MARYLAND DEPARTMENT OF HUMAN SERVICES
FAMILY INVESTMENT ADMINISTRATION

APPLICATION FOR EMERGENCY ASSISTANCE

Date Signed Application Received in Local Department
MUST BE DATE STAMPED

For Case Manager Use Only:

LDSS Office	Case Manager Name	Appointment Date	Appointment Time	AU ID

WHAT IS YOUR EMERGENCY?

Have you or anyone living with you applied for or received Emergency Assistance, Public Assistance or SNAP benefits in Maryland? ☐Yes ☐No	If Yes: Who Applied?	Client ID	Date of Last Assistance
	What Type?		Amount Received $

Have you or anyone living with you received Emergency Assistance, Public Assistance or SNAP benefits in another state? If YES- Who _____ Type: Date last assistance received:

1. INDIVIDUAL INFORMATION {CLRE/DEM2/ALAS} Complete the section below for you and all persons who live with you. List your name first:

NAME Last First Middle Jr. III, etc. Maiden/Other	Relationship To YOU	Date of Birth Mo/Day/Yr.	Social Security Number	Sex M/ F	*Ethnicity	*Race	U.S. Citizen?	INS Status
	SELF						☐Yes ☐No	
							☐Yes ☐No	
							☐Yes ☐No	
							☐Yes ☐No	
							☐Yes ☐No	

*Use the codes below to complete the Race and Ethnicity blocks. Enter each code that applies, using at least one code for each person. **Ethnicity Codes:** 1= Hispanic or Latino, 2=Not Hispanic/Latino. **Race Codes: You can choose one or more race code -** 1=American Indian/Alaskan Native, 2=Asian, 3=Black/African American, 4=Native Hawaiian/Pacific Islander, 5=White

Note: You do not have to give information about your race or ethnicity. If you do, it will help show how we obey the Federal Civil Rights Law. We will not use this information to decide if you are eligible. If you do not give us your race, it will not affect your application. The case manager will enter a race code for statistical purposes only. Title VI of the Civil Rights Act of 1964 allows us to ask for this information.

Are you or anyone who lives with you pregnant? ☐Yes ☐No	If Yes, Who?	What is the due date?

What language do you speak? □ English □ Spanish □ Other _____

If you do not speak English and need free translation services, tell your case manager.

Are you visually impaired? ☐Yes ☐No	Are you hearing impaired? ☐Yes ☐No

2. WHERE DO YOU LIVE? {NAME}

Number Street	Apt. No. Floor No.	Telephone Number

City	State	Zip Code + 4	Telephone Number where you can be reached

3. LIST YOUR MAILING ADDRESS IF DIFFERENT FROM WHERE YOU LIVE {NAME}

Number Street	Apt. No.	Floor No.

P.O. Box	City	State	Zip Code + 4

4. PREVIOUS ADDRESS {ADDR/PRE} List any other address where you lived in the last 12 months:

Number Street	Apt. No.	Floor No.

P.O. Box	City	State	Zip Code + 4

When did you live there? From:_____ To:_____

5. AUTHORIZED REPRESENTATIVE (If Desired) {CIRC/AURP} List the name and address of your authorized representative:

Name {First, Middle, Last}	Relationship to You	Telephone Number

Number Street	Apt. No. Floor No.	P.O. Box	City	State	Zip Code + 4

Check what you want the representative to do: ☐ Complete interview for you ☐ Sign your application ☐ Receive your notices

6. VENDOR INFORMATION {EAFI/VEND} List the name and address of the person or company to be paid (f not you):				
Name (First, Middle, Last)		Social Security No. or Federal ID No. {of Company}	Telephone Number	
Number Street Apt. No. Floor No.		P.O. Box	City	State Zip Code + 4

7. ASSETS (EAWS) If you or anyone who lives with you has any assets listed below, fill in the amount(s).					
ASSET TYPE	**AMOUNT**	**ASSET TYPE**	**AMOUNT**	**ASSET TYPE**	**AMOUNT**
Savings Account/Credit Union	$	Checking Account	$	Cash	$
Property Other than Home	$	Stocks/Bonds	$	Insurance	$
Other, list:_____		Other, list:_____	$		$

8. COMMUNITY RESOURCE (EAWS) If you or anyone who lives with you has received contributions from others, list names and amount(s).			
NAME	AMOUNT	NAME	AMOUNT
	$		$
	$		$

9. INCOME {EAWS/ERN1/DEMS} If you or anyone who lives with you works or receives other income, list name(s) and amount(s):								
INCOME TYPE	AMOUNT	HOW OFTEN?	INCOME TYPE	AMOUNT	HOW OFTEN?	INCOME TYPE	AMOUNT	HOW OFTEN?
Public Assistance	$		Gross Salary, Wages, Tips	$		Self-Employment	$	
Support from Parent/Spouse	$		Social Security	$		SSI	$	
Unemployment	$		Worker's Compensation	$		Veteran's Benefits	$	
Insurance Benefits	$		Railroad Retirement	$		Other, list:_____	$	

Have you or anyone who lives with you stopped working? ☐Yes ☐No If Yes, Who? _____
Date Job Ended:_____ Reason for Leaving:_____
Are you or anyone who lives with you on strike? ☐Yes ☐No If Yes, Who? _____

10. EXPENSES {EAWS} If you or anyone who lives with you has any expenses list them below, fill in this section:								
EXPENSE TYPE	AMOUNT	HOW OFTEN?	EXPENSE TYPE	AMOUNT	HOW OFTEN?	EXPENSE TYPE	AMOUNT	HOW OFTEN?
Rent or Mortgage	$		Oil/Other Fuel	$		Gas/Electric	$	
Telephone	$		Food Costs	$		Mandatory Payroll Deduction	$	
Mandatory Working Expenses	$		Other, list:_____	$		Other, list_____	$	
Child Care	$		Other, list:_____	$		Other, list_____	$	

FACTS YOU SHOULD KNOW ABOUT APPLYING FOR TEMPORARY CASH ASSISTANCE, SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (FORMERLY FOOD SUPPLEMENT PROGRAM), EMERGENCY ASSISTANCE TO FAMILIES WITH CHILDREN AND MEDICAL ASSISTANCE

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:

Applying for benefits, or
Have questions about information you must give us,
Want to know what will happen to your benefits
Do not speak English and need free translation 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.

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; providing an assistive listening device
Visual Impairment: having a qualified reader read to a customer
Mobility Impairments: mailing forms to a customer; 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 (CAC) at your local department of social services. Ask the case manager for the name of the Customer Access Coordinator at your local department of social services. You may also ask for more information at the front desk.

For customers accessing TTY

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.
5. Then type "GA".

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

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 ten days unless you are part of the Supplemental Nutrition Assistance Program 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.

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 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 https://dhs.maryland.gov/food-supplement-program/able-bodied-adults-without-dependents-abawds/

MEDICAID WARNING AND PENALTY - Only use Medical Assistance cards if you are eligible.

Every person convicted of "Medicaid Fraud" with a value of **$500** or more in money, services, or goods is guilty of a felony, and shall:

1. Pay back money, services or goods; or the value of those services or goods unlawfully received;
2. Be subject to a fine of no more than $10,000, imprisoned for no longer than five years, or both.

Every person convicted of "Medicaid Fraud" with a value of less than $500 in money, services or goods is guilty of a misdemeanor, and shall:

1. Pay back money, services or goods; or the value of those services or goods unlawfully received;
2. Be fined no more than $1,000 and imprisoned for no longer than three years or both.

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 the 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 Supplemental Nutrition Assistance Program benefits.

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

- We may bar this person for ten 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.

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.

I understand by signing this application:

- I accept cash assistance including Emergency Assistance to Families with Children (EAFC) and/or medical assistance.
- I agree that Medicare Part B will make payments directly to doctors and medical suppliers.
- I give the Department the right to seek payment from private or public health insurance and any liable third party. I understand that I must cooperate with the department in securing such payments. The Department may seek payment without legal action, as long as it does not keep more than the amount Medical Assistance paid.
- I give the Department the right to inspect, review, and copy all medical records for services received through the Medical Assistance Program.

I understand that when a person is deceased who was at least 55 years old when receiving Medical Assistance the state may take money from the estate to repay payments made on behalf of that person. The program may take the money only if there is no surviving spouse, unmarried child younger than 21, or blind or disabled child (married or unmarried) of any age.

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		Date

Representative (If Applicable)		
Signature of Case Manager		Date

I do not wish to apply for assistance at this time. I withdraw my application for:

□ **Cash Assistance** □ **Supplemental Nutrition Assistance Program** □ **Medical Assistance**

□ **Emergency Assistance to Families and Children**

Signature of Applicant, Recipient, Authorized Representative		**Date**

I HAVE READ THESE STATEMENTS OR SOMEONE READ THEM TO ME. I UNDERSTAND WHAT THEY MEAN. BY SIGNING MY NAME BELOW, I AGREE TO FOLLOW WHAT THEY SAY.

Signature	**Date**
Printed Name	

FOR CASE MANAGER USE ONLY

AU ID

Emergency Type code

Need Type

Cost of Need

Vendor ID

Verifications

Customer Rights

In accordance with federal civil rights laws and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex (including gender identity and sexual orientation), 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. Programs that receive federal financial assistance from the U.S. Department of Health and Human Services (HHS), such as Temporary Assistance for Needy Families (TANF), and programs HHS directly operates are also prohibited from discrimination under federal civil rights laws and HHS regulations.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or who 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.

USDA provides federal financial assistance for many food security and hunger reduction programs such as the Supplemental Nutrition Assistance Program (SNAP), the Food Distribution Program on Indian Reservations (FDPIR) and others. To file a program complaint of discrimination, complete the Program Discrimination Complaint Form, (AD-3027) found online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, 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 mail: Food and Nutrition Service, USDA,1320 Braddock Place, Room 334, Alexandria, VA 22314; or fax: (833) 256-1665 or (202) 690-7442; or phone: (833) 620-1071; or email: FNSCIVILRIGHTSCOMPLAINTS@usda.gov.

For any other information regarding 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: SNAP hotline.

HHS provides federal financial assistance for many programs to enhance health and well-being, including TANF, Head Start, the Low Income Home Energy Assistance Program (LIHEAP), and others. If you believe that you have been discriminated against because of your race, color, national origin, disability, age, sex (including pregnancy, sexual orientation, and gender identity), or religion in programs or activities that HHS directly operates or to which HHS provides federal financial assistance, you may file a complaint with the Office for Civil Rights (OCR) for yourself or for someone else
To file a complaint of discrimination for yourself or someone else regarding a program receiving federal financial assistance through HHS, complete the form online through OCR's Complaint Portal at https://ocrportal.hhs.gov/ocr/. You may also contact OCR via mail at: Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201; fax: (202) 619-3818; or email: OCRmail@hhs.gov. Persons who need assistance with filing a civil rights complaint can email OCR at OCRMail@hhs.gov or call OCR toll-free at 1-800-368-1019, TDD 1-800-537-7697. For persons who are deaf, hard of hearing, or have speech difficulties, please dial 7-1-1 to access telecommunications relay services.

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