

# Statement of Need

Name \_\_\_\_\_  
Last
First
Middle

Mailing Address \_\_\_\_\_  
Street
Apt. #
Floor  
 \_\_\_\_\_  
City
State
Zip Code

Residence Address \_\_\_\_\_  
Street
Apt. #
Floor  
 \_\_\_\_\_  
City
State
Zip Code

Telephone Number where you can be reached: Daytime: \_\_\_\_\_ Evening: \_\_\_\_\_

Do you or any adult member of the household speak English?  Yes  No

If no, what is the primary language spoken? \_\_\_\_\_

**IF YOU ARE APPLYING FOR SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) BENEFITS (formerly called Food Stamps), 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.**

Please enter phone number where you can be reached for a telephone interview: \_\_\_\_\_

Complete this form if you are applying for  
 RI Works Program (RIW),  
 Supplemental Nutrition Assistance Program (SNAP)- (formerly called Food Stamps),  
 Medical Assistance [Nursing Home/Waiver] (MA),  
 and/or  
 General Public Assistance (GPA)

Program RIW <input type="checkbox"/> MA <input type="checkbox"/> SNAP <input type="checkbox"/> GPA <input type="checkbox"/>	Application <input type="checkbox"/> Recertification <input type="checkbox"/> Add a Member <input type="checkbox"/>	Case ID
Agency Representative		Interview Date

# General Instructions for Completing the Statement of Need

## PLEASE READ THIS PAGE CAREFULLY BEFORE FILLING OUT THIS FORM

You can ask for help in completing this form. You can ask for the form and notices to be translated. If you have a disability or condition that makes it hard for you to understand or answer questions on this application, we can help. Please let us know.

### Answer All Questions

This form consists of 38 questions. Except for Question 1, each is followed by a section of boxes used for filling in the required information. Respond to each question by indicating either YES or NO with a check mark in the box next to the question.

### IF the answer is YES [ ]

Supply the requested information by writing in the yellow-boxed area beneath the question. You must provide the information asked for EVERY household member whether or not you are requesting assistance for her or him.

### IF the answer is NO [ ]

THE QUESTION DOES NOT APPLY TO YOU OR ANYONE IN YOUR HOUSEHOLD. With the exception of Question 38, leave the yellow box blank, and move on to the next question.

### IF YOU need more space to answer questions

Write "SEE PAGE 25" if you run out of space. Turn to page 25, where there are boxes to write in additional information. Indicate in one of the boxes, which question you are referring with its number. You may also attach a separate sheet, if necessary.

### Read pages 25, 26 and 27

These pages contain important information about your Rights and Responsibilities.

### About the Interview

Page 3 has a list of "Things to Bring for Your Interview." Be sure to provide all the documents listed.

### About the Questions

#### Question 1.

List yourself on the first line providing all the requested information. Then list all persons who live with you, one person per line. Indicate how each person is related to you (for example "son", "cousin", etc.) in the "Relationship" blocks. You must list each person who lives in your home REGARDLESS OF WHETHER OR NOT YOU ARE SEEKING ASSISTANCE FOR THAT PERSON.

#### Question 1a. through 13.

Complete the information in the yellow areas for each person requesting assistance. These questions follow the list of household members (Question 1.) and ask for personal information about everyone listed in Question 1. If the answer to any of these questions is YES [ ] complete the information asked for in the yellow shaded area. When doing so, write the names of household members exactly as they appear in Question 1.

#### Question 14. through 19.

These questions ask about the financial assets (such as bank accounts) of all household members. If the answer to any of these questions is YES [ ], complete the information asked for in the yellow shaded area. When doing so, write the name of household members exactly as they appear in Question 1.

#### Questions 20. through 28.

These questions ask about the income of all household members. If the answer to any of these questions is YES [ ], complete the information asked for in the yellow shaded area. When doing so, write the names of household members exactly as they appear in Question 1.

#### Questions 29. through 38.

These questions ask about shelter and miscellaneous expenses and medical coverage of all household members. If the answer to any of these questions is YES [ ], complete the information asked for in the yellow shaded area. When doing so, write the name of household members exactly as they appear in Question 1. If you report and provide proof of your expenses shown in these questions, you will get the maximum amount of Supplemental Nutrition Assistance Program benefits allowed. Failure to report or provide proof of your expenses will be regarded as your statement that you do not want to receive a deduction for the unreported or unproven expense. You can ask for assistance in getting documentation of the deductions and/or expenses from your agency representative. The agency representative may assist you by contacting other people for confirmation if you are having trouble getting written proof of deductions and/or expenses.

# STATEMENT OF NEED

This document should be filled out by you, or an adult member of your household, or a relative, friend or authorized representative who knows the financial situation of all household members. The person filling out this document is the primary information source, and will usually be the RIW and/or SNAP recipient unless other arrangements are made with your agency representative.

Do not write in blue shaded areas. On the following pages list all members of your household. All of your answers must be complete, clear and correct before your application will be processed. If they are not, the form may be returned to you for more information. If you do not understand a question, see your agency representative for help. If you need more space to report information, use page 25 titled, “For Client Use Only”.

## ELECTRONIC BENEFIT TRANSFER (EBT) CARD

RIW cash assistance and SNAP benefits are issued through the Electronic Benefit Transfer (EBT) process. You can get your benefits by using your EBT card. You will receive more information about this process from your local office.

### THINGS YOU MAY NEED TO PROVIDE FOR YOUR INTERVIEW

- Birth Certificate for all household members
- Photo ID
- Passport or Certificate of Naturalization or other documentation to prove Citizenship and Identity
- Death certificate of deceased parent for any dependent child for whom you may be applying or for any deceased MA applicant
- Proof of pregnancy, if pregnant
- Social Security numbers for all household members and absent parents
- If not a U.S. Citizen, proof of Immigration status
- Proof of identity (driver’s license, rent receipt, etc.)
- Life insurance policies and Burial contracts
- Proof of health and or dental insurance coverage
- Veteran’s claim number
- Pay stubs, pay envelopes, earnings statement and/or proof of last date worked and last pay
- Self-employed persons: Federal tax return, bookkeeping records, or sales and expenditures records
- Proof of income from rental property
- Award letters or proof of Social Security, SSI, UCB, TDI, Worker’s Compensation, etc.
- Bank statements for checking accounts, savings accounts, certificates of deposit, credit union accounts, or stocks and bonds
- Trust documents
- Deeds for any home or property
- Rent receipt/mortgage payment (including home insurance, taxes, and other shelter expenses)
- Proof of medical expenses such as: medications, hospital bills, doctor bills, or insurance premiums
- Child care receipts
- Copy of child support orders, proof of child support and/or alimony payments, divorce decree, marriage license
- Utility receipts
- Vehicle registration (s)
- Copy of Power of Attorney or guardianship
- Public Assistance/MA/SNAP closing notice from another state

**If you try and are unable to obtain any of the above, the Agency will assist any cooperating households.**

### SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

Your SNAP application will be considered from the date the signed form is received. If you are found eligible for SNAP benefits, those benefits will be determined from the date your signed application is received by the agency. You will be sent a written request for any verification missing from your application. Your application will be denied if the missing verification is not received within ten (10) days of the written request

### FINANCIAL ASSISTANCE (RIW) (GPA)

If you are applying for RIW or GPA and are determined eligible for RIW or GPA benefits, those benefits will be determined from the date the signed application is received.

### MEDICAL ASSISTANCE (MA)

Medical benefits for adults may be provided for up to three (3) months prior to the month in which the signed application is received provided all factors of eligibility are met for each month.



**DO NOT WRITE IN  
BLUE SHADED  
AREAS**



**WRITE IN YELLOW  
SHADED AREAS  
ONLY**

**1**

**List everyone who lives in your home now.**

*(Be sure to list everyone, including any unborn children, even if they do not want assistance.)*

**HOUSEHOLD**

	Last Name (Maiden) First Initial				Relation to you	Assistance asked for <input checked="" type="checkbox"/>					Date Of Birth	Ver
	SNAP	RIW	MA	GPA		NONE						
1											___/___/___	
2											___/___/___	
3											___/___/___	
4											___/___/___	
5											___/___/___	
6											___/___/___	
7											___/___/___	
8											___/___/___	
9											___/___/___	
10											___/___/___	
11											___/___/___	
12											___/___/___	

**1a**

*If there are more people in your household, please list them on page 25 marked, "for client use only".*

Are you or any one in your household fleeing to avoid prosecution, custody, or confinement after conviction, under the law of the place from which you are fleeing, for a crime or attempt to commit a crime that is a felony under the law of the place from which you are fleeing or which, in the case of New Jersey, is a high misdemeanor under the state of New Jersey or violating a condition of probation or parole imposed under a federal or state law? YES  NO  If YES, Name of household member(s) \_\_\_\_\_ Date \_\_\_\_\_ State \_\_\_\_\_

Have you or anyone in your household ever been found by the Department through its Administrative Hearing process of having made, or been convicted in a Federal or State court of having made a fraudulent statement or representation with respect to one's identity or place of residence in order to receive multiple benefits simultaneously under assistance from the RI Works Program (TANF), Supplemental Nutrition Assistance Program, or Medical Assistance Program? YES  NO  If YES, Name of household member(s) \_\_\_\_\_ Date of finding/conviction \_\_\_\_\_ State \_\_\_\_\_

**\*Race**  
 DHS is requesting this information to conform with Federal Guidelines.  
 1) The information is voluntary.  
 2) The race and ethnic information will not affect an applicant's eligibility or level of benefits.  
 3) The reason for the collection of this information is to assure that program benefits are distributed without regard to race, color, or national origin.

**MEMBERS**

MEMB

	Social Security Number <i>(Provide this information only if the person is requesting benefits)</i>	Var	Sex	Marital Status	Last Grade Compl	U.S. Citizen <i>(Provide this information only if the person is requesting benefits)</i>	Is this person's Ethnicity Latino/ Hispanic?	Race*	Citizenship Date	Var	Rel	Ver	Eth	Work Part	Tax Dep
1	____/____/____		F <input type="checkbox"/> M <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian							
2	____/____/____		F <input type="checkbox"/> M <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian							
3	____/____/____		F <input type="checkbox"/> M <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian							
4	____/____/____		F <input type="checkbox"/> M <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian							
5	____/____/____		F <input type="checkbox"/> M <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian							
6	____/____/____		F <input type="checkbox"/> M <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian							
7	____/____/____		F <input type="checkbox"/> M <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian							
8	____/____/____		F <input type="checkbox"/> M <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian							
9	____/____/____		F <input type="checkbox"/> M <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian							
10	____/____/____		F <input type="checkbox"/> M <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian							
11	____/____/____		F <input type="checkbox"/> M <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian							
12	____/____/____		F <input type="checkbox"/> M <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian							

*If there are more people in your household, please list them on page 25 marked, "for applicant/recipient use only".*

**ANSWER THIS IF YOU ARE APPLYING FOR SNAP benefits** and you live in a household with children under eighteen (18) and more than one adult parent or adult who has parental control over the children.

Your household must choose an adult parent of children living in the household, or an adult who has parental control over children under 18 years of age living in the household, to be the head of the household. All adult members must agree to the selection.

If you live in such a household, please designate the head of the household here. Name \_\_\_\_\_

**1b**

Are you, your spouse, or anyone in the household a military veteran, a dependent of a veteran, or a survivor of a veteran?

Yes No 

If yes, complete the boxes below about each person.

Last Name	First Name	Initial	Veteran's Status		Applied for Veteran's Benefits	Date of Service	Serial Number	V.A. Claim Number
			Veteran	<input type="checkbox"/>	Yes <input type="checkbox"/>	___/___/___		
			Dependent	<input type="checkbox"/>	No <input type="checkbox"/>			
			Survivor	<input type="checkbox"/>				
			Veteran	<input type="checkbox"/>	Yes <input type="checkbox"/>	___/___/___		
			Dependent	<input type="checkbox"/>	No <input type="checkbox"/>			
			Survivor	<input type="checkbox"/>				
			Veteran	<input type="checkbox"/>	Yes <input type="checkbox"/>	___/___/___		
			Dependent	<input type="checkbox"/>	No <input type="checkbox"/>			
			Survivor	<input type="checkbox"/>				

**2**

Were you, your spouse, or anyone in the household born outside the U.S.?

Yes No 

If yes, complete the boxes below about each person that is requesting benefits who is not a U.S. citizen.

ALIE

Last Name	First Name	Initial	Country of Origin	Alien Registration Number	Immigration Number
Alien Status:	<input type="checkbox"/> Refugee		Date of Entry _____	INS Status Date _____	
	<input type="checkbox"/> Permanent Resident		Date of Entry _____	Permanent Residence Date _____	
	<input type="checkbox"/> Other		Date of Entry _____	INS Status Date _____	
Name of Sponsor			Sponsor's Address		Alien
Reside in RI Prior to 8/22/96			Yes <input type="checkbox"/> No <input type="checkbox"/>	Reside in RI Prior to 7/1/97	Yes <input type="checkbox"/> No <input type="checkbox"/>
					Origin

Last Name	First Name	Initial	Country of Origin	Alien Registration Number	Immigration Number
Alien Status:	<input type="checkbox"/> Refugee		Date of Entry _____	INS Status Date _____	
	<input type="checkbox"/> Permanent Resident		Date of Entry _____	Permanent Residence Date _____	
	<input type="checkbox"/> Other		Date of Entry _____	INS Status Date _____	
Name of Sponsor			Sponsor's Address		Alien
Reside in US Prior to 8/22/96			Yes <input type="checkbox"/> No <input type="checkbox"/>	Reside in RI Prior to 7/1/97	Yes <input type="checkbox"/> No <input type="checkbox"/>
					Origin

**3** Are you, your spouse, or anyone in the household in a group living arrangement such as the types listed below? Yes   
No

EXAMPLES

Shelter for Homeless                      Drug Treatment Center                      Hospital                      Assisted Living Facility  
Group Home                                  Alcohol Treatment Center                      Shelter for Battered Women                      Dormitory

If yes, complete the boxes below about each person. G R O P

Last Name	First Name	Initial	Name of Facility	Type
Last Name	First Name	Initial	Name of Facility	Type

**4** Are you or anyone in the household who is sixteen (16) or older in school or a job-training program? Yes   
No

If yes, complete the boxes below about each person. S C H L

Last Name	First Name	Initial	School/Training Program	Address							
Check One	Full Time [ ]	Half Time [ ]	Less than Half Time [ ]	Date of Completion	Type	Status	Ver	Count RIW	Count SNAP	MA	GPA

Last Name Initial	First Name	Initial	School/Training Program	Address							
Check One	Full Time [ ]	Half Time [ ]	Less than Half Time [ ]	Date of Completion	Type	Status	Ver	Count RIW	Count SNAP	MA	GPA

**5** Besides you or your spouse, is there anyone in the household who has children under age twenty-one (22) who also lives in the household? Yes   
No

If yes, complete the boxes below about each person. P A R E

Parent's Last Name	First Name	Initial	Child's Last Name	First Name	Initial	Ver	Child's Last Name	First Name	Initial	Ver
--------------------	------------	---------	-------------------	------------	---------	-----	-------------------	------------	---------	-----

**6**

Is there anyone who lives with you who purchases and prepares food separately?

Yes   
No

If yes, list the people who do not eat with you. E A T S

Last Name	First Name	Initial	Last Name	First Name	Initial	Last Name	First Name	Initial

**7**

Are you or anyone in the household pregnant?

Yes   
No

If yes, complete the boxes below about the pregnant person. P R E G

Last Name	First Name	Initial	Date Baby is Due	Ver	Last Name	First Name	Initial	Date Baby is Due	Ver
			___/___/___					___/___/___	

**8**

Are you, your spouse, or anyone in the household mentally or physically ill, incapacitated, disabled or blind?

Yes   
No

If yes, complete the boxes below about each person. D I S A

Last Name	First Name	Initial	Medical problem (describe)	Caused by an accident? Yes [ ] No [ ]					
Is this person active with the Office of Rehabilitation Services or Services for the Blind?				Yes [ ]	No [ ]	Factor	Ver	Review	Blind
Has this person applied for SSI or Social Security Benefits (RSDI)?				Yes [ ]	No [ ]				

**9**

Are there children in the household whose parents are deceased?

Yes   
No

If yes, complete the boxes below about each person. D E C P

Last Name	First Name	Initial	Social Security Number	Sex	Date of Birth	Date of Death	Ver				
			___/___/___	Male [ ] Female [ ]	___/___/___	___/___/___					
List the children of this deceased parent in the spaces below.											
Last Name	First Name	Initial	P	Last Name	First Name	Initial	P	Last Name	First Name	Initial	P
Last Name	First Name	Initial	P	Last Name	First Name	Initial	P	Last Name	First Name	Initial	P

**10**

Are there child(ren) in the household who do not have both parents (natural or adoptive) living with them?

Yes No 

List as Absent Parent present or former husband for children born during that marriage, or within 10 months of a final decree of divorce from that husband. If divorce decree or court order excludes your husband or former husband as father of any of the child(ren) listed in the application, you need to list the biological father of the child(ren) and provide copies of the decree or order with this application.

If yes, complete the boxes below about each absent parent and the children in this household of each absent parent. A B S P

Absent Parent's Last Name		First Name		Initial	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Absent Parent's Social Security No. ____/____/____		Absent Parent's Birth Date ____/____/____	
Absent Parent's Address					Absent Parent's Telephone Number				
Employer Name				Employer Address			Is this absent parent disabled and/or a veteran? Yes <input type="checkbox"/> No <input type="checkbox"/>		Coop
Were the parents of the child(ren) married to each other? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, date married ____/____/____			Are the parents of the child(ren) currently married to each other? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, date divorced ____/____/____			Absent Parent's Marital Status Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown <input type="checkbox"/>			
Child(ren) of the absent parent living in this household.				State of Birth	Is child support, health coverage or paternity court ordered? (If yes, list date)				P
Child's Last Name		First		Initial					
1.					Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____		
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____		
						Paternity <input type="checkbox"/>	Date _____		
2.					Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____		
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____		
						Paternity <input type="checkbox"/>	Date _____		
3.					Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____		
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____		
						Paternity <input type="checkbox"/>	Date _____		
4.					Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____		
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____		
						Paternity <input type="checkbox"/>	Date _____		
5.					Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____		
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____		
						Paternity <input type="checkbox"/>	Date _____		

Absent Parent's Last Name		First Name		Initial	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Absent Parent's Social Security No. ____/____/____		Absent Parent's Birth Date ____/____/____	
Absent Parent's Address					Absent Parent's Telephone Number				
Employer Name				Employer Address			Is this absent parent disabled and/or a veteran? Yes <input type="checkbox"/> No <input type="checkbox"/>		Coop
Were the parents of the child(ren) married to each other? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, date married ____/____/____			Are the parents of the child(ren) currently married to each other? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, date divorced ____/____/____			Absent Parent's Marital Status Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown <input type="checkbox"/>			
Child(ren) of the absent parent living in this household.				State of Birth	Is child support, health coverage or paternity court ordered? (If yes, list date)				P
Child's Last Name		First		Initial					
1.					Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____		
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____		
						Paternity <input type="checkbox"/>	Date _____		
2.					Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____		
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____		
						Paternity <input type="checkbox"/>	Date _____		
3.					Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____		
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____		
						Paternity <input type="checkbox"/>	Date _____		
4.					Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____		
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____		
						Paternity <input type="checkbox"/>	Date _____		
5.					Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____		
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____		
						Paternity <input type="checkbox"/>	Date _____		

# Question 10 (continued)

If yes, complete the boxes below about each absent parent and the children in this household of each absent parent.							A B S P		
Absent Parent's Last Name		First Name		Initial	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Absent Parent's Social Security No. ____/____/____		Absent Parent's Birth Date ____/____/____	
Absent Parent's Address					Absent Parent's Telephone Number				
Employer Name				Employer Address			Is this absent parent disabled and/or a veteran? Yes <input type="checkbox"/> No <input type="checkbox"/>		Coop
Were the parents of the child(ren) married to each other? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, date married ____/____/____			Are the parents of the child(ren) currently married to each other? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, date divorced ____/____/____			Absent Parent's Marital Status Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown <input type="checkbox"/>			
Child(ren) of the absent parent living in this household. Child's Last Name				State of Birth	Is child support, health coverage or paternity court ordered? (If yes, list date)				P
First		Initial			Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____		
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____		
						Paternity <input type="checkbox"/>	Date _____		
1.					Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____		
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____		
						Paternity <input type="checkbox"/>	Date _____		
2.					Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____		
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____		
						Paternity <input type="checkbox"/>	Date _____		
3.					Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____		
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____		
						Paternity <input type="checkbox"/>	Date _____		
4.					Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____		
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____		
						Paternity <input type="checkbox"/>	Date _____		
5.					Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____		
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____		
						Paternity <input type="checkbox"/>	Date _____		

Absent Parent's Last Name		First Name		Initial	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Absent Parent's Social Security No. ____/____/____		Absent Parent's Birth Date ____/____/____	
Absent Parent's Address					Absent Parent's Telephone Number				
Employer Name				Employer Address			Is this absent parent disabled and/or a veteran? Yes <input type="checkbox"/> No <input type="checkbox"/>		Coop
Were the parents of the child(ren) married to each other? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, date married ____/____/____			Are the parents of the child(ren) currently married to each other? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, date divorced ____/____/____			Absent Parent's Marital Status Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown <input type="checkbox"/>			
Child(ren) of the absent parent living in this household. Child's Last Name				State of Birth	Is child support, health coverage or paternity court ordered? (If yes, list date)				P
First		Initial			Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____		
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____		
						Paternity <input type="checkbox"/>	Date _____		
1.					Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____		
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____		
						Paternity <input type="checkbox"/>	Date _____		
2.					Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____		
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____		
						Paternity <input type="checkbox"/>	Date _____		
3.					Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____		
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____		
						Paternity <input type="checkbox"/>	Date _____		
4.					Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____		
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____		
						Paternity <input type="checkbox"/>	Date _____		
5.					Yes <input type="checkbox"/>	Support <input type="checkbox"/>	Date _____		
					No <input type="checkbox"/>	Health Cov <input type="checkbox"/>	Date _____		
						Paternity <input type="checkbox"/>	Date _____		

**11**

Are you or any other parent in the household unemployed or working only part time?(please check one)  Unemployed  Part-time

Yes No 

If yes, complete the boxes below.

UNEM

Last Name	First Name	Initial	Did this person receive unemployment compensation in the last 12 months?		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Dates Received: From _____ to _____	UC	Ver
Did this person refuse a job or training program offer in the last 30 days?					Yes <input type="checkbox"/>	No <input type="checkbox"/>	Allow		
Has this person registered with the Department of Labor and Training (D.L.T.)?					Yes <input type="checkbox"/>	No <input type="checkbox"/>	Ver		
List the hours and weeks worked in the past 30 days below.				List all the jobs held in the past five(5) years.					
Work Week	Date	No. of days Worked	Hours Worked	Employer's Name	Employer's Address	Dates of Employment	Amount Earned		
Week one (1)						From _____ To _____			
Week two (2)						From _____ To _____			
Week three (3)						From _____ To _____			
Week four (4)						From _____ To _____			
Week five (5)						From _____ To _____			

Last Name	First Name	Initial	Did this person receive unemployment compensation in the last 12 months?		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Dates Received: From _____ to _____	UC	Ver
Did this person refuse a job or training program offer in the last 30 days?					Yes <input type="checkbox"/>	No <input type="checkbox"/>	Allow		
Has this person registered with the Department of Labor and Training (D.L.T.)?					Yes <input type="checkbox"/>	No <input type="checkbox"/>	Ver		
List the hours and weeks worked in the past 30 days below.				List all the jobs held in the past five(5) years.					
Work Week	Date	No. of days Worked	Hours Worked	Employer's Name	Employer's Address	Dates of Employment	Amount Earned		
Week one (1)						From _____ To _____			
Week two (2)						From _____ To _____			
Week three (3)						From _____ To _____			
Week four (4)						From _____ To _____			
Week five (5)						From _____ To _____			

**12**

Did you or anyone in the household leave a job in the last sixty (60) days?

Yes No 

If yes, complete the boxes below.

QUIT

Last Name	First Name	Initial	Reason for leaving job	Date left job _____/_____/_____	Pri	GC
Employer's Name			Employer's Address			
If anyone in the household has answered yes to this question, complete the section below for everyone age 16 or older in the household who has worked in the past two (2) months.						
Last Name	First Name	Initial	Gross earnings last month \$ _____	Gross earnings this month \$ _____	Total gross earning both months \$ _____	
Last Name	First Name	Initial	Gross earnings last month \$ _____	Gross earnings this month \$ _____	Total gross earning both months \$ _____	

**13**

Are you or anyone in the household on strike?

Yes No 

If yes, complete the boxes below about each person.

STRK

Last Name	First Name	Initial	Date strike began ____/____/____	Employer's Name	Employer's Address	Type
-----------	------------	---------	-------------------------------------	-----------------	--------------------	------

**14**

Do you, your spouse, or anyone in the household have any cash?

Yes No 

If yes, complete the boxes below about each person with cash.

CASH

Last Name	First Name	Initial	Amount \$ _____	Last Name	First Name	Initial	Amount \$ _____
-----------	------------	---------	--------------------	-----------	------------	---------	--------------------

**15**

Do you, your spouse, or anyone in the household have his/her name on any accounts such as the type listed below?

Yes No **EXAMPLES**

Checking account

Credit union account

Savings certificate

IRA

Burial Set Aside

Savings account

Money market account

Certificate of deposit

Keogh Plan

Trust

If yes, complete the boxes below for each account.

BANK

Last Name	First Name	Initial	Type of account	Account number			Amount \$ _____		Type
Co-owner name Address		Financial Institution Address		Ver	Count RIW	Count SNAP	Count MA	Count GPA	MA Lien

Last Name	First Name	Initial	Type of account	Account number			Amount \$ _____		Type
Co-owner name Address		Financial Institution Address		Ver	Count RIW	Count SNAP	Count MA	Count GPA	MA Lien

Last Name	First Name	Initial	Type of account	Account number			Amount \$ _____		Type
Co-owner name Address		Financial Institution Address		Ver	Count RIW	Count SNAP	Count MA	Count GPA	MA Lien

Last Name	First Name	Initial	Type of account	Account number			Amount \$ _____		Type
Co-owner name Address		Financial Institution Address		Ver	Count RIW	Count SNAP	Count MA	Count GPA	MA Lien

Last Name	First Name	Initial	Type of account	Account number			Amount \$ _____		Type
Co-owner name Address		Financial Institution Address		Ver	Count RIW	Count SNAP	Count MA	Count GPA	MA Lien

**15a**

Did you, your spouse, or anyone in the household receive a Social Security or RSDI lump sum in the past 6 months?

Yes   
No

If yes, complete box below.

Last Name	First Name	Initial	Amount received \$ _____	Date received ____/____/____
-----------	------------	---------	-----------------------------	---------------------------------

**16**

Do you, your spouse, or anyone in the household own, and/or have registered in his/her name any vehicle such as the types listed below?

Yes   
No

**EXAMPLES** Car Camper Boat Snowmobile Truck Recreational Vehicle Motorcycle

If yes, complete the boxes below for each vehicle.

CARS

Owner's Last Name	First Name	Initial	Vehicle	Make	Model	Year	Blue book value \$ _____				
What is the vehicle used for?	Amount owed \$ _____	Ver	Vehicle ID Number	Registration Number	Count RIW	Count SNAP	Count MA	Count GPA	MA Lien		
Insurance Company											

Owner's Last Name	First Name	Initial	Vehicle	Make	Model	Year	Blue book value \$ _____				
What is the vehicle used for?	Amount owed \$ _____	Ver	Vehicle ID Number	Registration Number	Count RIW	Count SNAP	Count MA	Count GPA	MA Lien		
Insurance Company											

Owner's Last Name	First Name	Initial	Vehicle	Make	Model	Year	Blue book value \$ _____				
What is the vehicle used for?	Amount owed \$ _____	Ver	Vehicle ID Number	Registration Number	Count RIW	Count SNAP	Count MA	Count GPA	MA Lien		
Insurance Company											

**17**

Do you, your spouse, or anyone in the household own any items of value?

Yes No 

(Include any items of value not listed in questions 14, 15 or 16)

**EXAMPLES**Stocks  
BondsPersonal Property (antiques, collections, jewelry, etc.)  
Life Insurance

Burial Contract

If yes, complete the boxes below.

RESO

**STOCKS, BONDS, OTHER**

Last Name	First Name	Initial	Type of Resource	Count RIW	Count SNAP	Ver
Co-owner's Last Name	First Name	Initial	Co-owner's Address	Count MA	Count GPA	MA Lien

Last Name	First Name	Initial	Type of Resource	Count RIW	Count SNAP	Ver
Co-owner's Last Name	First Name	Initial	Co-owner's Address	Count MA	Count GPA	MA Lien

Last Name	First Name	Initial	Type of Resource	Count RIW	Count SNAP	Ver
Co-owner's Last Name	First Name	Initial	Co-owner's Address	Count MA	Count GPA	MA Lien

**LIFE INSURANCE**

Last Name	First Name	Initial	Company Name	Policy Number	Type	Count RIW	Count SNAP	Ver
Owned By			Face Value	Cash Value	Loan Amount	Count MA	Count GPA	MA Lien

Last Name	First Name	Initial	Company Name	Policy Number	Type	Count RIW	Count SNAP	Ver
Owned By			Face Value	Cash Value	Loan Amount	Count MA	Count GPA	MA Lien

Last Name	First Name	Initial	Company Name	Policy Number	Type	Count RIW	Count SNAP	Ver
Owned By			Face Value	Cash Value	Loan Amount	Count MA	Count GPA	MA Lien

**BURIAL CONTRACT**

Last Name	First Name	Initial	Value	Irrevocable	Effective Date	Count RIW	Count SNAP	Ver
Funeral Home			Funeral Home Address			Count MA	Count GPA	MA Lien

Last Name	First Name	Initial	Value	Irrevocable	Effective Date	Count RIW	Count SNAP	Ver
Funeral Home			Funeral Home Address			Count MA	Count GPA	MA Lien

**18**

Do you, your spouse, or anyone in the household own any interest in any property such as land, buildings, life estate, time share, etc?

Yes   
No

If yes, complete the boxes below about each person.

PROP

Owner's Last Name	First Name	Initial	Type of property (describe)	Cash Value \$ _____		Amount Owed \$ _____			Ver	
How is the property owned? Solely <input type="checkbox"/> Jointly <input type="checkbox"/> Other <input type="checkbox"/>			Address of Property		Count RIW	Count SNAP	Count MA	Count GPA	MA Lien	Review Date
Is this property your home? Yes <input type="checkbox"/> No <input type="checkbox"/> ; The home of your spouse? Yes <input type="checkbox"/> No <input type="checkbox"/> ; Your dependents? Yes <input type="checkbox"/> No <input type="checkbox"/>										

**19**

Have you, your spouse, or anyone in the household given away, sold, deeded, or transferred to anyone or any entity, any items of value in the past sixty (60) months?

Yes   
No

If yes, complete the boxes below.

TRAN

Last Name	First Name	Initial	Resource Transferred							
Amount Transferred \$ _____	Date Transferred ____/____/____	What did you receive in return?			Allow RIW	Allow SNAP	Allow MA	Allow GPA		

Last Name	First Name	Initial	Resource Transferred							
Amount Transferred \$ _____	Date Transferred ____/____/____	What did you receive in return?			Allow RIW	Allow SNAP	Allow MA	Allow GPA		

Last Name	First Name	Initial	Resource Transferred							
Amount Transferred \$ _____	Date Transferred ____/____/____	What did you receive in return?			Allow RIW	Allow SNAP	Allow MA	Allow GPA		

**19a**

Are you named as a beneficiary (primary, secondary, etc.) on any trust?

Yes   
No

If yes, you must provide copies of the trust even if you are not currently receiving any payments from the trust.

Principal amount and date established \$ _____ Date ____/____/____	Amount of payments to you \$ _____	Frequency of payments to you _____
---	---------------------------------------	---------------------------------------

**19b**

Have you, your spouse, or anyone acting on your behalf (including a court) established a trust or put any money into a trust within the last sixty(60) months?

Yes   
No

If yes, you must provide copies of the trust.

Established by _____	Date established ____/____/____	Amount \$ _____
-------------------------	------------------------------------	--------------------

**20**

Do you or anyone in the household have or expect income from a job this month?

Yes   
No

EXAMPLES      Salaries/Wages      Commissions      National Guard      Army Reserve  
Work Study      Job Training      Sheltered Workshop      US Military

If yes, complete the boxes below about each person. JINC

Last Name		First Name		Initial	How often paid?		Employer Name	
Date Job Began ____/____/____		Day of Week Paid		Job held	<input type="checkbox"/> Weekly	<input type="checkbox"/> Every two weeks	Employer Address	
					<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly		
					<input type="checkbox"/> Other (how often) _____			
List the gross amount paid on each pay day this month.								
Pay day	Date Paid	Pay period end date	Hours worked per pay period	Gross wages before taxes	Tips/Commissions	Recur	Ver	
1 <sup>st</sup>	____/____/____	____/____/____		\$	\$			
2 <sup>nd</sup>	____/____/____	____/____/____		\$	\$			
3 <sup>rd</sup>	____/____/____	____/____/____		\$	\$			
4 <sup>th</sup>	____/____/____	____/____/____		\$	\$		Count	Count
5 <sup>th</sup>	____/____/____	____/____/____		\$	\$		SNAP	RIW
Did you receive earned income tax credit in your paycheck? Yes <input type="checkbox"/> No <input type="checkbox"/>							Count	Count
Is this an On the Job training program? Yes <input type="checkbox"/> No <input type="checkbox"/>						List the number of hours you expect to be paid for next month.		
Is this job part of a work study program? Yes <input type="checkbox"/> No <input type="checkbox"/>						No. of hours	Expected Gross Earnings	Tips/Commissions
Will this income be received in the following month? Yes <input type="checkbox"/> No <input type="checkbox"/>							\$	\$

Last Name		First Name		Initial	How often paid?		Employer Name	
Date Job Began ____/____/____		Day of Week Paid		Job held	<input type="checkbox"/> Weekly	<input type="checkbox"/> Every two weeks	Employer Address	
					<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly		
					<input type="checkbox"/> Other (how often) _____			
List the gross amount paid on each pay day this month.								
Pay day	Date Paid	Pay period end date	Hours worked per pay period	Gross wages before taxes	Tips/Commissions	Recur	Ver	
1 <sup>st</sup>	____/____/____	____/____/____		\$	\$			
2 <sup>nd</sup>	____/____/____	____/____/____		\$	\$			
3 <sup>rd</sup>	____/____/____	____/____/____		\$	\$			
4 <sup>th</sup>	____/____/____	____/____/____		\$	\$		Count	Count
5 <sup>th</sup>	____/____/____	____/____/____		\$	\$		SNAP	RIW
Did you receive earned income tax credit in your paycheck? Yes <input type="checkbox"/> No <input type="checkbox"/>							Count	Count
Is this an On the Job training program? Yes <input type="checkbox"/> No <input type="checkbox"/>						List the number of hours you expect to be paid for next month.		
Is this job part of a work study program? Yes <input type="checkbox"/> No <input type="checkbox"/>						No. of hours	Expected Gross Earnings	Tips/Commissions
Will this income be received in the following month? Yes <input type="checkbox"/> No <input type="checkbox"/>							\$	\$

## Question 20 (continued)

Last Name		First Name		Initial	How often paid? [ ] Weekly [ ] Every two weeks		Employer Name	
Date Job Began ____/____/____		Day of Week Paid		Job held	[ ] Twice a month [ ] Monthly		Employer Address	
					[ ] Other (how often) _____			
List the gross amount paid on each pay day this month.								
Pay day	Date Paid	Pay period end date	Hours worked per pay period	Gross wages before taxes	Tips/Commissions	Recur	Ver	
1 <sup>st</sup>	____/____/____	____/____/____		\$	\$			
2 <sup>nd</sup>	____/____/____	____/____/____		\$	\$			
3 <sup>rd</sup>	____/____/____	____/____/____		\$	\$			
4 <sup>th</sup>	____/____/____	____/____/____		\$	\$	Count	Count	
5 <sup>th</sup>	____/____/____	____/____/____		\$	\$	SNAP	RIW	
Did you receive earned income tax credit in your paycheck? Yes [ ] No [ ]						Count	Count	
						MA	GPA	
Is this an On the Job training program? Yes [ ] No [ ]					List the number of hours you expect to be paid for next month.			
Is this job part of a work study program? Yes [ ] No [ ]					No. of hours	Expected Gross Earnings	Tips/Commissions	
Will this income be received in the following month? Yes [ ] No [ ]						\$	\$	

**21**

Do you, your spouse, or anyone in the household have an outstanding claim or lawsuit for injuries or illness sustained due to an automobile accident, workers' compensation claim, etc, or for any lawsuit in which you may receive money?

Yes

No

If yes, complete the boxes below about each person who is injured.

SETT

Last Name		First Name		Initial	Type of Claim (describe)		Date of Incident ____/____/____		Workers' Compensation Yes [ ] No [ ]	
Person (or company) responsible				Insurance Company			Attorney Name			
Address				Address			Address			

Last Name		First Name		Initial	Type of Claim (describe)		Date of Incident ____/____/____		Workers' Compensation Yes [ ] No [ ]	
Person (or company) responsible				Insurance Company			Attorney Name			
Address				Address			Address			

**22**

Do you, your spouse, or anyone in the household receive income from rent?

Yes   
No

If yes, complete the boxes below about each person who receives the rent. R I N C

Last Name	First Name	Initial	Hours worked per week maintaining property	Total Number Of Units	Freq	Ver	Recur	Count RIW	Count SNAI	Count MA	Count GPA
Total Rent Received? \$ _____			_____	_____	_____	_____	_____	_____	_____	_____	_____
How often? _____											
Does the person listed above live here? Yes [ ] No [ ]				Will the income be received in the following months? Yes [ ] No [ ]							
Rental Expense		How Often?	Rental Expense		How Often?	Rental Expense			How Often?		
Mortgage	\$ _____	_____	Water	\$ _____	_____	Electric	\$ _____	_____			
			Sewage	\$ _____	_____	Oil	\$ _____	_____			
Taxes	\$ _____	_____	Garbage	\$ _____	_____	Repairs	\$ _____	_____			
			Gas	\$ _____	_____	Other	\$ _____	_____			

**23**

Do you, your spouse, or anyone in the household have income from taking care of children in your home?

Yes   
No

If yes, complete the boxes below about each person taking care of children. Attach documentation if you wish to claim actual expenses. D C I N

Last Name	First Name	Initial	Total Amount Received per week \$ _____	Number of weeks worked	Hours worked per week	Number of children cared for					
Will this income be received in the following months? Yes [ ] No [ ]					Freq	Ver	Recur	Count RIW	Count SNAP	Count MA	Count GPA

**24**

Do you, your spouse, or anyone in the household receive payment from roomers or boarders?

Yes   
No

If yes, complete the boxes below about each person. Attach documentation if you wish to claim actual expenses. R B I N

Name of person receiving payment			Number of hours worked per week							Recur
Last Name	First Name	Initial	Will this income be received in the following months? Yes [ ] No [ ]							
Names of Roomer/Boarders	Amount Received/How Often	Includes		Date Received	Freq	Ver	Count RIW	Count SNAP	Count MA	Count GPA
	\$ _____ per _____	Room only	[ ]	____/____/____						
		Board (1-2 meals)	[ ]							
		Board (3 meals)	[ ]							
	\$ _____ per _____	Room only	[ ]	____/____/____						
		Board (1-2 meals)	[ ]							
		Board (3 meals)	[ ]							
	\$ _____ per _____	Room only	[ ]	____/____/____						
		Board (1-2 meals)	[ ]							
		Board (3 meals)	[ ]							

**25**

Do you, your spouse, or anyone in the household receive income from self employment?

Yes   
No

**EXAMPLES**

Farming

Fishing

Out-of-home day care

Door-to-door sales

Home Sales

If yes, complete the boxes below about each person.

**B U S I**

Last Name	First Name	Initial	Gross Income/How Often \$_____per_____	Expenses \$_____			Average number of hours worked per week			
Type of Business	Name of Business		Will this income be received in the following months? Yes [ ] No [ ]	Ver	Recur	Count RIW	Count SNAP	Count MA	Count GPA	

Last Name	First Name	Initial	Gross Income/How Often \$_____per_____	Expenses \$_____			Average number of hours worked per week			
Type of Business	Name of Business		Will this income be received in the following months? Yes [ ] No [ ]	Ver	Recur	Count RIW	Count SNAP	Count MA	Count GPA	

**26****RESERVED****27**

Do you, your spouse, or anyone in the household receive a student grant, scholarship, educational loan or VA educational benefits?

Yes   
No

If yes, complete the boxes below using separate lines for each source. Please bring verification for all tuition and fees.

**S T I N**

Last Name	First Name	Initial	Amount received \$_____	Period covered by grant/loan From_____to_____	Date received ____/____/____		Date of last payment ____/____/____		
Type of Grant/Loan	Will this income be received in the following months? Yes [ ] No [ ]			Recur	Ver	Count RIW	Count SNAP	Count MA	Count GPA

Last Name	First Name	Initial	Amount received \$_____	Period covered by grant/loan From_____to_____	Date received ____/____/____		Date of last payment ____/____/____		
Type of Grant/Loan	Will this income be received in the following months? Yes [ ] No [ ]			Recur	Ver	Count RIW	Count SNAI	Count MA	Count GPA

**28**

Do you, or your spouse, or anyone in the household received,  
or expect to receive, income such as the type below?

Yes   
No

**EXAMPLES:**

Adoption Subsidy	Gifts, Prizes, Inheritance, Lottery	Railroad Retirement	Unemployment Compensation
Alien Sponsorship	In-kind Shelter	Retirement Pensions	VA Aid and Attendance
Annuities	Other in-kind	Section 8 Utility Payment	VA Basic Benefits
Alimony	Income Tax Refund	Social Security (RSDI)	VA Compensation
Child Support	Insurance and Lawsuit Claim	SSI	VA Improved Pension
Dividends, Interest	Strike Benefits	Workers' Compensation	
Earned Income Tax Credit Refund	Military Allotment	TDI	
Foster Care	Out of State Assistance	Trust Funds	

If yes, complete the boxes below for each type of income that person receives.

U N E A

Last Name	First Name	Initial	Amount/How Often \$ _____ per _____	Date Income Received ____/____/____	Claim Number					
Type of Income	Will this income be received in the following months? Yes [ ] No [ ]		Type	Freq	Ver	Recur	Count RIW	Count SNAI	Count MA	Count GPA

Last Name	First Name	Initial	Amount/How Often \$ _____ per _____	Date Income Received ____/____/____	Claim Number					
Type of Income	Will this income be received in the following months? Yes [ ] No [ ]		Type	Freq	Ver	Recur	Count RIW	Count SNAI	Count MA	Count GPA

Last Name	First Name	Initial	Amount/How Often \$ _____ per _____	Date Income Received ____/____/____	Claim Number					
Type of Income	Will this income be received in the following months? Yes [ ] No [ ]		Type	Freq	Ver	Recur	Count RIW	Count SNAI	Count MA	Count GPA

Last Name	First Name	Initial	Amount/How Often \$ _____ per _____	Date Income Received ____/____/____	Claim Number					
Type of Income	Will this income be received in the following months? Yes [ ] No [ ]		Type	Freq	Ver	Recur	Count RIW	Count SNAI	Count MA	Count GPA

If anyone in the household expects income in the future, fill in the boxes below for that person(s).

Last Name	First Name	Initial	Type of income Expected	Expected Date income will be received ____/____/____
-----------	------------	---------	-------------------------	---

**28a**

Has anyone in the household ever received SSI and  
RSDI in the same month?

Yes   
No

If yes, complete the box below.

Last Name	First Name	Initial	Year Received
-----------	------------	---------	---------------

\*(If you report and provide proof of your expenses shown in questions 29 through 38, you will get the maximum amount of SNAP benefits allowed. Failure to report or provide proof of your expenses will be regarded as your statement that you do not want to receive a deduction for the unreported or unproven expense)

Yes

**29** Do you, your spouse, or anyone in the household pay for someone to baby-sit or care for a child or disabled adult in the home? No

If yes, complete the boxes below about each person who paid for daycare. D C E X

Name of person paying for care	Day Care is needed because s/he is: Working [ ] In school training [ ] Looking for work [ ]		Is this cost subsidized Yes [ ] No [ ]		If yes, amount of subsidy? \$ _____ per _____			Amount of out-of-pocket Payment or co-payment \$ _____ per _____		
Name of person in care	Adult/Child Adult [ ] Child [ ]	Will this cost continue? Yes [ ] No [ ]		Freq	Type	Recur	Count RIW	Count SNAP	Count MA	Count GPA
Name of Day/Adult Care Provider					Address of Provider					

Name of person paying for care	Day Care is needed because s/he is: Working [ ] In school training [ ] Looking for work [ ]		Is this cost subsidized Yes [ ] No [ ]		If yes, amount of subsidy? \$ _____ per _____			Amount of out-of-pocket Payment or co-payment \$ _____ per _____		
Name of person in care	Adult/Child Adult [ ] Child [ ]	Will this cost continue? Yes [ ] No [ ]		Freq	Type	Recur	Count RIW	Count SNAP	Count MA	Count GPA
Name of Day/Adult Care Provider					Address of Provider					

**30** Do you, your spouse, or anyone in the household pay child support, alimony, or claim as a tax dependent any persons not living in this household? Yes   
No

If yes, complete the boxes below about each person who pays child support, alimony, or claims someone as a tax dependent. S U P P

Last Name	First Name	Initial	Who is the person claiming?	Type of claim made Child Support [ ] Alimony [ ] Other tax dependent [ ]	Amount Paid \$ _____ How Often?	Freq	Ver
Last Name	First Name	Initial	Who is the person claiming?	Type of claim made Child Support [ ] Alimony [ ] Other tax dependent [ ]	Amount Paid \$ _____ How Often?	Freq	Ver

**31** Do you, your spouse, or anyone in the household, or anyone outside the household, pay rent, or a share of the rent, for the apartment, house, mobile home, or shelter where you live? Yes   
No

If yes, complete the boxes below about each person who pays rent. R E N T

Last Name	First Name	Initial	Total Rent amount/how often \$ _____ per _____	Amount paid by you \$ _____	Included in Rent Heat [ ] Utilities [ ]			
Is the rent subsidized? (i.e., Section 8)? Yes [ ] No [ ]		If yes, the amount of the subsidy is \$ _____ per _____		Does anyone share the cost of the rent? Yes [ ] No [ ]			If yes Name _____ Amount \$ _____	
Landlord's Name			Landlord's Address			Type	Freq	Ver
Landlord's Telephone Number								

**32**

Do you, your spouse, or anyone in the household pay all or a share of a mortgage payment, property taxes, insurance, or other costs of the house, condo, or mobile home where you live?

Yes   
No

If yes, complete the boxes below about each person who pays a homeowner cost. HOME

Last Name	First Name	Initial	Homeowner Expenses/How Often	Mortgage Holder & Address	Type	Ver
			First Mortgage Principal \$_____per_____ Interest \$_____per_____ Includes Taxes [ ] Insurance [ ]			
			Second Mortgage Principal \$_____per_____ Interest \$_____per_____ Includes Taxes [ ] Insurance [ ]			
			Taxes \$_____per_____ (if not included in the mortgage)	Does anyone share the cost of this expense? Yes [ ] No [ ]		
			Insurance \$_____per_____	If yes, name the person sharing the expenses		
			Lot Rental \$_____per_____	What is the amount paid		
			Other \$_____per_____	By this person? \$_____		

**33**

Do you, your spouse, or anyone in the household pay all, or a share of, the fuel or utilities?

Yes   
No

Did you get a Low Income Home Energy Assistance Act Grant at your current address in the last twelve (12) months.

Yes   
No

If yes, complete the boxes below about each person who pays a homeowner cost. UTIL

Last Name	First Name	Initial	Utility	Amount Paid/How Often	Used to Heat/Cool	Freq	Ver
			Oil	\$_____per_____	Heat [ ] Cool [ ]		
			Gas	\$_____per_____	Heat [ ] Cool [ ]		
			Wood or Coal	\$_____per_____	Heat [ ] Cool [ ]		
			Electric	\$_____per_____	Heat [ ] Cool [ ]		
			Telephone	\$_____per_____			
			Water	\$_____per_____			
			Sewer	\$_____per_____			
			Rubbish Removal	\$_____per_____			
			Other	\$_____per_____			
Does anyone share the heating or cooling costs in your home? Yes [ ] No [ ]						LIHEAA	Ver
If yes, name of the person(s) sharing the heating or cooling costs _____						SUA	
What is the amount of the heating/cooling costs this person pays? \$ _____							

**34**

Do you, your spouse, or anyone in the household pay for room and/or board?

Yes   
No

If yes, complete the boxes below about each person who pays room and/or board.

R B E X

Last Name	First Name	Initial	Amount Paid/How Often \$ _____ per _____	What does the room/board cover? Room only [ ] Board(1-2 meals) [ ] Board(3meals) [ ]	Freq	Ver	Type

**35**

If you are applying for SNAP benefits, is there anyone in the household who is over sixty (60) or disabled, who incurs any medical expenses not covered by health insurance?

Yes   
No

EXAMPLES Health insurance premiums Hearing aids Dental care Prescription Drugs  
Medicare premiums Eyeglasses Transportation to medical treatment or services

If yes, complete the boxes below about each person who pays room and/or board.

F M E D

Last Name	First Name	Initial	Type of medical expense	Amount Incurred \$ _____ How Often? _____	When do you expect this to end?	Ver

**IF YOU ARE APPLYING FOR SNAP BENEFITS ONLY,  
DO NOT COMPLETE QUESTIONS 36, 37, OR 38 BELOW.**

**36**

Are you, your spouse, or anyone in the household covered by Medicare?

Yes   
No

If yes, complete the boxes below about each person.

M E D I

Last Name	First Name	Initial	Medicare Claim Number _____-_____-_____		MPP	QDWI
Part A begin date (month/day/year)			Part A Premium \$ _____	Who pays this expense?	P A Y O R	
Part B begin date (month/day/year)			Part B Premium \$ _____	Who pays this expense?	PAYOR	BUY IN

Last Name	First Name	Initial	Medicare Claim Number _____-_____-_____		MPP	QDWI
Part A begin date (month/day/year)			Part A Premium	Who pays this expense?	P A Y O R	
Part B begin date (month/day/year)			Part B Premium	Who pays this expense?	PAYOR	BUY IN

**37**

Are you, your spouse, or anyone in the household covered by a health or dental insurance program or HMO other than Medicare, Medicaid, RItCare or RItShare?

Yes   
No

If no, is anyone eligible to be covered by a health or dental plan offered by his or her employer?  Yes  No

If no, has anyone declined or voluntarily terminated health or dental insurance coverage within the last four (4) months?  Yes  No

EXAMPLES    BlueCross/Blue Shield                      United HealthCare of New England                      Delta Dental  
                    BlueChip    Neighborhood Health Plan of RI                      BCBS Dental

If yes, complete the boxes below. INSU

Policy Holder's name Last Name      First Name      Initial		Health and/ or Dental Insurance Name	Type of Coverage	Family <input type="checkbox"/> Individual <input type="checkbox"/>	If premium paid by you Amount/How Often \$ _____ per _____		
Policy Number	Group Number	Is insurance provided by employer? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, name of employer providing insurance		Code	Type	Req
Please list below person(s) covered by this policy.							
Last Name	First Name	Initial	Relation	Individual's Policy Number	Begin Date	End Date	

Policy Holder's name Last Name      First Name      Initial		Health and/ or Dental Insurance Name	Type of Coverage	Family <input type="checkbox"/> Individual <input type="checkbox"/>	If premium pad by you Amount/How Often \$ _____ per _____		
Policy Number	Group Number	Is insurance provided by employer? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, name of employer providing insurance		Code	Type	Req
Please list below person(s) covered by this policy.							
Last Name	First Name	Initial	Relation	Individual's Policy Number	Begin Date	End Date	

**38**

Do you, your spouse, or anyone in the household have any unpaid medical bills?

Yes   
No

If yes, did you have any medical coverage when the bills were incurred?

Yes   
No

If you have any unpaid medical bills, complete the boxes below about each person who received medical treatment. MED X

Last Name	First Name	Initial	Date of Service	Who do you owe?	Amount Owed
					\$ _____
					\$ _____
					\$ _____

## FOR APPLICANT/RECIPIENT USE ONLY

Use this page to add information about questions 1 through 38. Be sure to include the question number.

Question # \_\_\_\_\_ Page # \_\_\_\_\_

# RIGHTS AND RESPONSIBILITIES

Of Applicants/Recipients of RI Works Program (RIW),  
Supplemental Nutrition Assistance Program (SNAP), Medical Assistance (MA), and General Public Assistance (GPA)

## RIGHTS

**You have a RIGHT** to request, and if found eligible, to receive Financial or Medical Assistance or Supplemental Nutrition Assistance Program benefits based on policies and standards established under State laws.

**You have a RIGHT** to appeal and to receive a Hearing before a Hearing Officer of the Department if you are dissatisfied with any Department decision, or if the Department delays in making a decision. If you request a Hearing, your appeal will be heard promptly. You may be represented by a lawyer or any other person you select to appear on your behalf. . If you are not satisfied with any Department decision regarding your application, you have a right to request a hearing. You must request a hearing within ninety (90) days from the date you receive a written notice for Supplemental Nutrition Assistance Program benefits, thirty (30) days from the date you receive a written notice for RIW, Child Care, and Medical Assistance, and (10) days from the date you receive a written notice for GPA.

**You have a RIGHT** to non-discriminatory treatment. In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794); Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), and Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.); the Food Stamp Act; the Age Discrimination Act of 1975; the U.S. Department of Health and Human Services implementing regulations (45 C.F.R. Parts 80 and 84) and the U.S. Department of Education implementing regulations (34 C.F.R. Parts 104 and 106); and the U.S. Department of Agriculture, Food and Nutrition Services (7 C.F.R. 272.6); the Rhode Island Department of Human Services (DHS), does not discriminate on the basis of race, color, national origin, disability, religion, political beliefs, age, religion or gender in acceptance for or provision of services, employment or treatment, in its education and other program activities. Under other provisions of applicable law, DHS does not discriminate on the basis of sexual orientation. For further information about these laws, regulations and DHS' discrimination complaint procedures for resolution of complaints of discrimination, contact DHS at 57 Howard Avenue, Cranston, Rhode Island 02920, telephone number 462-2130 (for deaf/hearing impaired 462-6239 or 711). The Community Relations Liaison Officer is the coordinator for implementation of Title VI; the Office of Rehabilitation Services (ORS) Administrator or his/her designee is the coordinator for implementation of the Title IX, Section 504, and ADA. The Director of DHS or his/her designee has the overall responsibility for DHS' civil rights compliance.

In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, relation, political beliefs or disability. To file a complaint of discrimination for SNAP, write to USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410, or call (202) 720-5964 (voice and TDD). USDA is an Equal Opportunity provider and employer.

DHS has my consent to use or disclose protected health information for the purposes of treatment, payment and health care operations in accordance with DHS notice of privacy practices.

**You have a RIGHT** to confidentiality. The Department uses information about you and other members of your household only for purposes directly related to the administration of the programs and in compliance of the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information.

**You have a RIGHT to confidentiality. The Department uses information about you and other members of your household only for purposes directly related to the administration of the programs and in compliance of the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information.**

## RIGHTS (CONTINUED)

The Department does not release information about you or other members of your household without your consent except as provided in Rhode Island General Laws 40-6-12 and 40-6-12.1, and regulations set forth in the DHS and SNAP Policy Manuals. Any person found guilty of violating the provisions of Rhode Island General Laws 40-6-12 shall be deemed guilty of a misdemeanor. Violators are subject to a maximum fine of two hundred dollars (\$200), or imprisonment of up to six (6) months, or both.

## RESPONSIBILITIES

**You have a RESPONSIBILITY** to supply the Department with accurate information about your income, resources and living arrangements.

**You have a RESPONSIBILITY** to tell us immediately (within ten (10) days) of any changes in your income, resources, family composition, or any other changes that affect your household. For RIW Cash you must tell us immediately (within five (5) days) when a child leaves your household for any reason. For SNAP, if you are a simplified reporter, you must report changes in income which bring the household's gross income in excess of the applicable SNAP Gross Income Eligibility Standard for your household size.

**You have a RESPONSIBILITY** to provide Social Security numbers (or proof that you have applied for one) for yourself and your household, or to apply, if you are required to, for them as a condition of eligibility. The collection of this information, as well as the Social Security numbers of all members of your household for whom you receive assistance, will be used in computer matching with the Department of Labor and Training, the Social Security Administration, the Internal Revenue Service, the Food and Nutrition Services, and other governmental and non-governmental entities authorized by law, regulation or contract, and they will be subject to verification by Federal, State, and local officials. The income and eligibility information obtained from these agencies will be used to make sure your household is eligible for and receiving the correct amount of SNAP benefits, GPA, Child Care, RIW, and/or Medical Assistance. This information will also be used to monitor compliance with program regulations and for program management. This information may be disclosed to other Federal and State agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law. If a claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies as well as private claims collection agencies for claims collection action. Providing the requested information is voluntary. However, failure to provide a SSN will result in the denial of benefits to each individual failing to provide a SSN. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible household members.

**You have a RESPONSIBILITY** to report and provide proof of your expenses shown in questions 29 through 38 in order to get the maximum amount of SNAP benefits allowed. Failure to report or provide proof of your expenses will be regarded as your statement that you do not want to receive a deduction for the unreported or unproven expense.

**You have a RESPONSIBILITY** to cooperate fully with State and Federal personnel conducting quality control reviews. Only U.S. citizens and certain legal immigrants may be eligible for SNAP benefits. If there are non-citizens living with you who are not eligible, you may still apply for and receive benefits for other eligible household members. You are not required to provide immigration information for people not applying for benefits, but you may need to provide other information for those people, such as, income and resources.

# DECLARATION OF APPLICANT/RECIPIENT

(Applicant must Read and Sign)

## I. RI WORKS PROGRAM, MEDICAL ASSISTANCE, AND GENERAL PUBLIC ASSISTANCE.

I understand that pursuant to Rhode Island General Law, Sections 40-6-9, 40-6-10, or 40-8-15, without the necessity of signing any document:

### a.) Regarding Child Support and Establishment of Paternity

I have assigned any and all rights that I may have for and on behalf of myself, and for and on behalf of my child or children, to the Department of Human Services, against any person failing to provide for support, maintenance, and medical care for myself and my minor child or children for whom assistance is paid by the Department of Human Services. The Department of Human Services is authorized to perform the act of instituting suit to establish paternity and/or to collect support for myself or my child or children who receive or received assistance from the Department of Human Services.

### b.) Regarding Amounts Recoverable from a Third Party

I have assigned any and all rights to the Department of Human Services, for and on behalf of myself and any person for whom I may legally act, for amounts recoverable from a third party equal to the amount of financial assistance and medical assistance provided as a result of accident, injury, or illness.

### c.) Regarding Amounts Recoverable from Workers' Compensation

The Department of Human Services may place a lien upon any pending award, order, or settlement, which I may be entitled to under the provisions of the Rhode Island Workers Compensation Act, Chapters 28-29 through 28-38 of the Rhode Island General Laws. The purpose of the lien is to secure reimbursement to the Department for financial and medical assistance payments made to me or on my behalf for the period of time for which my workers' compensation award, order, or settlement is made.

### d.) Regarding Lien on Deceased Recipient's Estate for Medical Assistance Reimbursement

The Department of Human Services may place a lien upon the estate of a Medical Assistance recipient who was fifty-five (55) years of age or older at the time of death. R.I.G.L. 40-8-15 provides that the total sum of Medical Assistance paid on behalf of a Medical Assistance recipient who was fifty-five (55) years of age or older at the time of receipt of such assistance shall be a debt to the state and shall constitute a lien upon the estate of the recipient in favor of the Department of Human Services. However, the lien shall not be effective and shall not apply to the estate of a recipient who is survived by a spouse, or a child who is under the age of twenty-one (21) or a child who is blind or permanently and totally disabled as defined in Title XVI (SSI) of the Social Security Act.

I understand that as a condition of receiving RIW benefits, all persons from whom I am requesting RIW, unless exempt by law, are required to comply with the RI Works Program requirements.

I understand that this application will serve as authorization to the Department of Human Services to obtain from Medical providers information that is pertinent to me or any person included in this application for as long as the case remains open.

I understand and agree that the DHS office may contact other persons or organizations to obtain the necessary proof of my eligibility and level of benefits.

## II. AUTHORIZED REPRESENTATIVE

You can authorize someone outside your home 1) to get your SNAP benefits for you and/or 2) to use them to buy food for you. If you would like to authorize such representative(s), write the person's name below.

\_\_\_\_\_  
Last Name                      First Name                      Initial

\_\_\_\_\_  
Address                      City                      Zip

## III. SNAP PENALTY WARNINGS

I understand that:

1. Any member of my household who intentionally breaks a SNAP rule can be barred from the Supplemental Nutrition Assistance Program:

\*For a period of one (1) year for the first violation, with the exceptions in numbers 2. and 3. below;

\*For a period of two (2) years after the second violation, with the exception in number 3. below; and,

\*Permanently for the third occasion of any intentional program violation.

2. Individuals found by a Federal, State, or local court to have used or received SNAP benefits in a transaction involving the sale of firearms, ammunitions or explosives shall be permanently ineligible for the Supplemental Nutrition Assistance Program upon the first occasion of such violation.

3. Individuals convicted of trafficking SNAP benefits of five hundred dollars (\$500) or more shall be permanently disqualified from the Supplemental Nutrition Assistance program.

4. Individuals found by the Department of having made, or convicted in a Federal or State court of having made, a fraudulent statement or representation with respect to their benefits simultaneously under the Supplemental Nutrition Assistance Program would be disqualified for a ten (10) year period.

**DO NOT** give false information or hide information to get or continue to get SNAP benefits.

**DO NOT** trade or sell EBT cards.

**DO NOT** use SNAP benefits to buy ineligible items, such as alcoholic drinks and tobacco.

**DO NOT** use someone else's EBT card for your household.

DHS can use or share information on this application for the administration of DHS programs, as well as the administration of other federally funded assistance programs in accordance with state and federal law, contract and regulation.

DHS can release non-identifying information for research purposes. Any release of identifying information shall be done in accordance with state and federal law.

I understand the questions on this application and the penalty for hiding or giving false information or breaking any of the rules listed in this Penalty Warning.

## IV. PENALTIES FOR PERJURY

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.

Under penalty of perjury, I attest to the identity of the minor children identified herein and that all of the information contained in this application is true. I understand that I am breaking the law if I give wrong information and can be punished under federal law, state law or both.

Signature of Applicant or Recipient	Date	Signature of Authorized Representative	Date
Signature of Spouse or other parent of child(ren)	Date	Signature of Person Helping you Complete this Form	Date
Signature of Guardian, Conservator or Holder of Power of Attorney	Date	Signature of Agency Representative	Date





## Notice to Applicant Registering to Vote in Rhode Island

The State Board of elections urges all of its citizens to register to vote. Your vote will benefit you and your family.

Included in this packet of forms is a voter registration form. If you would to register to vote, complete and sign the form and mail it to your local Board of Canvassers. (directory listed on the back of the form)

### Register to vote

- If you are not registered to vote where you live today, complete the enclosed form.
- Applying to register or declining to register to vote will not affect the amount of assistance provided by this agency.
- If you would like help in completing the voter registration application form, you can bring it with you when you return the other completed forms in this package, or go to the local Board of Canvassers in the city/town where you live. (City/Town directory is on the back of the voter registration form.) The decision whether to seek or accept help is yours.
- If you believe that someone has interfered with your right to register or decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Voter Registration Coordinator, 50 Branch Avenue, Providence, RI 02904 or (401)222-2345.



# RHODE ISLAND VOTER REGISTRATION FORM

Please print clearly in ink. All information is required unless marked optional.

## YOU MAY USE THIS FORM TO:

- Register to vote in Rhode Island.
- Change your name and/or address on your registration.
- Choose a political party or change parties.

## TO REGISTER TO VOTE IN RI YOU MUST BE:

- A legal resident of Rhode Island.
- A citizen of the United States.
- At least 16 years of age.  
(You must be at least 18 years of age to vote on Election Day.)

### INSTRUCTIONS

**Box 2: REQUIRED.** Rhode Island citizens who are at least 16 years of age may pre-register to vote using this form. If you fail to check either of these boxes, this form will be returned to you. If you checked NO to either of these statements, do not complete this form.

**Box 3:** If you are registering to vote for the first time in Rhode Island by mail or if someone else turns this form in for you, it is **REQUIRED** that you provide your driver's license number or state ID number issued by the RI Department of Motor Vehicles (DMV). If you do not have either, you must provide the last 4 digits of your Social Security Number. If you do not provide the above information or it cannot be verified, you will be required to provide identification to an election official before voting. Acceptable forms of identification are on the Board of Elections website at <http://www.elections.ri.gov> or contact your local Board of Canvassers (see reverse side of this form).

**Box 5:** A person may have only one legal residence. You must register from your legal residence. A post office box or rural route may only be used as a "Mailing Address" in Box 6.

**Box 9:** If you want to affiliate to vote, choose a party. If you leave Box 9 blank, you will be listed as unaffiliated.

**Box 10:** You must SIGN and DATE the registration form. If you fail to sign and date the form, it will be returned to you.

**Box 11:** If you are updating your voter registration because you legally changed your name, enter your previous legal name.

**Box 12:** If you are updating your voter registration because of an address change, enter your previous address, even if out-of-state.

You will receive an acknowledgement receipt of this voter registration form within 3 weeks. If you do not receive it, contact your local Board of Canvassers (see reverse side for list). For questions and deadlines relating to this form, visit the Board of Elections website at <http://www.elections.ri.gov> or contact your local Board of Canvassers (see reverse side for list).

(This form may be reproduced)

<b>1. Check Boxes that Apply:</b> <input type="checkbox"/> New Voter Registration <input type="checkbox"/> Address Change <input type="checkbox"/> Party Change <input type="checkbox"/> Name Change							
<b>2.</b> I am a U.S. Citizen and resident of Rhode Island. <input type="checkbox"/> Yes <input type="checkbox"/> No  I am at least 16 years of age. (You must be at least 18 years of age to vote.) <input type="checkbox"/> Yes <input type="checkbox"/> No  If you checked NO to either of these statements, do not complete this form.		<b>3.</b> RI driver's license or ID Number: <input style="width: 150px;" type="text"/>  If you do not have a RI driver's license or ID, enter last 4 digits of your social security number: <input style="width: 80px;" type="text"/>  <b>If you do not enter either number, see instructions for Box 3.</b>					
<b>4.</b> Last Name		Suffix (if any)	First Name		Middle Name (or initial)		
<b>5.</b> Home Address (Do not enter a post office box)			Apt.	City/Town		State	ZIP Code
						RI	
<b>6.</b> Mailing Address (If different from Box 5)			Apt.	City/Town		State	ZIP Code
<b>7.</b> Date of Birth (mm/dd/yyyy)		<b>8.</b> Phone No./ E-mail Address (optional)		<b>9.</b> Party Affiliation:			
Month    Day    Year				<input type="checkbox"/> Americans Elect <input type="checkbox"/> Democrat <input type="checkbox"/> Moderate <input type="checkbox"/> Republican <input type="checkbox"/> Unaffiliated <input type="checkbox"/> Other _____			
<b>10. I swear or affirm that:</b> - I am not incarcerated in a correctional facility upon a felony conviction. - I am not presently judged "mentally incompetent" to vote by a court of law. - The information I have provided is true to the best of my knowledge under penalty of perjury. If I have provided false information, I may be fined, imprisoned, or (if not a U.S. citizen) deported from or refused entry into the United States.				<i>Official Use For Barcode</i>			
<b>PLEASE SIGN FULL NAME OR PLACE MARK BELOW</b> <input style="width: 400px; height: 40px;" type="text"/>				Are you interested in working at the polls? (check box below) <input type="checkbox"/>			
				<b>Date:</b> _____ (mm/dd/yyyy) <b>Signed</b>			
<b>Warning:</b> If you sign this form and know it to be false, you can be convicted and fined up to \$5,000 or jailed up to 10 years.							
<b>11. PREVIOUS NAME</b> (if different from Box 4)			<b>12. PREVIOUS ADDRESS OF REGISTRATION</b> (City/Town, State, ZIP & County)				

Return Address

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Postage  
Required Post  
Office will not  
deliver  
without proper  
postage.

Mail To: **BOARD OF CANVASSERS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*\*\*\*\*FOLD HERE & TAPE AT TOP\*\*\*\*\*

**INSTRUCTIONS FOR MAILING THE VOTER REGISTRATION FORM**

An applicant who chooses to mail his/her voter registration form shall do so in the following manner:

1. Fold the form at the dotted line and tape the bottom to the top of the form.
2. From the list below, locate the address of the board of canvassers in the city or town in which you are registering to vote and insert that address in the appropriate space beneath "Mail To: BOARD OF CANVASSERS" on the addressed side of the voter registration form. Insert your return address in the space provided.

**NOTICE:** *It is against the law for anyone to interfere with your privacy in registering to vote or in choosing a political party. If you believe someone has interfered with your right to register or not register, or with your privacy in making this decision, or in choosing a political party, you may file a complaint with the State Board of Elections, 50 Branch Avenue, Providence, Rhode Island 02904.*

**LOCAL BOARDS OF CANVASSERS**

- |  |  |  |   |
|--|--|--|---|
| Barrington Town Hall, 283 County Rd.,<br>Barrington, RI 02806                | Exeter Town Hall, 675 Ten Rod Rd.,<br>Exeter, RI 02822                   | New Shoreham Town Hall, PO Drawer,<br>220 Block Island, RI 02807                       | Smithfield Town Hall, 64 Farnum Pike,<br>Smithfield, RI 02917           |
| Bristol Town Hall, 10 Court St.,<br>Bristol, RI 02809                        | Foster Town Hall, 181 Howard Hill Rd.,<br>Foster, RI 02825               | Newport City Hall, 43 Broadway,<br>Newport, RI 02840                                   | S. Kingstown Town Hall, 180 High St.,<br>Wakefield, RI 02879            |
| Burrillville Town Hall, 105 Harrisville<br>Main St., Harrisville, RI 02830   | Glocester Town Hall 1145 Putnam Pike<br>PO Drawer B, Glocester, RI 02814 | N. Kingstown Town Hall, 80 Boston<br>Neck Rd., North Kingstown, RI 02852               | Tiverton Town Hall, 343 Highland Rd.,<br>Tiverton, RI 02878             |
| Central Falls City Hall, 580 Broad St.,<br>Central Falls, RI 02863           | Hopkinton Town Hall, 1 Town House<br>Rd., Hopkinton, RI 02833            | North Providence Town Hall, 2000<br>Smith St., North Providence, RI 02911              | Warren Town Hall, 514 Main St., Warren,<br>RI 02885                     |
| Charlestown Town Hall, 4540 S. County<br>Trail, Charlestown, RI 02813        | Jamestown Town Hall, 93 Narragansett<br>Ave., Jamestown, RI 02835        | North Smithfield Municipal Annex, 575<br>Smithfield Rd., North Smithfield, RI<br>02896 | Warwick City Hall, 3275 Post Rd.,<br>Warwick, RI 02886                  |
| Coventry Town Hall, 1670 Flat River<br>Rd., Coventry, RI 02816               | Johnston Town Hall, 1385 Hartford<br>Ave., Johnston, RI 02919            | Pawtucket City Hall, 137 Roosevelt<br>Ave., Pawtucket, RI 02860                        | W. Greenwich Town Hall 280 Victory<br>Highway, W. Greenwich, RI 02817   |
| Cranston City Hall, 869 Park Ave.,<br>Cranston, RI 02910                     | Lincoln Town Hall, 100 Old River Rd.,<br>PO Box 100, Lincoln, RI 02865   | Portsmouth Town Hall, 2200 East Main<br>Rd., Portsmouth, RI 02871                      | West Warwick Town Hall, 1170 Main St.,<br>West Warwick, RI 02893        |
| Cumberland Town Hall, 45 Broad St.,<br>Cumberland, RI 02864                  | Little Compton Town Hall, PO Box 226,<br>Little Compton, RI 02837        | Providence City Hall, 25 Dorrance St.,<br>Providence, RI 02903                         | Westerly Town Hall, 45 Broad St.,<br>Westerly, RI 02891                 |
| East Greenwich Town Hall, PO Box 111,<br>East Greenwich, RI 02818            | Middletown Town Hall, 350 East Main<br>Rd., Middletown, RI 02842         | Richmond Town Hall, 5 Richmond<br>Townhouse Rd., Wyoming, RI 02898                     | Woonsocket City Hall, P.O. Box B,<br>169 Main St., Woonsocket, RI 02895 |
| East Providence City Hall,<br>145 Taunton Ave.,<br>East Providence, RI 02914 | Narragansett Town Hall, 25 Fifth Ave.,<br>Narragansett, RI 02882         | Scituate Town Hall, PO Box 328, North<br>Scituate, RI 02857                            |   |

**Voter Registration Questions May Be Addressed To:**

Rhode Island Board of Elections  
50 Branch Avenue  
Providence, RI 02904  
elections@elections.ri.gov