

1. County and Case No. _____

2. Date _____

3. Applicant Name _____
(Last) (First) (M.I.)

4. Mailing Address _____ 5. Phone _____ []Applicant []Other
(Street, P.O. Box, etc.) (City) (State) (Zip Code)

6. Residence (if different from mailing address) _____

7. Directions to Residence _____

8. Have you or anyone else in this application previously applied for or received assistance? []Yes []No If yes, Who? _____
Where? _____ When? _____ Case Number? _____

9a. This is an application for: []AFDC []AFDC RELATED MA b. Type of Application: []New []Reapplication (Use old case number.)

c. Other Program Status: []AFDC []MA: Case Name(s) and Number(s) _____
[]Food Stamps: Case Name and Number _____

10a. If you are not receiving Food Stamps, have you applied? []Yes Date _____ []No b. Are you interested in applying? []Yes []No

11. Persons for Whom Assistance is Requested

			AGENCY USE ONLY									
a. Name (Last)	(First)	(M.I.)	b. Depr.	c. Race	d. Sex	e. Citizen/ Alien No.	f. DOB	g. Ver.	h. Marriage/ Relation	i. SSAN	j. Rec. AFDC in Last 4 Months	k. Med. Exp. in Last 3 Months
SR									Self		Yes No	Yes No
SP											Yes No	Yes No
Children											Yes No	Yes No
											Yes No	Yes No
											Yes No	Yes No
											Yes No	Yes No
											Yes No	Yes No
											Yes No	Yes No

12. I hereby make application for a money payment and or medical assistance. I agree to give the Department for Social Insurance any information necessary to establish my eligibility. I understand furnishing Social Security Numbers for all persons for whom application is made is required in order to receive AFDC. I understand if I receive too much money, for whatever reason, I will be required to repay it. I understand in accepting AFDC, I assign all past, current and future child support for children for whom I receive AFDC to the Department for Social Insurance. I understand if I am applying for AFDC or Medical Assistance for myself, or for child(ren) as a parent or legal guardian, I am assigning my rights for third party payments and am willing to cooperate with the Department for Social Insurance. I certify, under penalty of perjury, 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 my statements. I understand if I give false information, withhold information or fail to report changes within 10 days, I may be subject to prosecution for fraud.

13. Signature of Applicant _____ Date _____ If signed by mark:
Signature of Worker _____ Date _____ Signature of Witness _____ Date _____

YOUR RIGHTS

As an applicant you have certain rights. These are:

1. The right to prompt action on your case.
2. The right to have your case treated confidentially.
3. The right to receive a money payment and or medical assistance if it is determined that you meet all eligibility requirements.
4. If you are eligible for a money payment, the right to spend it any way you wish.
5. The right to a hearing before an impartial hearing officer if you are dissatisfied with any action or inaction of the Department. If your complaint involves alleged discrimination due to race, color or national origin, you have the right to appeal directly to the Secretary of Health and Human Services, Washington, D.C., if you prefer.

CIVIL RIGHTS

The Programs of the Department for Social Insurance are administered in such a manner that no person will, on the grounds of color or national origin, be excluded from any benefits under the program or otherwise be subjected to any discrimination.

YOUR OBLIGATIONS

Give the worker complete and accurate information, substantiated by documents as requested on:

1. Any factor of technical eligibility, including proof as appropriate, that the parent of the child(ren) is out of the home.
2. Income, including wage stubs, award letters, etc., for yourself, spouse, children, and other household members such as alien sponsors and parents of minor parents.
3. Resources.
4. Your marital status.
5. Your living arrangements.
6. Any other fact that has any bearing on your eligibility, including medical reports of physical or mental examinations to determine the existence or degree of incapacity including submission to additional examinations when indicated.

Keep any appointment to see your worker or give advance notice if the date or hour is unsatisfactory to you.

If your application is approved, inform the Department within 10 days of any changes in your circumstances affecting your eligibility or amount of payment. Failure to do so may result in a loss of benefits and or in prosecution for fraud.

During your interview, your worker will assist you in applying for a Social Security number for anyone for whom you request assistance who does not already have a Social Security Card. The Social Security Act requires that all recipients of money payments must be identified by such a number. The Department shall not make a payment for any individual who refuses to apply for a number. If you are applying for Medical Assistance only, the Department will also need a Social Security number for identification purposes. The information you provide in order to obtain a number and the number when received, will be used only for purposes of administering the program of the Cabinet for Human Resources, and will be disclosed by the Cabinet or the Social Security Administration only as permitted by law.