LDSS-3174 **Statewide** (Rev. 10/18)

DO NOT WRITE IN THE SHADED AREAS OF THIS RECERTIFICATION FORM

CENTER/ OFFICE	INTERVIEW DATE	UNIT ID	WORKER ID	CASE TYPE	CASE NUMBER	DISTRICT	CATEGORY	LANG	NUMBER REUSE INDICATOR

CASE NAME	EFFECTIVE DATE	DISPOSITION
		☐ RECERTIFICATION ☐ CLOSE ☐☐☐ REASON CODE

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	
FROM	TO	FROM	TO	FROM	TO

NEW YORK STATE RECERTIFICATION FORM FOR CERTAIN BENEFITS AND SERVICES

If you are blind or seriously visually impaired and need this recertification form 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 a recertification form in an alternative format, see the instruction book (PUB-1313 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 recertification form, 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-1313 Statewide) and "What You Should Know" Books 1, 2 and 3 (LDSS-4148A, LDSS-4148B, and LDSS-4148C) when completing this recertification form, and contact your social services district with any questions.

When you see "MA" on the recertification form, it means "Medicaid." You may apply for MA using this recertification form only if you are also recertifying for Public Assistance or the Supplemental Nutrition Assistance Program at the same time. If you wish to only recertify for MA, you can go online at https://nystateofhealth.ny.gov/ and/or call 1-855-355-5777 for more information or to recertify, 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 recertify 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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LDSS-3174 Statewide (Rev. 10/18)

SECTION 1 CHECK EACH PROGRAM YOU OR ANY HOUSEHOLD MEMBER ARE RECERTIFYING FOR

☐ Public Assistance (PA) ☐ Supplemental Nutrition Assistance Program (SNAP) ☐ Medicaid (MA) and SNAP ☐ Medicaid (MA) and PA

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 RECIPIENT 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 RECERTIFICATION FORM AND THE POTENTIAL RECEIPT OF ANY MEDICAID COVERAGE TO BE KEPT CONFIDENTIAL? ☐ YES ☐ NO

LIST THE THINGS THAT HAVE CHANGED SINCE YOUR APPLICATION OR LAST RECERTIFICATION (such as moved, had a baby, income, etc.) _____

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 Reapplying For SNAP: You can file a recertification form the day you get it. In order to file a SNAP recertification, it must have, at minimum, your name, address (if you have one) and signature below. You must complete the recertification process, including signing the last page of the recertification and being interviewed. If eligible, you will get SNAP benefits back to the date you filed the recertification. You must be told, within 30 days of the date you turned in (filed) your recertification for SNAP benefits, if your recertification 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 recertifying for both Supplemental Security Income (SSI) and SNAP benefits prior to leaving the institution, the filing date of the recertification is the date you leave the institution.

SNAP RECIPIENT/REPRESENTATIVE SIGNATURE	DATE SIGNED
X	

SECTION 6 – HOUSEHOLD INFORMATION – List everybody who lives with you, even if they are not recertifying with you. List yourself on the first line.

DOES THIS PERSON (INCLUDING MINOR CHILDREN) BUY FOOD OR PREPARE MEALS WITH YOU?

HIGHEST SCHOOL GRADE COMPLETED

RI	LN	FIRST NAME	M.I. (Middle Initial)	LAST NAME	THIS PERSON IS RECERTIFYING FOR: PA	SNAP	MA	DATE OF BIRTH Month	Day	Year	SEX M OR F	RELATIONSHIP TO YOU	SOCIAL SECURITY NUMBER OF RECERTIFYING HOUSEHOLD MEMBERS *(See instruction book, PUB-1313 Statewide, or talk to your social services district)*		YES	NO
	01											**SELF**				
	02															
	03															
	04															
	05															
	06															
	07															
	08															

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

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

SECTION 7

HAS ANYONE MOVED **INTO** THE HOUSEHOLD IN THE PAST YEAR? ☐ YES ☐ NO
IF YES, INCIDATE BELOW.

NAME	DID THEY EVER LIVE IN NEW YORK STATE BEFORE NOW?
	☐ YES ☐ NO
	☐ YES ☐ NO

HAS ANYONE MOVED **OUT** OF THE HOUSEHOLD IN THE LAST YEAR?
☐ YES ☐ NO IF YES, INCIDATE BELOW.

NAME	WHEN?

IS ANYONE SANCTIONED? ☐ YES ☐ NO

IF YES, WHO

REASON

END DATE

NON-APPLICANT INFORMATION

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

NON-CITIZEN WITH SATISFACTORY IMMIGRATION STATUS INFORMATION

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

INDIVIDUAL EDUCATION

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

CONSIDER

✓ RCA/RMA REFERRAL

DO NOT WRITE IN THE SHADED AREAS OF THIS RECERTIFICATION FORM

SECTION 8 – RACE/ETHNICITY – Providing this information is voluntary. It will not affect the eligibility of the persons recertifying or the level of benefits received. The reason for requesting this information is to ensure that program benefits are distributed without regard to race, color, or national origin.

H HISPANIC OR LATINO
I NATIVE AMERICAN OR ALASKAN NATIVE
A ASIAN
B BLACK OR AFRICAN AMERICAN
P NATIVE HAWAIIAN OR PACIFIC ISLANDER
W WHITE
U UNKNOWN **(MA ONLY)**

LN	↓ ENTER Y (YES) OR N (NO) FOR HISPANIC OR LATINO	ENTER Y (YES) OR N (NO) FOR EACH RACE					
	H	**I**	**A**	**B**	**P**	**W**	**U**
01							
02							
03							
04							
05							
06							
07							
08							

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

NEEDED	**REFERRALS**	**COMPLETED**
	Legal	
	Services	
	SSA	
	NYSoH	
	Chronic Care/SSI-Related	
	MA-Only	
	Medicare Savings Program	

CONSIDER

- ✓ Relationship
- ✓ Filing Unit
- ✓ Legally Responsible Relative
- ✓ Single Economic Unit
- ✓ SNAP Household Composition
- ✓ SNAP Aged/Disabled Individual
- ✓ Photo ID
- ✓ AFIS (PA Only)
- ✓ CBIC/PIN
- ✓ RFI/OCA
- ✓ Health Insurance
- ✓ Child Support Pass-Through

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

Please read this entire page carefully before completing it. If you have questions, see the instruction book (PUB-1313 Statewide) or talk to your social services district.

SECTION 9 – CITIZENSHIP/NON-CITIZEN WITH SATISFACTORY IMMIGRATION STATUS

LIST EVERYONE WHO IS RECERTIFYING OR WHO IS REQUIRED TO RECERTIFY.

SECTION 10 – CERTIFICATION

Some social services programs require that you certify that you are a United States citizen, Native American or national of the U.S., or a non-citizen with satisfactory immigration status. Other programs do not.

You MUST sign the Certification below only if you are a United States citizen, Native American or national of the United States, or a non-citizen with satisfactory immigration status, and you are recertifying for:

- Public Assistance (where there are children in the household or a member of the household is pregnant), or
- The Supplemental Nutrition Assistance Program, or
- Medicaid (except if the applicant is pregnant)

An adult household member or authorized representative may sign for all household members. Example: A parent without a satisfactory non-citizen status may sign for his/her child with a satisfactory non-citizen status.

NEEDED	REFERRALS	COMPLETED
	Systematic Alien Verification for Entitlements (SAVE)	

A recertification for SNAP must list all persons living in the SNAP household. A recertification for PA must list all children for whom you are recertifying, their brothers and sisters, and all parents of those children who live together. If you do not check whether a listed person is a United States citizen, national of the U.S. or an non-citizen with a satisfactory immigration status, or provide an U.S. Citizenship and Immigration Services (USCIS) number (Alien Registration Number) or a non-citizen number (if applicable), that person will not be given assistance and the remaining members of the household will receive reduced benefits. If you are a Native American, check citizen/national.

SIGN* AND DATE THE BOX BELOW FOR EACH APPLICANT.

In the case of a recertifying non-citizen with a satisfactory immigration status, check the program(s) for which each recertifying non-citizen has satisfactory immigration status. (See the instruction book, Pub-1313 Statewide.)

LN	FIRST NAME	MI	LAST NAME	Check either "CITIZEN / NATIONAL" or "NON-CITIZEN" for each person.		USCIS NUMBER (ALIEN REGISTRATION NUMBER) OR NON-CITIZEN NUMBER (If Applicable)	CERTIFICATION	DATE	PA	SNAP	MA
01				☐ CITIZEN/ NATIONAL	☐ NON-CITIZEN	A	Sign Name X				
02				☐ CITIZEN/ NATIONAL	☐ NON-CITIZEN	A	Sign Name X				
03				☐ CITIZEN/ NATIONAL	☐ NON-CITIZEN	A	Sign Name X				
04				☐ CITIZEN/ NATIONAL	☐ NON-CITIZEN	A	Sign Name X				
05				☐ CITIZEN/ NATIONAL	☐ NON-CITIZEN	A	Sign Name X				
06				☐ CITIZEN/ NATIONAL	☐ NON-CITIZEN	A	Sign Name X				
07				☐ CITIZEN/ NATIONAL	☐ NON-CITIZEN	A	Sign Name X				
08				☐ CITIZEN/ NATIONAL	☐ NON-CITIZEN	A	Sign Name X				

By checking a box above and by signing the certification form in Section 10, I hereby certify, under penalty of perjury, that I, and/or the person(s) for whom I am signing, am a United States citizen, Native American or national of the United States, or a non-citizen with satisfactory immigration status.
I understand that signing the above Certification may result in information about recertifying members of my household being submitted to the United States Citizenship and Immigration Services for verification of non-citizen status, if applicable.
The use or disclosure of the information above is restricted to persons and organizations directly connected with the verification of citizenship status, and the administration or enforcement of the provisions of the Public Assistance, Supplemental Nutrition Assistance, and Medicaid.

*A person who wishes to sign the Recertification Form 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: _____

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SECTION 11 – INFORMATION REGARDING REFERRAL TO THE CHILD SUPPORT ENFORCEMENT UNIT

If you are recertifying for Medicaid in addition to Public Assistance or the Supplemental Nutrition Assistance Program, you may have to help us obtain medical support for yourself and your recertifying children. Answer the following questions to determine if you need to complete this section. Include yourself, as appropriate:

1. Are you recertifying for an individual under the age of 21 who was born out of wedlock and for whom paternity (legal fatherhood) has not been established? ☐ Yes ☐ No
2. Are you recertifying for an individual under the age of 21 who has an absent father or mother (noncustodial parent)? ☐ Yes ☐ No

You do not need to complete this section if you answered "No" to both of these questions. Go to the next section.

You must complete this section if you answered "Yes" to either or both of these questions. Provide the names of all individuals under the age of 21 for whom you are recertifying and any information you currently have about those individuals' noncustodial parents or putative (alleged) fathers.

3. Are you under the age of 21? ☐ Yes ☐ No

If you answered "Yes" to this question, provide the information for your noncustodial parent(s) or putative father(s).

As a condition of obtaining assistance, you are required to assign certain rights related to support, as described in the Notices, Assignments, Authorizations, and Consents section at the end of this recertification. You will be provided with the LDSS-4882 form, "Information About Child Support Services and Application/Referral for Child Support Services," to complete and return to the Child Support Enforcement Unit. Except in situations of domestic violence or other good cause, as a condition of obtaining assistance you are required to cooperate with the Child Support Enforcement Unit to locate any noncustodial parent or putative father; establish paternity for each individual under the age of 21 born out of wedlock; and establish, modify, and/or enforce orders of support. You also will be provided with the LDSS-4279 form, "Notice of Responsibilities and Rights for Support," which explains your responsibilities and your rights if you do not cooperate with the Child Support Enforcement Unit.

REQUESTED	DOCUMENTATION	IN FILE
	Acknowledgement of Paternity	
	Child Support Order	
	Good Cause Form (LDSS-4279)	
	IV-D Attestation (LDSS-4281)	
	Death Certificate	
	Divorce Decree	
	VA Benefits	
	Order of Filiation/Paternity	
	Birth Certificate	
NEEDED	**REFERRALS**	**COMPLETED**
	CTHP	
	CAP	
	Application/Referral for Child Support Services (LDSS-4882)	
	Paternity	

CONSIDER

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

NAME OF INDIVIDUAL UNDER AGE 21	NONCUSTODIAL PARENT OR PUTATIVE FATHER'S NAME AND ADDRESS	NONCUSTODIAL PARENT OR PUTATIVE FATHER'S DATE OF BIRTH			NONCUSTODIAL PARENT OR PUTATIVE FATHER'S SOCIAL SECURITY NUMBER
		MONTH	DAY	YEAR	
A.					
B.					
C.					
D.					
E.					

SECTION 12 – TAX FILING/DEPENDENT STATUS - Please select the tax status for each individual living in the household.

			TAX STATUS						
FIRST NAME	MIDDLE INITIAL	LAST NAME	SINGLE	MARRIED FILING JOINTLY	MARRIED FILING SINGLE	HEAD OF HOUSEHOLD (WITH QUALIFYING INDIVIDUAL)	QUALFIYING WIDOW(ER) WITH DEPENDENT CHILD	DEPENDENT AND WILL BE FILING TAXES	WILL NOT BE FILING TAXES

Tax dependents not living in the household. Please list any tax dependents who do not live with you and are claimed by you or anyone in your household. If you do not file taxes, you can skip this question.

NAME OF TAX DEPENDENT			NAME OF TAX FILER		
FIRST NAME	MIDDLE INITIAL	LAST NAME	FIRST NAME	MIDDLE INITIAL	LAST NAME

SECTION 13 – ABSENT/DECEASED SPOUSE INFORMATION – If the spouse of anyone recertifying lives someplace else or is deceased, please indicate below.

NAME OF PERSON RECERTIFYING	NAME OF SPOUSE	DATE OF SPOUSE'S BIRTH	DATE OF SPOUSE'S DEATH, IF APPLICABLE	SPOUSE'S SOCIAL SECURITY NUMBER

SPOUSE'S ADDRESS, IF APPLICABLE	CITY	COUNTY	STATE	ZIP CODE

SECTION 14 – ABSENT CHILD INFORMATION – If anyone recertifying has a child under the age of 21 living someplace else, please indicate below.

NAME OF PERSON RECERTIFYING	NAME OF ABSENT CHILD	DATE OF BIRTH	ADDRESS OF CHILD (STREET, CITY, COUNTY, STATE, AND ZIP CODE)	PATERNITY ESTABLISHED?		DO YOU PAY CHILD SUPPORT?	
				Yes	No	Yes	No

SECTION 15 – TEEN PARENT INFORMATION

Is there a parent under the age of 18 ("teen parent") in the household? ☐ Yes ☐ No

Name _____

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/High School Equivalent? _____

LN NO. _____ Marital Status _____

High School Diploma/High School Equivalent? _____

TEEN PARENT CHILDREN

LN NO. _____

LN NO. _____

DO NOT WRITE IN THE SHADED AREAS OF THIS RECERTIFICATION FORM

SECTION 16 – INCOME INFORMATION:

Indicate if you or anyone who lives with you receives money from:	YES	NO	WHO	AMOUNT/VALUE & FREQUENCY	WHO	AMOUNT/VALUE & FREQUENCY
Unemployment Insurance Benefits 1						
Supplemental Security Income (SSI) Benefits (State and Federal Total) 2						
Social Security Disability (SSD) Benefits 3						
Social Security Dependent Benefits 4						
Social Security Survivor's Benefits 5						
Social Security Retirement Benefits 6						
Railroad Retirement Benefits 7						
Retirement Benefits (Pensions) 8						
Dividends/Interest from Stocks, Bonds, Savings, etc. 9						
Workers' Compensation 10						
NYS Disability Benefits 11						
Veteran's Pension/Benefits/Aid and Attendance 12						
Public Assistance Grant 13						
GI Dependency Allotments 14						
Education Grants or Loans 15						
Contributions/Gifts (Received) 16						
Foster Care Payments (Received) 17						
Child Support Payments (Received) Received From:_____ 18						
Spousal Support (Received) 19						
Private Disability Insurance - Health/Accident Insurance Policy Income 20						
No-Fault Insurance Benefits 21						
Union Benefits (including Strike Benefits) 22						
Loans, Other than Education (Received) 23						
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) 24						
Training Allotments/Stipends 25						
Rental Income (Received) 26						
Boarders/Lodgers Income (Received) 27						
Other Income (Please Specify)						

INCOME

LN No.	SOURCE CODE	AMOUNT	PERIOD

CONSIDER

- ✓ Child Support Disregard/Pass-Through
  - ☐ Explained ☐ Budgeted
- ✓ SNAP Aged/Disabled Indicator
- ✓ Disability Review
- ✓ Reception and Placement Grant (SNAP Only)
- ✓ Refugee Matching Grant
- ✓ Change in Income from Last Budget

Deductions: Certain types of Medicaid budgeting allow applicants/recipients to reduce their countable income with deductions that they take on their federal taxes. These are specific expenses that the Internal Revenue Service (IRS) allows people to deduct to reduce their taxable income. Only record deductions here if you will claim them on the current year's tax return.	YES	NO	WHO	AMOUNT/VALUE & FREQUENCY	WHO	AMOUNT/VALUE & FREQUENCY
Educator expenses 1						
Individual Retirement Account (IRA) deduction 2						
Student loan interest deduction 3						
Tuition and fees 4						
Certain business expenses (reservists, artists, fee-based government officials) 5						
Health savings account deduction 6						
Job-related moving expenses 7						
Deductible part of self-employment (S/E) tax 8						
S/E, SIMPLE & qualified plans 9						
S/E health insurance deduction 10						
Penalty on early withdrawal of savings 11						
Alimony paid 12						
Domestic production activities deduction 13						
Additional adjustments added on line 36 (IRS Form 1040 only) 14						
Archer MSA deduction 15						
Other Adjustment (Please Specify)						

SECTION 17 – STEP-PARENT/NON-CITIZEN WITH SATISFACTORY IMMIGRATION STATUS 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 income of any kind?			
Is anyone in your household a non-citizen with satisfactory immigration status who was sponsored for admission into the U.S.?			

NAME OF SPONSOR: PHONE NO.:

ADDRESS:

NEEDED	REFERRAL	COMPLETED
	UIB	

DO NOT WRITE IN THE SHADED AREAS OF THIS RECERTIFICATION FORM

SECTION 18 – EMPLOYMENT INFORMATION

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

Gross Income $ _____ Hours Worked Monthly _____

(Include wages, salary, overtime pay, commissions, and tips)

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 $ _____ Hours Worked Monthly _____

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

Employer's Name and Address:

_____ Phone No. _____

_____

Is health insurance available through your employer? ☐ Yes ☐ No

Does anyone who lives with you have health insurance with an employer? ☐ Yes ☐ No

Who: _____ 3

Name of Insurance Company: _____

Do you or anyone who lives with you have a child or dependent care expenses due to employment? ☐ Yes ☐ No

Who: _____ 4

Do you or anyone who lives with you have other employment-related expenses? ☐ Yes ☐ No

Who: _____ 5

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	
	Workers' Compensation	
	Drug/Alcohol	
	Domestic Violence	
	Refugee Cash Assistance	

CONSIDER
✓ Limited English Proficiency
✓ Earned Income Tax Credit (see PUB-4786)
✓ 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

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? _____

Did you or anyone living with you file for unemployment? ☐ Yes ☐ No

If yes, who? _____ When?: _____

Status of filing: ☐ Approved ☐ Denied ☐ Pending

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

Who: _____ 7

When the strike began: _____

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

Who: _____ 8

Do you or any other adult who lives with you have any medical conditions that limit the ability to work or the type of work that can be performed? ☐ Yes ☐ No

Who: _____

Describe Limitations: _____

_____ 9

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

If not, why? _____

What type of work would you like to do? _____

_____ 11

CHILD/DEPENDENT CARE EXPENSES

Who Pays	Amount	Name	Age	Care Provider
	$			
	$			
	$			
	$			
	$			
	$			
	$			
	$			

DO NOT WRITE IN THE SHADED AREAS OF THIS RECERTIFICATION FORM

SECTION 19 – EDUCATION/TRAINING

What is your highest level of education completed?

__ Less than high school diploma
If so, last grade completed? _____
__ Completion of an Individualized Education Plan (IEP)
__ High school diploma or General Equivalency Diploma (GED) or Test Assessing Secondary Completion (TASC™)
__ Associate's Degree (2-year college degree)
__ Bachelor's Degree (4-year college degree) or higher

1

Does anyone else in the household have a high school diploma, General Equivalency Diploma (GED) or Test Assessing Secondary Completion (TASC™), or higher level of education? ☐ Yes ☐ No

If yes, who: _____

Degree attained:_____

Date completed: _____

2

Indicate if you or anyone who lives with you who is recertifying for or getting assistance:

Is or has been in any training program in the last 12 months? ☐ Yes ☐ No

Who _____

Where _____

Program _____

Dates attended _____

Dates completed _____

3

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

Who _____

Where _____

4

Is getting a Training Allowance? ☐ Yes ☐ No

Who _____ Amt. $ _____

5

Is getting Educational Grants or Loans? ☐ Yes ☐ No

Who _____ Amt. $ _____

6

Is under 16 years of age and is attending school? ☐ Yes ☐ No

Who _____

School _____

Who _____

School _____

7

Who _____

School _____

Who _____

School _____

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

NEEDED	REFERRALS	COMPLETED
	Supportive Services	

CONSIDER	YES	NO
Does anyone 18 through 49 who is attending college half-time or more meet the SNAP 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 or equivalency diploma and who is not attending school?	☐	☐
Is anyone in training?	☐	☐
Are any other supportive services appropriate?	☐	☐
Are there any training related expenses?	☐	☐

SECTION 20 – RESOURCES INFORMATION

Indicate if you or anyone who lives with you who is recertifying:	YES	NO	WHO	IF YES, AMOUNT/VALUE	WHO	IF YES, AMOUNT/VALUE
Has cash available 1				$		$
Has a checking account(s) 2						
Has a savings account(s) or certificate(s) of deposit 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): Year _____ Make/Model _____ Year _____ Make/Model _____ Other_____ 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 his/her 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 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(es) 20						
Has resources other than those listed above 21						
Has anyone (including your spouse, even if not recertifying 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 recertifying or living with you) ever created a trust in the past or transferred any assets to a trust within the past 60 months? If yes, when? _____ 23						

VEHICLE INFORMATION

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

*IF EXEMPT, WHY?

NEEDED	REFERRAL	COMPLETED
	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 (Older Models)	
	Bank Clearance	
	RFI/OCA	
	1099	

CONSIDER

- ✓ Children's Resources
- ✓ Lump Sum
- ✓ Boats, Campers, Snowmobiles
- ✓ Individual Development Account (IDA)
- ✓ Exempt Vehicles
- ✓ EIC
- ✓ Change in Resources from Last Budget

DO NOT WRITE IN THE SHADED AREAS OF THIS RECERTIFICATION FORM

SECTION 21 – MEDICAL INFORMATION

Indicate if you or anyone who lives with you who is recertifying:	YES	NO	IF YES, WHO
Has any medical bills or medically-related expenses 1			
Is on Medicaid with a spend-down 2			
Has health or hospital/accident insurance (including insurance from employer) 3			
Has health insurance available through an employer 4			
Has Medicare (red, white, and blue card) 5			
Has a health attendant/home health aide 6			
Is blind, sick or disabled 7			
Is a child with a developmental disability 8			
Is in a hospital, nursing home or other medical institution 9			
Has paid or unpaid medical bills within 3 months preceding the month of this recertification 10			
Is or was drug or alcohol dependent 11			
Needs home care/personal care 12			
Is on SSI or has ever applied for SSI 13			
Is pregnant If pregnant, due date: _____ Expected number of births: _____ 14			
Receives treatment from a drug abuse or alcohol treatment program 15			
Has not been able to work for at least 12 months because of a disability or illness 16			
Has daily activity limited because of a disability or illness that has lasted or will last at least 12 months 17			
Has been in a car accident or work-related accident in the past two years 18			
Has had a government agency (public program) besides Medicaid or Medicare pay any of your medical bills If yes, what agency _____ 19			
Will billing any other health insurance cause harm to your physical or emotional health or safety, and/or will it interfere with the privacy and confidentiality of your application for or receipt of Medicaid? 20			

POLICY NO.:

AMOUNT:

FREQUENCY OF PAYMENT:

INSURANCE COMPANY NAME:

WHO IS COVERED:

EFFECTIVE DATE:

Is the answer to question 7 in this section consistent with Section 18 asking if the applicant or any other adult who lives in the household have any medical conditions that limit their ability to work or the type of work that they can perform?

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 (**PA ONLY**)	

CONSIDER

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

NEEDED	REFERRALS	COMPLETED
	SSI (D-CAP)	
	Disability Interview (LDSS-1151)	
	Medical Report (LDSS-486, 486t)	
	Disability Report	
	AD	
	TPHI	
	ACCES-VR	
	CTHP	
	Family Planning	
	SSA (RSDI)	
	Veteran's Benefits	
	Veteran's Counseling	
	Child Health Plus	
	COBRA Eligibility	
	Nurse's Aide Service	
	Home Care	
	NYSoH	
	MA-Only (DOH-4220)	
	SSI-Related/Chronic Care (DOH-4220 with Supplement A)	
	LDSS-4526 or local equivalent	

RETROACTIVE MEDICAID	WHO	DATE	RECURRING MEDICAL EXPENSES	WHO	AMOUNT $	

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

HEALTH PLAN SELECTION

Most people enrolled in Medicaid are required to join a managed care health plan unless they are in an exempt category. Use this section to choose a health plan. If you do not know what health plans are available, ask your worker or call 1-800-505-5678.

Name of Plan You Are Enrolling In	Last Name	First Name	Date Of Birth mm/dd/yy	Sex M/F	ID# (from Medicaid Card if you have one)	Social Security # (optional if pregnant)	Primary Care Provider (PCP) or Health Center (check box if current provider)	Name and ID# of OB/GYN (check box if current provider)
							☐	☐
							☐	☐
							☐	☐
							☐	☐

SECTION 22 – SHELTER

WHAT IS YOUR LANDLORD'S NAME?

_____

WHAT IS YOUR LANDLORD'S ADDRESS?

_____

_____

_____

WHAT IS YOUR LANDLORD'S PHONE NUMBER?

( ) _____

	YES	NO	IF YES, 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 other shelter expense?			$

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 (incl. Fire Insurance)	
5.	Taxes Included in Mortgage (Escrow Payment)	
6.	Assessments (Sewer, etc.)	
E. Total Mortgage Payment (Line 1-6)		
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
- ✓ SNAP Household Composition Rules
- ✓ SNAP Aged/Disabled Indicator
- ✓ Real Property Tax Credit
- ✓ AIDS/HIV Emergency Shelter Allowance
- ✓ Property Lien
- ✓ If Shelter Expenses/Living Quarters Are Shared by More than One Household

DO NOT WRITE IN THE SHADED AREAS OF THIS RECERTIFICATION FORM

SECTION 22 – SHELTER (CONT.)

Do you or anyone who lives with you have the following expenses separate from your rent or other shelter expense?	YES	NO	IF YES, AMOUNT
Electricity (for needs other than heat; example: lights, cooking, hot water, etc.) 1			$
Natural Gas (for needs other than heat; example: cooking, hot water, etc.) 2			$
Water 3			$
Air Conditioning 4			$
Propane (for needs other than heat) 5			$
Sewer 6			$
Trash 7			$
Other Utilities and Expenses 8 Specify _____			$
Do you live in public housing? 9			
Do you live in Section 8, HUD, or other subsidized housing? 10			
Do you live in a drug/alcohol treatment facility? 11			

MONTHLY EXPENSES	MONTHLY ACTUAL COST	NAME OF DEALER	ACCOUNT NUMBER	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 or Expenses					
F. Air Conditioning					
G. Utility Installation Fees					
H. Sewer					
I. Trash					
J. Water					

***Check Primary Heat Type:**

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

☐ Kerosene ☐ Propane ☐ Municipal Electric ☐ Wood

ADDITIONAL INFORMATION

SECTION 23 – OTHER EXPENSES

Indicate if you or anyone who lives with you who is recertifying:	YES	NO	IF YES, AMOUNT	HOW OFTEN PAID	LEGALLY OBLIGATED YES	LEGALLY OBLIGATED NO	CHILD IN SNAP HH YES	CHILD IN SNAP HH NO
Pays child support 1			$					
Pays spousal support 2			$					
Pays for child care 3			$					
Pays for dependent care 4			$					
Pays tuition, fees, or other educational expenses 5			$					
Has additional expenses (Example: car payment, car insurance payment, credit card payments, other loan payments, etc.) Specify: _____ 6			$					
Do you or anyone who lives with you who is recertifying owe at least four months of support for a child under the age of 21? 7	☐ YES	☐ NO						

SECTION 24 – 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 cook or prepare meals at home? 9	☐ YES	☐ NO	VETERAN STATUS	VETERAN CODE
Have you or anyone in your household ever been in the U.S. military? Who? _____ 10	☐ YES	☐ NO		
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		

Indicate if you or anyone who lives with you who is recertifying:	YES	NO	WHO
Have you or anyone who lives with you who is recertifying 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 Public Assistance and/or the Supplemental Nutrition Assistance Program (SNAP) because of fraud/an 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 Public Assistance in two or more states?			
Have you or any member of your household been convicted of fraudulently receiving duplicate SNAP Benefits in any state after September 22, 1996?			
Have you or any member of your household been convicted of buying or selling SNAP Benefits for a combined amount of over $500 or more after September 22, 1996?			
Have you or any member of your household been convicted of trading SNAP benefits for firearms, ammunition or explosives, or drugs?			
Are you or any member of your household fleeing to avoid prosecution, custody or confinement after conviction of a felony or attempted felony and actively being pursued by law enforcement?			
Are you or any member of your household violating probation or parole according to a court order?			

PROPERTY TRANSFER STATUS

I have ☐ I have not ☐ sold, transferred or given away any of my property to anyone to get Public Assistance or SNAP Benefits.

NEEDED	REFERRALS	COMPLETED	CONSIDER
	Services		✓ SNAP Dependent Care Deductions
	UIB		✓ District of Fiscal Responsibility (SSL 62.5)

REQUESTED	DOCUMENTATION	IN FILE
	Child/Dependent Care Statement	
	Recoupments	
	Outstanding Overpayment	
	Pending Disqualification	

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

Actual Expenses $

Actual Income $

= Difference $

CONSIDER
✓ Actual Expenses, including: shelter, fuel/utility costs, telephone costs, etc.
✓ Actual Shelter
✓ Actual Fuel/Utility Costs
✓ Telephone Expenses
✓ Car Expenses
✓ Furniture/Appliance Rental
✓ Cable TV
✓ Tuition
✓ Out-of-Pocket Medical Expenses

Does Client Receive Contribution Towards Difference ☐ Yes ☐ No

If Yes, From Whom? _____

Based on the information contained in this recertification, make sure you reconsider the category. For PA, especially, consider the following:

- Eligible Child Status
- Essential Persons Status
- Family Assistance Extensions

Category is _____

Documented by _____

NOTES/COMMENTS

NOTICES, ASSIGNMENTS, AUTHORIZATIONS, and CONSENTS

COLLECTION AND USE OF SOCIAL SECURITY NUMBERS – The collection of Social Security Numbers (SSNs) is authorized for each household member with respect to the Supplemental Nutrition Assistance Program (SNAP), pursuant to the Food and Nutrition Act of 2008 (as amended). Anyone applying for SNAP must provide an SSN in order to receive benefits. If you or anyone applying does not have an SSN, that person must apply for an SSN with the Social Security Administration (visit www.SSA.gov or call 1-800-772-1213).

With respect to all other programs for which this recertification form requires an SSN, the collection of SSNs is also mandatory and is authorized under one or more of the following sections of law: Section 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 instruction book (PUB-1313 Statewide) or talk to your social services district if you have questions.

The information we collect will be used to determine whether your household is eligible or continues to be eligible for assistance or benefits. 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. 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. Besides using the information you give us in this way, the state will use the information to prepare statistics about all of the people receiving benefits from the Home Energy Assistance Program (HEAP) (see below).

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. 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 SNAP claim arises against your household, the information on this recertification, including all SSNs, may be referred to federal and state agencies, as well as private claims collection agencies, for claims collection action.

SSNs of ineligible household members will also be used and disclosed in the manner above.

Besides using the information you give us in this way, the State also uses the information to prepare statistics about all the people receiving benefits from HEAP. The information is used for quality control by the State to make sure social services districts are doing the best job they can. It is used to verify your energy supplier and to make certain payments to such vendors.

NONDISCRIMINATION NOTICE – 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 United States Department of Agriculture (USDA) 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 Supplemental Nutrition Assistance Program (SNAP) 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.

Under certain circumstances, New York State additionally prohibits discrimination based on gender identity, transgender status, gender dysphoria, sexual orientation, marital status, military status, domestic violence victim status, pregnancy-related conditions, predisposing genetic characteristics, prior arrest or conviction record, familial status, and retaliation for opposing unlawful discriminatory practices.

CONSENT FOR INVESTIGATION – I agree to any investigation to verify or confirm the information I have given in connection with my request for Public Assistance (PA), Medicaid, Supplemental Nutrition Assistance Program (SNAP) Benefits, Home Energy Assistance Program Benefits, 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 any PA and/or SNAP Quality Control Review.

If I am recertifying for SNAP, I understand that the social services district will request and use information available through the Income and Eligibility Verification System to investigate my recertification, and may verify this information through collateral contacts if discrepancies are found. I also understand that such information may affect my eligibility for SNAP and/or the level of SNAP Benefits I receive.

CONSENT FOR RELEASE OF CONFIDENTIAL UNEMPLOYMENT INSURANCE INFORMATION – I authorize the New York State Department of Labor (DOL) to release any confidential information maintained by DOL for Unemployment Insurance (UI) purposes to the New York State Office of Temporary and Disability Assistance (OTDA). This information includes UI benefit claims and wage records. I understand that OTDA, along with state and local agency employees working in social services district offices, will use the UI information for establishing or verifying eligibility for, and the amount of, Public Assistance, Medicaid, Supplemental Nutrition Assistance Program Benefits, Home Energy Assistance Program Benefits or Child Care Assistance, applied for in this application/recertification and for investigations to determine whether I received benefits to which I was not entitled. OTDA may also share the information with the New York State Office of Children and Family Services (OCFS) and the New York State Department of Health (DOH). OCFS will use the information to monitor the Child Care Assistance program.

RELEASE OF INFORMATION TO SERVICE PROVIDERS – I give permission to the social services district and New York State to share information regarding Public Assistance or Supplemental Nutrition Assistance Program benefits that I or any member of my household for whom I can legally give authorization have received, for purposes of verifying my eligibility for services and payment related to program administration provided by a State or local contractor. Such services may include, but are not limited to, job placement or training services provided to help me or members of my household obtain and retain employment.

CHANGE REPORTING – I agree to inform the agency **promptly** of any change in my needs, residency/address, living arrangements, household size, income, employment, property/resources, dependent care costs, health insurance, non-citizen with satisfactory immigration status/citizenship status, able-bodied adult without dependents (ABAWD) status, pregnancy status or living arrangements, to the best of my knowledge or belief.

If I am applying for Child Care Assistance, I agree to inform the agency **immediately** of any change in family income, who lives in my home, employment, child care arrangements or other changes which may affect my continued eligibility or amount of my benefit.

PENALTIES – Federal and state laws provide for penalties of fine, imprisonment or both if you do not tell the truth when you recertify for Public Assistance, Medicaid, Supplemental Nutrition Assistance Program, 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 recertification 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 recertified to obtain or continue to receive Assistance, Benefits or Services. If you are an authorized representative, 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 60 months 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 Medicaid, 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.

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM DISQUALIFICATION PENALTIES – Any information you provide in connection with your application for the Supplemental Nutrition Assistance Program (SNAP) will be subject to verification by federal, state and local officials. If any information is incorrect, you may be denied SNAP Benefits. You may be subject to criminal prosecution if you knowingly provide incorrect information which affects eligibility or the amount of benefits. Any person convicted of a felony for knowingly using, transferring, acquiring, altering or possessing SNAP authorization cards or access devices may be fined up to $250,000, imprisoned up to 20 years or both. The individual may also be subject to prosecution under the applicable federal and state laws. Anyone who is violating a condition of probation or parole, or anyone who is fleeing to avoid prosecution, custody or confinement of a felony and is actively being pursued by law enforcement, is not eligible to receive SNAP Benefits.

You may be found ineligible for SNAP or found to have committed an Intentional Program Violation (IPV) if you make a false or misleading statement, or misrepresent, conceal or withhold facts, in order to qualify for benefits or receive more benefits; purchase a product with SNAP benefits with the intent of obtaining cash by intentionally discarding the product and returning the container for the deposit amount; or commit or attempt to commit any act that constitutes a violation of federal or state law for the purpose of using, presenting, transferring, acquiring, receiving, possessing or trafficking SNAP Benefits, authorization cards or reusable documents used as part of the Electronic Benefit Transfer (EBT) system. Additionally, the following is not allowed and you may be disqualified from receiving SNAP Benefits and/or be subject to penalties for actions that include:

- Using SNAP benefits to buy non-food items, such as alcohol or cigarettes;
- Using SNAP benefits to pay for food previously purchased on credit;
- Allowing someone else to use your EBT card in exchange for cash, firearms, ammunition or explosives, or drugs, or to purchase food for individuals who are not members of your SNAP household; or
- Using or having in your possession EBT cards that do not belong to you, without the card owner's consent.

Individuals found to have committed an IPV either through an administrative disqualification hearing or by a federal, State or local court, or have signed either a waiver of right to an administrative disqualification hearing or a disqualification consent agreement in cases referred for prosecution shall be ineligible to participate in SNAP for a period of:

- 12 months for the first SNAP IPV;
- 24 months for the second SNAP IPV;
- 24 months for the first SNAP IPV that is based on a court finding that the individual used or received SNAP Benefits in a transaction involving the sale of a controlled substance (illegal drugs or certain drugs for which a doctor's prescription is required); or
- 120 months if the individual is found to have made a fraudulent statement about who he/she is or where he/she lives in order to get multiple SNAP Benefits simultaneously, unless permanently disqualified for a third SNAP IPV.
  Additionally, a court may bar an individual from participating in SNAP for an additional 18 months.

An individual can be permanently disqualified from receiving SNAP Benefits for:

- The first SNAP IPV based on a court finding that the individual used or received SNAP Benefits in a transaction involving the sale of firearms, ammunition or explosives;
- The first SNAP IPV based on a court conviction for trafficking SNAP Benefits for a combined amount of $500 or more (trafficking includes the illegal use, transfer, acquisition, alteration or possession of SNAP authorization cards or access devices);
- The second SNAP IPV based on a court finding that the individual used or received SNAP Benefits in a transaction involving the sale of a controlled substance (illegal drugs or certain drugs for which a doctor's prescription is required); or
- A third SNAP IPV.

REQUIREMENT TO REPORT/VERIFY HOUSEHOLD EXPENSES – Your household must report child care and utility expenses in order to get a Supplemental Nutrition Assistance Program (SNAP) 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 SNAP 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 these unreported/unverified expenses. A deduction for these expenses may make you eligible for SNAP or may increase your SNAP benefits. You may report/verify these expenses at any time in the future. The deduction would then be applied to the calculation of SNAP benefits in future months, in accordance with the rules for change reporting (see Change Reporting, above).

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM AUTHORIZED REPRESENTATIVE – You can authorize someone who knows your household circumstances to recertify for Supplemental Nutrition Assistance Program (SNAP) Benefits for you. You can also authorize someone outside your household to get SNAP Benefits for you or to use them to buy food for you. If you would like to authorize someone, you must do so in writing. You may authorize someone by printing the person's name, address, and phone number immediately below, and having them sign in the signature section at the end of this recertification. When an Authorized Representative is applying on behalf of a SNAP household that does not reside in an institution, both the Authorized Representative and a responsible adult member of the household must sign and date the signature section at the end of this recertification, unless the SNAP household has otherwise designated the Authorized Representative to do so in writing.

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

STANDARD UTILITY ALLOWANCE – I understand that Public Assistance and Supplemental Nutrition Assistance Program (SNAP) recipients are categorically income eligible for the Home Energy Assistance Program (HEAP). I also understand that if I have not received a HEAP benefit of greater than $20 in the current month or previous 12 months, or a similar energy assistance benefit, I must pay for heating or air conditioning separately from my rent in order to receive the heating/cooling standard utility allowance (i.e., a deduction) for SNAP. I understand that the State will use my Social Security Number to verify with my home energy vendors the receipt of HEAP. This authorization also includes permission for any of my home energy vendors (including my utility) to release certain statistical information, including but not limited to, my annual electricity usage, electricity cost, fuel consumption, fuel type, annual fuel cost and payment history to the New York State Office of Temporary and Disability Assistance, the local social services district and the United States Department of Health and Human Services for the purposes of Low Income Home Energy Assistance Program performance measurement.

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 (DOH) 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 DOH and other authorized federal, state, and local agencies for purposes of administration of Medicaid; 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 authorize the release of any health-related information about me and any members of my family for whom I can legally give authorization related to the provision of assistance and services and my ability to participate in work activities, including employment, to the New York State Office of Temporary and Disability Assistance (OTDA), the New York State Office of Children and Family Services or the local social services district, as reasonably necessary for the provision of Public Assistance benefits; for services, including child welfare services; for determining appropriate work activity assignments; for determining the need to apply and for making application for Supplemental Security Income Benefits; for establishing appropriate treatment plans for restoring employability; and for determining eligibility for exemptions from the State sixty-month time limit on cash assistance receipt. If I am required to apply for benefits administered by the Social Security Administration, the information specified above may be shared with the Social Security Administration. 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, unless a box is checked below. If more than one adult in the family is joining a

Medicaid health plan, the signature of each adult applying is necessary for consent to release information. I understand that my ability to consent to the release of information relating to any minor children for whom I may give consent is limited by the extent to which I can obtain information regarding treatment, diagnosis and procedures on their behalf.

_____ Do not disclose HIV/AIDS information _____ Do not disclose drug and alcohol information
_____ Do not disclose mental health information

RELEASE OF INFORMATION TO HEALTH SERVICE PROVIDERS – I give permission to the social services district and the State of New York to share information with health service providers, as designated by the social services district or the State of New York, regarding Public Assistance benefits that I or any member of my household for whom I can legally give authorization have received or are eligible to receive, for the purpose of improving the quality of my healthcare and overall well-being, and to facilitate receipt of additional benefits for which I, or members of my household, may be eligible.

RELEASE OF EDUCATIONAL RECORDS – I give permission to the New York State Department of Health and the social services district to:1) obtain any information regarding the educational records of myself and/or my minor child(ren), herein named, including information necessary for claiming Medicaid reimbursement for health-related educational services; and 2) 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 social services district and New York State to share my child's Medicaid eligibility information with my county or municipal Early Intervention Program for the purpose of billing Medicaid.

CHILD/TEEN HEALTH PROGRAM – I understand that if my child is on Medicaid, he or she can get comprehensive primary and preventive care, including all necessary treatment through the Child/Teen Health Program. I can get more information on this program from the social services district.

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 Medicaid.

REIMBURSEMENT OF MEDICAL EXPENSES

MEDICAID – You have a right as part of your Medicaid **application**, or within two years from the date of your **application**, 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.

ASSIGNMENT OF INSURANCE/OTHER BENEFITS AND DIRECT PAYMENT – For Public Assistance and Medicaid, 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 district to whom this recertification is made. In addition, I will assist in making any assigned benefits available to the social services district to whom this recertification is made.

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 district for medical and other health services furnished while we are eligible for Medicaid.

MEDICAID RECOVERIES – Upon receipt of Medicaid, 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. MA may also recover the cost of services and premiums incorrectly paid.
I understand that effective April 1, 2014, if I get Medicaid through New York State of Health:

- No lien will be placed on my real property prior to my death.

- Recovery from assets in my estate upon my death is limited to the amount Medicaid paid for the cost of nursing home care, home and community-based services, and related hospital and prescription drug services received on or after my 55th birthday.

PUBLIC ASSISTANCE RECOVERIES – Public Assistance (PA) 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 PA, 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 PA.

AUTHORIZATION TO REPAY PUBLIC ASSISTANCE BENEFITS FROM RETROACTIVE SUPPLEMENTAL SECURITY INCOME – I authorize the Commissioner of the Social Security Administration (SSA) to use my first payment of Supplemental Security Income (SSI); i.e. my retroactive SSI payment) to reimburse the local social services district (SSD) for Public Assistance (PA) the SSD pays me from State or local funds while SSA decides if I am eligible for SSI. SSA will not reimburse the SSD for PA that was paid using any federal funds.

I will be bound by this authorization only if the State gives notice to SSA that I and an SSD representative have signed it. The State must give notice within 30 calendar days of matching my SSI record with my State record. SSA will not accept it after 30 calendar days. Instead, SSA will send me my retroactive SSI payment under SSA rules.

Only my first payment of SSI can be used. If my first payment is larger than the amount owed to the SSD, SSA will send the rest to me under its rules.

SSA can reimburse the SSD in two situations:

(1) It will repay the SSD if I apply for SSI and SSA finds me eligible.
(2) It will repay the SSD if my SSI benefits are reinstated after termination or suspension.

SSA will only reimburse the SSD for PA it paid me during the time I am waiting for an SSA determination of eligibility. This is called “interim assistance.” The period begins: 1) with the first month I become eligible for payment of SSI benefits; or 2) on the first day I am reinstated after my SSI was suspended or terminated. The period includes the month SSI payments actually begin. If the SSD cannot stop my last PA payment, the period ends the next month.

No later than 10 days after SSA reimburses the SSD, the SSD must send me a notice telling me the amount of interim assistance paid. The notice will also tell me that SSA will send me a letter telling me how any remaining SSI money owed to me will be sent by SSA and that, if I do not agree with a state decision, how I can appeal the decision to the state.

Under its rules, SSA may use the date I sign this authorization as the date I first become eligible for SSI. It will do this only if I apply for SSI within the next 60 days.

This authorization applies to any SSI application or appeal I now have pending before SSA. This authorization terminates if my SSI case is completely decided. It terminates when SSA first pays me. The State and I can also agree to terminate the authorization. I must sign a new authorization consistent with NYS rules if I reapply for SSI after this authorization terminates, or if I file a new SSI claim while I have an SSI application or appeal pending.

I will be given an opportunity for a fair hearing if I disagree with a decision the SSD made about reimbursement.

I received a copy of the pamphlet called “What You Should Know About Social Services Programs.” I understand what it says about interim assistance.

SUPPORT – Applying for or receiving Family Assistance (FA), Safety Net Assistance (SNA) or Title IV-E foster care 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 for, or receiving, assistance (Social Services Law, Sections 158 and 348). This assignment is limited in certain situations. Other sections of this recertification contain additional assignments.

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 for whom I am applying for or receiving assistance. Where applying for or receiving Family Assistance or Safety Net Assistance, my assignment of support rights is limited to support which accrues during the period that I and/or any family member receives assistance. However, any support rights that I assigned to the state on behalf of myself or any family member prior to October 1, 2009, continue to be assigned to the state.

HOME ENERGY ASSISTANCE PROGRAM – I understand that by signing this application/certification, I consent to any investigation to verify or confirm the information I have given and other investigation by any authorized government agency in connection with Home Energy Assistance Program (HEAP) benefits. I also consent to allow the information provided on this recertification to be used in referrals to available weatherization assistance programs and my utility company's low income programs.

I understand that the State will use my Social Security Number to verify with my home energy vendors the receipt of HEAP. This authorization also includes permission for any of my home energy vendors (including my utility) to release certain statistical information, including but not limited to, my annual electricity usage, electricity cost, fuel consumption, fuel type, annual fuel cost and payment history to the New York State Office of Temporary and Disability Assistance, the local social services district and the United States Department of Health and Human Services for the purposes of Low Income Home Energy Assistance Program performance measurement.

SEXUAL ASSAULT INFORMATION – If you are a victim of sexual assault, you have the right to request referral information from the social services district. If you request referral information, the social services district must provide you with the addresses and phone numbers of any: 1) local hospitals offering sexual assault forensic examiner services certified by the NYS Department of Health; 2) local rape crisis centers; and 3) local advocacy, counseling, and hotline services appropriate for victims of sexual assault. In addition, the social services district must provide you with the NYS Hotline for Sexual Assault and Domestic Violence numbers: (800) 942-6906 and (800) 818-0656 (TTY).

CERTIFICATION FOR CHILD CARE ASSISTANCE – If I am applying for Child Care Assistance, I certify that my family resources do not exceed $1,000,000.

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 social services district is complete and correct.			
APPLICANT SIGNATURE **x**	**DATE SIGNED**	**SPOUSE OR PROTECTIVE REPRESENTATIVE SIGNATURE** **x**	**DATE SIGNED**
AUTHORIZED REPRESENTATIVE SIGNATURE **x**	**DATE SIGNED**		

ONLY COMPLETE THE FOLLOWING IF YOU WANT TO CLOSE YOUR CASE FOR ONE OR MORE PROGRAMS.

I REQUEST THAT MY CASE BE CLOSED FOR:

☐ **Public Assistance** ☐ **Supplemental Nutrition Assistance Benefits** ☐ **Medical Assistance**

I understand that I may reapply at any time.

Give Reason: _____

Signature x _____ **Date** _____

NYS Agency-Based Voter Registration Form

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

- ☐ **YES** If you checked **YES**, please complete the **VOTER REGISTRATION APPLICATION** below
- ☐ **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 _____

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.

Información en español: si le interesa obtener este formulario en español, llame al 1-800-367-8683

中文資料:若您有興趣索取中文資料表格, 請電: 1-800-367-8683

한국어: 한국어 한국어 양식을 원하시면 1-800-367-8683 으로 전화 하십시오.

যদি আপনি এই ফর্মটি ইংরেজীতে পেতে চান তাহলে 1-800-367-8683 নম্বরে ফোন করুন

Rev. 01/2019

VOTER REGISTRATION APPLICATION (instructions on back)

☐ 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 **Will you be 18 years old on or before election day?** ☐ YES ☐ NO
If you answered **NO**, do not complete this form unless you will be 18 by the end of the year

For Board Use Only

3 Last Name | First Name | Middle Initial | Suffix

4 Address where you live (do not give P.O. box) | Apt. No. | City/Town/Village | Zip Code | County

5 Address where you get your mail (if different than above) | P.O. Box, Star Route, etc. | Post Office | Zip Code

6 Date of Birth | **7** Gender (optional) | **8** Telephone (optional) | Email (optional)

10 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)

9 **ID Number** (Check the applicable box and provide your number)
- ☐ New York State DMV number — — — — — — — — —
- ☐ Last four digits of your Social Security number — — — —
- ☐ I do not have a New York State DMV or Social Security number

11 **Political Party**

I wish to enroll in a political party

- ☐ Democratic party
- ☐ Republican party
- ☐ Conservative party
- ☐ Working Families party
- ☐ Green party
- ☐ Libertarian party
- ☐ Independence party
- ☐ SAM party
- ☐ Other _____

I do not want to enroll in any political party and wish to be an independent voter

- ☐ No party

12 **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.
- I will meet all requirements to register to vote in New York State.
- 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 in ink _____ Date ___/___/___

(Optional) Register to donate your organs and tissues

Last Name

First Name | Middle Initial | Suffix

Address

Apt Number | City/Town/Village | Zip Code

Birth Date | Gender ☐ M ☐ F

Eye Color | Height Ft. In.

Email | DMV or ID NYC Number

By signing below, you certify that you are:

- 16 years of age or older
- Consent to donate all of your organs and tissues for transplantation, research, or both;
- Authorizing the Board of Elections to provide your name and identifying information to NYS Donate Life Registry for enrollment;
- And authorizing the Registry to allow access to this information to federally regulated organ procurement organizations and NYS-licensed tissue and eye banks and others approved by the NYS Commissioner of Health upon your death.

DONATE LIFE New York State

Signature _____ Date ___/___/___

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 prison or on parole for a felony conviction (unless parole pardoned or restored rights of citizenship);
- not claim the right to vote elsewhere;
- not found to be incompetent by a court.

Important!

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:

NYS Board of Elections
40 North Pearl St, Suite 5
Albany, NY 12207-2729
Telephone: 1-800-469-6872;
TDD/TTY users contact the New York State Relay at 711;
or visit our web site - www.elections.ny.gov

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.

Verifying your identity

We will try to check your identity before Election Day, through the DMV number (driver's license number or non-driver ID number), or the last four digits of your social security number, which you will fill in Box 9.

If you do not have a DMV or Social Security number, you may use a valid photo ID, a current utility bill, bank statement, paycheck, government check or some other government document that shows your name and address. You may include a copy of one of those types of ID with this form.

If we are unable to verify your identity before Election Day, you will be asked for ID when you vote for the first time.

To complete this form:

It is a crime to procure a false registration or to furnish false information to the Board of Elections.

Box 9: You must make one selection. For questions refer to Verifying your identity above.

Box 10: If you have never voted before, write "None". If you can't remember when you last voted, put a question mark (?). If you voted before under a different name, put down that name. If not, write "Same".

Box 11: Check one box only. Political party enrollment is optional but that, in order to vote in a primary election of a political party, a voter must enroll in that political party, unless state party rules allow otherwise.