
LDSS-3174 LP Statewide (Rev. 07/23)

This information is being provided in this alternate format for informational purposes only. In order to apply, you must submit an application in written, non-alternative format.

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 for this form (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. 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.” **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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**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 (_____) _____

MOBILE NUMBER?

Yes

No

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

PHONE NUMBER AREA CODE (____) _____

EMAIL ADDRESS (OPTIONAL) _____

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 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 X

DATE SIGNED _____

SECTION 5

DO ANY OF THESE APPLY TO YOU?

1. Pregnant
2. Victim of Domestic Violence
3. Need To Establish Parentage
4. Need Child Support
5. Drug/Alcohol Problem
6. Fuel Or Utility Shutoff
7. No Place To Stay/Homeless
8. Fire Or Other Disaster
9. Have No Income
10. Serious Medical Problem
11. Pending Eviction
12. No Food
13. Need Foster Care

- 14. Need Child Care
- 15. Problems with English
- 16. Reasonable Accommodations
- 17. Other _____

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SECTION 6 – HOUSEHOLD INFORMATION –

List everybody who *lives* with you, even if they are not recertifying with you. List yourself on the first line.

RI

LN 01

First Name, Middle Initial, Last Name _____

This person is recertifying for:

PA

SNAP

MA

Date of Birth: (mm/dd/yyyy) _____

Sex: (M/F/X) _____

Gender Identity (Optional): (Male, Female, Non-Binary, X, Transgender, Different Identity [please describe]) _____

Relationship to you: **SELF**

Social Security Number of Recertifying Household Members (*See instruction book, PUB-1313 Statewide, or talk to your social services district*) _____

Highest School Grade Completed _____

Does This Person (Including Minor Children) Buy Food or Prepare Meals with You?

YES

NO

RI

LN 02

First Name, Middle Initial, Last Name _____

This person is recertifying for:

PA

SNAP

MA

Date of Birth: (mm/dd/yyyy) _____

Sex: (M/F/X) _____

Gender Identity (Optional): (Male, Female, Non-Binary, X, Transgender, Different Identity [please describe]) _____

Relationship to you: _____

Social Security Number of Recertifying Household Members (*See instruction book, PUB-1313 Statewide, or talk to your social services district*) _____

Highest School Grade Completed _____

Does This Person (Including Minor Children) Buy Food or Prepare Meals with You?

YES

NO

RI

LN 03

First Name, Middle Initial, Last Name _____

This person is recertifying for:

PA

SNAP

MA

Date of Birth: (mm/dd/yyyy) _____

Sex: (M/F/X) _____

Gender Identity (Optional): (Male, Female, Non-Binary, X, Transgender, Different Identity [please describe]) _____

Relationship to you: _____

Social Security Number of Recertifying Household Members (*See instruction book, PUB-1313 Statewide, or talk to your social services district*) _____

Highest School Grade Completed _____

Does This Person (Including Minor Children) Buy Food or Prepare Meals with You?

YES

NO

RI

LN 04

First Name, Middle Initial, Last Name _____

This person is recertifying for:

PA

SNAP

MA

Date of Birth: (mm/dd/yyyy) _____

Sex: (M/F/X) _____

Gender Identity (Optional): (Male, Female, Non-Binary, X, Transgender, Different Identity [please describe]) _____

Relationship to you: _____

Social Security Number of Recertifying Household Members (*See instruction book, PUB-1313 Statewide, or talk to your social services district*) _____

Highest School Grade Completed _____

Does This Person (Including Minor Children) Buy Food or Prepare Meals with You?

YES

NO

RI

LN 05

First Name, Middle Initial, Last Name _____

This person is recertifying for:

PA

SNAP

MA

Date of Birth: (mm/dd/yyyy) _____

Sex: (M/F/X) _____

Gender Identity (Optional): (Male, Female, Non-Binary, X, Transgender, Different Identity [please describe]) _____

Relationship to you: _____

Social Security Number of Recertifying Household Members (*See instruction book, PUB-1313 Statewide, or talk to your social services district*) _____

Highest School Grade Completed _____

Does This Person (Including Minor Children) Buy Food or Prepare Meals with You?

YES

NO

RI

LN 06

First Name, Middle Initial, Last Name _____

This person is recertifying for:

PA

SNAP

MA

Date of Birth: (mm/dd/yyyy) _____

Sex: (M/F/X) _____

Gender Identity (Optional): (Male, Female, Non-Binary, X, Transgender, Different Identity [please describe]) _____

Relationship to you: _____

Social Security Number of Recertifying Household Members (See *instruction book, PUB-1313 Statewide, or talk to your social services district*) _____

Highest School Grade Completed _____

Does This Person (Including Minor Children) Buy Food or Prepare Meals with You?

YES

NO

RI

LN 07

First Name, Middle Initial, Last Name _____

This person is recertifying for:

PA

SNAP

MA

Date of Birth: (mm/dd/yyyy) _____

Sex: (M/F/X) _____

Gender Identity (Optional): (Male, Female, Non-Binary, X, Transgender, Different Identity [please describe]) _____

Relationship to you: _____

Social Security Number of Recertifying Household Members (*See instruction book, PUB-1313 Statewide, or talk to your social services district*) _____

Highest School Grade Completed _____

Does This Person (Including Minor Children) Buy Food or Prepare Meals with You?

YES

NO

RI

LN 08

First Name, Middle Initial, Last Name _____

This person is recertifying for:

PA

SNAP

MA

Date of Birth: (mm/dd/yyyy) _____

Sex: (M/F/X) _____

Gender Identity (Optional): (Male, Female, Non-Binary, X, Transgender, Different Identity [please describe]) _____

Relationship to you: _____

Social Security Number of Recertifying Household Members (*See instruction book, PUB-1313 Statewide, or talk to your social services district*) _____

Highest School Grade Completed _____

Does This Person (Including Minor Children) Buy Food or Prepare Meals with You?

YES

NO

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 _____

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

NAME _____

DID THEY EVER LIVE IN NEW YORK STATE BEFORE NOW?

YES

NO

HAS ANYONE MOVED **OUT** OF THE HOUSEHOLD IN THE LAST YEAR?

YES

NO

IF YES, INCIDATE BELOW.

NAME _____

WHEN? _____

NAME _____

WHEN? _____

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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)

FOR EACH PERSON IN SECTION 6, PLEASE ENTER Y (YES) IF HISPANIC OR LATINO.

FOR EACH PERSON IN SECTION 6, PLEASE ENTER Y (YES) WHERE APPLICABLE FOR RACE. YOU MAY SELECT MORE THAN ONE RACE.

LN 01

H _____

I _____

A _____

B _____

P _____

W _____

U _____

LN 02

H _____

I _____

A _____

B _____

P _____

W _____

U _____

LN 03

H _____

I _____

A _____

B _____

P _____

W _____

U _____

LN 04

H _____

I _____

A _____

B _____

P _____

W _____

U _____

LN 05

H _____

I _____

A _____

B _____

P _____

W _____

U _____

LN 06

H _____

I _____

A _____

B _____

P _____

W _____

U _____

LN 07

H _____

I _____

A _____

B _____

P _____

W _____

U _____

LN 08

H _____

I _____

A _____

B _____

P _____

W _____

U _____

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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, or
- The Supplemental Nutrition Assistance Program, or
- Medicaid

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 their child with a satisfactory non-citizen status.

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 siblings, 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 a 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.

LN 01

FIRST NAME _____

MI _____

LAST NAME _____

Check either "CITIZEN / NATIONAL" or "NON-CITIZEN" for each person.

CITIZEN/ NATIONAL

NON-CITIZEN

USCIS NUMBER (ALIEN REGISTRATION NUMBER)
OR NON-CITIZEN NUMBER (If Applicable) A _____

**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.)

CERTIFICATION

Sign Name X _____

DATE _____

PA

SNAP

MA

LN 02

FIRST NAME _____

MI _____

LAST NAME _____

Check either "CITIZEN / NATIONAL" or "NON-CITIZEN" for each person.

CITIZEN/ NATIONAL

NON-CITIZEN

USCIS NUMBER (ALIEN REGISTRATION NUMBER)
OR NON-CITIZEN NUMBER (If Applicable) A _____

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.)

CERTIFICATION

Sign Name X _____

DATE _____

PA

SNAP

MA

LN 03

FIRST NAME _____

MI _____

LAST NAME _____

Check either "CITIZEN / NATIONAL" or "NON-CITIZEN" for each person.

CITIZEN/ NATIONAL

NON-CITIZEN

USCIS NUMBER (ALIEN REGISTRATION NUMBER)
OR NON-CITIZEN NUMBER (If Applicable) A _____

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.)

CERTIFICATION

Sign Name X _____

DATE _____

PA

SNAP

MA

LN 04

FIRST NAME _____

MI _____

LAST NAME _____

Check either "CITIZEN / NATIONAL" or "NON-CITIZEN" for each person.

CITIZEN/ NATIONAL

NON-CITIZEN

USCIS NUMBER (ALIEN REGISTRATION NUMBER)
OR NON-CITIZEN NUMBER (If Applicable) A _____

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.)

CERTIFICATION

Sign Name X _____

DATE _____

PA

SNAP

MA

LN 05

FIRST NAME _____

MI _____

LAST NAME _____

Check either "CITIZEN / NATIONAL" or "NON-CITIZEN" for each person.

CITIZEN/ NATIONAL

NON-CITIZEN

USCIS NUMBER (ALIEN REGISTRATION NUMBER)
OR NON-CITIZEN NUMBER (If Applicable) A _____

**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.)

CERTIFICATION

Sign Name X _____

DATE _____

PA

SNAP

MA

LN 06

FIRST NAME _____

MI _____

LAST NAME _____

Check either "CITIZEN / NATIONAL" or "NON-CITIZEN" for each person.

CITIZEN/ NATIONAL

NON-CITIZEN

USCIS NUMBER (ALIEN REGISTRATION NUMBER)
OR NON-CITIZEN NUMBER (If Applicable) A _____

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.)

CERTIFICATION

Sign Name X _____

DATE _____

PA

SNAP

MA

LN 07

FIRST NAME _____

MI _____

LAST NAME _____

Check either "CITIZEN / NATIONAL" or "NON-CITIZEN" for each person.

CITIZEN/ NATIONAL

NON-CITIZEN

USCIS NUMBER (ALIEN REGISTRATION NUMBER)
OR NON-CITIZEN NUMBER (If Applicable) A _____

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.)

CERTIFICATION

Sign Name X _____

DATE _____

PA

SNAP

MA

LN 08

FIRST NAME _____

MI _____

LAST NAME _____

Check either "CITIZEN / NATIONAL" or "NON-CITIZEN" for each person.

CITIZEN/ NATIONAL

NON-CITIZEN

USCIS NUMBER (ALIEN REGISTRATION NUMBER)
OR NON-CITIZEN NUMBER (If Applicable) A _____

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.)

CERTIFICATION

Sign Name X _____

DATE _____

PA

SNAP

MA

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: _____

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 to unmarried parents and/or for whom legal parentage has not been established?

Yes

No

2. Are you recertifying for an individual under the age of 21 who has an absent parent (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, alleged, or intended parent(s).

3. Are you under the age of 21?

Yes

No

If you answered “Yes” to this question, provide the following information for your noncustodial, alleged, or intended parents: _____

A. NAME OF INDIVIDUAL UNDER AGE 21 _____

NONCUSTODIAL, ALLEGED, OR INTENDED
PARENT’S NAME AND ADDRESS _____

NONCUSTODIAL, ALLEGED, OR INTENDED
PARENT'S DATE OF BIRTH

MONTH _____

DAY _____

YEAR _____

NONCUSTODIAL, ALLEGED, OR INTENDED
PARENT'S SOCIAL SECURITY NUMBER _____

B. NAME OF INDIVIDUAL UNDER AGE 21 _____

NONCUSTODIAL, ALLEGED, OR INTENDED
PARENT'S NAME AND ADDRESS _____

NONCUSTODIAL, ALLEGED, OR INTENDED
PARENT'S DATE OF BIRTH

MONTH _____

DAY _____

YEAR _____

NONCUSTODIAL, ALLEGED, OR INTENDED
PARENT'S SOCIAL SECURITY NUMBER _____

C. NAME OF INDIVIDUAL UNDER AGE 21 _____

NONCUSTODIAL, ALLEGED, OR INTENDED
PARENT'S NAME AND ADDRESS _____

NONCUSTODIAL, ALLEGED, OR INTENDED
PARENT'S DATE OF BIRTH

MONTH _____

DAY _____

YEAR _____

NONCUSTODIAL, ALLEGED, OR INTENDED
PARENT'S SOCIAL SECURITY NUMBER _____

D. NAME OF INDIVIDUAL UNDER AGE 21 _____

NONCUSTODIAL, ALLEGED, OR INTENDED
PARENT'S NAME AND ADDRESS _____

NONCUSTODIAL, ALLEGED, OR INTENDED
PARENT'S DATE OF BIRTH

MONTH _____

DAY _____

YEAR _____

NONCUSTODIAL, ALLEGED, OR INTENDED
PARENT'S SOCIAL SECURITY NUMBER _____

E. NAME OF INDIVIDUAL UNDER AGE 21 _____

NONCUSTODIAL, ALLEGED, OR INTENDED
PARENT'S NAME AND ADDRESS _____

NONCUSTODIAL, ALLEGED, OR INTENDED
PARENT'S DATE OF BIRTH

MONTH _____

DAY _____

YEAR _____

NONCUSTODIAL, ALLEGED, OR INTENDED
PARENT'S SOCIAL SECURITY NUMBER _____

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SECTION 12 – TAX FILING/DEPENDENT STATUS –

Please select the tax status for each individual living in the household.

FIRST NAME _____

MIDDLE INITIAL _____

LAST NAME _____

TAX STATUS

SINGLE _____

MARRIED FILING JOINTLY _____

MARRIED FILING SINGLE _____

HEAD OF HOUSEHOLD (WITH QUALIFYING
INDIVIDUAL) _____

QUALIFYING WIDOW(ER) WITH DEPENDENT
CHILD _____

DEPENDENT AND WILL BE FILING TAXES _____

WILL NOT BE FILING TAXES _____

FIRST NAME _____

MIDDLE INITIAL _____

LAST NAME _____

TAX STATUS

SINGLE _____

MARRIED FILING JOINTLY _____

MARRIED FILING SINGLE _____

HEAD OF HOUSEHOLD (WITH QUALIFYING
INDIVIDUAL) _____

QUALIFYING WIDOW(ER) WITH DEPENDENT
CHILD _____

DEPENDENT AND WILL BE FILING TAXES _____

WILL NOT BE FILING TAXES _____

FIRST NAME _____

MIDDLE INITIAL _____

LAST NAME _____

TAX STATUS

SINGLE _____

MARRIED FILING JOINTLY _____

MARRIED FILING SINGLE _____

HEAD OF HOUSEHOLD (WITH QUALIFYING
INDIVIDUAL) _____

QUALIFYING WIDOW(ER) WITH DEPENDENT
CHILD _____

DEPENDENT AND WILL BE FILING TAXES _____

WILL NOT BE FILING TAXES _____

FIRST NAME _____

MIDDLE INITIAL _____

LAST NAME _____

TAX STATUS

SINGLE _____

MARRIED FILING JOINTLY _____

MARRIED FILING SINGLE _____

HEAD OF HOUSEHOLD (WITH QUALIFYING
INDIVIDUAL) _____

QUALIFYING WIDOW(ER) WITH DEPENDENT
CHILD _____

DEPENDENT AND WILL BE FILING TAXES _____

WILL NOT BE FILING TAXES _____

FIRST NAME _____

MIDDLE INITIAL _____

LAST NAME _____

TAX STATUS

SINGLE _____

MARRIED FILING JOINTLY _____

MARRIED FILING SINGLE _____

HEAD OF HOUSEHOLD (WITH QUALIFYING
INDIVIDUAL) _____

QUALIFYING WIDOW(ER) WITH DEPENDENT
CHILD _____

DEPENDENT AND WILL BE FILING TAXES _____

WILL NOT BE FILING TAXES _____

FIRST NAME _____

MIDDLE INITIAL _____

LAST NAME _____

TAX STATUS

SINGLE _____

MARRIED FILING JOINTLY _____

MARRIED FILING SINGLE _____

HEAD OF HOUSEHOLD (WITH QUALIFYING
INDIVIDUAL) _____

QUALIFYING WIDOW(ER) WITH DEPENDENT
CHILD _____

DEPENDENT AND WILL BE FILING TAXES _____

WILL NOT BE FILING TAXES _____

FIRST NAME _____

MIDDLE INITIAL _____

LAST NAME _____

TAX STATUS

SINGLE _____

MARRIED FILING JOINTLY _____

MARRIED FILING SINGLE _____

HEAD OF HOUSEHOLD (WITH QUALIFYING
INDIVIDUAL) _____

QUALIFYING WIDOW(ER) WITH DEPENDENT
CHILD _____

DEPENDENT AND WILL BE FILING TAXES _____

WILL NOT BE FILING TAXES _____

FIRST NAME _____

MIDDLE INITIAL _____

LAST NAME _____

TAX STATUS

SINGLE _____

MARRIED FILING JOINTLY _____

MARRIED FILING SINGLE _____

HEAD OF HOUSEHOLD (WITH QUALIFYING INDIVIDUAL) _____

QUALIFYING 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

FIRST NAME _____

MIDDLE INITIAL _____

LAST NAME _____

NAME OF TAX FILER

FIRST NAME _____

MIDDLE INITIAL _____

LAST NAME _____

NAME OF TAX DEPENDENT

FIRST NAME _____

MIDDLE INITIAL _____

LAST NAME _____

NAME OF TAX FILER

FIRST NAME _____

MIDDLE INITIAL _____

LAST NAME _____

NAME OF TAX DEPENDENT

FIRST NAME _____

MIDDLE INITIAL _____

LAST NAME _____

NAME OF TAX FILER

FIRST NAME _____

MIDDLE INITIAL _____

LAST NAME _____

NAME OF TAX DEPENDENT

FIRST NAME _____

MIDDLE INITIAL _____

LAST NAME _____

NAME OF TAX FILER

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) _____

LEGAL PARENTAGE ESTABLISHED?

Yes

No

DO YOU PAY CHILD SUPPORT?

Yes

No

NAME OF PERSON RECERTIFYING _____

NAME OF ABSENT CHILD _____

DATE OF BIRTH _____

ADDRESS OF CHILD (STREET, CITY, COUNTY,
STATE, AND ZIP CODE) _____

LEGAL PARENTAGE ESTABLISHED?

Yes

No

DO YOU PAY CHILD SUPPORT?

Yes

No

NAME OF PERSON RECERTIFYING _____

NAME OF ABSENT CHILD _____

DATE OF BIRTH _____

ADDRESS OF CHILD (STREET, CITY, COUNTY,
STATE, AND ZIP CODE) _____

LEGAL PARENTAGE ESTABLISHED?

Yes

No

DO YOU PAY CHILD SUPPORT?

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 _____

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SECTION 16 – INCOME INFORMATION:

Indicate if you or anyone who lives with you receives money from:

1. Unemployment Insurance Benefits

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

2. Supplemental Security Income (SSI) Benefits (State and Federal Total)

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

3. Social Security Disability (SSD) Benefits

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

4. Social Security Dependent Benefits

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

5. Social Security Survivor's Benefits

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

6. Social Security Retirement Benefits

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

7. Railroad Retirement Benefits

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

8. Retirement Benefits (Pensions)

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

9. Dividends/Interest from Stocks, Bonds, Savings, etc.

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

10. Workers' Compensation

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

11. NYS Disability Benefits

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

12. Veteran's Pension/Benefits/Aid and Attendance

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

13. Public Assistance Grant

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

14. GI Dependency Allotments

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

15. Education Grants or Loans

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

16. Contributions/Gifts (Received)

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

17. Foster Care Maintenance Payments (Received)

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

18. Child Support Payments (Received)

Received From: _____

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

19. Spousal Support (Received)

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

20. Private Disability Insurance - Health/Accident
Insurance Policy Income

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

21. No-Fault Insurance Benefits

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

22. Union Benefits (including Strike Benefits)

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

23. Loans, Other than Education (Received)

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

24. 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)

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

25. Training Allotments/Stipends

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

26. Rental Income (Received)

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

27. Boarders/Lodgers Income (Received)

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

Other Income (Please Specify) _____

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

Other Income (Please Specify) _____

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

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If you are recertifying for Medicaid, please complete the following section:

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.

1. Educator expenses

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

2. Individual Retirement Account (IRA) deduction

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

3. Student loan interest deduction

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

4. Tuition and fees

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

5. Certain business expenses (reservists, artists, fee-based government officials)

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

6. Health savings account deduction

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

7. Job-related moving expenses

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

8. Deductible part of self-employment (S/E) tax

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

9. S/E, SIMPLE & qualified plans

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

10. S/E health insurance deduction

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

11. Penalty on early withdrawal of savings

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

12. Alimony paid

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

13. Domestic production activities deduction

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

14. Additional adjustments added on line 36 (IRS Form 1040 only)

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

15. Archer MSA deduction

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

Other Adjustment (Please Specify) _____

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

Other Adjustment (Please Specify) _____

YES

NO

WHO _____

AMOUNT/VALUE & FREQUENCY _____

WHO _____

AMOUNT/VALUE & FREQUENCY _____

SECTION 17 – STEPPARENT/NON-CITIZEN WITH SATISFACTORY IMMIGRATION STATUS SPONSOR INFORMATION

Answer all questions listed below.

Does the stepparent of any children who live with you have any resources or receive income of any kind?

YES

NO

WHO? _____

Is anyone in your household a non-citizen with satisfactory immigration status who was sponsored for admission into the U.S.?

YES

NO

WHO? _____

NAME OF SPONSOR: _____

PHONE NO.: _____

ADDRESS: _____

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SECTION 18 – EMPLOYMENT INFORMATION

1. I am currently:

employed

self-employed

unemployed

Gross Income \$ _____

Hours Worked Monthly _____

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

Paid:

Weekly

Biweekly

Monthly

Day of the week paid: _____

Employer's Name and Address: _____

Phone No. _____

2. Is anyone else who lives with you currently:

employed

self-employed

Who: _____

Gross Income \$ _____

Hours Worked Monthly _____

Paid:

Weekly

Biweekly

Monthly

Day of the week paid: _____

Employer's Name and Address: _____

Phone No. _____

3. Is health insurance available through your employer?

Yes

No

Does anyone who lives with you have health insurance with an employer?

Yes

No

Who: _____

Name of Insurance Company: _____

4. Do you or anyone who lives with you have child or dependent care expenses due to employment?

Yes

No

Who: _____

5. Do you or anyone who lives with you have other employment-related expenses?

Yes

No

Who: _____

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

Who: _____

When: _____

Where: _____

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

7. Are you or is anyone who lives with you participating in a strike?

Yes

No

Who: _____

When the strike began: _____

8. Are you or is anyone who lives with you a migrant or seasonal farm worker?

Yes

No

Who: _____

9. 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: _____

10. Could you accept a job today?

Yes

No

If not, why? _____

11. What type of work would you like to do? _____

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SECTION 19 – EDUCATION/TRAINING

1. 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

2. 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: _____

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

3. Is or has been in any training program **in the last 12 months?**

Yes

No

Who _____

Where _____

Program _____

Dates attended _____

Dates completed _____

4. Is 16 years of age or older and is attending school or college?

Yes

No

Who _____

Where _____

5. Is getting a Training Allowance?

Yes

No

Who _____

Amt. \$ _____

6. Is getting Educational Grants or Loans?

Yes

No

Who _____

Amt. \$ _____

7. Is under 16 years of age and is attending school?

Yes

No

Who _____

School _____

Who _____

School _____

Who _____

School _____

Who _____

School _____

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SECTION 20 – RESOURCES INFORMATION

Indicate if you or anyone who lives with you who is recertifying:

1. Has cash available

YES

NO

WHO _____

IF YES, AMOUNT/VALUE \$ _____

WHO _____

IF YES, AMOUNT/VALUE \$ _____

2. Has a checking account(s)

YES

NO

WHO _____

IF YES, AMOUNT/VALUE \$ _____

WHO _____

IF YES, AMOUNT/VALUE \$ _____

3. Has a savings account(s) or certificate(s) of deposit

YES

NO

WHO _____

IF YES, AMOUNT/VALUE \$ _____

WHO _____

IF YES, AMOUNT/VALUE \$ _____

4. Has a credit union account(s)

YES

NO

WHO _____

IF YES, AMOUNT/VALUE \$ _____

WHO _____

IF YES, AMOUNT/VALUE \$ _____

5. Has life insurance

YES

NO

WHO _____

IF YES, AMOUNT/VALUE \$ _____

WHO _____

IF YES, AMOUNT/VALUE \$ _____

6. Has title or registration to a motor vehicle(s) or other vehicle(s):

Year _____

Make/Model _____

Year _____

Make/Model _____

Other _____

YES

NO

WHO _____

IF YES, AMOUNT/VALUE \$ _____

WHO _____

IF YES, AMOUNT/VALUE \$ _____

7. Has stocks, bonds, certificates or mutual funds

YES

NO

WHO _____

IF YES, AMOUNT/VALUE \$ _____

WHO _____

IF YES, AMOUNT/VALUE \$ _____

8. Has savings bonds

YES

NO

WHO _____

IF YES, AMOUNT/VALUE \$ _____

WHO _____

IF YES, AMOUNT/VALUE \$ _____

9. Has an IRA, Keogh, 401(k) or deferred compensation account(s)

YES

NO

WHO _____

IF YES, AMOUNT/VALUE \$ _____

WHO _____

IF YES, AMOUNT/VALUE \$ _____

10. Has an irrevocable burial trust

YES

NO

WHO _____

IF YES, AMOUNT/VALUE \$ _____

WHO _____

IF YES, AMOUNT/VALUE \$ _____

11. Has a burial fund

YES

NO

WHO _____

IF YES, AMOUNT/VALUE \$ _____

WHO _____

IF YES, AMOUNT/VALUE \$ _____

12. Has a burial space

YES

NO

WHO _____

IF YES, AMOUNT/VALUE \$ _____

WHO _____

IF YES, AMOUNT/VALUE \$ _____

13. Has their own home

YES

NO

WHO _____

IF YES, AMOUNT/VALUE \$ _____

WHO _____

IF YES, AMOUNT/VALUE \$ _____

14. Has real estate, including income-producing and non-income-producing property

YES

NO

WHO _____

IF YES, AMOUNT/VALUE \$ _____

WHO _____

IF YES, AMOUNT/VALUE \$ _____

15. Is eligible for an income tax refund

YES

NO

WHO _____

IF YES, AMOUNT/VALUE \$ _____

WHO _____

IF YES, AMOUNT/VALUE \$ _____

16. Has an annuity

YES

NO

WHO _____

IF YES, AMOUNT/VALUE \$ _____

WHO _____

IF YES, AMOUNT/VALUE \$ _____

17. Is the beneficiary of a trust

YES

NO

WHO _____

IF YES, AMOUNT/VALUE \$ _____

WHO _____

IF YES, AMOUNT/VALUE \$ _____

18. Expects to receive a trust fund, lawsuit settlement, inheritance or income from any other sources

YES

NO

WHO _____

IF YES, AMOUNT/VALUE \$ _____

WHO _____

IF YES, AMOUNT/VALUE \$ _____

19. Has an "in trust" account(s)

YES

NO

WHO _____

IF YES, AMOUNT/VALUE \$ _____

WHO _____

IF YES, AMOUNT/VALUE \$ _____

20. Has a safe deposit box(es)

YES

NO

WHO _____

IF YES, AMOUNT/VALUE \$ _____

WHO _____

IF YES, AMOUNT/VALUE \$ _____

21. Has resources other than those listed above

YES

NO

WHO _____

IF YES, AMOUNT/VALUE \$ _____

WHO _____

IF YES, AMOUNT/VALUE \$ _____

22. 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?

YES

NO

WHO _____

IF YES, AMOUNT/VALUE \$ _____

WHO _____

IF YES, AMOUNT/VALUE \$ _____

23. 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? _____

YES

NO

WHO _____

IF YES, AMOUNT/VALUE \$ _____

WHO _____

IF YES, AMOUNT/VALUE \$ _____

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SECTION 21 – MEDICAL INFORMATION

Indicate if you or anyone who lives with you who is recertifying:

1. Has any medical bills or medically-related expenses

YES

NO

IF YES, WHO _____

2. Is on Medicaid with a spend-down

YES

NO

IF YES, WHO _____

3. Has health or hospital/accident insurance (including insurance from employer)

YES

NO

IF YES, WHO _____

POLICY NO.: _____

AMOUNT: _____

FREQUENCY OF PAYMENT: _____

4. Has health insurance available through an employer

YES

NO

IF YES, WHO _____

INSURANCE COMPANY NAME: _____

WHO IS COVERED: _____

EFFECTIVE DATE: _____

5. Has Medicare (red, white, and blue card)

YES

NO

IF YES, WHO _____

INSURANCE COMPANY NAME: _____

WHO IS COVERED: _____

EFFECTIVE DATE: _____

6. Has a health attendant/home health aide

YES

NO

IF YES, WHO _____

INSURANCE COMPANY NAME: _____

WHO IS COVERED: _____

EFFECTIVE DATE: _____

7. Is blind, sick or disabled

YES

NO

IF YES, WHO _____

**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?

8. Is a child with a developmental disability

YES

NO

IF YES, WHO _____

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?

9. Is in a hospital, nursing home or other medical institution

YES

NO

IF YES, WHO _____

10. Has paid or unpaid medical bills within 3 months preceding the month of this recertification

YES

NO

IF YES, WHO _____

11. Is or was drug or alcohol dependent

YES

NO

IF YES, WHO _____

12. Needs home care/personal care

YES

NO

IF YES, WHO _____

13. Is on SSI or has ever applied for SSI

YES

NO

IF YES, WHO _____

14. Is pregnant

If pregnant, due date: _____

Expected number of births: _____

YES

NO

IF YES, WHO _____

15. Receives treatment from a drug abuse or alcohol treatment program

YES

NO

IF YES, WHO _____

16. Has not been able to work for at least 12 months because of a disability or illness

YES

NO

IF YES, WHO _____

17. Has daily activity limited because of a disability or illness that has lasted or will last at least 12 months

YES

NO

IF YES, WHO _____

18. Has been in a car accident or work-related accident in the past two years

YES

NO

IF YES, WHO _____

19. Has had a government agency (public program) besides Medicaid or Medicare pay any of your medical bills

If yes, what agency _____

YES

NO

IF YES, WHO _____

20. 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?

YES

NO

IF YES, WHO _____

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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/X _____

ID# (from Medicaid Card if you have one) _____

Social Security # _____

Primary Care Provider (PCP) or Health Center (check box if current provider) _____

Name and ID# of OB/GYN (check box if current provider) _____

Name of Plan You Are Enrolling In _____

Last Name _____

First Name _____

Date Of Birth mm/dd/yy _____

Sex M/F/X _____

ID# (from Medicaid Card if you have one) _____

Social Security # _____

Primary Care Provider (PCP) or Health Center (check box if current provider) _____

Name and ID# of OB/GYN (check box if current provider) _____

Name of Plan You Are Enrolling In _____

Last Name _____

First Name _____

Date Of Birth mm/dd/yy _____

Sex M/F/X _____

ID# (from Medicaid Card if you have one) _____

Social Security # _____

Primary Care Provider (PCP) or Health Center (check box if current provider) _____

Name and ID# of OB/GYN (check box if current provider) _____

Name of Plan You Are Enrolling In _____

Last Name _____

First Name _____

Date Of Birth mm/dd/yy _____

Sex M/F/X _____

ID# (from Medicaid Card if you have one) _____

Social Security # _____

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?
(____) _____

Do you or anyone who lives with you have a rent, mortgage or other shelter expense?

YES

NO

IF YES, AMOUNT \$ _____

Do you or anyone who lives with you have a heat bill separate from your rent or other shelter expense?

YES

NO

IF YES, AMOUNT \$ _____

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SECTION 22 – SHELTER (CONT.)

Do you or anyone who lives with you have the following expenses separate from your rent or other shelter expense?

1. Electricity (for needs other than heat; example: lights, cooking, hot water, etc.)

YES

NO

IF YES, AMOUNT \$ _____

2. Natural Gas (for needs other than heat; example: cooking, hot water, etc.)

YES

NO

IF YES, AMOUNT \$ _____

3. Water

YES

NO

IF YES, AMOUNT \$ _____

4. Air Conditioning

YES

NO

IF YES, AMOUNT \$ _____

5. Propane (for needs other than heat)

YES

NO

IF YES, AMOUNT \$ _____

6. Sewer

YES

NO

IF YES, AMOUNT \$ _____

7. Trash

YES

NO

IF YES, AMOUNT \$ _____

8. Other Utilities and Expenses

Specify _____

YES

NO

IF YES, AMOUNT \$ _____

9. Do you live in public housing?

YES

NO

10. Do you live in Section 8, HUD, or other subsidized housing?

YES

NO

11. Do you live in a drug/alcohol treatment facility?

YES

NO

ADDITIONAL INFORMATION

SECTION 23 – OTHER EXPENSES

Indicate if you or anyone who lives with you who is recertifying:

1. Pays child support

YES

NO

IF YES, AMOUNT \$ _____

2. Pays spousal support

YES

NO

IF YES, AMOUNT \$ _____

3. Pays for child care

YES

NO

IF YES, AMOUNT \$ _____

4. Pays for dependent care

YES

NO

IF YES, AMOUNT \$ _____

5. Pays tuition, fees, or other educational expenses

YES

NO

IF YES, AMOUNT \$ _____

6. Has additional expenses (Example: car payment, car insurance payment, credit card payments, other loan payments, etc.)

Specify: _____

YES

NO

IF YES, AMOUNT \$ _____

7. 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?

YES

NO

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SECTION 24 – OTHER INFORMATION

8. Do you buy or plan to buy meals from a home delivery or communal dining service?

YES

NO

9. Are you able to cook or prepare meals at home?

YES

NO

10. Have you or anyone in your household ever been in the U.S. military?

Who? _____

YES

NO

11. Has your spouse ever been in the U.S. military?

YES

NO

12. Is anyone in your household a dependent of someone who is or was in the U.S. military?

Who? _____

YES

NO

Indicate if you or anyone who lives with you who is recertifying:

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?

YES

NO

WHO _____

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?

YES

NO

WHO _____

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?

YES

NO

WHO _____

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?

YES

NO

WHO _____

Have you or any member of your household been convicted of fraudulently receiving duplicate SNAP benefits in any state after September 22, 1996?

YES

NO

WHO _____

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?

YES

NO

WHO _____

Have you or any member of your household been convicted of trading SNAP benefits for firearms, ammunition or explosives, or drugs?

YES

NO

WHO _____

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?

YES

NO

WHO _____

Are you or any member of your household violating probation or parole according to a court order?

YES

NO

WHO _____

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.

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.

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NONDISCRIMINATION NOTICE –In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and

sexual orientation), religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity.

New York State additionally prohibits discrimination based on transgender status, gender dysphoria, 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.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), 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.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form, which can be obtained online at

<https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, from any USDA office by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must

contain the Complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted by: 1) mail: Food and Nutrition Service, USDA, 1320 Braddock Place, Room 334, Alexandria, VA 22314; 2) fax at (833) 256-1665 or (202) 690-7442; or 3) email: FNSCIVILRIGHTSCOMPLAINTS@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 available in Spanish, or call the State Information/Hotline Numbers found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

This institution is an equal opportunity provider.

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.

RELEASE OF EDUCATIONAL RECORDS I give permission to the New York State Department of Health and the social services district to obtain any information regarding the educational records of myself and/or my minor child(ren) for the following purposes: 1) verifying my

eligibility for Public Assistance, the Supplemental Nutrition Assistance Program, and/or Medicaid; 2) conducting reviews or investigations that result from conflicting information provided as part of the eligibility process; 3) claiming Medicaid reimbursement for health-related educational services; and 4) providing the appropriate federal government agency with access to this information for the sole purpose of audit.

NEW YORK CITY HOUSING AUTHORITY RESIDENT CONSENT TO SHARE INFORMATION – If you are applying for assistance in New York City, this consent will allow the New York City Housing Authority (“NYCHA”) to share information about you with the New York City Human Resources Administration/Department of Social Services (HRA) to help you and your household apply for assistance under the Supplemental Nutrition Assistance Program (“SNAP”), and/or for HRA cash assistance, which may include payment of rental arrears.

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If you sign this application below, NYCHA may share with HRA information relevant to your eligibility for, or level of, SNAP and/or cash assistance benefits including your

name, address, date of birth, and rent and utility payment information (such as monthly rent amount, rent payment history, rent balance, and appliance fees). Additionally, by signing this application below, you represent that you have the authority to consent on behalf of minor children listed in this application and you authorize NYCHA to share that child's name, address, and date of birth with HRA.

HRA will keep confidential any information that NYCHA shares and may only share the information with the local, state, and federal agencies that oversee HRA's SNAP and cash assistance benefit programs.

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 waived 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 they are or where they live 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.

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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.

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_____ 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 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, they 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 UNDER MEDICAID – I understand that I have a right as part of my Medicaid recertification, or within two years from the date of my application, to request reimbursement of expenses I paid for covered medical care, services, and supplies

received during the three-month period prior to the month of my application. I understand that after the date of my 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 whom you are legally responsible to support is recoverable from money you possess or may acquire. 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.

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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 their 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 understand that I will be provided with the LDSS-5145 form, “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, I understand that I am required to cooperate with the Child Support Enforcement Unit to locate any noncustodial, alleged, or intended parent; establish legal parentage for each individual under the age of 21 born to unmarried parents; and establish, modify, and/or enforce orders of support. I also understand that I will be provided with the LDSS-4279 form, “Notice of Responsibilities and Rights for Support,” which explains my responsibilities and rights if I do not cooperate with the Child Support Enforcement Unit.

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.

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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 _____

Rev. 05/04/2021



THE GREAT SEAL OF THE STATE OF NEW YORK

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

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. A) Will you be 18 years old on or before election day?

YES

NO

B) Are you at least 16 years of age and understand that you must be 18 years of age on or before

election day to vote, and that until you will be eighteen years of age at the time of such election your registration will be marked “pending” and you will be unable to cast a ballot in any election?

YES

NO

If you answered **NO** to both of the prior questions, you cannot register to vote.

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) _____

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

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)

11. Political Party

I wish to enroll in a political party

Democratic party

Republican party

Conservative party

Working Families party

Other _____

I do not wish 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



DONATE LIFE
New York State

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 hospitals upon your death.

Signature _____

Date _____

Rev. 05/04/2021

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;
- pre-register to vote if you are 16 or 17 years of age.

To Register You Must:

- be a U.S. citizen;
- be 18 years old (you may pre-register at 16 or 17 but cannot vote until you are 18);
- be a resident of the County, or of the City of New York at least 30 days before an election;
- not be in prison for a felony conviction
- not claim the right to vote elsewhere; and
- 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.