Maryland Department of Human Services
Family Investment Administration
Elderly Simplified Application Project

For an online application, go to https://mydhrbenefits.dhr.state.md.us

OFFICE USE ONLY Date the Signed Application Received in the Local Department **MUST BE DATE STAMPED**
CLIENT ID NUMBER

This application is used for persons applying for SNAP benefits where:

1. **Everyone in the household is aged 60 or older; or**
2. **All household members aged 60 or older purchase and prepare food separately from the other household members; AND**
3. **No member receives earnings from work.**

You may file this application by completing at least your name and address and signing the form. However, the more information provided, the sooner we can make a decision. If you need help completing this application, call toll-free **1-800-332-6437.**

1. ADDRESS — Tell who you are and where you live. Be sure to provide a current phone number.			
Last Name	**First Name**		**MI**
Number Street	**Apt No.**	**Floor No.**	**Telephone Number**
City	**State**	**Zip Code + 4**	**Number where you can be reached during the day**

2. MAILING ADDRESS *(IF DIFFERENT)*				
Number Street		**Apt. No.**	**Floor No.**	**Telephone Number**
P.O. Box	**City**		**State**	**Zip Code + 4**

3. AUTHORIZED REPRESENTATIVE – *Complete if you would like someone to represent you.*			
First Name	**Middle Name**	**Last Name**	**Jr., III, etc.**
Number Street	**City**	**State**	**Zip Code+ 4**
Telephone Number	**Relationship to you**		
Check what you want the representative to do:	☐**Complete interview for you** ☐ **Receive your notices** ☐**Sign your application** ☐**Use your EBT card to access your Food benefits**		

4. HOUSEHOLD MEMBERS – Tell us who lives with you. List yourself on the first line.

	NAME (Last, First, Middle Initial)	How are they related to you?	AGE	Date of birth	SEX (M)ale (F)male	*Ethnicity	*Race	Marital Status	Last Grade Completed	U.S. CITIZEN (Yes or No)	SOCIAL SECURITY NUMBER
1	**SELF**	**SELF**									
2											
3											
4											

***FOR STATISTICAL PURPOSES ONLY PLEASE FILL IN ETHINICITY AND RACE BLOCKS USING THE BELOW CODES:**

Ethnicity: **1 = Hispanic or Latino** **2 = Not Hispanic or Latino**	**Race:** **BL=Black or African American; WH = White; AS = Asian; AI = American Indian/Alaskan Native; NH = Native Hawaiian or Other Pacific Islander**

What language do you/household member speak?	**Do you/household member need an interpreter? ☐YES ☐ NO**
Are you/household member visually impaired ☐YES ☐NO	**Are you/household member hearing impaired? ☐YES ☐ NO**

5. IMMIGRATION STATUS — If you are not a United States citizen, fill in this section			
INS Status	Newly Legalized Status Date	US Entry Date	Sponsored Alien ☐YES ☐NO
INS Number		Country of Origin	

6. DETAILS ABOUT YOUR HOUSEHOLD *(declaratory questions)* – Complete considering all household members

a) Did anyone in your household receive money this month? □ YES □ NO **If yes, how much?**

b) How much money do you and all household members have in cash and/or in the bank? **$_______ cash $______ bank**

c) Has anyone in your household ever been convicted of a felony committed on or after August 22, 1996 that involved drugs?
□ YES □ NO **If yes, who?**

d) Has anyone in your household been convicted after February 7, 2014 of aggravated sexual abuse, murder, sexual exploitation and other abuse of children, sexual assault as defined in the Violence Against Women Act of 1994, or a similar state law, and is also not in compliance with the terms of their sentence?
□ YES □ NO **If yes, who?**

e) Is anyone in your household currently violating parole or probation or fleeing from the police or the courts?
□ YES □ NO **If yes, who?**

f) Has anyone in your household been convicted since August 22, 1996 in a Federal or State Court for not telling the truth about where they lived or their identity in order to receive SNAP benefits or cash assistance from more than one place in the same month? □ YES □ NO **If yes, who?**

g) Has a court convicted any member of your household for trafficking SNAP benefits of $500 or more?
□ YES □ NO **If yes, who?**

h) Is anyone in your household receiving benefits under another identity or as a member of another household or in another State? □ YES □ NO **If yes, who?**

7. INCOME

Tell us about the income your household receives. Types of income may include Social Security benefits, SSI, pensions, veteran's benefits, child support, cash contributions, gambling or lottery winnings, unemployment, railroad retirement, dividends, interest and any other income.

Type of Income	Who Receives It?	Gross Monthly Income

8. SHELTER COSTS — Are you paying for any of the following?

Expenses	Check One	Amount	How Often Paid?	Who Pays?	Expenses	Check One	Amount	How Often Paid?	Who Pays?
Rent	☐YES☐NO	$			Telephone	☐YES☐NO	$		
Mortgage	☐YES☐NO	$			Water/Sewer	☐YES☐NO	$		
Property Taxes	☐YES☐NO	$			Condo Fee	☐YES☐NO	$		
Homeowner Insurance (if not included in mortgage)	☐YES☐NO	$			Electric	☐YES☐NO	$		
					Oil	☐YES☐NO	$		
					Gas	☐YES☐NO	$		

Question	Answer	Question	Answer
Is heat included in your rent?	☐YES☐NO	Do you pay an electric bill for lights or cooking?	☐YES☐NO
If heat is **not** included in the rent, what is your source of heat?		Do you pay for air conditioning?	☐YES☐NO
Are you sharing any of the shelter costs listed above?	☐YES☐NO	Have you received Energy Assistance at your current address within the past 12 months?	☐YES☐NO
If yes, with whom?			

Do you live in: □ Public Housing □ Section 8 Housing □ FMHA 515 Housing □ Private Housing

9. EXPENSES

Please list any out of pocket medical expenses you are paying or responsible to pay monthly. Type of medical expenses could include: prescriptions, doctor visits, hospital bills, health insurance, adult dependent care, medical supplies, etc.

Type of Medical Expense	Medical Expense Paid to	Monthly Payment Amount
		$
		$

10. SIGNATURE SECTION

I certify that the information I or my authorized representative have provided above is true to the best of my knowledge. I give permission for the Department of Social Services to make any necessary contacts to check my statements. I know that I could be penalized if I knowingly give false information.

Signature of applicant:		Date:	
Authorized Representative:		Date:	
Signature of two witnesses, if signed by and "X"	1.	2.	

Rights and Responsibilities

You Should Know About Applying For Supplemental Nutrition Assistance Program (SNAP) (Formerly Food Supplement Program)

Social Security Numbers

- You must give us a social security number for each family member who wants benefits.
- If a person who wants benefits does not have a social security number, that person must apply for a number. We can help applicants get their numbers.
- If a family member has applied for a social security number, we will not delay your application while you wait for the number.
- We use social security numbers to prove income. We do not give numbers to other agencies like Immigration and Customs Enforcement.

Citizenship and Immigration Status

- You must tell us about the citizenship and immigration status for each family member who wants benefits.
- Maryland uses the Systematic Alien Verification and Eligibility or SAVE system through the United States Citizenship and Immigration Service (USCIS) formerly known as Immigration and Naturalization Service (INS) to verify the alien status of all applicant and recipient non-citizen households. Information received from USCIS may affect your household’s eligibility and benefit amount.

Information

- If a family member will not tell us about citizenship, immigration status or social security number, that person will not get benefits.
- They must still give us proof of income, expenses and other things.
- The other family members who give us their information will get benefits if they meet the rules.

Emergency Medical Assistance

- Immigrants who are not eligible for other kinds of medical assistance and apply only for emergency medical assistance do not have to tell us their social security number, immigration or citizenship status.

Time Limits

- Temporary Cash Assistance has time limits.
- The Supplemental Nutrition Assistance Program (formerly Food Supplement Program) and Medical Assistance do not have a time limit.
- When Temporary Cash Assistance ends because of time limits, earnings or other reasons, you may still get SNAP benefits and Medical Assistance.

Interviews

- You, a responsible family member or someone you choose to represent you must be interviewed.
- In most cases we can interview you by telephone.
- You must give or send us the proof we ask for at your interview.

If you need help

If you need help, applying for benefits, or have questions, or need translations services, call your case manager or call 1-800-332-6347.

Si necesita ayuda para llenar el formulario favor de llamar al 1-800-332-6347.

Rights and Responsibilities for Elderly Simplified Application Project

The Family Investment Administration is committed to providing access, and reasonable accommodation in its services, programs, activities, education and employment for individuals with disabilities. If you need assistance or need to request a reasonable accommodation, please contact your case manager or call 1-800-332-6347 or fill out the form on the next page.

Requesting a reasonable accommodation:

If you are an individual with a disability, you may be entitled to reasonable accommodation to help you access DHS' activities, programs and services. This applies even if you are working with a local department of social services or a vendor who provides services for DHS' customers.

A reasonable accommodation is a modification or adjustment to an activity, program or service which helps a qualified individual with a disability have meaningful access to DHS' activities, programs and services.

Examples of reasonable accommodations:

Hearing Impairment: Sign language interpreter and providing an assistive listening device.

Visual Impairment: Having a qualified reader read to a customer.

Mobility Impairments: Mailing forms to a customer and meeting a customer at a more accessible location.

Developmental Disabilities: Having things written down, taking breaks, scheduling appointments around a customer's medical needs.

You may request a reasonable accommodation from the local department of social services or a vendor at any time. Your request may be oral or written. A request for a reasonable accommodation may be made in person, in writing or over the telephone. There are no particular words that you need to use to request an accommodation. A request may be made by you or someone helping you. If you need to request a reasonable accommodation because of your disability, you should speak with the case manager or the supervisor or the Customer Access Coordinator at your local department. You may ask the case manager for the name of the Customer Access Coordinator at your local department. You may use the form on the reverse side of this notice. You may also ask for more information at the front desk.

1. Dial 7-1-1 or 800-735-2258 to initiate a TTY call through Maryland Relay.
2. The Maryland Relay Operator’s typed greeting, including the Operator’s identification number, will display on your TTY or VCO phone.
3. When the Operator is finished typing, you will see the letters “GA” This means “Go Ahead.”
4. Type the number of the person you want to call, along with any special calling instructions. Then type “GA”.

Request for Reasonable Accommodation

<table>
<tr><td>Name of person needing an accommodation:</td><td>Name of person requesting an accommodation:</td></tr>
<tr><td colspan="2">Address:</td></tr>
<tr><td>City/State/Zip Code:</td><td>Telephone number:</td></tr>
<tr><td colspan="2">Nature of Disability or Impairment (specify):</td></tr>
<tr><td colspan="2">Local Department of Social Services Location:</td></tr>
<tr><td colspan="2">Accommodation Request (Type of accommodation requested.) Please print or type. Be as specific as possible. If needed, attach additional pages.</td></tr>
<tr><td colspan="2">Note: If requesting sign language services, specify type: American Sign Language Interpreter (ASL), Certified Deaf Interpreter (CDI) or Communication Access Real Time Translation (CART).
Please provide any additional information that may assist us in providing a reasonable accommodation (specify):</td></tr>
<tr><td colspan="2">Customer/Applicant's Signature :____________________________ Date:________________</td></tr>
<tr><td colspan="2">Return this form to the case manager or the Customer Access Coordinator in your local department of social services.

For Office Use Only

Date Request Received:
Action Taken:
____
____
____

CAC Signature: ____________________________ Date: _________________</td></tr>
</table>

Customer Rights

Equal Rights – This institution is prohibited from discrimination 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.

Right to Written Notice – We must always give you a written notice explaining your benefits when we approve your case. We must always give you written notice when we change your benefits, deny or close your case. You have 90 days from the notice date to ask for a hearing. If you ask for a hearing within 10 days, you may be able to keep getting benefits while you wait for the hearing.

Right to Appeal – Ask for a hearing if you disagree with the Department's decision. Your case manager can help you write your appeal. At the hearing, you can speak for yourself or bring a lawyer, friend or relative to speak for you.

Right to Privacy – You are giving personal information in the application. We use the information to see if you are eligible for benefits. If you do not give the information, we may deny your application. You have a right to review, change, or correct any information. We will not show your information or give it to others unless you give us permission or federal and state law allows us to do so.

Right to Claim Good Cause – If you want Temporary Cash Assistance (TCA), you must help the Department get child support. You may not have to help if it puts you or your family in danger.

Right to Refuse Help – You do not have to accept help from a religious organization if it is against your religious beliefs.

Right to Timely Application Processing – If you are eligible for expedited Supplemental Nutrition Assistance Program benefits we must give you your benefits within 7 days. For the regular SNAP and other programs, except for certain Medical Assistance programs, we must process your application within 30 days. There are times when there is a delay in processing. If there is a delay, we will send you a letter to tell you why there is delay in processing your application. If you are incarcerated or in another such institution and file an application for SNAP benefits or cash assistance, you may not receive SNAP or cash benefits until you are released. The filing date of your application for assistance will be the date of your release from the institution, if it is less than 30 days from the date your signed application was received in the Local Department of Social Services (LDSS). SNAP benefits are issued from the date of your release based upon your application date.

Authorization to Receive Family Planning Information

If you want information, you can ask your case manager for a Family Planning Guide. You may also contact:

- 1-800-546-8900 if you need help in finding a provider for birth control or arranging prenatal care, or
- The Center for Maternal and Child Health at 410-767-6713 https://phpa.health.maryland.gov/mch/Pages/home.aspx

You Have the Following Responsibilities

Provide Information – You must give true and complete information. You may need to give us proof of this information. We will keep this information private. Any delay in providing proof may result in your case being delayed or denied.

Collecting application information, including the social security number of each household member, is authorized under the Food and Nutrition Act of 2008, U.S.C.2011-2036, Social Security Act §1137(f) and 42 U.S.C. §1320b-7(d). We use the information to find out if your household is eligible. We check this information by matching computer programs.

We also use the information to see if you meet program rules. We may contact your employer, bank or other party. We may also contact local, state or federal agencies to make sure the information is correct. We can give your information to other federal or state agencies for official use and to law enforcement officers who need it to find persons fleeing to avoid the law.

If you get too much in benefits:

- You may have to repay the money for the benefits, and
- We may give the application information, including social security numbers, to federal or state agencies, as well as private claims collections agencies, for action.

Giving information is voluntary. If you do not give us information such as social security numbers for everyone who wants help, we may deny benefits for each person who does not give a social security number. If you do not have a social security number, we will help you get one.

Report Changes - You must report all changes within 10 days unless you are part of the Supplemental Nutrition Assistance Program (SNAP) simplified reporting group and are not receiving Cash Assistance or Medical Assistance. If you want to know if you are part of this group, ask your case manager. You may tell us about any changes in person, by telephone, or by mail to the Department.

Note: For all SNAP customers including those who are simplified reporters:

1. If you receive lottery/gambling winnings in the amount equal or greater than $3,500, you must report the amount and the date the winnings received to the local department within 10 days.
2. If you are an Able Bodied Adult Without Dependents (ABAWD) and your work hours decrease below 80 hours per month, you must report the change to the Local Department within 10 days.

Warning – We may deny, lower or stop your benefits if you give us wrong information or do not report changes. A judge may fine and/or imprison you if you deliberately give wrong information or do not report changes.

Work Requirements for the Supplemental Nutrition Assistance Program

Individuals applying for or receiving Supplemental Nutrition Assistance Program (SNAP) benefits must know and understand the following information about the Supplemental Nutrition Assistance Program (SNAP) work registration and work requirements. SNAP work requirements are covered in federal law at 7 CFR 273.24.

Everyone over age 18 is required to be registered for work unless otherwise exempt, because they are: over age 60, caring for a child under age 6 living in their home, applied for or receiving unemployment benefits, self-employed- working a minimum of 30 hours or more per week at the equivalent of federal minimum wage, attending a recognized school or institution of higher education at least half time, or the individual is mentally or physically unfit for work. Work registration is not the same as participation.

Beginning January 1, 2016 able bodied individuals without dependents (ABAWDS), ages 18-50, who are not exempt for work registration under one of the above reasons or they reside in an area that is designated as exempt, are required to be work registered and participate in a work program/activity or be employed.

These individuals known as ABAWDS may only receive SNAP benefits for three months in a fixed 36 month period unless the individual is employed or participating in an approved work or educational activity a minimum of 80 hours per month. The individual may not receive SNAP benefits again until he or she meets the work requirements. You will receive additional information from the case manager and information is available on the DHS website at: http://dhs.maryland.gov/food-supplement-program/able-bodied-adults-without-dependents-abawds/.

Authorized Representatives – In most instances, if your authorized representative gives us wrong information, you will have to pay back any amount you are overpaid.

If your authorized representative knowingly gives us the wrong information or does not use your benefits properly, we may disqualify the person from being an authorized representative and prosecute them for fraud under state and federal law.

If a drug and alcohol treatment center or a group living arrangement acts as your authorized representative for your food benefits and they willfully give us wrong information about your situation, we may prosecute under applicable State or federal law.

TCA and Supplemental Nutrition Assistance Program Penalties

Do not:

- Give false information or withhold information to get or continue to get TCA and/or SNAP benefits.
- Trade or sell TCA or SNAP benefits, or electronic benefit cards.
- Use TCA and SNAP or electronic benefit cards to buy items not allowed, such as alcohol and tobacco or to pay on credit accounts.
- Use someone else's TCA or SNAP benefits.
- Use someone else's Electronic Benefits Card without authorization.
- Use your EBT card containing TCA benefits in a liquor store, adult entertainment venue such as a strip club or in a gambling establishment such as a casino.

Your SNAP benefits will not increase if your cash assistance is reduced or closed because you did not follow the rules.

If a household member deliberately breaks the rules, we may bar the person from TCA or SNAP.

- We may bar this person for one year after the first violation.

- We may bar this person for two years:
  - After the second violation, or
  - After the first time a court finds this person guilty of buying illegal drugs with TCA or SNAP benefits.

- We may bar this person permanently:
  - After the third violation;
  - After the second time a court finds a person guilty of buying illegal drugs with TCA or SNAP benefits;
  - After the first time a court finds this person guilty of buying guns, bullets, or explosives, with TCA or SNAP benefits; or
  - After a court finds this person guilty of trafficking TCA or SNAP benefits of $500 or more.

- We may bar this person for 10 years if found guilty of making a false statement about the person's identity in order to receive multiple benefits at the same time.

A judge can also fine this person up to $250,000, imprison the person for up to 20 years, or both. A judge can also bar this person for an additional 18 months. The person may also have to face further prosecution under other federal laws.

SNAP/EBT Card: Multiple Card Replacements
Individuals who request four or more replacement Independence cards in one year may be referred to the Office of the Inspector General for investigation of trafficking benefits.

READ BEFORE SIGNING:

I understand that it is important to give true information and if I do not, I am breaking the law.

I understand that I can be fined, imprisoned or have my benefits reduced for making false statements or for pretending to be another person.

I know I can be punished for not reporting changes that may affect my eligibility or benefit amount.

I understand that if I get more SNAP benefits than I should, all adult members of my household are liable for repaying the debt.

I know the Department can use the application against me in a court of law for fraud prosecution.

I know that failing to report or verify shelter, medical or dependent care expenses or child support payments is the same as saying I do not want a deduction for the expenses I did not verify or report.
I understand that the Department may check the information on this form to see if it is correct and may select my case for a spot check, such as for a Quality Control Review.

I agree to allow someone from the Department to visit me at home. I will help them get all needed proofs from any source.

SIGNATURE SECTION

I understand that, as required by Maryland law, certain law enforcement agencies that investigate fraud can obtain information about my application, income, benefits and other documentation as part of their investigation. While access to my application and benefit information is normally limited (under Md. Code Ann. Human Services Article § 1-201), these limits do not apply to these investigative agencies. Such agencies include the Department of Human Services' Office of the Inspector General. I understand that I do not need to provide consent to these agencies in order for them to investigate any allegations of fraud against me. Any information found as a result of the investigation may be used against me if an allegation of fraud is prosecuted.

I have read or someone has read and explained the entire application to me. I swear or affirm under penalty of perjury, that all the information I gave is true, correct, and complete to the best of my ability, belief and knowledge. I received a copy of my rights and responsibilities. I authorize any person, partnership, corporation, association, or governmental agency that knows the facts about my eligibility to give that information to the Department. I also authorize the Department to contact any person, partnership, corporation, association, or governmental agency that has given proof of my eligibility for benefits. I certify, under penalty of perjury, that by signing my name below, all persons for whom I am applying are U.S. citizens, lawfully admitted immigrants or individuals in satisfactory immigration status.

Signature of Applicant/ Recipient		Date	
Signature of Witness (If you Signed an X)		Date	
Signature of Spouse (If Applicable)		Date	
Signature of Authorized Representative (If Applicable)		Date	
Signature of Case Manager		Date	

☐ **I want to withdraw this application. I DO *NOT* WANT TO APPLY FOR SUPPLEMENTAL NUTRITION ASSISTANCE BENEFITS**

Signature of Applicant/ Recipient		Date	
Signature of Witness (If you Signed an X)		Date	
Signature of Spouse (If Applicable)		Date	
Signature of Authorized Representative (If Applicable)		Date	
Signature of Case Manager		Date	