



RHODE ISLAND DEPARTMENT OF HUMAN SERVICES APPLICATION FOR SNAP SERVICE FOR ELDERLY HOUSEHOLDS

For Office use only:
Screener's Name: _____ Date Screened: _____ Intake: _____

Do you speak English? YES NO If no, what is the primary language spoken? _____

Can you read and write in English? YES NO

If you do not speak English, does any adult member of the household speak English? YES NO

Your Last Name: _____ Your Date of Birth: _____ / _____ / _____
MM DD YYYY

Your First Name: _____ Your Social Security Number: _____ / _____ / _____

Your Middle Initial: _____ Maiden / Other Names: _____

Your Address (where you live): _____ Apartment/Floor: _____

City: _____ State: _____ Zip: _____

Your Mailing Address (if different): _____ Apartment/Floor: _____

City: _____ State: _____ Zip: _____

Your Telephone Number (home): _____ Other: _____

Do you need help filling out this application? YES NO

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

Name: _____ Date of Birth _____ Telephone Number: _____

Street/Route Apt./Floor City State Zip

If you have a disability of condition that makes it hard for you to understand or answer questions on this application, we can help. For example, we can read the form with you and write your answers for you. We can make other accommodations, depending on what assistance you need. Please let us know.

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

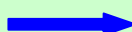
- 1) If your household's gross monthly income is less than \$150 and your household's resources, such as cash, checking or savings accounts are \$100 or less;
- 2) If your rent/mortgage and utilities are more than your household's combined gross monthly income and liquid resources; or,
- 3) If you are a migrant or seasonal farm worker household.

If you qualify for this service, we are required to provide SNAP benefits within seven (7) days from the time you give us this form during normal work hours and it is date stamped.

I CERTIFY THAT THE INFORMATION CONTAINED ON *THIS PAGE* IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF, AND THAT THERE ARE PENALTIES FOR NOT TELLING THE TRUTH ABOUT MY FAMILY AND MYSELF. Please sign below and **continue** to following pages.

Signature of Applicant

Date

List EVERY ONE in your home on THIS SIDE of the line 					List information on THIS SIDE of the line only if the person is requesting SNAP benefits	
Last Name	First Name, MI	Sex	D.O.B. (mm/dd/yyyy)	Relationship to you	S.S.N.	U.S. Citizen? * (If NO, you will be required to provide Alien documentation**)
		<input type="checkbox"/> M <input type="checkbox"/> F		Self		<input type="checkbox"/> YES <input type="checkbox"/> NO
		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> YES <input type="checkbox"/> NO
		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> YES <input type="checkbox"/> NO
		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> YES <input type="checkbox"/> NO

*Alien status information may be subject to verification through USCIS and such information may affect the household's eligibility and level of benefits

** Alien documentation includes: Alien number; origin country; Alien Status; Entry date; Status date; Sponsor information.

My shelter arrangement is (Check one):

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

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

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

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

Where did you move from? _____

Do you receive any assistance now? YES NO

Have you previously applied for, or received any type of assistance payments, benefits or SNAP in R.I. or in another state? YES NO

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

Are you or is anyone 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 a TANF cash program, Food Stamp (SNAP) program or Medicaid Assistance Program? YES NO

If yes, name of household member(s) _____ Date _____ State _____

Has anyone in the household received any income from any source so far this month? YES NO

If YES, how much gross income?

TYPE OF INCOME	\$ GROSS AMOUNT	FREQUENCY (Weekly, monthly, etc)	NAME OF RECIPIENT
RSDI (SOCIAL SECURITY)			
SSI			
PENSION			
VA BENEFITS			
WORKER'S COMP			
WAGES			
OTHER (SPECIFY)			
OTHER (SPECIFY)			

Did your household's only income recently stop? YES NO

If Yes, when? _____ Why? _____

Does anyone in your household expect to receive *other* income later this month? YES NO

If Yes, how much _____ When? _____

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

How much is your monthly **rent** or **mortgage**? _____

Monthly Utilities: Heat: _____ Air Conditioning: _____ Other Utilities: _____

Do you pay for any **medical expenses** such as prescriptions, over the counter medications, diabetic supplies, eyeglasses, dental expenses, hearing aid, etc? \$_____ per month

I certify under penalty of perjury that I have read (or have had read to me) and I understand the Notice of Rights, Responsibilities and Penalties and 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.

Do you prefer a **TELEPHONE** or an **IN-OFFICE** interview?

DATE

APPLICANT'S SIGNATURE

SIGNATURE OF APPLICANT'S
SPOUSE or OTHER ADULT
APPLICANT LIVING IN THE
HOUSEHOLD

FOR OFFICE USE ONLY

**CASE RECORD CLEARANCE FOR PARTICIPATION
PERS SEARCH**

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

DISPOSITION:

SNAP Intake Appt Date _____

Expedited SNAP Intake Appt Date _____

Comments:

Signature of Screener Date

IMPORTANT:

[This Notice is for your information only](#)
[You do not need to sign or return this page of the application to DHS](#)

RIGHTS AND RESPONSIBILITIES of Applicants/Recipients of SNAP

RIGHTS

You have a RIGHT to appeal and 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. Hearing forms, on which you may file your complaint, are available in every local and State Department office. If are not satisfied with any Department decision regarding your application, you have a right to request a hearing. You must request a hearing within 90 days from the date that you receive a written notice for SNAP benefits.

You have a RIGHT to non-discriminatory treatment. DHS does not discriminate against any person on the basis of race, color, national origin (Limited English Proficiency persons), age, sex, disability, religion, political beliefs, sexual orientation, gender identity or expression in admission, treatment, or participation in its programs, services and activities, or in employment. For further information about this policy, contact: Community Relations Liaison Officer, (401) 462-2130 or (for deaf/hearing impaired) (401) 462-6239 or 711.

In accordance with Federal law and U.S. Department of Agriculture policy, DHS is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political beliefs, or disability.

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

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.

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 and provide proof 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 affects your household. For SNAP, if you are a simplified reporter, you must report when your income exceeds 130% of the Federal Poverty Level.

You have a RESPONSIBILITY to provide Social Security numbers for yourself and your household, or to apply, if you are required to, for them as a condition of eligibility. Your Social Security number,

As well as the social security number (SSN) of each household member, is authorized under the Food Stamp Act of 1977, as amended, 7 U.S.C. 2011-2036. The information will be used to

determine whether your household is eligible or continues to be eligible to participate in the SNAP. We will verify this information through computer matching programs. 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 SNAP 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, including the SSN of each household member, is voluntary. However, failure to provide an SSN will result in the denial of SNAP benefits to each individual failing to provide an 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; you will get the maximum amount of SNAP 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.

DECLARATION OF APPLICANT/RECIPIENT SNAP PENALTY WARNINGS

I understand that:

1. Any member of my household who intentionally breaks a SNAP rule can be barred from the SNAP 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 SNAP 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 SNAP 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 SNAP 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.

PLEASE SIGN APPLICATION, Page 3