COMMONWEALTH OF VIRGINIA

Case Number _____

Date Received _____

RENEWAL APPLICATION FOR AUXILIARY GRANT (AG), SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP), AND TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

This is an application to renew your eligibility for benefits. You may bring this application to the local Department of Social Services office or mail it to the local Department of Social Services office. You may also apply online for renewal for SNAP or TANF at https://commonhelp.virginia.gov/access/.

A. HOUSEHOLD INFORMATION

1. Your Contact Information

Your Name (last, first, middle initial)

Your Street Address (include apartment number) | **City, State, ZIP**

Your Mailing Address (if different from your street address) | **City, State, ZIP**

In what city or county do you live? | **E-mail Address**

Primary Telephone Number | **Alternate Telephone Number**

Primary Method of Correspondence

If you would like to receive either text or email messages notifying you that some notices about your benefits may be accessed electronically through CommonHelp (www.CommonHelp.Virginia.gov), select one of the choices below. List either a cell telephone number or an email address. Once you choose a preferred electronic method of correspondence, it will be used for all programs on the case for which you have applied. If you do not choose to be notified by text or email, you will receive all written correspondence through the U.S. mail.

If you are completing this application on behalf of another individual as an authorized representative, all correspondence to you will be mailed. The applicant may contact the local department of social services to learn how to change the method of correspondence.

❑ **Text** ❑ **Email Cell Phone Number** _____ **Email Address** _____

2. **Household Composition**: This section includes information about everyone living in your home, even if you are not applying for that person. You may leave the Social Security Number blank if you are not applying for assistance for the person.

1 | **Self** | _____

Name (last, first, middle initial) | **Relationship to You** | **Birth Date** (mm-dd-yyyy)

Social Security Number:_____ **City, State, Country of Birth:**_____

Gender: ❑ Male ❑ Female **Are you a U.S. citizen?** ❑ Yes ❑ No

Marital Status: ❑ Married ❑ Never Married If No, immigration status: _____

❑ Separated ❑ Divorced ❑ Widowed **US Residency Date:** __/____/____

Highest Grade Completed:____ **Alien Registration Number:**_____

School Name if a Student: _____ **Are you disabled or pregnant?** ❑ Yes ❑ No

Are you a veteran or dependent? ❑ Yes ❑ No **:** **Are you temporarily living away from home?** ❑ Yes ❑ No

Program(s) Requested: **Date Left**___/___/_____ **Expected Return Date**___/____/____

❑ None ❑ AG ❑ SNAP ❑ TANF **Reason for being away:**

Providing the following information is voluntary and will not affect eligibility. Please check all that apply.

Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino

Racial Heritage: ❑ White ❑ Black/African American ❑ Asian ❑ Asian & Black/African American ❑ Asian & White
❑ American Indian/Alaskan Native ❑ Black/African American & White ❑ American Indian/Alaskan Native & White
❑ Native Hawaiian/Other Pacific Islander ❑ American Indian/Alaskan Native & Black ❑ Other/Unknown

Household Composition (continued)
If you need more space to list your household members, please ask for another form or write the information on a separate sheet.

2

Name (last, first, middle initial) | **Relationship to Applicant** | **Birth Date** (mm-dd-yyyy)

Social Security Number:_____ **City, State, Country of Birth:**_____

Gender: ❑ Male ❑ Female **Is this person a U.S. citizen?** ❑ Yes ❑ No

Marital Status: ❑ Married ❑ Never Married If No, immigration status: _____

❑ Separated ❑ Divorced ❑ Widowed **US Residency Date:** __/____/____

Highest Grade Completed:____ **Alien Registration Number:**_____

School Name if a Student: _____ **Is this person disabled or pregnant?** ❑ Yes ❑ No

Is this person a veteran or dependent? ❑ Yes ❑ No **:** **Is this person temporarily away from home?** ❑ Yes ❑ No

Program(s) Requested: **Date Left**___/___/_____ **Expected Return Date**___/____/____

❑ None ❑ AG ❑ SNAP ❑ TANF **Reason for being away:**

Providing the following information is voluntary and will not affect eligibility. Please check all that apply.
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Racial Heritage: ❑ White ❑ Black/African American ❑ Asian ❑ Asian & Black/African American ❑ Asian & White
❑ American Indian/Alaskan Native ❑ Black/African American & White ❑ American Indian/Alaskan Native & White
❑ Native Hawaiian/Other Pacific Islander ❑ American Indian/Alaskan Native & Black ❑ Other/Unknown

3

Name (last, first, middle initial) | **Relationship to Applicant** | **Birth Date** (mm-dd-yyyy)

Social Security Number:_____ **City, State, Country of Birth:**_____

Gender: ❑ Male ❑ Female **Is this person a U.S. citizen?** ❑ Yes ❑ No

Marital Status: ❑ Married ❑ Never Married If No, immigration status: _____

❑ Separated ❑ Divorced ❑ Widowed **US Residency Date:** __/____/____

Highest Grade Completed:____ **Alien Registration Number:**_____

School Name if a Student: _____ **Is this person disabled or pregnant?** ❑ Yes ❑ No

Is this person a veteran or dependent? ❑ Yes ❑ No **:** **Is this person temporarily away from home?** ❑ Yes ❑ No

Program(s) Requested: **Date Left**___/___/_____ **Expected Return Date**___/____/____

❑ None ❑ AG ❑ SNAP ❑ TANF **Reason for being away:**

Providing the following information is voluntary and will not affect eligibility. Please check all that apply.
Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino
Racial Heritage: ❑ White ❑ Black/African American ❑ Asian ❑ Asian & Black/African American ❑ Asian & White
❑ American Indian/Alaskan Native ❑ Black/African American & White ❑ American Indian/Alaskan Native & White
❑ Native Hawaiian/Other Pacific Islander ❑ American Indian/Alaskan Native & Black ❑ Other/Unknown

4

Name (last, first, middle initial) | **Relationship to Applicant** | **Birth Date** (mm-dd-yyyy)

Social Security Number:_____ **City, State, Country of Birth:**_____

Gender: ❑ Male ❑ Female **Is this person a U.S. citizen?** ❑ Yes ❑ No

Marital Status: ❑ Married ❑ Never Married If No, immigration status: _____

❑ Separated ❑ Divorced ❑ Widowed **US Residency Date:** __/____/____

Highest Grade Completed:____ **Alien Registration Number:**_____

School Name if a Student: _____ **Is this person disabled or pregnant?** ❑ Yes ❑ No

Is this person a veteran or dependent? ❑ Yes ❑ No **:** **Is this person temporarily away from home?** ❑ Yes ❑ No

Program(s) Requested: **Date Left**___/___/_____ **Expected Return Date**___/____/____

❑ None ❑ AG ❑ SNAP ❑ TANF **Reason for being away:**

Providing the following information is voluntary and will not affect eligibility. Please check all that apply.
Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino
Racial Heritage: ❑ White ❑ Black/African American ❑ Asian ❑ Asian & Black/African American ❑ Asian & White
❑ American Indian/Alaskan Native ❑ Black/African American & White ❑ American Indian/Alaskan Native & White
❑ Native Hawaiian/Other Pacific Islander ❑ American Indian/Alaskan Native & Black ❑ Other/Unknown

Household Composition (continued)

5

Name (last, first, middle initial) _____ **Relationship to Applicant** _____ **Birth Date** (mm-dd-yyyy) _____

Social Security Number:_____ **City, State, Country of Birth:**_____

Gender: ❑ Male ❑ Female **Is this person a U.S. citizen?** ❑ Yes ❑ No

Marital Status: ❑ Married ❑ Never Married If No, immigration status: _____

❑ Separated ❑ Divorced ❑ Widowed **US Residency Date:** __/____/____

Highest Grade Completed:____ **Alien Registration Number:**_____

School Name if a Student: _____ **Is this person disabled or pregnant?** ❑ Yes ❑ No

Is this person a veteran or dependent? ❑ Yes ❑ No **:** **Is this person temporarily away from home?** ❑ Yes ❑ No

Program(s) Requested: **Date Left**___/___/_____ **Expected Return Date**___/____/____

❑ None ❑ AG ❑ SNAP ❑ TANF **Reason for being away:**

Providing the following information is voluntary and will not affect eligibility. Please check all that apply.
Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino
Racial Heritage: ❑ White ❑ Black/African American ❑ Asian ❑ Asian & Black/African American ❑ Asian & White
❑ American Indian/Alaskan Native ❑ Black/African American & White ❑ American Indian/Alaskan Native & White
❑ Native Hawaiian/Other Pacific Islander ❑ American Indian/Alaskan Native & Black ❑ Other/Unknown

6

Name (last, first, middle initial) _____ **Relationship to Applicant** _____ **Birth Date** (mm-dd-yyyy) _____

Social Security Number:_____ **City, State, Country of Birth:**_____

Gender: ❑ Male ❑ Female **Is this person a U.S. citizen?** ❑ Yes ❑ No

Marital Status: ❑ Married ❑ Never Married If No, immigration status: _____

❑ Separated ❑ Divorced ❑ Widowed **US Residency Date:** __/____/____

Highest Grade Completed:____ **Alien Registration Number:**_____

School Name if a Student: _____ **Is this person disabled or pregnant?** ❑ Yes ❑ No

Is this person a veteran or dependent? ❑ Yes ❑ No **:** **Is this person temporarily away from home?** ❑ Yes ❑ No

Program(s) Requested: **Date Left**___/___/_____ **Expected Return Date**___/____/____

❑ None ❑ AG ❑ SNAP ❑ TANF **Reason for being away:**

Providing the following information is voluntary and will not affect eligibility. Please check all that apply.
Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino
Racial Heritage: ❑ White ❑ Black/African American ❑ Asian ❑ Asian & Black/African American ❑ Asian & White
❑ American Indian/Alaskan Native ❑ Black/African American & White ❑ American Indian/Alaskan Native & White
❑ Native Hawaiian/Other Pacific Islander ❑ American Indian/Alaskan Native & Black ❑ Other/Unknown

❑ YES ❑ NO 3. Is anyone in violation of parole or probation or fleeing capture to avoid prosecution or punishment of a felony? If YES, explain: _____

❑ YES ❑ NO 4. Has anyone been convicted of a felony that occurred after August 22, 1996, for possession, use, or distribution of drugs? If YES, explain: _____

❑ YES ❑ NO 5. Have any of your children received any immunizations since approval of your original application or since your most recent review? If YES, explain: _____

❑ YES ❑ NO 6. Have you or anyone for whom you are applying ever been disqualified from receiving TANF (AFDC) or SNAP benefits? If YES, explain: _____

B. RESOURCES

You do not have to complete this section if you are only renewing for TANF. Otherwise, answer for everyone for whom you are applying. Include any resources anyone owns, or that are jointly owned with someone else, even if that person does not live with you. List the names of all joint owners.

1. Do you or anyone who lives with you have any of the following resources or assets? .

Yes	No		Yes	No		Yes	No	
❑	❑	Cash $_____	❑	❑	Checking, Savings	❑	❑	Credit Union
❑	❑	401K, 403B, etc.	❑	❑	Promissory notes	❑	❑	Money Market Funds
❑	❑	Individual Retirement Account (IRA)	❑	❑	Christmas Club	❑	❑	Deeds of Trust
❑	❑	Deferred Compensation Plan	❑	❑	Uniform Gift to Minor Account	❑	❑	Retirement accounts
❑	❑	Keogh Plan	❑	❑	Certificate of Deposit (CD)	❑	❑	Trust funds
❑	❑	Stocks or bonds	❑	❑	Pension plans	❑	❑	Other

— If you have **any of the above**, please provide the following information:

a.

Owner Name (last, first, middle initial) | **Co-Owner Name** (last, first, middle initial)

Name of Bank or Institution | **Account Type** | **Account Number** | **$ Balance**

Address of Bank or Institution

b.

Owner Name (last, first, middle initial) | **Co-Owner Name** (last, first, middle initial)

Name of Bank or Institution | **Account Type** | **Account Number** | **$ Balance**

Address of Bank or Institution

❑ YES ❑ NO 2. Has anyone sold, transferred or given away any resources in the last 3 months (for SNAP), in the last 3 years (for Auxiliary Grants)? If YES, explain: _____

Note: Additional Resource information may be needed section if you are applying for the Auxiliary Grant program.

C. INCOME

1. Do you or anyone who lives with you receive or expect to receive any of the following types of money from working? Include money from all jobs that you have now or expect to begin: full time, part time, seasonal, temporary, self-employment. Answer Yes or No below and provide the requested information:

Yes	No		Yes	No		Yes	No	
❑	❑	Wages/Salary	❑	❑	Earned Sick Pay	❑	❑	Self-employment
❑	❑	Contract Income	❑	❑	Babysitting/Adult or child care	❑	❑	Any other money from working
❑	❑	Vacation Pay	❑	❑	Farming/Fishing			
❑	❑	Commissions, Bonuses, Tips	❑	❑	Odd jobs			

Name (last, first, middle initial) | **Employer Name, Address and Telephone Number**

Number of Hours Per Week | **Rate of Pay** | **Pay Schedule**: ❑ Weekly ❑ Monthly ❑ Biweekly ❑ Twice a Month ❑ Other

Date Job Started | **Next Pay Date** (mm/dd/yyyy)

Name (last, first, middle initial) | **Employer Name, Address and Telephone Number**

Number of Hours Per Week | **Rate of Pay** | **Pay Schedule**: ❑ Weekly ❑ Monthly ❑ Biweekly ❑ Twice a Month ❑ Other

Date Job Started | **Next Pay Date** (mm/dd/yyyy)

INCOME (continued)

❑ YES ❑ NO 2. Has anyone been fired, laid off, gone on sick or maternity leave, gone on strike, quit a job, or reduced hours worked since you applied? If **YES**, give name and explain: _____

3. Do you or anyone who lives with you (including children) receive or expect to receive any of the following? Answer yes or no below and provide the requested information

Yes	No		Yes	No		Yes	No	
❑	❑	Social Security	❑	❑	VA benefits	❑	❑	Strike benefits
❑	❑	Child support, alimony	❑	❑	Unemployment benefits	❑	❑	Prize winnings
❑	❑	Cash gifts or contributions	❑	❑	Room/board income	❑	❑	All food, clothing, utilities, or rent
❑	❑	Loans	❑	❑	Black Lung benefits	❑	❑	Other retirement
❑	❑	SSI	❑	❑	Worker compensation	❑	❑	Interest, dividends
❑	❑	Military Allotment	❑	❑	Rental Income	❑	❑	Insurance settlement
❑	❑	Public Assistance (TANF, GR etc)	❑	❑	Inheritance	❑	❑	Any other type of money
❑	❑	Training allowances (WIA, etc.)	❑	❑	Railroad retirement			

a. _____	$ _____	_____	_____
Name of Person	**Amount**	**Type of Money or Help**	**How Often Received?**
b. _____	$ _____	_____	_____
Name of Person	**Amount**	**Type of Money or Help**	**How Often Received?**
c. _____	$ _____	_____	_____
Name of Person	**Amount**	**Type of Money or Help**	**How Often Received?**

❑ YES ❑ NO 4. Does anyone <u>besides the people on your case</u> pay directly for you, help you pay, or lend you money to pay rent, utilities, medical bills or any other bills? <u>OR</u> does anyone totally supply food, shelter or clothing for you or someone else on a regular basis? If **YES**, give name, amount, and explain:_____

_____

❑ YES ❑ NO 5. Does anyone have a day care expense for a child, an elderly person, or an adult with a disability? If **YES**, give name, amount and explain: _____

_____

❑ YES ❑ NO 6. Does anyone pay legally obligated child support to someone not in the household? If **YES**, give name of person paying, person supported, and amount: _____

_____

D. FINANCIAL ASSISTANCE FOR CHILDREN

❑ YES ❑ NO 1. Has the absent parent(s) begun supporting the children or changed the amount of support?

If **YES**, explain: _____

❑ YES ❑ NO 2. Has the legal parent(s) become disabled such that he or she is unable to work? If **YES**, explain:

_____

❑ YES ❑ NO 3. Do you have any new information that would help us locate the absent parent(s)? If **YES**, explain;

_____

E. SNAP BENEFITS

1. List the name of the person who is the head of your household:_____

2. An authorized representative may apply for SNAP benefits on your behalf, receive and use your SNAP benefits on your behalf, or receive copies of your program notices. If you want to name an authorized representative, please give the information below about the representative and what you want the representative to do on your behalf.

Name, Address and Telephone Number of the Authorized Representative	Check (✓) each duty authorized for that person
	❑ Apply for SNAP benefits ❑ Receive correspondence ❑ Receive or use SNAP benefits

❑ YES ❑ NO 3. Is anyone living in your home NOT included in your SNAP application? If **YES**, do you and everyone for whom you are applying usually purchase and prepare meals apart from these people? Or, do you intend to do so if your application for SNAP benefits is approved? Check (✓) ❑ YES ❑ NO

❑ YES ❑ NO 4. Is anyone living in your home a roomer or boarder? If **YES**, list names: _____

_____

❑ YES ❑ NO 5. Is anyone age 60 or older OR approved to receive Medicaid because of a disability OR receiving any type of disability payment? If **YES**, list all current medical expenses for these people.

Household Member with Medical Expense	Type of Expense	Amount	Name of Doctor, Hospital, Pharmacy

❑ YES ❑ NO 6. Do you have any of the following shelter expenses? If **YES**, list your current expenses.
Check (✓) here ❑ if these expenses are for a house you do not live in.

Expense	Amount Billed	How Often Billed?	Who is Responsible for the Bill?
Rent/Mortgage			
Taxes			
Insurance			
Electricity			
Gas/Oil/Kerosene			
Coal/Wood			
Water/Sewage/Garbage			
Telephone			
Installation			

6a How do you heat your home? _____

❑ YES ❑ NO 6b Do you have air conditioning in your home?

❑ YES ❑ NO 6c Did you receive energy/fuel assistance during this past year while living in your current home?

❑ YES ❑ NO 6d Are you staying temporarily in someone else's home, an emergency shelter, welfare hotel, other halfway house, or a place not usually used for sleeping? If **YES**, how much does it cost to stay there during the month?

_____

If you are staying temporarily in someone else's home, when did you move there? _____

USDA Nondiscrimination Statement

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

Commonwealth of Virginia Voter Registration Agency Certification

If you are not registered to vote where you live now, would you like to apply to register to vote here today?
(Please check only one)

- ❑ I am already registered to vote at my current address, or I am not eligible to register to vote and do not need an application to register to vote.
- ❑ Yes, I would like to apply to register to vote. (Please fill out the voter registration application form)
- ❑ No, I do not want to register to vote.

If you do not check any box, you will be considered to have decided **not to** register to vote at this time. Applying to register to vote or declining to register to vote will not affect the assistance or services that you will be provided by this agency. If you decline to register to vote, this fact will remain confidential. If you do register to vote, the office where your application was submitted will be kept confidential, and it will be used only for voter registration purposes. If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private if you desire.

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, you may file a complaint with: Secretary of the Virginia State Board of Elections, Washington Building, 1100 Bank Street, Richmond, VA 23219-3497, telephone (804) 864-8901.

Applicant Name	Signature	Date

for agency use only

Voter Registration form completed: ❑ Yes ❑ No
Voter Registration form given to applicant for later mailing (at applicant's request) ❑

Agency Staff Signature	Date

VERIFICATION AND USE OF INFORMATION

Information you give on this application, including Social Security numbers (SSN), may be matched against federal, state, and local records. These records include:

- Virginia Employment Commission (VEC)
- Internal Revenue Service (IRS)
- Social Security Administration (SSA)
- Department of Motor Vehicles (DMV)
- US Citizenship and Immigration Services (USCIS)
- Income and Eligibility Verification System IEVS)

SNAP CHANGE REPORTING,

You must report changes that occur for SNAP but, what you must report is tied to how long you are determined eligible for benefits, the certification period. You must report changes that occur during the certification period within 10 days, but no later than the 10th day of the month after the change occurs.

Changes that need to be reported during the certification period for SNAP depend on the length of the certification period. "Simplified Reporting" applies to households that are eligible for SNAP benefits for five (5) months or longer. "Change Reporting" applies to households that are eligible for one (1) month to four (4) months.

INTERIM REPORT FILING

In addition to reporting changes when they occur during the SNAP certification period, Simplified Reporting households may be required to submit an Interim Report in the sixth or twelfth month. The Interim Report is used to determine the amount of SNAP benefits households will receive for the second half of the certification period. The Interim Report provides a snapshot of household circumstances that were presented at the time of application. We will ask for proof of income changes and changes in legal obligations to pay child support. If households fail to return the completed Interim Report by the fifth of the month, SNAP benefits for the seventh or thirteenth month may be delayed or closed. Assistance for filing the Interim Report is available by calling the telephone number printed on the form.

BY MY SIGNATURE BELOW, I DECLARE, UNDER PENALTY OF PERJURY, THAT THE INFORMATION PRESENTED HERE IS CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

I understand:

- All of my responsibilities, including my responsibility to report required changes on time.
- If I give false, incorrect, or incomplete information, or do not report required changes on time, I may be breaking the law and could be prosecuted.
- If I helped someone complete this form so as to get benefits he or she is not entitled to, I may be breaking the law and could be prosecuted.
- If I refuse to cooperate with any review of my eligibility, including reviews by Quality Assurance, my benefits may be denied until I cooperate.
- If my application is for SNAP, failure to report or verify of my expenses will be seen as a statement by my household that I do not want to receive a deduction for unreported expenses.

My signature authorizes the release to this agency of all information necessary to both determine and review my eligibility This authorization is valid for one year from the date of my signature below. I understand that this time limit does not apply to investigations regarding possible fraud.

I filled in this application myself: ❑ Yes ❑ No
If NO, it was read back to me when complete: ❑ Yes ❑ No

_____ _____
Your Signature or Authorized Representative's Signature or Mark Date

_____ _____
Witness to Mark or Interpreter Date

Complete this section if this application was completed for the applicant by someone else.

_____ _____ _____
Name of person completing application Date Relationship to applicant

Primary Telephone Number _____ Alternate Telephone Number _____

AUXILIARY GRANT SUPPLEMENTAL RENEWAL APPLICATION

Name: _____ Case Number _____ Date Received _____

Note: This form must be completed in addition to the Renewal Application Form (032-03-729A).

This supplemental application may be used for the renewal of Medical Assistance programs for persons receiving Auxiliary Grant benefits. The following questions will help determine Medicaid eligibility through the Department of Social Services. If you are not eligible for Medicaid at renewal and you do not have Medicare, your information will be used for possible eligibility for Advanced Premium Tax Credits (APTC) for private health insurance through the Federal Marketplace (Healthcare.gov).

❑ YES ❑ NO 1. Do you own any household goods or personal effects worth more than $500? If YES, list the items and their value here. _____

❑ YES ❑ NO 2. Has anyone made any third party payments to an Assisted Living Facility on your behalf? If YES, who made the payments? _____

How much was paid on your behalf? _____

❑ YES ❑ NO 3. Does anyone own any personal property, such as campers/trailers, non-motorized boats, utility trailers, tools, equipment, supplies, or livestock?

Owner(s)	Type	Is this property used in your business or trade, including farming?	Value	Amount Owed	Date Acquired
		YES ( ) NO ( )			

❑ YES ❑ NO 4. Does anyone own any real property, including life estates, inherited property, land, buildings, or mobile homes? If YES, do you live there? Check (✓): ❑ YES ❑ NO

Owner(s)	Type	YES ( ) NO ( ) Currently rented? YES ( ) NO ( ) Income-producing? YES ( ) NO ( ) Currently for sale?	Value	Amount Owed	Date Acquired
			$	$	

❑ YES ❑ NO 5. Does anyone own vehicles, such as cars, trucks, vans, motorboats, motor homes, recreational vehicles, or motorcycles/mopeds?

Owner(s)	Type, Make, Model, Year	Currently Licensed?	Vehicle ID# License #	Value Amount Owed	How Used	Date Acquired
		❑ YES ❑ NO	# #	$ $		

❑ YES ❑ NO 6. Does anyone have health insurance?

Policy Holder	Company Name, Address, Phone	Begin Date End Date	ID Number Premium Amount	Coverage Type	Person(s) Insured
			# $		

❑ YES ❑ NO 7. Does anyone have Medicare?

Person Insured	Claim Number	Coverage			
		❑ Part A ❑ Part B			
		❑ Part A ❑ Part B			

032-03-729C-01-eng (08/14)

❑ YES ❑ NO 8. Does anyone have life insurance, retirement insurance, or other related types of insurance policies?

Owner(s)	Person(s) Insured	Company Name, Address, Phone,	Type of Policy	Policy Number	Face Value Cash Value	Date Acquired

9) List the names of everyone expected to be included on the same tax return as you for this year, whether or not they live in the same home as you. For anyone in the home that does not file taxes and does not expect to be on anyone else's tax return, list those names under "Non-filer(s)".

Tax Filer:	
Joint Taxpayer:	
Tax Dependent(s):	
Non-filer(s):	

BY MY SIGNATURE BELOW, I DECLARE, UNDER PENALTY OF PERJURY, THAT THE INFORMATION PRESENTED HERE IS CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

I understand:
All of my responsibilities, including my responsibility to report required changes on time.
If I give false, incorrect, or incomplete information, or do not report required changes on time, I may be breaking the law and could be prosecuted.
If I helped someone complete this form so as to get benefits he or she is not entitled to, I may be breaking the law and could be prosecuted.
If I refuse to cooperate with any review of my eligibility, including reviews by Quality Assurance, my benefits may be denied until I cooperate.
I understand that if I do not qualify for Medical Assistance my local department of social services will check to so see if I qualify for other kinds of health coverage. My local department of social services may send my information to another program so they can see if I qualify.

My signature authorizes the release to this agency of all information necessary to both determine and review my eligibility This authorization is valid for one year from the date of my signature below. I understand that this time limit does not apply to investigations regarding possible fraud.

I filled in this application myself: ❑ YES ❑ NO If NO, it was read back to me when complete: ❑ YES ❑ NO

_____ _____
Your Signature or Authorized Representative's Signature or Mark Date

_____ _____
Witness to Mark or Interpreter Date

Complete this section if this application was completed for the applicant by someone else.

_____ _____ _____
Name of person completing application Date Relationship to applicant

Primary Telephone Number _____ Alternate Telephone Number _____

032-03-729C-01-eng (08/14)

AUXILIARY GRANT (AG), SUPPLEMENTAL RENEWAL APPLICATION

FORM NUMBER - 032-03-729C

PURPOSE OF FORM – To collect additional information to renew eligibility for AG and persons receiving Medicaid with AG benefits.

USE OF FORM – This supplemental application is limited to renewal of AG. This application may not be used in lieu of an application to apply for initial benefits, or to protect the date of application. This supplemental application must be accompanied by the Renewal Application for Auxiliary Grant (AG), Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance For Needy Families (TANF) (032-03-729A) to be a valid application. This form also allows for the renewal of Medical Assistance (MA) programs for individuals receiving the Auxiliary Grant benefit.

NUMBER OF COPIES - One.

DISPOSITION OF FORM – This application must be completed at the time of the eligibility review for AG. The completed application must be filed in the AG case record.

INSTRUCTIONS FOR PREPARATION OF FORM – The supplemental renewal application must be completed in its entirety.