DELAWARE HEALTH AND SOCIAL SERVICES (DHSS)
DIVISION OF SOCIAL SERVICES (DSS)

Application for Food Stamps, Cash Assistance, Medical Assistance, and Child Care Assistance.

We consider all applications without regard to race, color, national origin, sex, age, disability or political beliefs.

Please Read Carefully Before Completing and Be Sure to SIGN THE LAST PAGE

- Your food stamp application date begins the day we receive this page of the application.
- The whole application must be completed before you can get benefits.
- Return this application within 30 days of the date you asked for medical assistance. If you do not, this may change the date your medical assistance will start.
- Give complete and honest answers on your application and to your worker.
- You must provide proof of the information you give us before we can give you benefits.
- We will give you a list of what information must be verified.
- There are criminal, civil, and administrative penalties if you give false or misleading information on your application or to your worker.
- Do not sign any statement or form you have not read or you do not understand.
- Your worker will answer and explain anything you do not understand.
- You must report all changes in your family circumstances to your worker as soon as you become aware of the change.
- You must report all income, including part-time or casual work, and failure to do so may result in disqualification proceedings.
- If you are in a public institution and apply for food stamps at the same time you apply for Supplemental Security Income (SSI), your application date is the date of your release from the institution.
- We are required to take action on your Food Stamp or Cash Assistance application within 30 days after the date we receive your application, 45 days for Medical Assistance.

Name (Last, First, MI.)		
Street Address	Apt. #	Development / Apartment Name
City/Town	State	Zipcode
Telephone Number (Home)	(Work)	
Mailing Address (if different from above)		
Please list any other names that you may have used		
Signature		Date
Signature of Authorized Representative (if Applying for Someone Else)		Date

SCREENING FOR EXPEDITED FOOD STAMP SERVICES

If your household has little or no income right now, you may be able to receive food stamps within seven (7) days from the day we receive your completed application:

- If your household expects to receive less than $150 in income this month;
- If your household has no more than $100 available in cash and bank accounts;
- If your household is a migrant or seasonal farm worker household; or
- If the total amount of monthly gross income and available cash and bank accounts of all household members is less than your rent/mortgage and utility costs (or Standard Utility Allowance) for this month.

Answer the Questions Below

	Amount	Y / N
What is the total income your household expects to receive this month?	$	
How much do the members of your household have in cash and savings?	$	
What is your total rent/mortgage and utility amount this month?	$	
Is anyone in your household a migrant or seasonal farmworker?		Y / N
If anyone in your household is a migrant or seasonal farmworker at anytime during the current migrant season, was your household approved for a postponement of verification requirements?		Y / N
If yes, when and where?		

PLEASE CHECK THE BENEFITS YOU ARE APPLYING FOR:

☐ Food Stamps ☐ Cash Assistance ☐ Medical Assistance ☐ Child Care

Has anyone in your household received benefits from the above programs in another state in the past three months? ☐ YES ☐ NO

Has anyone in your household received cash assistance benefits in another state since August 22, 1996? ☐ YES ☐ NO If yes, please list the state(s):

AUTHORIZED REPRESENTATIVES

You can name an adult outside your household to fill out your application, go for an interview for you, get an EBT card, and use the EBT card to buy food for you.

Name: _____ Name: _____
Address: _____ Address: _____
_____ _____
Phone: _____ Phone: _____
SSN#: _____ SSN#: _____

☐ Fill out application and go to interview ☐ Buy food ☐ Fill out application and go to interview ☐ Buy food

FILL OUT THE FOLLOWING PAGES FOR EACH PERSON YOU ARE APPLYING FOR.

IF YOU ARE APPLYING FOR YOUR SELF, LIST YOURSELF FIRST AND THEN EVERYONE YOU ARE APPLYING FOR.

(For food stamps, include your spouse or unmarried partner, children under 22 years of age, parents if you are under 22 years of age, anyone temporarily away from home, friends or other relatives who eat with you, any others who eat with you except roomers and boarders)

Note: Individuals incarcerated in Federal, State or local correctional facilities are not eligible for food stamps.

APPLICANT – IF YOU ARE APPLYING FOR YOURSELF

NAME: (Last, First, Middle Initial)	**Date of Birth**	**Social Security Number** For medical assistance – only applicants must give number

Relationship to Applicant: SELF **SEX:** ☐ **Male** ☐ **Female**

ETHNIC/RACE: You are not required to fill in the ethnic/race information below. However, if you do not check the blocks, the worker will check the ethnic/race blocks to meet the Federal civil rights law. If you do not want to give us this information it will have no affect on your case. We are authorized to ask for this information under the Civil Rights Act of 1964. **Ethnic:** ☐ Hispanic/Latino ☐ Non-Hispanic/Latino **Race:** ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

MARITAL STATUS:
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
☐ Unmarried Partnership ☐ Unknown

CITIZENSHIP / IMMIGRANT STATUS: (For medical assistance – only applicants must answer)
Place of Birth:_____ ☐ US citizen ☐ Naturalized US citizen ☐ Documented Alien ☐ Undocumented Alien If a documented alien, enter your Alien Registration Number here:

Are you fleeing to avoid prosecution, or custody or confinement after conviction for a crime or attempt to commit a crime that is a felony under the law of any State? (Not for medical assistance)
☐ Yes ☐ No

Are you violating a condition of probation or parole? (Not for medical assistance) ☐ Yes ☐ No

Have you been convicted of distributing or selling controlled substances under any Federal or State law that is a felony? (Not for medical assistance) ☐ Yes ☐ No

Have you been convicted of having or using controlled substances under any Federal or State law that is a felony? (Not for medical assistance) ☐ Yes ☐ No

MEDICAL QUESTIONS

UNPAID MEDICAL EXPENSES:
Do you have any unpaid medical bills for the last three months? ☐ Yes ☐ No

HEALTH CONCERNS:
Are you unable to work due to medical reasons? ☐ Yes ☐ No

PREGNANCY INFORMATION: Are you pregnant? ☐ Yes ☐ No If yes, what is your estimated due date? _____ How many babies are expected? _____

EDUCATION INFORMATION (not required for medical assistance)

Are you a student? ☐ Yes ☐ No Name of School: Grade Level:

STRIKER INFORMATION
(not required for medical assistance)

Are you on strike? ☐ Yes ☐ No

DO YOU HAVE INCOME? ☐ Yes ☐ No			**DO YOU HAVE RESOURCES?** ****FOR CASH ASSISTANCE ONLY****		
SOURCE OF INCOME	GROSS AMOUNT	HOW OFTEN PAID	SOURCE OF RESOURCE	GROSS AMOUNT or VALUE	HOW OFTEN
Wages			Cash on hand		
Commissions			Checking Account		
Training Allowances			Saving Account		
Self-employment			Holiday Club Account		
Unemployment Compensation			Vacation Club Account		
Workers' Compensation			Credit Union		
Social Security Benefits			Trust Fund		
Supplemental Security Income (SSI)			Stocks		
Veterans Pensions or Benefits			Bonds		
Disability Benefits			Certificates of Deposit		
Sick/Maternity Benefits			Money Market Funds		
Insurance Benefits			Individual Retirement Acct.		
Union/Strike Benefits			Burial Trust		
Railroad Retirement Benefits			Burial Funds		
Child Support or Alimony			Burial Plots		
Boarder/Roomer Income			Real Estate		
Rental Income			Income Producing Property		
Educational Assistance Income			Recreational Vehicles		
Military Income			Boat		
Interest or Dividend Income			Trailer		
Foster Care Assistance			Vehicle #1		
On-the-Job Allowances			Vehicle #2		
Sponsor/Spouse Income			Vehicle #3		
Other			Other		

HAVE YOU QUIT A JOB IN THE LAST 60 DAYS? ☐ Yes ☐ No When? _____
(not required for medical assistance)

HOUSEHOLD MEMBER YOU ARE APPLYING FOR

NAME: (Last, First, Middle Initial)	**Date of Birth**	**Social Security Number** For medical assistance – only applicants must give number

Relationship to Applicant: **SEX:** ☐ **Male** ☐ **Female**

ETHNIC/RACE: You are not required to fill in the ethnic/race information below. However, if you do not check the blocks, the worker will check the ethnic/race blocks to meet the Federal civil rights law. If you do not want to give us this information it will have no affect on your case. We are authorized to ask for this information under the Civil Rights Act of 1964. **Ethnic:** ☐ Hispanic/Latino ☐ Non-Hispanic/Latino **Race:** ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

MARITAL STATUS:
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
☐ Unmarried Partnership ☐ Unknown

CITIZENSHIP / IMMIGRANT STATUS: (For medical assistance – only applicants must answer)
Place of Birth:_____ ☐ US citizen ☐ Naturalized US citizen ☐ Documented Alien ☐ Undocumented Alien If a documented alien, enter the Alien Registration Number here:

Is he/she fleeing to avoid prosecution, or custody or confinement after conviction for a crime or attempt to commit a crime that is a felony under the law of any State? (Not for medical assistance)
☐ Yes ☐ No

Is he/she violating a condition of probation or parole? (Not for medical assistance) ☐ Yes ☐ No

Has he/she been convicted of distributing or selling controlled substances under any Federal or State law that is a felony? (Not for medical assistance) ☐ Yes ☐ No

Have you been convicted of having or using controlled substances under any Federal or State law that is a felony? (Not for medical assistance) ☐ Yes ☐ No

PARENT INFORMATION FOR CHILDREN UNDER 18 YEARS OF AGE (if not in the home): (Not needed for Food Stamps) (If you do not answer, your child may still be eligible for medical assistance.)

Mother's Name: _____ Date of Birth_____
Address_____
Employer_____ SSN_____

Father's Name: _____ Date of Birth_____
Address_____
Employer_____ SSN_____

MEDICAL QUESTIONS

UNPAID MEDICAL EXPENSES:
Does he/she have any unpaid medical bills for the last three months? ☐ Yes ☐ No

HEALTH CONCERNS:
Is he/she unable to work due to medical reasons? ☐ Yes ☐ No

PREGNANCY INFORMATION: Is she pregnant? ☐ Yes ☐ No If yes, what is her estimated due date? _____ How many babies are expected? _____

EDUCATION INFORMATION (not required for medical assistance)

Is he/she a student? ☐ Yes ☐ No Name of School: Grade Level:

STRIKER INFORMATION

(not required for medical assistance)

Is he/she on strike? ☐ Yes ☐ No

DOES HE/SHE HAVE INCOME? ☐ Yes ☐ No			**DOES HE/SHE HAVE RESOURCES?** ****FOR CASH ASSISTANCE ONLY****		
SOURCE OF INCOME	GROSS AMOUNT	HOW OFTEN PAID	SOURCE OF RESOURCE	GROSS AMOUNT or VALUE	HOW OFTEN
Wages			Cash on hand		
Commissions			Checking Account		
Training Allowances			Saving Account		
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Unemployment Compensation			Vacation Club Account		
Workers' Compensation			Credit Union		
Social Security Benefits			Trust Fund		
Supplemental Security Benefits (SSI)			Stocks		
Veterans Pensions or Benefits			Bonds		
Disability Benefits			Certificates of Deposit		
Sick/Maternity Benefits			Money Market Funds		
Insurance Benefits			Individual Retirement Acct.		
Union/Strike Benefits			Burial Trust		
Railroad Retirement Benefits			Burial Funds		
Child Support or Alimony			Burial Plots		
Boarder/Roomer Income			Real Estate		
Rental Income			Income Producing Property		
Educational Assistance Income			Recreational Vehicles		
Military Income			Boat		
Interest or Dividend Income			Trailer		
Foster Care Assistance			Vehicle #1		
On-the-Job Allowances			Vehicle #2		
Sponsor/Spouse Income			Vehicle #3		
Other			Other		

DID HE/SHE QUIT A JOB IN THE LAST 60 DAYS? ☐ Yes ☐ No When? _____
(not required for medical assistance)

HOUSEHOLD MEMBER YOU ARE APPLYING FOR

NAME: (Last, First, Middle Initial)	**Date of Birth**	**Social Security Number** For medical assistance – only applicants must give number

Relationship to Applicant: **SEX:** ☐ **Male** ☐ **Female**

ETHNIC/RACE: You are not required to fill in the ethnic/race information below. However, if you do not check the blocks, the worker will check the ethnic/race blocks to meet the Federal civil rights law. If you do not want to give us this information it will have no affect on your case. We are authorized to ask for this information under the Civil Rights Act of 1964. **Ethnic:** ☐ Hispanic/Latino ☐ Non-Hispanic/Latino **Race:** ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

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Is he/she violating a condition of probation or parole? (Not for medical assistance) ☐ Yes ☐ No

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Have you been convicted of having or using controlled substances under any Federal or State law that is a felony? (Not for medical assistance) ☐ Yes ☐ No

PARENT INFORMATION FOR CHILDREN UNDER 18 YEARS OF AGE (if not in the home): (Not needed for Food Stamps) (If you do not answer, your child may still be eligible for medical assistance.)

Mother's Name: _____ Date of Birth_____
Address_____
Employer_____ SSN_____

Father's Name: _____ Date of Birth_____
Address_____
Employer_____ SSN_____

MEDICAL QUESTIONS

UNPAID MEDICAL EXPENSES:
Does he/she have any unpaid medical bills for the last three months? ☐ Yes ☐ No

HEALTH CONCERNS:
Is he/she unable to work due to medical reasons? ☐ Yes ☐ No

PREGNANCY INFORMATION: Is she pregnant? ☐ Yes ☐ No If yes, what is her estimated due date? _____ How many babies are expected? _____

EDUCATION INFORMATION (not required for medical assistance)

Is he/she a student? ☐ Yes ☐ No Name of School: Grade Level:

STRIKER INFORMATION

(not required for medical assistance)

Is he/she on strike? ☐ Yes ☐ No

DOES HE/SHE HAVE INCOME? ☐ Yes ☐ No			**DOES HE/SHE HAVE RESOURCES?** ****FOR CASH ASSISTANCE ONLY****		
SOURCE OF INCOME	GROSS AMOUNT	HOW OFTEN PAID	SOURCE OF RESOURCE	GROSS AMOUNT or VALUE	HOW OFTEN
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Training Allowances			Saving Account		
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Social Security Benefits			Trust Fund		
Supplemental Security Benefits (SSI)			Stocks		
Veterans Pensions or Benefits			Bonds		
Disability Benefits			Certificates of Deposit		
Sick/Maternity Benefits			Money Market Funds		
Insurance Benefits			Individual Retirement Acct.		
Union/Strike Benefits			Burial Trust		
Railroad Retirement Benefits			Burial Funds		
Child Support or Alimony			Burial Plots		
Boarder/Roomer Income			Real Estate		
Rental Income			Income Producing Property		
Educational Assistance Income			Recreational Vehicles		
Military Income			Boat		
Interest or Dividend Income			Trailer		
Foster Care Assistance			Vehicle #1		
On-the-Job Allowances			Vehicle #2		
Sponsor/Spouse Income			Vehicle #3		
Other			Other		

DID HE/SHE QUIT A JOB IN THE LAST 60 DAYS? ☐ Yes ☐ No When? _____
(not required for medical assistance)

HOUSEHOLD MEMBER YOU ARE APPLYING FOR

NAME: (Last, First, Middle Initial)	**Date of Birth**	**Social Security Number** For medical assistance – only applicants must give number

Relationship to Applicant: **SEX:** ☐ **Male** ☐ **Female**

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Is he/she fleeing to avoid prosecution, or custody or confinement after conviction for a crime or attempt to commit a crime that is a felony under the law of any State? (Not for medical assistance)
☐ Yes ☐ No

Is he/she violating a condition of probation or parole? (Not for medical assistance) ☐ Yes ☐ No

Has he/she been convicted of having, using or selling illegal drugs under any Federal or State law that is a felony? (Not for medical assistance) ☐ Yes ☐ No

Have you been convicted of having or using controlled substances under any Federal or State law that is a felony? (Not for medical assistance) ☐ Yes ☐ No

PARENT INFORMATION FOR CHILDREN UNDER 18 YEARS OF AGE (if not in the home): (Not needed for Food Stamps) (If you do not answer, your child may still be eligible for medical assistance.)

Mother's Name: _____ Date of Birth_____
Address_____
Employer_____ SSN_____

Father's Name: _____ Date of Birth_____
Address_____
Employer_____ SSN_____

MEDICAL QUESTIONS

UNPAID MEDICAL EXPENSES:
Does he/she have any unpaid medical bills for the last three months? ☐ Yes ☐ No

HEALTH CONCERNS:
Is he/she unable to work due to medical reasons? ☐ Yes ☐ No

PREGNANCY INFORMATION: Is she pregnant? ☐ Yes ☐ No If yes, what is her estimated due date? _____ How many babies are expected? _____

EDUCATION INFORMATION (not required for medical assistance)

Is he/she a student? ☐ Yes ☐ No Name of School: Grade Level:

STRIKER INFORMATION
(not required for medical assistance)

Is he/she on strike? ☐ Yes ☐ No

DOES HE/SHE HAVE INCOME? ☐ Yes ☐ No			**DOES HE/SHE HAVE RESOURCES?** ****FOR CASH ASSISTANCE ONLY****		
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Self-employment			Holiday Club Account		
Unemployment Compensation			Vacation Club Account		
Workers' Compensation			Credit Union		
Social Security Benefits			Trust Fund		
Supplemental Security Benefits (SSI)			Stocks		
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Sick/Maternity Benefits			Money Market Funds		
Insurance Benefits			Individual Retirement Acct.		
Union/Strike Benefits			Burial Trust		
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Foster Care Assistance			Vehicle #1		
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Other			Other		

DID HE/SHE QUIT A JOB IN THE LAST 60 DAYS? ☐ Yes ☐ No When? _____
(not required for medical assistance)

HOUSEHOLD MEMBER YOU ARE APPLYING FOR

NAME: (Last, First, Middle Initial)	**Date of Birth**	**Social Security Number** For medical assistance – only applicants must give number

Relationship to Applicant: **SEX:** ☐ **Male** ☐ **Female**

ETHNIC/RACE: You are not required to fill in the ethnic/race information below. However, if you do not check the blocks, the worker will check the ethnic/race blocks to meet the Federal civil rights law. If you do not want to give us this information it will have no affect on your case. We are authorized to ask for this information under the Civil Rights Act of 1964. **Ethnic:** ☐ Hispanic/Latino ☐ Non-Hispanic/Latino **Race:** ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

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Is he/she violating a condition of probation or parole? (Not for medical assistance) ☐ Yes ☐ No

Has he/she been convicted of having, using or selling illegal drugs under any Federal or State law that is a felony? (Not for medical assistance) ☐ Yes ☐ No

Have you been convicted of having or using controlled substances under any Federal or State law that is a felony? (Not for medical assistance) ☐ Yes ☐ No

PARENT INFORMATION FOR CHILDREN UNDER 18 YEARS OF AGE (if not in the home): (Not needed for Food Stamps) (If you do not answer, your child may still be eligible for medical assistance.)

Mother's Name: _____ Date of Birth_____
Address_____
Employer_____ SSN_____

Father's Name: _____ Date of Birth_____
Address_____
Employer_____ SSN_____

MEDICAL QUESTIONS

UNPAID MEDICAL EXPENSES:
Does he/she have any unpaid medical bills for the last three months? ☐ Yes ☐ No

HEALTH CONCERNS:
Is he/she unable to work due to medical reasons? ☐ Yes ☐ No

PREGNANCY INFORMATION: Is she pregnant? ☐ Yes ☐ No If yes, what is her estimated due date? _____ How many babies are expected? _____

EDUCATION INFORMATION (not required for medical assistance)

Is he/she a student? ☐ Yes ☐ No Name of School: Grade Level:

STRIKER INFORMATION

(not required for medical assistance)

Is he/she on strike? ☐ Yes ☐ No

DOES HE/SHE HAVE INCOME? ☐ Yes ☐ No			**DOES HE/SHE HAVE RESOURCES?** ****FOR CASH ASSISTANCE ONLY****		
SOURCE OF INCOME	GROSS AMOUNT	HOW OFTEN PAID	SOURCE OF RESOURCE	GROSS AMOUNT or VALUE	HOW OFTEN
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Foster Care Assistance			Vehicle #1		
On-the-Job Allowances			Vehicle #2		
Sponsor/Spouse Income			Vehicle #3		
Other			Other		

DID HE/SHE QUIT A JOB IN THE LAST 60 DAYS? ☐ Yes ☐ No When? _____
(not required for medical assistance)

PLEASE FILL IN ALL EXPENSES YOUR HOUSEHOLD PAYS
****FOOD STAMP ONLY****

HOUSING	YES	NO	CURRENT AMOUNT DUE	**UTILITY**	YES	NO	CURRENT AMOUNT DUE
RENT				ELECTRIC			
MOBILE HOME LOT RENT				GAS			
MORTGAGE				OIL			
SECOND MORTGAGE				WATER			
HOMEOWNER'S INSURANCE				SEWER			
REAL ESTATE TAXES				GARBAGE			
ROOM RENT				PHONE (BASIC)			
ROOM & MEALS				OTHER			

ANSWER EACH QUESTION **FOOD STAMP ONLY**

Do you live in Section 8 / Public Housing?	☐YES ☐ NO
Do you pay for excess utilities?	☐YES ☐ NO
Do you receive a HUD/WHA utility allowance check?	☐YES ☐ NO
Do you share housing costs with anyone?	☐YES ☐ NO
Do you share utility costs with anyone?	☐YES ☐ NO
Do you pay to heat and/or cool your home? (heat or air conditioning costs separate from your rent)	☐YES ☐ NO
Do you expect any changes in your housing or utility costs?	☐YES ☐ NO

****IMPORTANT NOTICE ABOUT DEDUCTIONS****

Once Food Stamp eligibility can be determined, benefits will be issued even if all the deductions you have reported have not been verified. If the deductions are verified before the 30th day after the date of application, supplemental benefits may be issued.

MEDICAL EXPENSES **FOOD STAMP ONLY**

If you or anyone in your household is 60 or older and/or receiving disability payments such as SSI, Social Security Disability, or Veterans Benefits, and have medical costs, please list the name of the person and the amount of their medical expenses below:

Name:	**Amount**	**Name:**	**Amount**	**Name:**	**Amount**
Hospitalization		Hospitalization		Hospitalization	
Prescription drugs		Prescription drugs		Prescription drugs	
Eye Care		Eye Care		Eye Care	
Dental		Dental		Dental	
Insurance		Insurance		Insurance	

MEDICAL EXPENSES (Continued) **FOOD STAMP ONLY**					
Attendant Care		Attendant Care		Attendant Care	
Medical Supplies		Medical Supplies		Medical Supplies	
Doctor's visits		Doctor's visits		Doctor's visits	
Transportation		Transportation		Transportation	
Other		Other		Other	

MEDICAL QUESTIONS FOR FOOD STAMPS AND MEDICAL ASSISTANCE

Are any of the medical expenses paid for by any health insurance? ☐ YES ☐ NO

Do you anticipate any other medical expenses this year? ☐ YES ☐ NO

Do you or anyone in your household have health insurance? (not Medicaid) ☐ YES ☐ NO

Name of Policy Holder:_____ Name of Insurance:_____

Who is covered:_____ Policy Number:_____

Circle what is covered: Doctor Hospital Lab Tests Xray

Do you or anyone in your household have accident insurance? ☐ YES ☐ NO

Do you or anyone in your household possibly have other insurance? ☐ YES ☐ NO

Has anyone had health insurance in the last 6 months? If so, list name:_____

Circle what was covered: Doctor Hospital Lab Tests Xray When did the insurance stop?_____

Why did the insurance stop?_____

Is anyone in your household severely disabled or stopped getting SSI? If so, list name(s):
(medical assistance only)

DEPENDENT CARE EXPENSES

Does anyone in your household pay someone to care for a child or incapacitated adult?
☐ YES ☐ NO If yes, list each name, amount billed, and circle how often billed.

Name:	Amount Billed: $	Weekly Bi-weekly Monthly Semi-monthly Other
Name:	Amount Billed: $	Weekly Bi-weekly Monthly Semi-monthly Other
Name:	Amount Billed: $	Weekly Bi-weekly Monthly Semi-monthly Other
Name:	Amount Billed: $	Weekly Bi-weekly Monthly Semi-monthly Other
Name:	Amount Billed: $	Weekly Bi-weekly Monthly Semi-monthly Other

CHILD SUPPORT PAYMENTS (FOOD STAMP ONLY)

Do you, or any member of your household, pay child support to children who do not live in your home? ☐ YES ☐ NO

Are the payments court ordered? ☐ YES ☐ NO

Are you court ordered to pay arrears to a child returned to your home? ☐ YES ☐ NO

List name, amount paid, and circle how often paid.

Name:	Amount$	Weekly Bi-weekly Monthly Semi-monthly Other
Name:	Amount$	Weekly Bi-weekly Monthly Semi-monthly Other
Name:	Amount$	Weekly Bi-weekly Monthly Semi-monthly Other
Name:	Amount$	Weekly Bi-weekly Monthly Semi-monthly Other
Name:	Amount$	Weekly Bi-weekly Monthly Semi-monthly Other

READ THE FOLLOWING RIGHTS AND RESPONSIBILITIES

PRIVACY ACT/SOCIAL SECURITY NUMBERS

Federal Laws require the collection of information on the application, including Social Security Numbers (SSN). The providing of this information, including the SSN, is voluntary. However, failure to provide this information, including the SSN of each household member you are applying for, may result in the denial of benefits to your household or to a household member. You must give us the Social Security Numbers (SSN) for all household members you are applying for cash assistance, food stamps and medical assistance. The Division of Social Services will ask for the SSN of anyone whose income is used to determine eligibility although it is not required. For Medical Assistance, non-lawful aliens are not required to give a SSN. Non-lawful aliens may be eligible for emergency services and labor and delivery.

We will use the SSN to determine initial and ongoing eligibility, check the identity of household members, prevent duplicate participation and help us make mass changes. We will also use the SSN to check information you give us against information we have in our records and against other Federal, State and local government agency computer matching systems. This may mean that we will need to contact household employers, banks, or other parties. If you receive benefits you are not entitled to, the information on this application, including the SSN of each household applicant, may be referred to State/Federal agencies, as well as private collection agencies, for claims collections. This information will also be used to monitor compliance with program regulations and for program management. **If you give us false information on purpose, legal action may be taken against you.**

COOPERATION WITH SPECIAL REVIEWS

(Food Stamps, Cash Assistance, Child Care - not Medical Assistance.) I will cooperate fully with all State and Federal personnel, such as Quality Control and Audit and Recovery Management Services, in any special review of my case. **Failure to cooperate can result in your case being closed.**

APPEAL / FAIR HEARING RIGHTS

I understand that I, or my representative, may appeal to DSS, the U.S. Department of Health and Human Services, or the U.S. Department of Agriculture (USDA for food stamps) if I am not satisfied with any decision made by the Division, or if I feel that I have been discriminated against because of race, color, national origin, sex, religion, age, disability, or political beliefs. As part of the appeal process, I understand that I have a right to a fair hearing and that I may be represented at a hearing by any attorney or any other person I choose. If I am not satisfied with the decision on my fair hearing, I understand that I may request a judicial review in Superior Court in the County where I live. I also understand that I must file a request for a judicial review within 30 days of the date of my fair hearing decision.

DISCLOSURE OF INFORMATION

All information and documentation gathered for determining your Cash Assistance, Food Stamp, Child Care and Medical Assistance eligibility or other program related use is confidential. Each program provides safeguards, restricting the use and disclosure of information about you to purposes directly connected with the administration of the program.

Disclosure of information concerning your Cash Assistance, Food Stamp, Child Care and Medical Assistance eligibility to anyone not authorized to receive the information is a violation of State and Federal law. The

failure of any authorized source to safeguard the confidential nature of your information may result in legal action.

While Cash Assistance, Food Stamp, Child Care and Medical Assistance programs will keep your eligibility information confidential, these provisions do not affect your right to give specific written consent to release information to other persons or sources.

For the Food Stamp Program
DSS shall make available to law enforcement officers, on official duty, the address, SSN, and a photograph (if available) of a Food Stamp recipient if the officer furnishes the recipient's name and informs DSS that the individual is fleeing to avoid prosecution, custody or confinement for a felony, or is violating a condition of parole or probation, or has information needed for the officer to conduct an official duty related to a felony or parole violation.

For the Cash Assistance Program
DSS shall make available to law enforcement officers, on official duty, the address of a Cash Assistance recipient if the officer furnishes the recipient's name and informs DSS that the individual is fleeing to avoid prosecution, custody or confinement for a felony, or is violating a condition of parole or probation, or has information needed for the officer to conduct an official duty.

REPAYMENT AGREEMENT

I understand that I am obligated to repay DSS any assistance received (Cash Assistance, Food Stamps, or Medical Assistance) that is more than the amount to which I am entitled, or any medical service I receive that I am not entitled to. My obligation to repay any such overpayment applies both during my period of eligibility and after I am not longer receiving a benefit.

I understand that a reduction will be made each month from my Cash Assistance or Food Stamp benefits under procedures established in the DSS manual until the amount owed is paid back in full.

If and when my current case is closed, I will be obligated to pay the balance of any overpayment in full in one of the following ways:

1. Monthly payments to Audit and Recovery Management Services;
2. Work Referral Program;
3. Voluntary garnishment of wages;
4. Intercept of State and/or Federal Income Tax Refunds;
5. Intercept of lottery winnings;
6. Withholding of Unemployment Compensation benefits; or
7. Withholding or reducing Federal Payments which include the following:
   (a) Income tax refunds;
   (b) Federal salary pay including military pay;
   (c) Federal retirement, including military retirement pay;
   (d) Contractor/vendor payments;
   (e) Federal benefit payments, such as Social Security, Railroad Retirement, and Black Lung (part B) benefits; and
   (f) Other Federal payments, including certain loans to you , that are not exempt from offset.

I further understand that any unpaid balance will be automatically deducted should I return as a Cash Assistance or Food Stamp recipient.

Delaware's Food First Electronic Benefits Transfer (EBT) Card

Food stamp benefits are issued on an EBT card. when your benefits are approved, you can go to a card issuance site to get your card and select your Personal Identification Number (PIN). You must keep your PIN a secret. **DO NOT** write down your PIN on your card or in an unsafe place. **DO NOT** give anyone your PIN. If someone takes your EBT card and uses your PIN to get your benefits without permission, you will not get those benefits replaced.

If your EBT card is lost or stolen, you MUST CALL the e-Funds toll free Customer Support number at 1-800-526-9099 immediately. If you do not call this number immediately to freeze your account so no one can use your benefits, we will not replace those missing benefits. The number is operational 24 hours/7 days a week.

PENALTY WARNINGS (Food Stamp and Cash Assistance.)

The information you give us will be checked to make sure your household is eligible for Food Stamps and Cash Assistance. Federal, State, and Local officials will check the information you give us. The information will be checked by using the State Income and Eligibility Verification System, other computer matching systems, program reviews and audits. Some information may also be sent to the Immigration and Naturalization Service to see if the information you gave us is correct. Nonlawful alien status will not be checked. This will not affect any public charge determination or lead to deportation proceedings. The information you gave us may also be checked by other Federal Aid programs and Federally-Aided State Programs, such as School Lunch and Medicaid. If any information you give us is found to be incorrect, you may be denied Food Stamps/Cash Assistance. If you give us false information on purpose, legal action may be taken against you. You may also have to pay back the amount of benefits that you should not have received.

Any member of your household who breaks any of the following rules **ON PURPOSE** will not be able to get Food Stamps or Cash Assistance:

For Food Stamps:
DO NOT give false information, or hide information, to get or continue to get Food Stamps.
DO NOT trade or sell Food Stamps or authorization cards or any authorization document.
DO NOT alter authorization cards to get Food Stamps you are not entitled to receive.
DO NOT use someone else's Food Stamps or authorization cards for your household.
DO NOT use Food Stamps to buy ineligible items, such as alcoholic drinks and tobacco.

Any member of your household who breaks a Food Stamp rule on purpose will not be able to get Food Stamps for one year for the first violation, two years for the second violation, and permanently for the third violation.

The Court can also order an individual off the program for an additional 18 months. The individual can also be fined up to $250,000, sent to jail for up to 20 years, or both. Under other Federal laws, additional criminal or civil action may be taken against the individual.

If any member of your household is found guilty by a court (Federal, State, or local) of selling or purchasing controlled substances with Food Stamps, the individual will not be able to get Food Stamps for two years for the first time. The second time the individual is found guilty of selling or purchasing controlled substances with Food Stamps, he/she will **NEVER** get Food Stamps again.

If any member of your household is ever found guilty by a court of selling or purchasing firearms, ammunition, or explosives with Food Stamps, even for the first time, he/she will **NEVER** get Food Stamps again.

If any member of your household is found guilty by a court (Federal, State or local) of having trafficked Food Stamp benefits in the amount of $500 or more, even for the first time, he/she will **NEVER** get Food Stamps again.

If any member of your household is found guilty of misrepresenting their identity or place of residence in order to get multiple Food Stamps for the same month, the individual will not be able to get Food Stamps for a 10 year period.

If any member of your household is fleeing to avoid prosecution, or custody or confinement after a conviction, under the law of any state for a crime, or attempt to commit a crime, that is a felony, or violating a condition of probation or parole imposed under a Federal or State law, the individual will not be able to get Food Stamps.

If any member of your household is convicted of a felony for distributing or selling controlled substances, the individual will **NEVER** get Food Stamps again.

Drug Felon Having or Using Convictions for Food Stamps

Anyone convicted of a drug felony for using or having a controlled substance cannot get Food Stamps unless the person is:
(1) In a drug treatment program; or
(2) On a waiting list for drug treatment; or
(3) Has completed drug treatment; or
(4) Does not need drug treatment; and
(5) Has completed all court requirements including drug treatment.

The convicted drug felon must provide proof of meeting the conditions above. The individual must submit to random quarterly drug testing.

Failure to return the drug test will result in the termination of Food Stamp benefits. The individual will not be able to get Food Stamp benefits until a clean drug test free of controlled substances is provided.

If an individual fails the drug test, he or she will not be able to get Food Stamps for one year. After the one year disqualification period, the individual will be able to get Food Stamps again, if otherwise eligible, when a clean drug test free of controlled substances is provided.

For Cash Assistance:
DO NOT give false information, or hide information, to get or continue to get Cash Assistance.

Any member of your household who breaks a Temporary Assistance For Needy Families (TANF) rule on purpose will not be able to get Cash Assistance for one year for the first violation, two years for the second violation, and permanently for the third violation.

Any applicant or recipient who gives false information in order to obtain benefits is subject to penalties that include a fine of up to $500 and imprisonment up to 6 months.

If any member of your household is found guilty of misrepresenting their place of residence in order to get multiple benefits in two or more States for the same month from programs funded under TANF, Title XIX Medicaid, the Food Stamp Act of 1977, and Title XVI Supplemental Security Income Program, the individual will not be able to get Cash Assistance for a 10 year period.

If any member of your household is fleeing to avoid prosecution, or custody or confinement after conviction, under the law of any state for a crime, or attempt to commit a crime, that is a felony, or violating a condition of probation or parole imposed under a Federal or State law, the individual will not be able to get Cash Assistance.

If any member of your household is convicted of a felony for having, using, or selling controlled substances, the individual will **NEVER** get Cash Assistance again.

DELAWARE'S TEMPORARY ASSISTANCE FOR NEEDY FAMILIES PROGRAM (TANF) FAMILY CAP

Family cap children are included in the standard of need when determining eligibility but not in the payment standard to figure benefit amounts. This means that family cap children are considered TANF recipients. This includes assigning child support rights to the State and cooperating with the Contract of Mutual Responsibility.

TANF JOB QUIT

If an individual quits a job without good cause and fails to meet job search requirements, the result will be a loss of all cash benefits. If the individual is meeting job search requirements, the following penalties will apply for two months:

- For the first time, the cash benefit will be reduced by 1/3.
- For the second time, the cash benefit will be reduced by 2/3.
- For the third time, permanent loss of all cash benefits.

TANF WORK AND TRAINING PENALTIES

When an individual does not comply with work and training, the following penalties will happen:

- For the first time, the cash benefit will be reduced by 1/3.
- For the second time, the cash benefit will be reduced by 2/3.
- For the third time, permanent loss of all cash benefits.

After the first and second times, the individual must participate for two weeks to get benefits back.

APPLICATIONS FOR OTHER BENEFITS (For TANF and Medical Assistance)

I understand that I must apply for and accept other benefits that I may be eligible to get such as Unemployment Compensation or Social Security.

FOOD STAMP WORK REQUIREMENTS

I understand that no physically and mentally fit individual over the age of 15 and under the age of 60 shall be eligible to participate in the Food Stamp Program if the individual fails to comply with any work requirement, voluntarily quits a job without good cause or voluntarily reduces their hours of work to less than 30 hours per week without good cause.

When an individual, other than the head of household, fails to comply, the individual will not be able to get Food Stamps:

- For the first time, the individual will not be able to get Food Stamps for one month or until the individual complies with the work requirement, whichever is later.
- For the second time, the individual will not be able to get Food Stamps for three months or until the individual complies with the work requirement, whichever is later.

- For the third time, the individual will not be able to get Food Stamps for six months or until the individual complies with the work requirement, whichever is later.

When an individual who is the head of household, fails to comply, the whole household will not be able to get Food Stamps:

- For the first time, the household will not be able to get Food Stamps for one month or until the head of household complies with the work requirement, whichever is later.
- For the second time, the household will not be able to get Food Stamps for three months or until the head of household complies with the work requirement, whichever is later.
- For the third time, the household will not be able to get Food Stamps for six months or until the head of household complies with the work requirement, whichever is later.

For work requirement sanctions the individual or household must serve the minimum sanction period and the individual or head of household must comply (except for voluntary quit) before receiving Food Stamps again.

The minimum sanction periods must be served even if an individual or head of household complies before the end of the sanction period.

For voluntary quit sanctions, the individual or head of household can receive Food Stamps again after the minimum sanction periods are served.

WORK REQUIREMENTS FOR ABLE-BODIED ADULTS WITHOUT DEPENDENTS

I understand that individuals 18 to 50 years of age are ineligible to receive Food Stamps if they received Food Stamps for at least three months in a 36 month period while they did not either work a monthly average of at least 20 hours per week, participate in a work program at least 20 hours per week, participates in and complies in a work supplementation program; or participates in a workfare program, unless the individual is exempt from work requirements.

REPORTING AND VERIFYING EXPENSES:

Failure to report or verify any of the following expenses will be seen as a statement by your household that you do not want to receive a deduction for the unreported expenses:

- Shelter (rent/mortgage/lot) expenses;
- Homeowner's insurance;
- Real estate taxes;
- Utility expenses (gas/electric/oil);
- Water and sewage expenses;
- Garbage expenses;
- Phone expenses;
- Medical expenses;
- Dependent care expenses;
- Child support expenses paid to children who do not live in your home.

REPORTING REQUIREMENTS:
For Food Stamps

SIMPLIFIED REPORTING REQUIREMENTS (For all households except elderly or disabled households with no earned income.)

- Households are required to only report income changes when the monthly income exceeds 130 percent of the poverty income guideline for the household size that existed at the time of certification or recertification.
- When a household's monthly income exceeds the 130 percent of the poverty income guideline, the household is required to report that change within ten days after the end of the month that the household determines the income is over the 130 percent amount.
- Additional reporting requirement for ABAWD individuals. Adults living in a home without any minor children, who are getting food stamps because they are working over 20 hours a week, must report when they start working less than 20 hours per week.

CHANGE REPORTING REQUIREMENTS (For elderly or disabled households with no earned income.)

- Changes in the amount of gross unearned income of more than $50, except changes in the public assistance grants. Changes reported in person or by telephone are to be acted upon in the same manner as those reported on the change report form;
- A change in the source of income, including starting or stopping a job or changing jobs, if the change in employment causes a change in income.
- All changes in household composition, such as the addition or loss of a household member;
- Changes in residence and the resulting changes in shelter costs;
- The acquisition of a licensed vehicle not fully excludable under DSSM 9051 (for non-categorically eligible households);
- When cash on hand, stocks, bonds, and money in a bank account or savings institution reach or exceed a total of $2,000 (for non-categorically eligible households); and
- Changes in the legal obligation to pay child support.

Certified households must report changes within ten (10) days of the date the change becomes known to the household.

For reportable changes of new employment/income, households must report the change within 10 days of the date the household receives its first paycheck/payment.

An applying household must report all changes related to its food stamp eligibility and benefits at the certification interview. The household must report changes that occur after the interview but before the date of the notice of eligibility, within ten (10) days of the date of the notice.

For Cash Assistance and Medical Assistance:
I agree to report **IMMEDIATELY** to the local DSS office any changes in circumstances, which may affect my continuing eligibility for assistance or the amount of assistance I am entitled to receive.

CHILD CARE

I understand I may be eligible for child care for up to 24 months if my Cash Assistance (except for General Assistance) case is closed due to increased earnings or hours and/or loss of earned income disregards due to the time limitations.

I understand that I will need to contact DSS for a determination. If you are a single parent with a child under the age of six, and you are unable to find needed child care, DSS will not sanction you for failure to participate in work or other activities to find work. In order to claim that you are unable to find needed child care, you will have to notify your worker within ten days of your being unable to find care or within ten days of the time DSS told you that you must participate in work.

You also must show the following:

- that appropriate child care was not available within a reasonable distance of one hour from either your home or your job site; or
- that you were unable to make arrangements with a relative to provide care or to have someone come into your home to provide care; or
- that you were unable to find appropriate and affordable care.

If you were unable to find child care because one of the reasons above, you must tell your worker. Your worker will review this matter with you. YOU MUST BE ABLE TO SHOW THAT YOU HAVE A PROBLEM (for example, you went to five or more providers and no provider had an opening for your child.) DSS will tell you whether or not we agree that child care is a problem. In some cases, DSS may refer you to another source to help you find the care you need. During this time, DSS cannot sanction you for failure to participate in work or other work activities. This will not extend your time limit for receiving benefits.

As a participant in the DSS Purchase of Child Care Services Program, I understand the following:

1. That I may be required to pay a portion of the cost of my child's child care expense. The fee is based on my income and family size. (Your worker will advise you of the amount of your fee, or if you have to pay a fee.)

2. That if my child is absent DSS will pay my child care provider from between 1 to 5 absent days.

3. That I must report within ten days changes that effect either my need for subsidized child care or income. I must report changes that affect me, my spouse, my child(ren's) other parent living in my household, or child(ren) if applicable.
   Some of the changes I must report are:

   Getting a job, losing a job, changing jobs, taking a second job, no longer working at a second job, receiving child support, receiving VA benefits and so on, receiving an increase or decrease in wages of $75 or more a month, receiving an increase or decrease in public assistance or social security or child support or VA benefits and so on of $75 or more a month, enrolled in an education or training class, completed training, no longer need special needs' child care, changes to marital status, family size and address.

4. As a participant in DSS subsidized Child Care Program, I further understand:

   - That the information I give to qualify for child care will be subject to verification by federal, state and local officials. If it is found inaccurate, I can be subject to criminal prosecution for knowingly providing false information.
   - That if I do not have documents to verify needed information, I agree to give the name of a person or organization that DSS may contact to obtain verification and that I authorize DHSS personnel to verify any statement I make regarding my application for child care.
   - That if I plan to change my child care provider within the authorization period indicated that I will notify my worker at least five days before moving my child so that a new authorization can be processed.
   - That I will notify my current provider of my intent to move my child at least five care days before moving my child(ren).
   - That I may be responsible for payment to my child care provider at the provider's private fee if I fail to be redetermined eligible for service.

- That my provider may charge me a late pickup fee, late payment fee, and field trip fees. That I am not responsible for any other provider fees not included in the Child Care Contract or Certificate.
- I will be required to reimburse DSS for payment made for my child(ren) if I continue to use child care when I was not eligible to receive the service.
- That I may experience a disruption in my child care service if I fail to respond to DSS Attendance Quality Control inquires.

5. That in consideration for payment made by DSS, I hereby release DSS from any claim or cause of action and agree that I will not hold DSS liable for any injury, illness or disease resulting to my child(ren) that may arise out of or during the course of service.

MEDICAL ASSISTANCE PROGRAMS

I have read or have had read to me all statements on this form and the information I give is true and complete to the best of my knowledge. I understand that I could be penalized if I knowingly give false information. I understand that all information I give is confidential and federal and state laws limit disclosure of information about me.

I understand and agree to give proof of my statements. I understand and agree that DHSS may contact other persons or organizations to obtain the necessary proof of my eligibility.

I must give the Social Security Number for each person applying for medical assistance and it will be used to check records with other government agencies. DSS also asks me to give the Social Security Number of anyone whose income is used to determine my eligibility. Nonlawful aliens are not required to give a Social Security Number.

I understand that this application will be considered without regard to race, color, sex, age, disability, religion, national origin, or political belief.

I understand that I must apply for and accept other benefits that I may be eligible to get such as Unemployment Compensation or Social Security.

I will allow DHSS, or its representatives, to act as my agent in recovering money spent by the medical assistance programs when other money from insurance, etc., becomes available to pay my medical bills.

I may have to repay to DSS any medical assistance received for which I am not entitled. My obligation to repay such assistance applies both during my period of eligibility and after I am no longer receiving medical assistance.

As required by law as conditions of eligibility I assign all rights to medical support and to payment for medical care from any third party to DSS and I understand I must cooperate with the Division of Child Support Enforcement (DCSE) in establishing paternity and obtaining medical support for any child receiving medical assistance. If I do not cooperate with DCSE, my child(ren) may still be eligible.

I understand that pregnant women are not required to cooperate in establishing paternity and obtaining medical support and that I may claim to have good cause for refusing to cooperate in establishing paternity or in identifying and providing information about liable third parties.

I understand that as a medical assistance recipient I will automatically receive full child support services from DCSE, unless I state that I want to receive only child support services related to medical support.

At such time I am receiving services from the Division of Child Support Enforcement but I am not on public assistance, I hereby authorize and empower the Division to deduct directly from my support payments, any and all monies owed to the Division for reasons that include, but are not limited to: fees, recovery of monies improperly paid to me, or paid in error, or any other reason deemed to correct my account.

I understand I may be eligible for TRANSITIONAL MEDICAID for up to 12 months if my Medicaid under Section 1931 case is closed due to increased earnings or hours and/or loss of earned income disregards due to time limitations.

I understand that my children are eligible for preventative health care and that I will be contacted.

I understand that if I am a medical assistance applicant or recipient I have the right to a fair hearing if I am not satisfied with any decision made about my eligibility. I understand that I may be represented by an attorney or any other person I choose.

I agree to allow DHSS, directly or through its agents or the Diamond State Health Plan or the Delaware Healthy Children Program, to have access to all medical and school-based health and related services records of every member of my household who is eligible for Medical Assistance in order to administer the medical assistance program, coordinate care, determine medical necessity, and evaluate or pay for pending or incurred medical services.

I certify, under penalty of perjury, that I am a U.S. Citizen or alien in lawful immigration status. I must give proof of lawful immigration status and it will be checked with Immigration and Naturalization Service. Nonlawful alien status will not be checked. This will not affect any public charge determination or lead to deportation proceedings. Nonlawful aliens may be eligible for emergency services and labor and delivery only.

I agree to report within 10 days changes in my situation that could affect my eligibility, such as a change in how many people live with me, a new job or change in income, or if I move.

This application must be signed by an adult household member (age 18 or over) or by an emancipated minor (under age 18).

At such time I am receiving services from the Division of Child Support Enforcement but I am not on public assistance, I hereby authorize and empower the Division to deduct directly from my support payments, any and all monies owed to the Division for reasons that include, but are not limited to: fees, recovery of monies improperly paid to me, or paid in error, or any other reason deemed to correct my account.

I understand I may be eligible for TRANSITIONAL MEDICAID for up to 12 months if my Medicaid case under Section 1931 is closed due to increased earnings or hours and/or loss of earned income disregards due to the time limitations.

I understand that my children are eligible for preventive health care and that I will be contacted.

REQUIREMENTS FOR ALIEN REGISTRATION CARD

For each applicant who is not a U.S. citizen you will need to show either documentation from the Immigration and Naturalization Service (INS) or other documents DSS determines are proof of your immigration status. Alien status may be subject to verification with INS, which may require submission of

certain information from this application form to INS. Information received from INS may affect your household's eligibility and level of benefits.

For Medical Assistance this will not affect any public charge determination or lead to deportation proceedings.

CERTIFICATION OF CITIZENSHIP AND ALIEN STATUS

I certify, under penalty of perjury, the I, and any other members of my household, are U.S. citizens or aliens in lawful immigration status. Non-lawful aliens may be eligible for emergency services and labor and delivery only.

HEAD OF HOUSEHOLD DESIGNATION (For Food Stamps only)

Households with an adult parent of children, or an adult who has parental control over children, have the option of designing their head of household. Please read the following:

- I understand the person selected must be the parent of a child, regardless of age, or have parental control over children under 18 years of age.
- I understand that all adult household members must agree to the designation.
- I understand that failure to designate or agree on a head of household will not delay my certification or have my benefits denied.
- I understand that DSS will designate a head of household if I choose not to or the adults do not agree on a designation.
- I understand I can choose the designated head of household at each certification and whenever the household composition changes.
- I understand if DSS must designate a head of household, the designee will be the principal wage earner.
- I understand the entire household may be sanctioned and lose their benefits if the head of household does not comply with the Employment and Training Program or voluntary quit provisions.
- I understand that is another household member, not the head of household, does not comply with the Employment and Training Program or voluntary quit provisions, only that individual will be sanctioned and ineligible for benefits.

CERTIFICATION OF HEAD OF HOUSEHOLD SELECTION

I have read and have had explained to me the provisions about selecting a head of household. I have selected the following person to be the head of household and I certify that all adult members in my household agree to this selection.

_____

(Head of Household Designee)

NONDISCRIMINATION STATEMENT

The U.S. Department of Agriculture (USDA) prohibits discrimination in all its programs and activities on the basis of race, color, national origin, sex, religion, age, disability, or political beliefs. Persons with disabilities who require alternative means for communication of program information (Braille, large print, audiotape, etc.) should contact USDA's TARGET Center at (202) 720-2600 (voice and TDD).

To file a complaint of discrimination, write to USDA, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

AUTHORIZATION FOR RECEIPT OF PREGNANCY PREVENTION INFORMATION

You are authorized to receive pregnancy prevention information. If you wish to receive this information you can call Planned Parenthood at 1-800-230-PLAN (7526). If you wish to get teen pregnancy prevention information, you may also call the Alliance for Adolescent Pregnancy Prevention at 1-800-499-WAIT (9248). You can also call the Delaware Helpline at 1-800-464-4357 for the Public Health Family Planning clinic in your area.

CERTIFICATION OF UNDERSTANDING AND ACCURACY OF APPLICATION ANSWERS

I understand the questions on this application and the penalty for hiding or giving false information or breaking any of the rules listed in the penalty warning. I certify, under penalty of perjury, that all my answers are correct and complete to the best of my knowledge, including information about the citizenship or alien status of each household member applying for benefits. I understand and agree to provide documents to prove what I have said. I understand and agree that DHSS may contact other persons or organizations to obtain the necessary proof of my eligibility and level of benefits.

_____	_____	_____
(Applicant's Signature)	(Date)	(Witness)
_____	_____	_____
(Authorized Representative's Signature)	(Date)	(Witness)
_____	_____	_____
(Spouse/Partner's Signature) (Not needed for medical assistance.)	(Date)	(Witness)
_____	_____	_____
(Applicant's Signature)	(Date)	(Witness)
_____	_____	_____
(Authorized Representative's Signature)	(Date)	(Witness)
_____	_____	_____
(Spouse/Partner's Signature) (not needed for medical assistance)	(Date)	(Witness)

FOR PERSONS WHO CANNOT SPEAK ENGLISH

Translation services were offered or a family member or other person was present to translate.

_____	_____	_____
(Translator's Signature)	(Date)	(Phone Number & Agency/Relationship)
_____	_____	_____
(Translator's Signature)	(Date)	(Phone Number & Agency/Relationship)