

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES
APPLICATION FOR ASSISTANCE PART-1

For Office use only:

Screener's Name: _____ Date Screened: _____ Intake: _____

Do you speak English? Yes No If no, what is the primary language spoken? _____

Can you read and write in English? Yes No

If you do not speak English, does any adult member of the household speak English? Yes No

- I want to apply for:
- CASH ASSISTANCE (RHODE ISLAND WORKS PROGRAM- RIW)
 - SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) (formerly called Food Stamps)
 - MEDICAL ASSISTANCE (MA)
 - GENERAL PUBLIC ASSISTANCE (GPA)

SECTION 1. APPLICANT INFORMATION

Name: _____ Maiden/Other Name(s): _____
First MI Last

S.S.N.: _____ D.O.B. _____ Sex: Male _____ Female _____ Marital Status: _____

Spouse's Name: _____ Spouse's D.O.B.: _____ Spouse's S.S.N.: _____
First MI Last

Residence Address _____
Street/Route Apt./Floor City State Zip

Mailing Address _____
(if different) Street/Route Apt/Floor PO Box City/Town State Zip

Telephone Number : Day _____ Evening _____

IF YOU ARE APPLYING FOR SNAP-FOOD STAMP BENEFITS—DO YOU PREFER A

Telephone Interview (DHS will call you) (OR) Do you prefer an **In-Office Interview** ? (check one)

IMPORTANT: If you do not choose An In-Office Interview, a Telephone Interview will be scheduled for you.

Telephone Number where you can be reached for a telephone interview : _____

If you wish to authorize someone other than yourself to apply on your behalf, please indicate below:

I want _____ to apply on my behalf. _____
(Name of Individual) (Daytime Phone #) (Evening Phone #)

My shelter arrangement is (Check one):

- 01 Elderly/disabled housing 06 Own home/trailer 11 Non-traditional: lobby, street, car
- 02 Drug/alcohol rehab center 07 Rent home/apt/trailer 12 Residential care and assisted living
- 03 Disabled/blind group home 08 Living in another's home/apt 13 Long-Term Care Facility
- 04 Battered Women's shelter 09 No permanent address 99 Other (specify) _____
- 05 Shelter 10 Halfway house

Did you move to Rhode Island within the last three (3) months? Yes NO If YES, Date: _____

If yes, what was your reason for moving here? (Check One)

- L Looking for Employment R Close to Relatives W To get Cash, Food Stamps, and/or Medical
- D Domestic Violence K Hurricane Katrina O Other _____ (please specify)

Where did you move from? _____ Do you receive any assistance now? Yes No

Have you previously applied for, or received any type of assistance payments, benefits or Food Stamp/SNAP benefits in R.I. or in another state? Yes No

If Yes, under what name? _____ Where? _____ When? _____ Type? _____

Applicant's Signature

Date

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) (formerly called Food Stamps)

Step 1. – You may file your application immediately as long as we have your name, address and the signature of a responsible household member or your authorized representative on this application. Benefits are provided from the date we receive this form in our office, if you are determined eligible. We are required to verify information you provide and take action on your application within thirty (30) days of the filing date. The application filing date for pre-release applicants is the date of release from the institution.

Step 2. – To determine whether or not you are eligible, you must be interviewed. We are required to verify information you provide and to take action within thirty (30) days from the date your application is received, unless you are entitled to receive expedited services.

YOU MAY GET SNAP BENEFITS WITHIN SEVEN DAYS IF YOU ARE OTHERWISE ELIGIBLE:

- 1) if your household's gross monthly income is less than \$150 and your household's resources, such as cash, checking or savings accounts are \$100 or less;
- 2) if your rent/mortgage and utilities are more than your household's combined gross monthly income and liquid resources; or,
- 3) if you are a migrant or seasonal farm worker household. Please complete the questions on this page and complete the DHS-2 Statement of Need. If you qualify for this service we are required to provide food stamps within seven (7) days from the time you give us this form.

SECTION 2.

Has anyone in the household received any income from any source so far this month? Yes No
If yes, how much gross income? \$ _____

Did your household's only income recently stop? Yes No If Yes, when? _____
Why? _____

Does anyone in your household expect to receive income later this month? Yes No
If Yes, how much _____ When? _____

How many people live in your home and eat with you? (include yourself) _____

How much do the members of your household have in all bank accounts? \$ _____

How much is your monthly rent or mortgage? _____
Utilities: Heat: _____ Air Conditioning: _____ Other Utilities: _____

Is anyone in your household a migrant or seasonal farm worker? Yes No

In order to issue SNAP benefits under the expedited services provisions, the DHS-2 must be completed and filed. The above questions are a screening process and do not constitute the complete application.

SECTION 3.

A. HOUSEHOLD COMPOSITION (List everyone who lives in your home now, even if they do not want assistance. Please include any unborn children.)

<u>Last Name</u>	<u>First Name</u>	<u>D.O.B.</u> (mm/dd/yyyy)	<u>Relationship</u>	<u>S.S.N.</u> (Only required if member is applying for benefits)	<u>U.S. Citizen?</u> <u>Answer Yes or No</u> (Only required if member is applying for benefits)

B. Is anyone who wants assistance pregnant? Yes No If Yes, date due _____ What is this person's name? _____

I certify under penalty of perjury that my answers are correct, including information about citizenship and alien status, and complete to the best of my knowledge and belief. I know that under the state of Rhode Island General Laws, Section 40-6-15, a maximum fine of \$1,000, or imprisonment of up to five (5) years, or both, may be imposed for a person who obtains or attempts to obtain, or aids or abets any person to obtain, public assistance to which s/he is not entitled or who willfully fails to report income, resources, or personal circumstances or increases therein which exceed the amount previously reported.

Date

Applicant's Signature

Signature of Applicant's Spouse or
Child's other parent living in household

Screener/Eligibility Technician Signature

Date

**If applying for RIW Cash Assistance, both the Applicant and the Spouse/Child's other parent living in household, must appear at the initial interview.

WITHDRAWAL OF APPLICATION

After participating in the screening interview, I do not wish to make an application for RIW, SNAP, MA or GPA at this time. I understand that I may apply again at any time. I understand that this application will be denied and a notice of denial will be sent to me.

Please state your reason for withdrawing your application: _____

Applicant's Signature

Date

FOR OFFICE USE ONLY

CASE RECORD CLEARANCE FOR PARTICIPATION

PERS SEARCH

PREVIOUS CASE RECORD		STATUS	RECORD LOCATION	REQUEST DATE
RIW	<input type="checkbox"/> Yes <input type="checkbox"/> No			
SNAP	<input type="checkbox"/> Yes <input type="checkbox"/> No			
MA	<input type="checkbox"/> Yes <input type="checkbox"/> No			
RITE CARE	<input type="checkbox"/> Yes <input type="checkbox"/> No			
GPA	<input type="checkbox"/> Yes <input type="checkbox"/> No			
CCAP	<input type="checkbox"/> Yes <input type="checkbox"/> No			

DISPOSITION:

- RIW (Prompt appointment)
- RIW (Emerg. appointment)
- SNAP
- Expedited SNAP
- GPA

Date _____
Date _____
Date _____
Date _____
Date _____

- RITE CARE Application Sent
- MA Application Sent
- CCAP Application Sent

Comments:

Signature of Screener

Date