pensions/Benefits/Aid and Attendance	14							55
Public Assistance Grant	15							37
GI Dependency Allotments	16							10
Education Grants **or** Loans	17							
Contributions/Gifts (Received)	18							
Foster Care Payments (Received)	19							
Child Support Payments (Received)	20							02
Alimony/Support (Received)	21							
Private Disability Insurance-Health/Accident Insurance Policy Income	22							
No Fault Insurance Benefits	23							50
Union Benefits (Including Strike Benefits)	24							
Loans (Received)	25							
Income from a Trust (Including income you are currently entitled to receive, or were entitled to receive in the past, that has not been distributed.)	26							
Training Allotments	27							31
Rental Income (Received)	28							14
Boarders/Lodgers Income (Received)	29							
OTHER INCOME *(Please Specify)*								

14

INCOME				
LN No.	SOURCE CODE	AMOUNT		PERIOD

CONSIDER

- ✓ Child Support Pass-Through
  - ☐ Explained ☐ Budgeted
- ✓ FS Aged/Disabled Indicator
- ✓ Disability Review
- ✓ Refugee Matched Grants

STEP-PARENT/ALIEN SPONSOR INFORMATION

Answer all Questions listed below

	YES	NO	WHO?
Does the step-parent of any children who live with you have any resources or receive any income of any kind?			
Is anyone in your household an alien who was sponsored for admission into the U.S.?			

15

NAME OF SPONSOR: TELEPHONE NO.:

ADDRESS:

NEEDED	REFERRAL	COMPLETED
	UIB	

EMPLOYMENT INFORMATION

I am currently: ☐ employed ☐ self-employed ☐ unemployed

Gross Income $ _____ Current hours worked Monthly _____

Paid: ☐ Weekly ☐ Bi-Weekly ☐ Monthly Day of the week paid _____

Employer's Name and Address: 1

_____ Phone No. _____

_____

Is anyone else who lives with you currently: ☐ employed ☐ self-employed

Who: _____

Gross Income $ _____ Current hours worked Monthly _____

Paid: ☐ Weekly ☐ Bi-Weekly ☐ Monthly Day of the week paid _____ 2

Employer's Name and Address:

16

_____ Phone No. _____

_____

Does anyone have health insurance with their employer? ☐ Yes ☐ No

Who: _____ 3

Name of Insurance Company: _____

Does anyone have child or dependent care **expenses** due to **employment**? ☐ Yes ☐ No

Who: _____ 4

Does anyone have other employment-related expenses? ☐ Yes ☐ No

Who: _____ 5

If not employed, when was the last time you or anyone who lives with you worked?

Who: _____ When: _____

Where: _____ 6

Why did you (or they) stop working? _____

_____

Are you or is anyone who lives with you participating in a strike? ☐ Yes ☐ No

Who: _____ When: _____ 7

Are you or is anyone who lives with you a migrant or seasonal farm worker? ☐ Yes ☐ No

Who: _____ 8

What type of work would you like to do? (specify) _____

_____ 9

_____

Could you accept a job today? ☐ Yes ☐ No 10

If not, why? _____

DO NOT WRITE IN THE SHADED AREAS

REQUESTED	DOCUMENTATION	IN FILE
	CINTRAK/RFI/IRCS	
	1099	
	Employment Verification	
	Income Tax Return	
	Self-Employment Worksheet	
	Wage Stubs	
	Work Registration Form	
	Dependent/Child Care Form/Statement	
	Approval of Informal Child Care Provider	

NEEDED	REFERRALS	COMPLETED
	CAP	
	Disability	
	Employment	
	TPHI/COBRA	
	UIB	
	Worker's Compensation	
	Drug/Alcohol	
	Domestic Violence	

CONSIDER
✓ Earned Income Tax Credit (Flyer)
✓ Explaining Periodic Reporting Requirements
✓ Net Loss of Cash Income
✓ P.A.S.S. Income Amount and Sources
✓ Employment Sanctions
✓ Temporary Employment
✓ Disability Review
✓ Individual Development Account (IDA)
✓ Voluntary Quit

CHILD/DEPENDENT CARE EXPENSES

Who Pays	Amount	Name(s)	Age(s)	Care Provider
	$			
	$			
	$			
	$			
	$			
	$			
	$			
	$			

EDUCATION/TRAINING

INDICATE IF YOU OR ANYONE WHO LIVES WITH YOU WHO IS APPLYING FOR OR GETTING ASSISTANCE:

Has a High School diploma or G.E.D.? ☐ Yes ☐ No

Who _____ 1

Dates attended _____

Dates completed _____

Is or has been in any training program? ☐ Yes ☐ No

Who _____

Where _____ 2

Program _____

Dates attended _____

Dates completed _____

Is 16 years of age or older and is attending school or college? ☐ Yes ☐ No

Who _____ 3

Where _____

For your children under 16, list their names and what schools they attend:

Who _____

School _____

Who _____

School _____

Who _____

School _____ 4

Who _____

School _____

Who _____

School _____

Who _____

School _____

DO NOT WRITE IN SHADED AREAS

REQUESTED	DOCUMENTATION	IN FILE
	School Attendance Verification (LDSS- 3708)	
	Educational Grant Worksheet	
	Child Care Statement	

NEEDED	REFERRALS	COMPLETED
	Supportive Services	

FS STUDENT ELIGIBILITY CRITERIA	YES	NO
Does anyone 18 through 49 who is attending college half-time or more meet the FS student eligibility requirement?	☐	☐
Does anyone pay for child or dependent care to attend school or training?	☐	☐
Is there a 16-19 year old parent who does not have a high school diploma or G.E.D., and who is not attending school?	☐	☐
Is anyone in training?	☐	☐
Are any other supportive services appropriate?	☐	☐
Are there any training related expenses?	☐	☐

RESOURCES INFORMATION

INDICATE IF YOU OR ANYONE WHO LIVES WITH YOU WHO IS APPLYING:		YES	NO	WHO	IF YES, GIVE AMOUNT/VALUE	WHO	IF YES, GIVE AMOUNT/VALUE
Has cash on hand	1				$		$
Has a checking account(s)	2						
Has a savings account(s) or certificate of deposit(s)	3						
Has a credit union account(s)	4						
Has life insurance	5						
Has title or registration to a motor vehicle(s) or other vehicle(s) (Specify) Year _____ Make/Model _____ Year _____ Make/Model _____	6						
Has stocks, bonds, certificates or mutual funds	7						
Has savings bonds	8						
Has an IRA, Keogh, 401-(k) or deferred compensation account(s)	9						
Has an irrevocable burial trust	10						
Has a burial fund	11						
Has a burial space	12						
Has own home	13						
Has real estate including income-producing and non-income-producing property	14						
Is eligible for an income tax refund	15						
Has an annuity	16						
Is named the beneficiary of a trust	17						
Expects to receive a trust fund, lawsuit settlement, inheritance or income from any other sources	18						
Has an "in trust" account(s)	19						
Has a safe deposit box	20						
Has resources other than those listed above	21						
Has anyone (including your spouse, even if not applying or living with you) given away any cash, or sold/transferred any real estate, income or personal property in the past 36 months?	22						
Has anyone (including your spouse, even if not applying or living with you) ever created a trust in the past or transferred any assets into a trust within the past 60 months? If yes, when? _____	23						

18

VEHICLE INFORMATION

YR.	MAKE	MODEL	OWNER'S NAME	AMOUNT OWED	NADA VALUE	EXEMPT YES*	EXEMPT NO	LIEN HOLDER	ACCOUNT NO.
				$					
				$					

***IF EXEMPT, WHY?**

DO NOT WRITE IN SHADED AREAS

NEEDED	REFERRAL	COMPETED
	Legal	
	Resource	

LIFE INSURANCE

FACE AMOUNT	CASH VALUE

REQUESTED	DOCUMENTATION	IN FILE
	Resource Checklist	
	Market Value	
	DMV Clearance	
	Bank Statement	
	Assignment of Proceeds	
	Car/Vehicle Title	
	Car/Vehicle Registration	
	Bank Clearance	
	RFI/OCA	
	1099	

CONSIDER

- ✓ "In Trust" Accounts
- ✓ Children's Resources
- ✓ Lump Sum
- ✓ Boats, Campers, Snowmobiles
- ✓ Income Tax Refund
- ✓ Individual Development Account (IDA)
- ✓ Exempt Vehicles

MEDICAL INFORMATION

INDICATE IF **YOU OR ANYONE WHO LIVES WITH YOU** WHO IS APPLYING:	YES	NO	IF YES, WHO
Has any medical bills or medically-related expenses 1			
Has health or hospital/accident insurance (including insurance from employer) 2			
Has Medicare (red, white, and blue card) 3			
Has a health attendant 4			
Is blind, sick or disabled 5			
Is a handicapped child 6			
Is in a hospital, nursing home or other medical institution 7			
Has paid or unpaid medical bills within 3 months preceding the month of this application 8			
Is or was drug or alcohol dependent 9			
Needs home care 10			
Is on SSI or has ever applied for SSI 11			
Is pregnant 12			

IF PREGNANT PLEASE GIVE DUE DATE: _____ 13

INDICATE IF **YOU OR ANYONE WHO LIVES WITH YOU** WHO IS APPLYING:	YES	NO	IF YES, WHO
Receives treatment from a drug abuse or alcohol treatment program 14			
Has not been able to work for at least 12 months because of a disability or illness 15			
Has daily activity limited because of a disability or illness that has lasted or will last at least 12 months 16			
Has been in a car accident or work-related accident in the past two years 17			
Has any government agency (public program) besides Medical Assistance or Medicare paid any of your medical bills? 18			

RETROACTIVE MEDICAID	WHO	DATE

RECURRING MEDICAL EXPENSES	WHO	AMOUNT $	AMOUNT $

MEDICAL BILLS: ☐ YES ☐ NO **TPHI:** ☐ YES ☐ NO

DO NOT WRITE IN SHADED AREAS

POLICY NO.:

INSURANCE COMPANY NAME:

19

REQUESTED	DOCUMENTATION	IN FILE
	Pregnancy Statement	
	Med/Psych Statement	
	Drug/Alcohol Screening (LDSS-4571)	
	Drug/Alcohol Statement	
	Paid or Unpaid Medical Bills	
	SSI Application Verification **TA ONLY**	

CONSIDER

- ✓ AD/SSI Related
- ✓ FS Aged/Disabled Indicator
- ✓ FS Medical Deduction
- ✓ TPHI Reimbursement
- ✓ Buy-In Eligibility
- ✓ Kreiger (LDSS-3664)
- ✓ Domestic Violence
- ✓ SSI Referral
- ✓ Earned Income Credit

NEEDED	REFERRALS	COMPLETED
	SSI (D-CAP)	
	Disability Interview (LDSS-1151)	
	Medical Report (LDSS-486, 486t)	
	Disability Report	
	AD	
	TPHI	
	VESID	
	CTHP	
	PCAP	
	Family Planning	
	TASA	
	SSA (RSDI)	
	Veteran's Benefits	
	Veteran's Counseling	
	Child Health Plus	
	COBRA Eligibility	
	Nurse's Aide Service	
	Home Care	

SHELTER

WHAT IS YOUR LANDLORD'S NAME?

_____

WHAT IS YOUR LANDLORD'S ADDRESS?

_____

_____

_____

WHAT IS YOUR LANDLORD'S PHONE NUMBER?

( )_____

	YES	NO	IF YES, GIVE AMOUNT
Do **you (or anyone who lives with you)** have a rent, mortgage or other shelter expense?			$
Do **you (or anyone who lives with you)** have a heat bill separate from your rent or shelter expense?			
Do **you (or anyone who lives with you)** have the following expenses separate from your rent or shelter expense?	**YES**	**NO**	**IF YES, GIVE AMOUNT**
• Electricity 1			$
• Gas 2			
• Other utilities (water, etc.) 3			
• Standard telephone, cell phone, pay phone, pre-paid phone card 4			
• Air conditioning 5			
• Utility/telephone installation fees 6			
Does any person, group or organization outside the household pay any of the household expenses? 7			
Do you live in public housing? 8			
Do you live in Section 8 or other subsidized housing? 9			
Do you live in a drug/alcohol rehab. facility? 10			
Do you live in a domestic violence shelter? 11			

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DO NOT WRITE IN SHADED AREAS

SHELTER COSTS	MONTHLY ACTUAL COST
A. Room and Board	
B. Rent	
C. Trailer Lot Rent	
D. Mortgage Payment	
1. Principal	
2. Interest	
3. Property Tax (Including School Tax)	
4. Homeowner's Insurance on Structure (Incl. Fire Insurance)	
5. Taxes Included in Mortgage (Escrow Payment)	
6. Assessments (Sewer, etc.)	
D. Total Mortgage Payment (Line 1-6)	
E. Utility/Phone Installation Fees	
TOTAL *(Lines A - E)*	

REQUESTED	DOCUMENTATION	IN FILE
	Landlord Statement	
	Rent Receipt	
	Tenant of Record	
	Customer of Record	
	Voluntary Restrict	
	Mandatory Restrict	
	Subsidized Housing	
	Mortgage/Title Search	
	Section 8 Lease or Statement from Section 8 Office	
	Property Lien	
	Shelter/Utility Repayment Agreement	

CONSIDER

- ✓ Utility and/or Fuel Restrict
- ✓ Utility Guarantee
- ✓ HEAP
- ✓ Subsidized Housing May Show Total Rent, NOT Client Amount
- ✓ Foster Care Related Additional Allowances
- ✓ FS Household Comp. Rules
- ✓ FS Aged/Disabled Indicator
- ✓ Real Property Tax Credit
- ✓ Life Line
- ✓ AIDS/HIV Emergency Shelter Allowance
- ✓ Property Lien
- ✓ If Shelter Expenses/Living Quarters Are Shared By More than One Household

MONTHLY EXPENSES	MONTHLY ACTUAL COST	NAME OF DEALER	IN WHOSE NAME IS THE BILL? (CUSTOMER OF RECORD)	WHO IS THE TENANT OF RECORD?
A. Heat*				
B. Electricity (for cooking, lights, hot water)				
C. Gas (for cooking, hot water)				
D. Liquid Propane Gas				
E. Other Utilities (Water, etc.)				
F. Telephone				
G. Air Conditioning				
H. Utility Installation Fees				
I. Sewer				
J. Garbage				
K. Trash				
L. Other Expenses				

***Check Primary Heat Type:**

☐ Natural Gas ☐ Oil ☐ PSC Electric ☐ Coal ☐ Other _____

☐ Kerosene ☐ Propane ☐ Municipal Electric ☐ Wood

ADDITIONAL INFORMATION

OTHER EXPENSES

INDICATE IF **YOU OR ANYONE WHO LIVES WITH YOU** WHO IS APPLYING:	YES	NO	IF YES, GIVE AMOUNT
Pays child support 1			$
Pays alimony 2			$
Pays child care 3			$
Pays dependent care 4			$
Pays tuition and fees 5			$
Has additional expenses Specify _____ 6			$

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Do you or anyone who lives with you who is applying owe at least four months' court-ordered support for a child under age 18? 7 ☐ YES ☐ NO

OTHER INFORMATION

Do you buy or plan to buy meals from a home delivery or communal dining service? 8 ☐ YES ☐ NO

Are you able to prepare meals at home? 9 ☐ YES ☐ NO

Have you or anyone in your household ever been in the U.S. military? Who? _____ 10 ☐ YES ☐ NO

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Has your spouse ever been in the U.S. military? 11 ☐ YES ☐ NO

Is anyone in your household a dependent of someone who is or was in the U.S. military? Who? _____ 12 ☐ YES ☐ NO

Do you or does anyone who lives with you receive assistance or services **now?** ☐ YES ☐ NO

IF YES, WHO 13	TYPE OF ASSISTANCE	LOCATION RECEIVED	DATES RECEIVED

Have you or anyone who lives with you received assistance or services **in the past?** ☐ YES ☐ NO

IF YES, WHO 14	TYPE OF ASSISTANCE	LOCATION RECEIVED	DATES RECEIVED

NEEDED	REFERRALS	COMPLETED	CONSIDER
	Services		✓ FS Dependent Care Deductions
	UIB		

DO NOT WRITE IN SHADED AREAS

HOW OFTEN PAID	LEGALLY OBLIGATED		CHILD IN FS HH	
	Yes	No	Yes	No

VETERAN STATUS	VETERAN CODE

OTHER INFORMATION (cont.)

	YES	NO	WHO
Have you or anyone who lives with you who is applying moved into **this** county from another **New York State** county within the past two months?			
Have you or anyone who lives with you ever been found guilty of and/or been disqualified for Temporary Assistance and/or Food Stamp Benefits because of fraud/intentional program violation?			
Have you or anyone who lives with you received benefits for which they were not entitled, which have not been fully repaid to this or another agency?			
Have you or any member of your household been convicted of making a fraudulent statement or representation of residence in order to receive Temporary Assistance in two or more states?			
Are you or any member of your household fleeing prosecution, confinement or conviction for a felony?			
Are you or any member of your household violating probation or parole?			

PROPERTY TRANSFER STATUS

I have ☐ **I have not** ☐ sold, transferred or given away any of my property to anyone to get Temporary Assistance or Food Stamp Benefits.

REQUESTED	DOCUMENTATION	IN FILE
	School Attendance Verification (LDSS-3708)	
	Educational Grant Worksheet	
	Child/Dependent Care Statement	
	Recoupments	
	Outstanding Overpayment	
	Pending Disqualification	

IF TOTAL EXPENSES (INCLUDING EXPENSES NOT USED IN THE BUDGET DETERMINATION) EXCEED INCOME (INCLUDING TA GRANT), EXPLORE HOW THE HOUSEHOLD IS MEETING ITS OBLIGATIONS.

Actual Expenses $

- Actual Income $

= Difference $

Does Client Receive Contribution Towards Difference YES ☐ NO ☐

If Yes, From Whom?

_____

CONSIDER

- ✓ Actual Expenses
- ✓ Actual Shelter
- ✓ Actual Fuel/Utility Costs
- ✓ Telephone Expenses
- ✓ Car Expenses
- ✓ Furniture/Appliance Rental
- ✓ Cable TV
- ✓ Private School Tuition
- ✓ Out-of-Pocket Medical Expenses

NOTES/COMMENTS

READ THE IMPORTANT INFORMATION BELOW.

NOTICES

PRIVACY ACT STATEMENT -- COLLECTION AND USE OF SOCIAL SECURITY NUMBERS (SSNs) - The collection of SSNs is authorized for each household member with respect to Food Stamp Benefits pursuant to the Food Stamp Act of 1977 (as amended, 7 US Code 2011-2036).

With respect to all other programs for which this application form requires a SSN, the collection of SSNs is also mandatory and is authorized under one or more of the following sections of law: 205(c) of the Social Security Act (42 U.S. Code 405) , Section 1137 of the Social Security Act (42 U.S. Code 1320b-7) and Section 7(a)(2) of the Privacy Act of 1974. See the "How To Complete" instruction book Sections 6 and 23 or talk to your worker.

The information we collect will be used to determine whether your household is eligible or continues to be eligible for assistance or benefits. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management.

This information may be disclosed to other State and Federal agencies for official examination and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law.

The information will be used to check identity, to verify earned and unearned income, to determine if absent parents can receive health insurance coverage for applicants or recipients, to determine if applicants or recipients can obtain child or spousal support and to determine if applicants or recipients can receive money or other help.

Information collected with respect to applicants for and recipients of Family Assistance and Safety Net Assistance, including SSNs, may be used to assist in the formation of jury pools.

If a FS claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action. Providing the requested information, including the SSN of each household member, is voluntary for Food Stamp Benefits. However, anyone applying who fails to give a SSN will be denied FS. SSNs of ineligible members will also be used and disclosed in the manner above.

REIMBURSEMENT OF MEDICAL EXPENSES - You have a right as part of your Medical Assistance application, or later, to request reimbursement of expenses you paid for covered medical care, services and supplies received during the three month period prior to the month of your application. After the date of your application, reimbursement of covered medical care, services and supplies will only be available if obtained from Medicaid-enrolled providers.

SUPPORT - Applying for or receiving Family Assistance (FA), Safety Net Assistance (SNA) or foster care services operates as an assignment to the State and the social services district of any rights to support from any other person that the applicant or recipient may have in his or her own right or on behalf of any other family member for whom the applicant or recipient is applying or receiving assistance (Social Services Law, 158 and 348). Other sections of this application contain additional assignments.

NON-DISCRIMINATION NOTICE – In accordance with Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs.

To file a complaint of discrimination, contact USDA or HHS. Write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). USDA and HHS are equal opportunity providers and employers.

FOOD STAMPS AUTHORIZED REPRESENTATIVE - You can authorize someone who knows your household circumstances to **apply** for FS for you. If you do, have them **sign** in the Signature section at the bottom of page 16. You can also authorize someone outside your household to get FS for you or to use them to buy food for you. If you would like to authorize someone, print the person's name, address and phone number directly below.

NAME, ADDRESS AND PHONE NUMBER OF AUTHORIZED REPRESENTATIVE *(PLEASE PRINT)*

PENALTIES – Your application may be investigated. By signing this agreement you are consenting to cooperate in such an investigation. Federal and State laws provide for penalties of fine, imprisonment or both if you do not tell the truth when you apply for Temporary Assistance, Medical Assistance, Food Stamp Benefits, Services or Child Care Assistance (Assistance, Benefits or Services) or at any time when you are questioned about your eligibility, or cause someone else not to tell the truth regarding your application or your continuing eligibility. Penalties also apply if you conceal or fail to disclose facts regarding your initial and continuing eligibility for Assistance, Benefits or Services, or if you conceal or fail to disclose facts that would affect the right of someone for whom you have applied to obtain or continue to receive Assistance, Benefits or Services; and such Assistance, Benefits or Services must be used for the other person and not for yourself. Federal and State laws provide that any transfer of assets for less than fair market value made by an individual or an individual's spouse, within 36 months (or 60 months in the case of trust-related transfers) prior to the first of the month in which the individual is both in receipt of nursing facility services and has submitted an application for Medical Assistance, **may** render the individual ineligible for nursing facility services or home and community based waivered services for a period of time. It is unlawful to obtain Assistance, Benefits or Services by concealing information or providing false information.

READ THE IMPORTANT INFORMATION BELOW.

NOTICES (cont.)

FOOD STAMP BENEFITS (FS) PENALTY WARNING

Any information you provide in connection with your application for Food Stamp Benefits will be subject to verification by Federal, State and local officials. If any information is incorrect, you may be denied FS. You may be subject to criminal prosecution for knowingly providing incorrect information.

You will **never** be able to get FS again if you are:

- Found guilty in a court of law for the second time of buying or selling controlled substances (illegal drugs or certain drugs for which a doctor's prescription is required) in exchange for FS; **or**
- Found guilty in a court of law of selling or getting firearms, ammunition or explosives in exchange for FS; **or**
- Found guilty in a court of law of trafficking in FS worth $500 or more. Trafficking includes the illegal use, transfer, acquisition, alteration or possession of FS, authorization cards or access devices; **or**
- Found guilty of committing a third Intentional Program Violation (IPV).

You will not be able to get FS for two years if you are found guilty in a court of law for the first time of buying or selling controlled substances (illegal drugs or certain drugs for which a doctor's prescription is required) in exchange for FS.

If you have committed your:

- First IPV, you will not be able to get FS for one year.
- Second IPV, you will not be able to get FS for two years.

A court could also bar you from receiving Food Stamp Benefits for an additional 18 months.

If you make a false statement about who you are or where you live in order to get multiple FS, you will not be able to get FS for ten years (or **permanently** if this is the third IPV).

You may be found guilty of an Intentional Program Violation if you:

- Make a false or misleading statement, or misrepresent, conceal or withhold facts; **or**
- Commit any act that constitutes a violation of Federal or State law for the purpose of using, presenting, transferring, acquiring, receiving, possessing or trafficking of coupons, authorization cards or reusable documents used as part of the Electronic Benefit Transfer (EBT) system.

You could also be fined up to $250,000, sent to jail for up to 20 years, or both.

ASSIGNMENTS, AUTHORIZATIONS & CONSENTS

ASSIGNMENT OF INSURANCE AND OTHER BENEFITS - For Temporary Assistance and Medical Assistance, I agree to file any claims for health or accident insurance benefits and to pursue any personal injury claims or any other resources to which I may be entitled, and do hereby assign any such resources to the social services official to whom this application is made. In addition, I will assist in making any assigned benefits available to the social services official to whom this application is made.

TEMPORARY ASSISTANCE (TA) RECOVERIES - TA you receive for yourself and for persons for whom you are legally responsible to support is recoverable from property or money you possess or may acquire. You may be required, as a condition of receiving TA, to execute a deed or mortgage of real property you own. Your tax refunds and portions of lottery winnings may be taken to repay your debt for TA.

MEDICAL ASSISTANCE (MA) RECOVERIES - Upon receipt of MA, a lien may be filed and a recovery may be made against your real property under certain circumstances if you are in a medical institution and not expected to return home. MA paid on your behalf may be recovered from persons who had legal responsibility for your support at the time medical services were obtained.

REQUIREMENT TO REPORT/VERIFY HOUSEHOLD EXPENSES – Your household must report child care and utility expenses in order to get a FS deduction for these expenses. Your household must report and verify rent/mortgage payments, property taxes, insurance, medical expenses and child support paid to a non-household member in order to get a FS deduction for these expenses.

Failure to report/verify the above expenses will be seen as a statement by your household that you do not want to receive a deduction for those unreported/unverified expenses. A deduction for these expenses may make you eligible for FS or may increase your FS benefits. You may report/verify these expenses at any time in the future. This deduction would then be applied to the calculation of FS benefits in future months in accordance with the rules for change reporting.

DIRECT PAYMENT - I authorize payments owed to me or members of my household for health or accident insurance benefits to be made directly to the appropriate social services official for medical and other health services furnished while we are eligible for Medical Assistance.

MEDICARE - I authorize payments under "Medicare" (Part B of Title XVIII, Supplementary Medical Insurance Program) to be made directly to physicians and medical suppliers on any future unpaid bills for medical and other health services furnished to me while I am eligible for Medical Assistance.

CHANGES - I agree to inform the agency **promptly** of any change in my needs, income, property, living arrangements or address to the best of my knowledge or belief.

If I am applying for child care assistance, I agree to inform the agency promptly of any change in child care arrangements, including where care is provided, who is providing child care, provider fees, and hours for which child care is needed.

CONSENT FOR INVESTIGATION - I agree to any investigation to verify or confirm the information I have given in connection with my request for TA, MA, FS, Services or Child Care Assistance. If additional information is requested, I will provide it. I will also cooperate fully with State and Federal personnel in a Temporary Assistance and/or Food Stamp Quality Control Review.

TURN TO THE BACK PAGE (PAGE 16) AND READ AND SIGN AT THE BOTTOM OF PAGE 16 ➡

READ THE IMPORTANT INFORMATION BELOW AND SIGN AT THE BOTTOM.

ASSIGNMENTS, AUTHORIZATIONS & CONSENTS (cont.)

STANDARD UTILITY ALLOWANCE (SUA) - I understand that Temporary Assistance (TA) and Food Stamp Benefits (FS) recipients are categorically income eligible for the Home Energy Assistance Programs (HEAP). If I am not included in the annual automatic HEAP payment process for certain TA and FS recipients, I intend to apply for a HEAP benefit within the next 12 months. If I decide not to apply for HEAP within the next 12 months, I will let my worker know.

ASSIGNMENT OF SUPPORT RIGHTS – I assign to the State and social services district any rights I have to support from persons having legal responsibility for my support and any rights I have to support on behalf of any family member.

RELEASE OF EDUCATIONAL RECORDS - I give permission to the State and local department of social services to:

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- Obtain any information regarding the educational records of myself and/or my minor child(ren), herein named, including information necessary for claiming MA reimbursement for health-related educational services.
- Provide the appropriate federal government agency access to this information for the sole purpose of audit.

RELEASE OF INFORMATION FOR THE EARLY INTERVENTION PROGRAM – If my child is evaluated for or participates in the New York State Early Intervention Program, I give permission to the local Department of Social Services and New York State to share my child's Medical Assistance eligibility information with my county or municipal Early Intervention Program for the purpose of billing Medical Assistance.

RELEASE OF MEDICAL INFORMATION – I consent to the release of any medical information about me and any members of my family for whom I can give consent: by my Primary Care Provider, any other health care provider or the New York State Department of Health (SDOH) to my health plan and any health care providers involved in caring for me or my family, as reasonably necessary for my health plan or my providers to carry out treatment, payment, or health care operations; by my health plan and any health care providers to SDOH and other authorized federal, state, and local agencies for purposes of administration of the Medicaid, Child Health Plus and Family Health Plus programs; and, by my health plan to other persons or organizations, as reasonably necessary for my health plan to carry out treatment, payment, or health care operations. I also agree that the information released may include HIV, mental health or alcohol and substance abuse information about me and members of my family, to the extent permitted by law. If more than one adult in the family is joining a Family Health Plus or Medicaid health plan, the signature of each adult applying is necessary for consent to release information.

AUTHORIZATION FOR REIMBURSEMENT OF PUBLIC ASSISTANCE BENEFITS FROM SSI RETROACTIVE PAYMENT - I authorize the Commissioner of the Social Security Administration (SSA) to send to the local social services district the amount due to me at the time of my first payment of (1) retroactive Supplemental Security Income (SSI) benefits that I may receive upon an application for SSI or (2) retroactive SSI benefits I may receive if I am terminated or suspended from receiving SSI benefits and am later reinstated.

I understand that the local social services district may take from my SSI payment the amount of Public Assistance (except assistance paid wholly or partly with federal funds) that was paid to me during the period beginning with my first day of eligibility for SSI or the first day to which SSI benefits were reinstated after a period of suspension or termination and ending with the month that SSI payments actually began (or the following month if the local social services district cannot stop delivery of my last public assistance payment during the month that SSI payments began).

After taking this money from my SSI check(s), the local social services district will pay me the balance, if there is any, no later than 10 working days from the date it receives my SSI payment. I also understand that if the district takes more money than I believe was paid to me as Public Assistance, I will be given an opportunity for a hearing.

I understand that:

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- the SSA may treat the date that I submit this signed authorization to the local social services district as the date I first become eligible for SSI if I submit an application for initial SSI benefits within the next 60 days.
- this authorization will apply to any SSI application or appeal which is presently pending before the SSA with respect to me and to any SSI application I make or appeal I request with respect to the period ending one year after I sign this agreement.

This authorization will terminate one (1) year after it is received by the local social services district and will not have any effect upon future SSI applications, appeals or reviews if my case is completely decided, if the SSA makes an initial payment of SSI either on my application or after a period of suspension or termination or if the State and I mutually agree to terminate the authorization.

I have read and understand the notices above. I understand and agree to the assignments, authorizations and consents above. I swear and/or affirm under the penalties of perjury that the information I have given or will give to the local social services district is correct.

APPLICANT/REPRESENTATIVE SIGNATURE	DATE SIGNED	HUSBAND/WIFE OR PROTECTIVE REPRESENTATIVE SIGNATURE	DATE SIGNED
X	28	X	

NYS Agency-Based Voter Registration Form

ESTE FORMULARIO ESTÁ DISPONIBLE EN ESPAÑOL

本表格有中文文本

"If you are not registered to vote where you live now, would you like to apply to register here today?"

☐ **YES** **(If you check yes, please complete VOTER REGISTRATION APPLICATION at bottom of page)**

☐ NO because I choose not to register **OR**

☐ I am already registered at my current address **OR**

☐ I asked for and received a mail registration form.

If you do not check any box, you will be considered to have decided not to register to vote at this time.

_____ ___/___/___
(Signature) (Date)

_____
(Please Print Name)

Qualifications for Registration

You Can Use This Form To:

- **register to vote in New York State**
- **change your name and/or address, if there is a change since you last voted**
- **enroll in a political party or change your enrollment**

To Register You Must:

- **be a U.S. citizen**
- **be 18 years old by December 31 of the year in which you file this form (note: you must be 18 years old by the date of the general, primary, or other election in which you want to vote.)**
- **be a resident of the County, or of the City of New York at least 30 days before an election.**
- **not be in jail or on parole for a felony conviction**
- **not claim the right to vote elsewhere**

IMPORTANT!

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

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 application form in private.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with *New York State Board of Elections, 40 Steuben Street, Albany, New York 12207-2109.*
Tele: 1-800-469-6872, TTY 1-800-533-8683; or visit our web site - www.elections.state.ny.us

Your decision to register will remain confidential and will be used only for voter registration purposes. Anyone not choosing to register to vote and/or information regarding the office to which the application was submitted will remain confidential, to be used only for voter registration purposes.

Vote New York

VOTER REGISTRATION FORM

VOTER REGISTRATION APPLICATION

NVRA-05 (4/01)

☐ Yes, I need an application for an Absentee Ballot **Please print or type in blue or black ink** ☐ Yes, I would like to be an Election Day Worker

1 Are you a U.S. citizen? ☐ Yes ☐ No
If you answered NO, do not complete this form.

2 Check boxes that apply:
☐ new registration and enrollment ☐ address change
☐ party enrollment change ☐ name change

For Board Use Only

3 Last Name | First Name | Middle Initial | Suffix

4 Address Where You Live (do not give P.O. address) | Apt. No. | City/Town/Village | Zip Code | County

5 Address Where You Get Your Mail (if different from above) | P.O. box, star rte., etc. | Post Office | Zip Code

6 Date of Birth

7 Sex (circle) M F

8 Home Tel. Number (optional)

9 The last year you voted | Your Address was (give house number, street, and city) | In county/state | Under the name (if different from your name now)

10 **Choose a Party** — Check one box only
☐ REPUBLICAN PARTY
☐ DEMOCRATIC PARTY
☐ INDEPENDENCE PARTY
☐ CONSERVATIVE PARTY
☐ LIBERAL PARTY
☐ RIGHT TO LIFE PARTY
☐ GREEN PARTY
☐ WORKING FAMILIES PARTY
☐ I DO NOT WISH TO ENROLL IN A PARTY

Please note: In order to vote in a **primary election,** you must be enrolled in a party.

11 **AFFIDAVIT**: I swear or affirm that
- I am a citizen of the United States.
- I will have lived in the county, city, or village for at least 30 days before the election.
- This is my signature or mark on the line below.
- The above information is true. I understand that if it is not true I can be convicted and fined up to $5,000 and/or jailed for up to four years.

⬇ Signature or mark ⬇

X _____ Date

Please do not write in this space