

KAMES-INTEGRATION APPLICATION

ART I.

- (J) Assigned Caseload: _____ (J) Date of Application: _____ (J) Caseworker: _____
- (I) Program Applying For: _____ (If State Supp or Pass Through, complete Supp. 1; If Foster Care, complete Supp. K)
- (I) Applying for Self? _____
- (J) Case Name: _____ (J) Your SSN: _____
- (J) Home Address: _____
- (J) City/State/Zip: _____ (J) Phone: _____
- If your mailing address is different from your home address, what is it?
- (J) Mailing Address: _____
- (J) City/State/Zip: _____
- (F) Does the household have an authorized representative? _____
- (I) If IM, is person making application different from case name, or is there a protective payee? _____
- (If yes to either of the above questions, complete Supplement A)
- (J) Is anyone in your household on strike? _____ (If yes, complete a Supplement C, Part C)
- (J) Are all members of your household by definition homeless? _____
- (J) Is client/applicant a resident of Kentucky? _____ (J) County of Residence: _____
- (J) Residency verification source: _____ (J) Date: _____
- FOR: _____

FS applicants complete the following questions: If your household has little or no income or resources you may be able to receive food stamps within a few days. Please answer these questions to help us decide if you need food stamps right away.

- _____ How much do the members of your household have in cash and savings?
- _____ What is the total gross income for the month for everyone in your household?
- _____ Is anyone in your household a migrant or seasonal farm worker?
- _____ If yes, is this household destitute?
- _____ Has every member of your household been approved for or now receive AFDC or SSI?
- _____ Do shelter expenses exceed gross income and liquid resources?

(The **FS** applicant must sign here if only part I is completed.)

The information I gave on this application is complete and true to the best of my knowledge. I understand if I give false information or do not report all of the information needed, I may be subject to prosecution for fraud. I understand that I shall complete an interview and provide any needed information or proof of eligibility before this application can be approved.

Signature: _____ Date: _____

Witness if X: _____

All food stamp applications are considered without regard to race, color, age, sex, disability, religious creed, national origin or political belief.

You or someone you choose to represent you may request a fair hearing if you disagree with any action taken on your case or feel like you have been treated unfairly. The hearing can be requested by calling or going to the food stamp office or by writing a request and sending it to the office. At the hearing, you can be represented by anyone you choose.

Residents of public institutions, who apply for food stamps prior to their release from the institution, shall have eligibility for benefits determined beginning with the date they are released from the institution.

PART II. HOUSEHOLD LEVEL INFORMATION

A. HOUSEHOLD MEMBERS

List all people who live at this address. Enter a status code under each program(s) requested; apply FS policy and IM standard filing unit/relative responsibility. For IM, each "M" and "R" individual must have an ID Code entry.

First Name	MI	Last Name	SSN	Mult SSN?	Birthdate	Sex	FS	IM	ID Code	From	To
(J) _____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
(J) _____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
(J) _____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
(J) _____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
(J) _____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

(J) Household size verification source: _____ Date: _____
 (J) Are there more? _____ (If yes, complete Supp. C, Part A.) (For children and IM ID 61 in C, W, L, N, Y, I, P, or U cases, complete Supp. L.) (If any member has a boarder status, complete Supp. C, Part D or E.) (Complete Supp. X, if these conditions are met: If IM ID is 40-42, 47-50, or 60, Pg. 1; If IM ID is 43, 56-58, Pg. 2; If IM ID is 44, Pg. 3; If IM ID is 45, Pg. 4; If IM ID is 46, 51, 53-55, Pg. 5; If IM ID is 52, Pg.6.) (If FS Non-Member, complete Supp. XX.)

B. APPLICATION MEMBERS - IM applicants complete this section.

MEMBER NAME	SSN	ID CODE	HIGHEST GRADE	LAST JOB	AVG HRS PER WEEK CODE	WIC REFERRAL
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

(If more than 5 household members, complete Supplement C, Part B)

C. GENERAL HOUSEHOLD INFORMATION

Please answer the following questions about you and your household.

- _____ (F) Does anyone eat in a communal dining facility?
- _____ (F) Does anyone receive meals on wheels?
- _____ (F) Does anyone use a food delivery service?
- _____ (F) Is the household living in a certified Rehab Drug/Alcohol/Mental Health Center or a person defined as blind or disabled in an eligible group living arrangement?
- _____ (F) If a group living arrangement, how many people live in this home?
- _____ (F) Is anyone in your household a migrant or seasonal farmworker?
- _____ (J) Does anyone in your household own a vehicle? (If yes complete Supplement E)
- _____ (J) Does anyone receive income from self employment (non-farm and non-boarder)? (If yes, complete Supp. D, Part B.)
- _____ (J) Does anyone receive income from rental property? (If yes, complete Supp. D, Part B.)
- _____ (J) Does anyone receive income from self-employment (farm income)? (If yes, complete Supp. D, Part A.)
- _____ (I) If yes, have farming activities ceased?
- _____ (F) Is the household living in a center for abused spouses?
- _____ (I) Is the household living in an emergency shelter? (If yes, complete Supp. F.)
- _____ (I) What banking institution(s) does your household use to cash checks?
- _____ (I) Is the applicant eligibility test appropriate?
(FS Applicants must complete Supplement B.)

PART III. MEMBER LEVEL INFORMATION

GENERAL MEMBER INFORMATION

Please provide the following information for the head of the household. (If there are additional household members, complete a Supplement G. for each additional member.)

MEMBER #1:

_____ (SSN) _____ (First Name) _____ (MI) _____ (Last Name)

- _____ (J) If this person has no SSN, will this person apply for one?
- _____ (J) Date of SS-5: _____ (J) Good Cause Date: _____
- _____ (J) Is it "necessary" for anyone outside of the household to be paid to take care of this person (Dependent Care, not Medical Expenses)?
- _____ (J) What is the SSN of the member who pays for this care?
- _____ (J) Amt Paid: _____ (J) Ver Amt: _____ (J) Ver Src: _____ (J) Date: _____
- _____ (I) Is dependent care valid for an IM child over the age of 12?
- _____ (F) Is this a joint application for SSI and food stamps?
- _____ (J) Is this person providing care for a disabled person or child?
 - _____ (J) If yes and a child, what is the youngest child's birthdate?
 - _____ (I) If yes and a disabled person, does this person live with you?
 - _____ (I) If yes and a child, are you the parent or other relative?
 - _____ (F) Is adequate child care available?
- _____ (F) Is this person JOBS or UIB registered?
- _____ (F) Is this person verified unable to work?
- _____ (F) Is this person in a drug addiction or alcohol treatment program?
- _____ (F) Is this person working 30 hrs/wk or earnings/in-kind = 30 x min/wage?
- _____ (F) Is this person in a job/training program or exempt wk reg for medical reasons?
- _____ (J) Does this person live in an ineligible facility? If yes, ___FS ___IM

SAME FOR: _____

IM applicants complete the following questions:

_____ If not receiving food stamps, has this person applied?
 _____ Is she pregnant? If yes, expected date of delivery? _____
 _____ How many births are expected from this pregnancy? _____
 _____ Verification Source: _____ Date: _____
 _____ Is she in her postpartum period? If no longer pregnant, end date: _____
 _____ Was she pregnant at the time of previous termination in Kentucky?
 _____ Did she move out of state? Effective month of discontinuance: _____
 _____ Is this person covered by health insurance? (If yes, complete Supp.V)
 _____ Is this person married? If yes, is spouse living with this person? _____
 _____ Is this person potentially eligible for RSDI, Railroad Retirement, Black
 Lung, Veteran's Pension or Compensation, Workers Comp, Unemp Insurance, Veter-
 an's Admin Improved Pension, or other pensions?
 _____ If yes, has this person indicated they will apply for and comply with program
 requirements?
 _____ Verification Source: _____ Date: _____
 _____ Has this person complied with these requirements? Verif. Source: _____
 _____ Date: _____
 _____ Is this person potentially eligible for SSI? If yes, has this person ap-
 plied?
 _____ Verif Source: _____ Date: _____

SAME FOR: _____

MEMBER #1: _____
 (SSN) (First Name) (MI) (Last Name)

IM applicants please complete the following questions:

_____ Is this person attending school? (If yes, complete Supplement Y)
 _____ If child, and leaving foster care placement when will this child enter the
 household?
 _____ Is this person in a long term care facility, a waiver program (HCBS, AIS/MR),
 Hospice, or a child in an approved psychiatric facility? If yes, enter pro-
 vider number(s): _____ (Complete Supp. J for each provider
 number entered)
 _____ If the child is in an approved psychiatric facility, will the child be absent
 from the parents home for 30 days or more? Ver. Src: _____ Date: _____
 _____ If the child is in an approved psychiatric facility, is the child in custody
 of DSS?
 _____ Ver. Src: _____ Date: _____
 _____ Is child currently a patient? Date facility contacted: _____
 _____ If a U application, was the child previously in an X case?
 _____ Is this person receiving or conditionally enrolled in Medicare Part A?
 _____ Ver. Scr: _____ Date: _____
 _____ Has this person lost Social Security due to substantial gainful activity
 (SGA)?
 _____ Ver. Src: _____ Date: _____
 _____ End date of RSDI entitlement _____ Ver. Src. _____ Date: _____

(J) RACE: _____
04 White
05 Black
5 Asian
7 Hispanic
08 American Indian,
Alaskan
99 Refused to
Answer

(J) RELATIONSHIP TO APPLICANT: _____
01 Self
02 Parent
03 Spouse
04 Sibling
05 Child
06 Unrelated Adult
07 Unrelated Child
08 Grandson
09 Granddaughter
10 Stepson
11 Stepdaughter
12 Stepbrother
13 Stepsister
14 Nephew

(J) LANGUAGE: _____
01 English
02 Vietnamese
03 French
04 Spanish
05 Iranian
06 Russian
07 Sign
Language
99 Other

_____ (I) IM Relationship Type? (M-Maternal, P-Paternal, U-Unrelated)
_____ (J) Is this person a U.S. Citizen? _____ If an AFDC child, was this
child born out-of-state? (If No and an IM case, complete Supp. H)
_____ (F) If not, enter alien reg number Verif. Source: _____ Date: _____
_____ (I) If no, is he/she an alien in satisfactory status? (Y, N, or R)
_____ (I) When did he/she enter the U.S.A.?
_____ (F) Is this child under parental control?
_____ (F) Did this person receive FS in another state? This Month _____ Next Month _____
_____ (I) Are resources needed for this member for a QMB determination?

(J) SSN Verif Source: _____ Date: _____ (I) Date of Birth Verif Srce: _____ Date: _____
(F) Identity Verif Srce: _____ Date: _____ (I) Relationship Verif Srce: _____ Date: _____

(IM applicants please complete Supp. Q, Part I - JOBS and Part II - Work Registration, as appropriate).

(IM applicants please complete Supp. W, Part I - KenPAC and Part II - Lock In, as appropriate).

MBER #1: _____
(SSN) (First Name) (MI) (Last Name)

FS applicants please complete the following questions:

- _____ Is this person receiving or certified to receive Federal, State or local permanent disability retirement?
- _____ Is this person receiving or certified to receive SSI, State Supplementation, Railroad Retirement, or MA disability?
- _____ Is this person receiving or certified to receive SSA due to blindness/disability?
- _____ Is this person receiving or certified to receive Veteran's payments?
- _____ If yes, is it due to this persons verified 100% disability?
- _____ Is this person a veteran or surviving spouse of a veteran?
- _____ Is this person a surviving child of a veteran?
- _____ Is this person in need of aid or attendance?
- _____ Is this person permanently incapable of self support?
- _____ Is this person entitled to payment for a service connected death?
- _____ Is this person entitled to a nonservice connected death or disability pension?
- _____ Does this person have a verified permanent disability?
- _____ Is this person permanently housebound?
- _____ Does this person pay tuition or fees to attend a school for the mentally or physically handicapped?
- _____ Is this person 60 or over and verified as unable to purchase and prepare food?

SAME FOR: _____

FS applicants please complete the following questions:

- _____ Is this person work registering? If yes, date: _____
 - _____ If no, does this person refuse to register?
 - _____ Is this person an ETP volunteer? If yes, date: _____
 - _____ Concurrent Volunteer? Concurrent Volunteer Date: _____
 - _____ Is an AFDC app. pending on this member?
 - _____ Is this person the primary wage earner?
 - _____ Is another household member exempt from work reg. for caring for this member's child(ren)?
 - _____ Is this person potentially eligible for ETP child care?
 - _____ Has this person quit a job? If yes, why? _____ When? _____
 - _____ Does this make the household ineligible?
 - _____ Is this person receiving AFDC? _____ Is this person receiving State Supplementation?
 - _____ If not, has this person been approved for AFDC or State Supplementation?
 - _____ Is this person receiving SSI?
 - _____ In school 1/2 time or more? (High School/Job Training/ETP or TAA Higher Ed = Y)
 - _____ Is this person enrolled in a school or course of higher education?
 - _____ Are tuition/fees paid for technical, vocational, correspondence school or higher education?
- (If yes to student questions above, complete Supplement Y)

MEMBER #1: _____
 (SSN) (First Name) (MI) (Last Name)

- _____ (J) How many jobs will you be paid for in the period of _____ to _____?
(Complete a Supp. R for each job.)
- _____ (J) Does this person receive unearned income? If yes, types: _____ PA
 _____ RSDI _____ SSI _____ UIB _____ Defra Support _____ VA _____ Black
 Lung _____ RR Ret _____ Educ Income _____ Federal Civil Service Comm
 Pension _____ KEOGH/IRA Pension _____ Military Pension _____ State or
 Local Government or Private Pension _____ Insurance Pension
 _____ Support/Alimony _____ Friends/Relatives _____ Worker's Comp
 _____ Other(Interest, Strike Pay, Land Contracts, etc.)
 (Complete a Supplement S for the appropriate type(s) of unearned income indicated above)
- _____ (I) Did this person receive AFDC from another state this month?
- _____ (J) Is this person repaying an overissuance from any source?
- _____ (J) Does this person receive any Lump Sum? (If yes, complete Supp. SS)
- _____ (F) Is this member paying medical bills for an eligible non-member? (If yes, complete Supp. U)
- _____ (F) Is this member aged/blind/disabled with his/her own medical bills? (If yes, complete Supp. U)
- _____ (I) Has this member incurred medical expenses for the month? (If yes, complete Supp. U)
- _____ (I) Number of \$30 months remaining before this action.
- _____ (I) Number of \$30 and one-third months remaining before this action.
- _____ (I) Number of excluded student earned income months remaining for AFDC child.
- _____ (J) Does this person have any excluded income? If yes, sources: _____

SAME FOR: _____

- _____ (J) Does this person have any resources? If yes, _____
Checking/Savings/Stocks/Bonds, Cash
Burial Cont, Others (Mineral Rights, Tobacco Base, Deemed from alien
Sponsor)
_____ IRA/KEOGH _____ Non-Home Real Estate _____ Transferred Resources
- _____ (J) Does this person have Burial Spaces, Trusts, Land Contracts, Certificates
of Deposit, Promissory Notes, or Medicaid Qualifying Trusts?
- _____ (I) Is this person covered by Life/Burial Insurance Policies/Prepaid Burial
Funds?
- _____ (I) Does this person have money set aside for burial other than Life/Burial
Insurance Policy or Prepaid Burial Fund? If yes, amount: _____
_____ (I) Are these funds clearly designated as set aside for burial?
Verification Source: _____ Date: _____
- _____ (I) Does this person own items such as jewelry, tools, etc. worth \$50 or more?
- _____ (I) Does this person have a Lifetime Care Agreement? If yes, name of
person/organization providing care: _____
- _____ (I) Are resources still available? _____ Have resources been exhausted?
Verification Source: _____ Date: _____
- _____ (I) Is this person expecting an Accident Settlement?
- _____ (I) Has this person sold any Property?
- (Complete a Supplement T to document the appropriate resources indicated above)

PART V. FS RIGHTS, RESPONSIBILITIES AND SIGNATURE

PENALTY WARNING:

Anyone in your household who intentionally breaks any of the following rules may be stopped from receiving food stamps for 6 months the first time a rule is broken, 12 months the second time and permanently for the third time. The person may also be fined up to \$250,000, put in prison for up to 20 years or both, and subject to an additional suspension from the Food Stamp program of up to 18 months consecutive to the original suspension. The person may also be subject to being prosecuted under other applicable federal laws.

THE RULES ARE:

Do NOT give false information or hide information to get or continue to get food stamps.

Do NOT trade or sell food stamps or authorization cards.

Do NOT use food stamps to buy ineligible items, like alcoholic drinks, soap or tobacco products.

Do NOT use someone else's food stamps or authorization cards for your household.

YOUR SIGNATURE:

I understand the questions on this application. I have reviewed the entries made by the caseworker and certify under penalty of perjury that the information contained on my application for Food Stamps is true and correct. I understand that the information I have provided on the application including the information concerning citizenship and alien status is subject to verification by Federal, State and local officials to determine if such information is true. I understand that as an applicant for food stamps, I am required to provide a social security number for everyone who lives in my home. I understand that social security numbers will be used for various state and federal matches through the Income and Eligibility Verification System (IEVS). These matches include, but are not limited to, Social Security, IRS, SSI, Wage Records, Unemployment Insurance, and other matches as provided for under the authority of IEVS. This information may be verified through collateral contacts when discrepancies are found. Information provided under IEVS, after verification, may affect eligibility for and amount of benefits. This information will be disclosed to other agencies only as permitted by law. If any part of the information on this application is incorrect, I understand that food stamp benefits may be denied and that I may be subject to the criminal prosecution rules for knowingly providing incorrect information.

Your Signature _____ Today's Date _____

All food stamp applications are considered without regard to race, color, sex, age, disability, religious creed, national origin, or political belief.

You or your representative may request a fair hearing either orally or in writing if you disagree with any action taken on your case. Your case may be presented at the hearing by any person you choose.

PART V. IM RIGHTS, RESPONSIBILITIES AND SIGNATURE PENALTY WARNING:

I certify that the information provided by me in this statement is correct and true to the best of my knowledge and give my consent to the Department for Social Insurance to make any necessary contacts to verify statements and to allow for the disclosure of pertinent financial data.

I understand that the Social Security Act requires that all recipients of assistance furnish and be identified by a Social Security Number and if an individual refuses to apply for a number, that the Department cannot make a payment or provide Medical Assistance. I understand that Social Security Numbers will be used for various State and Federal matches through the Income and Eligibility Verification System (IEVS). These matches include, but are not limited to Social Security, IRS, SSI, Wage Records, Unemployment Insurance, and other matches as provided under the authority of IEVS. This information may be verified through collateral contact when discrepancies are found. Information provided under IEVS, after verification, may affect eligibility for and amount of benefits. This information will be disclosed to other agencies only as permitted by law.

I understand that if I receive Aid to Families with Dependent Children (AFDC) or Medical Assistance (MA) for children whose parent(s) is voluntarily absent, I am required to cooperate in child/medical support activities. If I receive AFDC I must send all support payments to the Cabinet within 10 days of receipt. Failure to forward all payments may result in the loss of AFDC benefits, and procedures for collection will be started against me. I understand that in accepting Medical Assistance, I assign my rights to third party payments from any source to the Cabinet for Human Resources, Department for Social Insurance. Refusal to cooperate will cause the specified relative to be sanctioned. I understand that by obtaining a medical card, I am responsible for notifying the medical provider of any hospital or health insurance. I also agree to reimburse the Medical Assistance Program for services received which are later covered by insurance settlements or payments.

I agree to select a doctor or clinic participating in the KenPAC Medical Assistance Program. I understand KenPAC is a part of the Kentucky Medical Assistance Program provided on a 24-hour basis and includes the following services: Physician; lab fees; hospital inpatient/outpatient services; home health; nurse anesthetists; primary care centers; ambulatory surgical centers and rural health centers. I understand that I must report all changes in circumstances and income to my worker within 10 days from the day I become aware of the change.

I understand that by receiving AFDC, all members of my case are automatically registered with the Job Opportunity Basic Skills Program (JOBS), established by Congress in 1988. If required to register for job services and seek employment, I will agree to cooperate with specified responsible agencies. I understand that all information will be used in the administration of the Medicaid Program.

I declare that all persons for whom application is made are U.S. Citizens or are admitted under approved alien status. I certify under penalty of perjury, the information, including citizenship or alien status, provided by me in this statement is correct and true to the best of my knowledge and give my consent to the Department for Social Insurance to make any necessary contacts to verify my statements.

I understand that if I give false information, withhold information or fail to report changes within 10 days, I may be subject to prosecution for fraud, reduction or loss of benefits, and I may be required to repay benefits I receive.

Your Signature: _____ Today's Date: _____
Spouses Signature: _____ Today's Date: _____
Witness, if signed with an X: _____

All applications for assistance are considered without regard to race, color, sex, disability, religious creed, national origin, or political belief. You or your representative may request a fair hearing either orally or in writing, if you disagree with any action taken in your case. Your case may be presented at the hearing by any person you choose.