

COMMONWEALTH OF KENTUCKY
Cabinet for Human Resources
Department for Social Insurance

FOR AGENCY USE ONLY

STATEMENT OF NEED

Name _____	
Case Number _____	
<input type="checkbox"/> Investigation	<input type="checkbox"/> Office Visit
<input type="checkbox"/> Reinvestigation	<input type="checkbox"/> Home Visit
Date Issued _____	Date Received _____

The following information is needed by the Kentucky Department for Social Insurance to make a decision about a monthly check or help with medical bills. It is important that this form be completed very carefully. Information must be true. False statements make you subject to prosecution for fraud. Bring the completed form with you when you come in for your appointment.

ALIENS ONLY. If you are an alien, and made your first application for assistance on or after October 1, 1981, both you and your private sponsor must answer all questions. Attach a separate sheet of paper with your private sponsor's signed and dated report of his or her own circumstances.

IF ADDITIONAL SPACE IS NEEDED TO ANSWER ANY QUESTIONS, ATTACH A SEPARATE SHEET OF PAPER.

1. Name _____
(First) (Middle Initial) (Last)
- White, not of Hispanic origin Hispanic
 Black, not of Hispanic origin American Indian or
 Asian or Pacific Islander Alaskan Native
2. Mailing Address _____
(Street, RFD or P.O. Box) (Apt. No.) (City) (State) (Zip Code)
3. Is your mail delivered in care of someone else? Yes No If yes, who _____
4. Street Address (if different from mailing address) _____
5. Directions to Home _____
6. County _____ Telephone where you can be reached _____ Yours Nearby
7. Are you planning to move? Yes No If yes, when? (Date) _____
- New mailing address _____
(Street, RFD or P.O. Box) (Apt. No.) (City) (State) (Zip Code)
- New Street Address (if different from mailing address) _____

8. On the following lines, list all persons living in your home. All columns must be answered for each person.

First Name	Last Name	Social Security Number	Sex M/F	Relation To You	Birthdate Mo/Day/Yr	Does this Person Receive AFDC? (circle one)		Highest School Grade Completed	Complete for All Children				
						Yes	No		*If school is not in session, base your answers on the child's attendance during last session.				
									Attending School Regularly*	Name and Address of School	Type of School	Expected Date of Completion	
				Self		Yes	No		Yes	No	-----		
				Spouse		Yes	No		Yes	No	-----		
						Yes	No		Yes	No	-----		
						Yes	No		Yes	No	-----		
						Yes	No		Yes	No	-----		
						Yes	No		Yes	No	-----		
						Yes	No		Yes	No	-----		
						Yes	No		Yes	No	-----		

9. Are you or anyone living in your home pregnant? Yes [] No []

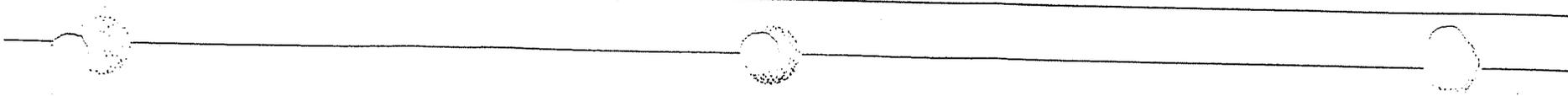
Name _____

Expected Delivery Date _____

Name _____

Expected Delivery Date _____

10. Is anyone in your home receiving Food Stamps? Yes [] No [] If yes, names _____



11. Complete the questions below for each person under age 19 for whom you want to receive assistance.

Child's Name	Name of Parent	Is Parent in Home? (circle one)	Is Parent Disabled? (circle one)	Is Parent Unemployed? (circle one)	Is Parent Deceased? (circle one)	Is Parent In Hospital or Prison? (circle one)	Absent Parent's Address	Date Parent Left Home
	Father:	Yes No	Yes No	Yes No	Yes No	Yes No		
	Mother:	Yes No	Yes No	Yes No	Yes No	Yes No		
	Father:	Yes No	Yes No	Yes No	Yes No	Yes No		
	Mother:	Yes No	Yes No	Yes No	Yes No	Yes No		
	Father:	Yes No	Yes No	Yes No	Yes No	Yes No		
	Mother:	Yes No	Yes No	Yes No	Yes No	Yes No		
	Father:	Yes No	Yes No	Yes No	Yes No	Yes No		
	Mother:	Yes No	Yes No	Yes No	Yes No	Yes No		
	Father:	Yes No	Yes No	Yes No	Yes No	Yes No		
	Mother:	Yes No	Yes No	Yes No	Yes No	Yes No		

Answer the following questions with complete information about your resources.

12. Do you, your spouse, or children own or are any of you buying the home in which you live? Yes [] No []

13. Do you, your spouse, or children own or have an interest in real property (land or buildings) other than where you live? Yes [] No [] If yes, complete the following:

Type of Property	Assessed Value	Amount Owed	Income from Property	Monthly	Yearly	Who receives this income?	Is property for sale?
	\$	\$	\$				Yes [] No []
	\$	\$	\$				Yes [] No []
	\$	\$	\$				Yes [] No []

If this property is being offered for sale, bring proof such as a newspaper ad, real estate listing, etc., to your worker with this form.

14. Did you, your spouse, or children buy, trade, sell, or give away any property or assets within the past 24 months?
 Yes No If yes, complete information below:

Type of Asset or Property Bought, Traded, Sold, or Given Away	Date of Transfer Assessed Value	Who Received this Property	Amount Owed on Property Transferred	Cost of Transferring	Amount Paid or Received
	\$		\$	\$	\$
	\$		\$	\$	\$

You will be expected to provide documents to verify the transfer of any property or assets listed.

15. Circle either "yes" or "no" if you, your spouse, or children have any of the following assets. If "yes", complete the remaining columns. Under "other items", list items worth more than \$50, such as, jewelry, burial plots, tools, etc. You will be expected to provide verification of any assets listed.

Type of Money or Savings	Circle One	Amount	Name of Bank or Location of Savings	Who has this?
Checking Account	Yes No	\$		
Savings Account	Yes No	\$		
Certificates of Deposit, Stocks, Savings Bonds, or Other Bonds	Yes No	\$		
Other Cash Not Listed Above	Yes No	\$		
*Other Savings or Trust Funds	Yes No	\$		
Other items: _____	Yes No	\$		
Other items: _____	Yes No	\$		
Other items: _____	Yes No	\$		

*Explain Savings or Trust Funds

16. Do you, your spouse, or children own or are you buying a motor vehicle? Yes [] No []

If yes, complete the following:

Owner's Name	Type (Car, Truck, Boat, Camper, etc.)	Year	Make (Ford, GMC, etc.)	Model (Escort, ½ ton, etc.)	Body Style (2-dr. sedan, pickup, etc.)	Value
						Amount Owed
						\$ ----- \$
						\$ ----- \$
						\$ ----- \$
						\$ ----- \$

Is any vehicle listed used to obtain medical treatment? Yes [] No []

Is any vehicle listed specifically equipped for use by a handicapped household member? Yes [] No []

Is any vehicle listed used for self-employment? Yes [] No []

17. Is anyone awaiting settlement from an accident? Yes [] No [] If no, skip to item 18. If yes, complete the following:

a. Date of accident _____ b. Person involved _____

c. Type of accident:

[] Employment Related

Employer's Name and Address _____

Have you applied for Workmen's Compensation? Yes [] No [] If yes, when? _____ Where? _____

[] Automobile

Your Insurance Company Name and Address _____ Policy No. _____

Other Party's Insurance Company Name and Address _____ Policy No. _____

Other Party's Name and Address _____

18. Do you, your spouse, or children own or are you covered by burial or life insurance policies? Yes No

Do you, your spouse, or children have a prepaid burial fund? Yes No If yes to either question, complete the following:

Owner of Policy or Fund	Persons Covered	Name of Bank, Funeral Home or Insurance Co.	Policy No. and Face Value	Value if Cashed In and Amount of Loan Against Policy	Amount of Fund
			----- \$	\$	\$
			----- \$	\$	\$
			----- \$	\$	\$
			----- \$	\$	\$

You will be expected to present verification of any policies or funds listed.

19. Are you, your spouse, or children covered by any of the following types of hospital or health insurance?

Insurance Types and Letter Codes:

- | | | | | | | | | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|---------------------------|--------------------------|--------------------------|--------------------------------------|
| Yes | No | | Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | None. If "Yes", skip to item 20M | <input type="checkbox"/> | <input type="checkbox"/> | Blue Cross/Blue Shield - | <input type="checkbox"/> | <input type="checkbox"/> | Health Maintenance (HMO)H |
| <input type="checkbox"/> | <input type="checkbox"/> | Part A Medicare OnlyA | | | Major MedicalE | <input type="checkbox"/> | <input type="checkbox"/> | Absent Parent's InsuranceL |
| <input type="checkbox"/> | <input type="checkbox"/> | Part B Medicare OnlyB | <input type="checkbox"/> | <input type="checkbox"/> | Private Medical Insurance | <input type="checkbox"/> | <input type="checkbox"/> | United Mine WorkersN |
| <input type="checkbox"/> | <input type="checkbox"/> | Both Parts A and B MedicareC | | | Specify _____F | <input type="checkbox"/> | <input type="checkbox"/> | Black LungP |
| <input type="checkbox"/> | <input type="checkbox"/> | Blue Cross/Blue ShieldD | <input type="checkbox"/> | <input type="checkbox"/> | ChampusG | <input type="checkbox"/> | <input type="checkbox"/> | OtherJ |

If yes to any of the above, complete the following. Enter the appropriate letter code to indicate type of insurance and complete all remaining columns. Bring policy to your worker.

Name and Address of Insurance Company or HMO	Type (Letter Code)	Policy Number		Amt. of Mo. Payment	Who pays this premium?	Name of Persons Covered by Policy
			Name of Insurance Agency			
				\$		
				\$		
				\$		
				\$		

20. Have you or your family received any medical bills in the last 3 months? Yes No

If yes, bring these bills to your worker with this form.

The following sections relate to income and must be completed for you, your children, spouse and parent if living in the home. You must indicate either "yes" or "no" for each type of income shown. You will be expected to present verification of income. Verification may be actual checks, wage stubs, award letters, etc. If you are an alien, information is also required regarding income of your sponsor.

21. Does any person in your home have any of the following types of unearned income?

Income Types and Letter Codes:

- | | | | | | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|--|
| Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Social Security (Green Check) | <input type="checkbox"/> | <input type="checkbox"/> | Oil, Gas, Coal or Other Leases,
or Mineral Rights |
| <input type="checkbox"/> | <input type="checkbox"/> | Supplemental Security Income (Gold Check) | <input type="checkbox"/> | <input type="checkbox"/> | Cash Rent From Land |
| <input type="checkbox"/> | <input type="checkbox"/> | Veteran's Benefits | <input type="checkbox"/> | <input type="checkbox"/> | Rental or Lease Income
(Including Farm Land or Crops) |
| <input type="checkbox"/> | <input type="checkbox"/> | Railroad Retirement | <input type="checkbox"/> | <input type="checkbox"/> | Money From Friends or Relatives
(Including Contributions or Cash Gifts) |
| <input type="checkbox"/> | <input type="checkbox"/> | Unemployment Insurance | <input type="checkbox"/> | <input type="checkbox"/> | Other (Specify) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Military Allotment | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Workman's Compensation | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Black Lung Benefits | | | |

If yes to any of the above, enter the name of each person receiving income. Enter the appropriate letter code to indicate the type of income received, and complete all remaining columns.

Person Receiving Income	Type of Income (Letter Code)	Amount Received Last Month	Amount Received This Month	Amount Expected Next Month	How Often Received (Monthly, Weekly, etc.)
		\$	\$	\$	
		\$	\$	\$	
		\$	\$	\$	
		\$	\$	\$	
		\$	\$	\$	

22. Have you ever received money from an absent parent? Yes No If yes, complete the following to show amounts received this month and the 3 months before this month:

Name of Absent Parent	Names of Children	Amount Received This Month	Amount Received _____, 19__	Amount Received _____, 19__	Amount Received _____, 19__
		\$	\$	\$	\$
		\$	\$	\$	\$
		\$	\$	\$	\$

23. Does anyone pay any bills for you or provide for any of your expenses (e.g., food, clothing, shelter, utilities, etc.)? Yes No If yes, complete the following:

Type of Bill or Expense Provided	Amount Paid	How Often Paid	Date Last Paid	Who Pays Bill or Provides for this Expense (Name and Address)
	\$			
	\$			
	\$			

24. Are you, your spouse, parents living in your home, and/or children now employed? Yes No Have any of you been employed in the past? Yes No If yes to either of these questions, complete the following:

Name of Employer or Person for Whom Worked	Person Employed	Working Now? (circle one)		Employed From	Last Date Paid
		Yes	No		
				_____ to _____	
				_____ to _____	
				_____ to _____	

25. Does any person in your home have any of the following types of earned income?

Income Types and Letter Codes:

- | | | | | | | | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|
| Yes | No | | Yes | No | | Yes | No |
| <input type="checkbox"/> | <input type="checkbox"/> | Employment (full-time, part-time, odd-jobs, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | Roomers or Boarders | <input type="checkbox"/> | <input type="checkbox"/> |
| | |A | <input type="checkbox"/> | <input type="checkbox"/> | Rental Property | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Training Allowances | | | | | |
| | |B | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

If yes to any of the above, enter the name of each person receiving income. Enter the appropriate letter code to indicate the type of income received, and complete all remaining columns. Under "Gross Earnings" enter the amount of earnings before any deductions are made.

Person Receiving Income	Type of Income (Letter Code)	Gross Earnings Last Month	Gross Earnings This Month	How Often Paid (monthly, weekly, etc.)	Day of Week Paid	Tips Received (circle one)
		\$	\$			Yes No
		\$	\$			Yes No
		\$	\$			Yes No
		\$	\$			Yes No

26. Is there a stepparent in your home? Yes [] No []

Are you under age 18, and living with your parent or legal guardian? Yes [] No []

If no to BOTH questions, skip to item 27. If yes to either question complete the following:

a. Does a parent, stepparent or legal guardian with whom you live pay child support for children not in the home?

Yes [] No [] If yes, name of person who pays _____ How much \$ _____

How often _____

b. Does a parent, stepparent or legal guardian with whom you live pay alimony? Yes [] No [] If yes, name of person who pays _____

How much? _____ How often _____

c. Does a parent, stepparent or legal guardian with whom you live claim children in your home as dependents for federal income tax purposes? Yes [] No [] If yes, names

of children claimed _____

d. Does a parent, stepparent or legal guardian with whom you live claim adult relatives in the home, other than you, for federal income tax purposes? Yes [] No [] If yes,

names of adult relatives claimed _____

27. a. Do you, or a minor parent (parent under age 18) living in your home, attend school or training? Yes [] No []

If yes, complete the following:

Name _____ No. of Hours _____ Name and Address of School _____

Name _____ No. of Hours _____ Name and Address of School _____

b. Are you, or a minor parent (parent under age 18) living in your home, employed? Yes [] No []

If yes, complete the following:

Name _____ Hours Worked Per Week _____

Name _____ Hours Worked Per Week _____

c. Do you, or a minor parent (parent under age 18) in your home, have to pay for care of any child or adult who is unable to work, so that the person paying may continue to work or attend school? Yes [] No []

If you answered yes, complete the chart below:

Name and Address of Person or Agency Providing Care	Phone Number	Relation to You	Name and Age of Person Receiving Care	Amount Paid	How Often
				\$	
				\$	

28. Have there been or do you expect any changes in the following areas: Someone starting or quitting work; changing jobs; changing a last name; getting married; starting or quitting school or training? Yes [] No [] If yes,

Who _____ Change _____ When _____

Who _____ Change _____ When _____

After completing the form, it is a good idea to read it over to make sure you have answered every question. If you are not sure about some of your answers, talk to your worker about them. Also, read your appointment letter carefully and bring with you any other papers your worker has requested when you come into the office.

29. I understand that during my interview, my worker will assist me in applying for a Social Security Number for anyone for whom I request assistance who does not already have a Social Security card. The Social Security act requires that all recipients of assistance be identified by such a number. Under that law and federal regulations, the Department cannot make a payment or provide medical assistance for any individual who refuses to apply for a number.

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.

I understand that in accepting Aid to Families with Dependent Children (AFDC), I assign all support rights for children for whom I receive AFDC to the Cabinet for Human Resources, Department for Social Insurance.

I understand that in accepting Medical Assistance, I assign my rights to third party payments from any source, including hospital or health insurance policies, to the Cabinet for Human Resources, Department for Social Insurance. I further understand that if I refuse to assign my rights to third party payments to the Cabinet for Human Resources, Department for Social Insurance, I and the members of my case will be ineligible to receive a check or medical card.

I understand that when I obtain medical services with a Medical Assistance card issued to me I am responsible for notifying the medical provider of any hospital or health insurance policies covering me or any members of my case.

I agree to reimburse the Medical Assistance Program for services received which are later covered by insurance settlements or payments.

I understand that I, or a member of my case, may be required to participate in the Job Opportunities and Basic Skills (JOBS) Training Program or I, or a member of my case, may volunteer to participate in JOBS at anytime.

I understand that I may receive help in paying certain expenses such as child care and transportation while I am attending a school or training program or while participating in the JOBS program.

30. 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.

31. I declare under penalty of perjury that all persons for whom application is made are U.S. citizens or are admitted under an approved alien status.

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.

(Signature) (Date Signed)

(Signature of Spouse) (Date Signed)

If signed by mark:

(Signature Worker) (Date Signed)

(Signature of Witness) (Date Signed)