BENEFITS REVIEW

COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE

- We must review your eligibility for cash, medical and/or food stamps benefits.
- To continue receiving benefits without delay, complete the entire form and sign page 8, then:
  - ☐ Bring this completed form to your interview
  - ☐ See attached instructions for a telephone interview
- If you want to add a new person, call your caseworker.

IMPORTANT NOTICE TO RECIPIENT

Please complete the following steps for use of the benefits review form.

1. Complete the form to the best of your ability. If you need help, another person can help you or you can get help from your County Assistance Office.
2. Sign and date the benefits review form.
3. Bring it to the County Assistance Office on the date and time of your scheduled interview. If you are to have a telephone interview, mail the form with any verification requested to your caseworker.

INSTRUCTIONS

Please print clearly. Try to complete as much information as possible. The information requested on this form is needed to determine your continued eligibility.

It is important that you read the Rights and Responsibilities on page 7 and the Affidavit on page 8.

CLIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL

STREET ADDRESS

CITY	ST	ZIP CODE

TELEPHONE NUMBER	SCHOOL DISTRICT	TOWNSHIP

OTHER PROGRAMS

IF YOU WOULD LIKE TO KNOW MORE ABOUT OTHER PROGRAMS FOR YOU AND YOUR CHILDREN, PLEASE CHECK BOXES BELOW.

- ☐ HOUSING ASSISTANCE
- ☐ FOOD BANKS
- ☐ IMMUNIZATIONS (Shots)
- ☐ FAMILY PLANNING/BIRTH CONTROL
- ☐ ENERGY ASSISTANCE
- ☐ WOMEN, INFANTS AND CHILDREN (WIC) NUTRITION PROGRAM
- ☐ WELL BABY CLINIC
- ☐ HEAD START (Kids Age 3 thru 6)
- ☐ CHILD CARE
- ☐ CHILD SUPPORT SERVICES
- ☐ FREE OR REDUCED COST SCHOOL MEALS
- ☐ SUPPLEMENTAL SECURITY INCOME (SSI)

DO NOT COMPLETE
COUNTY ASSISTANCE OFFICE USE

WORKER I.D.	CASELOAD	RECORD NUMBER	CAT

NAME	APPOINTMENT DATE/TIME

	AUTHORIZED	NOT AUTHORIZED
DATE		
BY		
CAT		
REASON CODE		

PLEASE PRINT

LIST YOURSELF FIRST, THEN LIST EVERYONE WHO LIVES WITH YOU

OFFICE USE LINE NO.	ENTER YOUR NAME FIRST LAST NAME	FIRST	MI	JR/SR I, II	ARE YOU APPLYING FOR THIS PERSON? YES	NO	BIRTHDATE MO	DAY	YR	SEX M	F	SOCIAL SECURITY NUMBER	NO. OF HOURS WORKED PER WEEK	LIST ALL EARNED AND UNEARNED INCOME GROSS MONTHLY INCOME	INCOME SOURCE	DOES THIS PERSON HAVE A PA ACCESS CARD YES	NO

EXPLAIN ALL CHANGES SINCE YOUR LAST REVIEW

			LIST CHANGES
☐ YES	☐ NO	INCOME CHANGES	
☐ YES	☐ NO	RESOURCE CHANGES	
☐ YES	☐ NO	HOUSEHOLD CHANGES	
☐ YES	☐ NO	CHILD CARE ARRANGEMENTS / CHANGE	
☐ YES	☐ NO	OTHER CHANGES	

VOTER REGISTRATION (Optional)

If you or any other adult in your household is not registered to vote where you live now, would you like to register to vote? __Yes __No
If yes, enter names below. IF YOU DO NOT CHECK 'YES' OR 'NO', you are choosing not to register to vote at this time.

To register you must: 1) Be at least age 18 on the day of the next election; 2) Be a citizen of the United States for at least one month PRIOR TO THE NEXT ELECTION; 3) Reside in Pennsylvania and the voting district at least 30 days prior to the next election.

LINE NO CAO ONLY	LAST NAME	FIRST NAME

LINE NO CAO ONLY	LAST NAME	FIRST NAME

YOUR BENEFITS WILL NOT BE AFFECTED IF YOU REGISTER OR DO NOT REGISTER.

If you need help filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. Please contact the county assistance office if you need help. If you believe that someone has interfered with your right to register to vote, or to 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 Secretary of the Commonwealth, PA Department of State, Harrisburg, PA 17120. (Toll-free telephone number 1-877-VOTESPA.)

DO NOT COMPLETE - COUNTY ASSISTANCE OFFICE USE

☐ Given to client ___/___/_____ ☐ Sent to voter registration ___/___/_____ ☐ Mailed to client ___/___/_____
☐ Declined, not interested ___/___/_____ ☐ Not a U.S. citizen ___/___/_____ ☐ Declined, already registered ___/___/_____

HIPP

☐ YES ☐ NO - If employed, is medical insurance available for you or anyone in your family?

☐ YES ☐ NO - Did you (or someone in the family) lose a job within the past 30 days where you had medical insurance?

☐ YES ☐ NO - Is there someone in your family who is pregnant?

☐ YES ☐ NO - Is anyone disabled, blind, seriously ill, or in need of special medical care or help to overcome a drug or alcohol problem? If yes, provide information below.

NAME OF PERSON WHO IS ILL OR DISABLED	DESCRIBE THE ILLNESS OR DISABILITY	PREGNANCY DUE DATE

WHERE DOES YOUR FAMILY RECEIVE HEALTH CARE?	NAME OF DOCTOR OR CLINIC	ADDRESS

☐ YES ☐ NO **Do you have medical insurance or does someone have medical insurance for you? If yes, list each policy below:**

NAME AND ADDRESS OF INSURANCE COMPANY	CONTRACT/POLICY #	GROUP NAME/GROUP #	POLICYHOLDER NAME ADDRESS AND SOCIAL SECURITY NUMBER	WHO COVERED?

RESC

LIST ALL RESOURCES SUCH AS CASH, VEHICLES, STOCKS, BONDS, BANK ACCOUNTS, PROPERTY, ETC.

NAME OF OWNER (Last, First, MI)	VALUE	RESOURCE / ACCT #	VALUE	NAME OF OWNER (Last,First, MI)	VALUE	RESOURCE / ACCT #
	$		$		$	
	$		$		$	

EXPE

ANSWER THE FOLLOWING QUESTIONS

☐ YES ☐ NO ARE YOU OR ANYONE ELSE IN YOUR HOUSE RESPONSIBLE FOR HEATING AND/OR COOLING COSTS AND EXPENSES?

☐ YES ☐ NO HAVE YOU GOTTEN ENERGY ASSISTANCE SINCE OCT. 1?

☐ YES ☐ NO DO YOU SHARE EXPENSES? IF YES, WITH WHOM?_____ PLEASE LIST SHARED EXPENSES AND AMOUNT YOU CONTRIBUTE_____

WHAT ARE YOUR MONTHLY MEDICAL EXPENSES FOR ANYONE WHO IS AGE 60 OR OLDER OR DISABLED? ▶

SHEL

LIST YOUR HOUSEHOLD EXPENSES BELOW

EXPENSES	HOW MUCH	HOW OFTEN	EXPENSES	HOW MUCH	HOW OFTEN	EXPENSES	HOW MUCH	HOW OFTEN
RENT OR MORTGAGE	$		ELECTRIC	$		SEWERAGE	$	
PROPERTY TAXES	$		GAS	$		GARBAGE	$	
HOMEOWNERS PROPERTY INSURANCE	$		OIL/COAL/WOOD	$		UTILITY INSTALLATION	$	
TELEPHONE	$		WATER	$		OTHER SUCH AS LOT RENT, KEROSENE, ETC.	$	

☐ **YES** ☐ **NO** **Is there anyone outside your household who pays any expenses?** **If so, what?** **How much?** **To who?**

DOES ANYONE IN YOUR HOUSEHOLD WHO IS WORKING, LOOKING FOR WORK, OR GOING TO SCHOOL OR TRAINING PAY ANY EXPENSES RELATED TO THE CARE OF A CHILD OR DISABLED ADULT IN YOUR HOUSEHOLD? ▶ ☐ **YES** ☐ **NO**

HOW MUCH DO YOU PAY TO TRAVEL TO WORK? ▶ MONTHLY AMOUNT $ | HOW DO YOU TRAVEL (Bus, Train, Car, Subway)? ▶

IF YOU USE YOUR CAR - HOW MANY ROUND TRIP MILES TO WORK? ▶ MILES | HOW MANY DAYS EACH WEEK? ▶

DO YOU OR ANOTHER HOUSEHOLD MEMBER PAY CHILD SUPPORT TO A PERSON WHO DOES NOT LIVE WITH YOU? ☐ **YES** ☐ **NO**

IF YES, IS IT VOLUNTARY OR COURT-ORDERED? ▶ ☐ VOLUNTARY ☐ COURT ORDERED

USE THIS PAGE FOR PARENTS AND/OR A SPOUSE NOT LIVING IN YOUR HOUSEHOLD.

ABS REL

YES ☐ NO ☐ **Does any unmarried child under 21 have a mother or father who is not living with you or who is deceased?**

YES ☐ NO ☐ **Does anyone have a husband or wife who is not living with you or who is deceased?**

If you answered yes to either or both questions, give the following information for each relative. **Complete a separate section for each relative.**

1

NAME OF RELATIVE (Last, First, Middle)	✓IF DECEASED	SEX	RACE	BIRTHDATE (MO/DAY/YR)	SOCIAL SECURITY #	HOW IS THIS PERSON RELATED TO YOU

ADDRESS (Street, City, State)	ZIP CODE	PHONE NUMBER

NAME OF RELATIVE'S EMPLOYER (Current or most recent)	EMPLOYER'S ADDRESS (Street, City, State)	ZIP CODE	PHONE NUMBER

NAMES FROM PAGE 2 THAT THIS PERSON IS RESPONSIBLE FOR	IF THE RELATIVE HAS MEDICAL INSURANCE FOR THESE DEPENDENTS, COMPLETE THE POLICY # AND COMPANY	
	POLICY NUMBER ▶	NAME OF INSURANCE COMPANY ▶

IF THIS RELATIVE PAYS SUPPORT OR IF HE OR SHE SHOULD BE PAYING SUPPORT - COMPLETE THE FOLLOWING:

	HOW MUCH	HOW OFTEN	LAST DATE PAID (MO/DAY/YR)	PAID TO WHOM
FOR VOLUNTARY SUPPORT ▶	$			

	COURT ORDER #	AMOUNT	HOW OFTEN IS IT PAID	DATE OF ORDER (MO/DAY/YR)	WHAT ARE THE SPECIAL TERMS -IF ANY	COURT NAME
FOR COURT ORDERED SUPPORT ▶		$				

2

NAME OF RELATIVE (Last, First, Middle)	✓IF DECEASED	SEX	RACE	BIRTHDATE (MO/DAY/YR)	SOCIAL SECURITY #	HOW IS THIS PERSON RELATED TO YOU

ADDRESS (Street, City, State)	ZIP CODE	PHONE NUMBER

NAME OF RELATIVE'S EMPLOYER (Current or most recent)	EMPLOYER'S ADDRESS (Street, City, State)	ZIP CODE	PHONE NUMBER

NAMES FROM PAGE 2 THAT THIS PERSON IS RESPONSIBLE FOR	IF THE RELATIVE HAS MEDICAL INSURANCE FOR THESE DEPENDENTS, COMPLETE THE POLICY # AND COMPANY	
	POLICY NUMBER ▶	NAME OF INSURANCE COMPANY ▶

IF THIS RELATIVE PAYS SUPPORT OR IF HE OR SHE SHOULD BE PAYING SUPPORT - COMPLETE THE FOLLOWING:

	HOW MUCH	HOW OFTEN	LAST DATE PAID (MO/DAY/YR)	PAID TO WHOM
FOR VOLUNTARY SUPPORT ▶	$			

	COURT ORDER #	AMOUNT	HOW OFTEN IS IT PAID	DATE OF ORDER (MO/DAY/YR)	WHAT ARE THE SPECIAL TERMS -IF ANY	COURT NAME
FOR COURT ORDERED SUPPORT ▶		$				

CRIMINAL HISTORY INQUIRY

Please answer the following questions for yourself and anyone else for whom you are applying. If you answer "yes" to a question, list the name of the household member(s) to whom the "yes" answer applies.

1. ☐ YES ☐ NO Have you or anyone for whom you are applying been issued a summons or warrant to appear as a defendant at a criminal court proceeding? If YES, who? _____
2. ☐ YES ☐ NO Do you or anyone for whom you are applying owe fines, costs, or restitution for a felony or misdemeanor offense? If YES, who? _____
3. ☐ YES ☐ NO Have you or anyone for whom you are applying been convicted of welfare fraud? If YES, who? _____
4. ☐ YES ☐ NO Are you or anyone for whom you are applying currently on probation or parole? If YES, who? _____
5. ☐ YES ☐ NO Are you or anyone for whom you are applying currently fleeing from law enforcement officials? If YES, who? _____

FAMILY SAFETY Information About Your Benefits and Domestic Violence

Domestic Violence happens when someone in your life harms you physically, sexually or emotionally, including:

- Physically hurting you or your children
- Threatening or trying to hurt you, your children or your property
- Forcing you to have sex
- Sexually abusing your children
- Controlling where you go and who you see
- Not allowing you or your children to have food, clothing or medical care
- Keeping you from going to work or school
- Following or stalking you

If you are or have been a victim of domestic violence or are at risk of further violence, your caseworker can:

- Help you find local programs where you can get counseling, safety planning, shelter, legal services and other help.
- Excuse you from requirements for cash assistance if domestic violence prevents you from complying: Sometimes people cannot safely follow welfare requirements because they fear that they or their children will be abused if they do so. These include:
  - Support cooperation
  - WORK (RESET)
  - Time limits
  - Requirements that teen parents live at home
  - Verification
  - Other requirements on a case-by-case basis

If you need to be excused from welfare requirements because of domestic violence, tell your caseworker.

You can ask to speak to your caseworker in private. you may not want to share this information with your caseworker or you may decide to discuss it with your worker later. Your caseworker and the staff at the county assistance office will keep your personal information confidential. However, the Department of Public Welfare is required by law to report child abuse to the local Children and Youth Agency.

CLIENT RIGHTS

RIGHT TO NONDISCRIMINATION - We may not discriminate on the basis of age, sex, race, color, ancestry, disability, religious creed, national origin, sexual preference, life-style, union membership, political belief, or because you applied for and/or received assistance before. If you feel you have been discriminated against by the Department or anyone providing services for the Department, you may file a verbal or written complaint with the Department or the County Assistance Office which will forward the complaint to the appropriate federal or state agency.

RIGHT TO APPEAL - You have the right to ask for a Departmental hearing to appeal a decision of or failure to act by the Department which affects your benefits or that you feel is unfair or incorrect. You may file the appeal at the County Assistance Office. At the appeal hearing, you may represent yourself or someone else, such as a lawyer, friend, or relative may represent you.

RIGHT TO AN AGENCY CONFERENCE - If you appeal, you may have an agency conference before the hearing. If you appeal because the Department decided that you are not eligible for expedited food stamp service, you have a right to an agency conference with a supervisor within 2 work days.

RIGHT TO A WRITTEN NOTICE - We will give you a written notice explaining your benefits. If we deny, change, suspend, or stop benefits, we will explain the reason on the notice. You have 30 days (90 days for food stamps) from the date of the notice to ask for a hearing if you disagree with the action taken and/or the reasons given.

CHILD CARE PROVIDER INFORMATION - You have the right to request a child abuse and criminal background clearance from your child care provider.

RIGHT TO CONFIDENTIALITY - We keep information you give confidential and use it only to administer the programs you apply for and/or may be eligible for, such as the school lunch program. Any person knowingly violating any of the rules and regulations of this Department made in accordance with this article shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay a fine, not exceeding one hundred dollars ($100), or to undergo imprisonment, not exceeding six months, or both (62 P.S. Section 483).
The CAO, when requested, must provide federal, state and local law enforcement officials with the address, Social Security Number, and photograph (if available) of an individual who is fleeing to avoid prosecution, custody, or confinement for a felony or violating probation or parole.

RIGHT TO CLAIM GOOD CAUSE - The law requires you to cooperate in establishing paternity for any child born out of marriage and get any support owed to you and/or any child(ren) for whom you want cash and/or medical assistance. The Department will excuse you from cooperating with the support requirements if you prove that it would not be in the best interest of the child(ren) for whom assistance is claimed.
If you are not exempt from employment and training requirements, you must comply unless you have good cause. You must meet Monthly Reporting requirements unless you have good cause.

CLIENT RESPONSIBILITIES

RESPONSIBILITY TO ACKNOWLEDGE LIABILITY OF REAL OR PERSONAL PROPERTY - If you are applying for cash assistance and have non-resident real property and/or personal property, we may require you to sign an agreement to repay benefits received by you, your spouse, and minor children.

If you are age 55 or older and receive Medical Assistance to pay for nursing facility services, home and community-based waiver services and any related hospital and prescription drug service, you will be required to repay the cost of these services from your probate estate.

RESPONSIBILITY TO PROVIDE INFORMATION - You must give true, correct and complete information. You must cooperate in documenting or proving the information you give. Cash assistance may be denied if you fail to provide certain verification. If you cannot provide proof, you should ask the County Assistance Office to help. You must cooperate fully with persons or investigators of the Department or the Inspector General's Office conducting investigations.

RESPONSIBILITY TO REPORT CHANGES -For cash assistance and Medical Assistance, you must report changes in: the number of people in your household, address, new unearned income, real property or other resources (such as bank accounts or life insurance). However, for Medical Assistance, if you are pregnant, under 21 years of age or have a dependent child under 21 years of age living with you, you are not required to report changes in resources. You must report any plans to leave the state, even temporarily. If you have no earned income, you must report new employment or new income from self-employment. If you have earned income, you must report if your gross monthly earned income increases by more than $100 than the estimated gross monthly earned income used to determine your benefit. If you have unearned income, you must report if your gross monthly unearned income increases by more than $50 than the amount used to determine your benefit. You must report changes within the first 10 days of the month following the month of the change.

For Food Stamp households that are not participating in Semiannual Reporting (SAR), you must report changes as described for cash assistance with three exceptions. If you have unearned income, you must report increases or decreases in gross monthly unearned income of more than $50. Additionally, changes in life insurance and temporary absences from the state or county do not need to be reported.

For Food Stamp households that are participating in SAR, you must report if your household's total gross monthly income exceeds 130 percent of the Federal Income Poverty Guidelines (FPIGs) for your household size. The report must be made within 10 calendar days from the end of the month in which the gross monthly income exceeds the 130 percent FPIGs. Your caseworker will explain your specific income reporting requirement.

In addition, for Food Stamp households that contain an Able-Bodied Adult Without Dependents (ABAWD) that are participants in SAR, the household must report if the ABAWD work hours fall below an average of 20 hours weekly. An ABAWD means that you are able to work, you are age 18 through 49 and you have no children under age 18 who live with you.

If you are proven to have failed, without good cause, to report earned income in a timely manner, you may not receive an earned income deduction on the unreported income. This may reduce the amount of cash assistance and/or Food Stamps to which you are entitled and increase the amount of the overpayment claim.

You can report changes to the CAO in person, by telephone, by fax or by mail.

RESPONSIBILITY TO LAWFULLY USE THE PA ACCESS CARD - You may use the PA ACCESS card for services only during the period you are eligible. You must use the card only for the person who is eligible and you may get only services that are needed and reasonable.

RESPONSIBILITY TO PROVIDE SOCIAL SECURITY NUMBERS - For cash, medical and/or food stamps benefits, you must provide a Social Security Number (SSN) for each person for whom you are applying. If you do not have an SSN you must apply for one. Refusal or failure to provide an SSN may result in disqualification. For cash and medical benefits, we will also ask you to supply an SSN for anyone else whose income and/or resources affect your eligibility or amount of benefits. We use the SSN to verify identity, administer our programs, prevent duplication in state and federal programs, for computer matches with other programs, and to get information about income and resources to determine eligibility for, and/or he amount of, your benefits (42 U.S.C. § 1320b-7)

PROHIBITIONS AND PENALTIES

You must **not:**

- give false, incorrect, or incomplete information;
- trade, sell or alter your food stamps or your Authorization To Participate (ATP), Electronic Benefit Transfer (EBT) Card or your PA ACCESS Card;
- use other people's food stamps, ATP's, EBT, or PA ACCESS Card;
- use your food stamps to buy ineligible items, such as alcoholic drinks or tobacco; **or**
- use your food stamps to buy illegal drugs, firearms, ammunition, or explosives.

Any member of your household who is found guilty by a court or an Administrative Disqualification hearing of breaking any of the above rules or who signs a voluntary disqualification consent agreement or waiver of Administrative Disqualification hearing will be barred from getting cash assistance or food stamps for up to:

- 12 months for the first violation;
- 24 months for the second violation; **and**
- permanently for the third violation.

Any household member found guilty by a court of having used food coupons to buy illegal drugs will be disqualified for:

- 24 months for the first violation; **and**
- permanently for the second violation.

Any household member found guilty by a court of buying or selling food stamp coupons, ATP cards, or other benefit instruments for cash or consideration other than food or the exchange of firearms, ammunition, explosives, or controlled substances in the amount of $500 or more in food stamp coupons will be disqualified permanently.

Any household member found by a court or an administrative disqualification hearing of misrepresenting his identity or residence to receive multiple food stamps will be disqualified for 10 years.

Any household member fleeing to avoid prosecution, custody, or confinement for a felony, or attempted felony, or violating a condition of probation or parole will be ineligible until the situation is rectified.

An individual who has been sentenced for a felony or misdemeanor offense and who has not satisfied the penalty imposed by the court is ineligible for Cash Assistance.

An individual is ineligible for Cash Assistance for a period of 10 years if he is convicted of fraudulent misrepresentation of residence for the purpose of receiving welfare benefits in two or more states.

Cash Assistance will be reduced by amounts received by cashing an assistance check at a gambling casino, race track, bingo hall or other establishment that derives more than 50% of its gross revenues from gambling.

If you do not report changes as required, your benefits may be reduced or stopped. If you purposely fail to give correct information or report changes, you may be fined and/or put in jail. Improper use of the PA ACCESS Card for medical services and/or cash and food stamp electronic benefit transfers may result in a fine or imprisonment, or both.

If you are found guilty of violating these rules, or committing fraud, you also may be:

- fined up to $250,000 for food stamps and up to $15,000 for cash;
- jailed up to 20 years for food stamps and up to 7 years for cash; **and/or**
- required to repay the benefits you received.

FOOD STAMP WORK REQUIREMENTS/SANCTIONS - If you are physically and mentally fit, over 15 years of age and under 60 years of age, and not otherwise exempt, you may not refuse to register for employment; participate in an approved employment and training program unless you have good cause; accept employment unless you have good cause; provide sufficient information to your County Assistance Office about your employment status and job availability unless you have good cause or comply with workfare. Additionally, you must not voluntarily and without good cause quit your job or reduce the number of hours you work if, after the reduction, you are employed less than 30 hours per week.

If you or another member of your household violates any of the above work requirements, you or that person may be disqualified from receiving food stamps. Before a disqualification is imposed, you will receive a notice and will have the right to appeal and have a fair hearing.

The minimum disqualification periods are as follows: for the first violation, 1 month and thereafter until the failure to comply ceases; the second violation is 3 months and thereafter until the failure to comply ceases; and for the third and subsequent violations, 6 months and thereafter until the failure to comply ceases.

CASH ASSISTANCE WORK REQUIREMENTS/SANCTIONS - A mandatory participant who fails to cooperate with the work or work-related activity requirement; participate in ETP; accept a bona fide offer of employment; or who terminates employment; reduces earnings or fails to apply for work; without good cause, is ineligible for cash assistance.

The period of sanction is:

First occurrence - 30 days or until the failure to comply ceases, whichever is longer.

Second occurrence - 60 days or until the failure to comply ceases, whichever is longer.

Third occurrence - permanently.

If the reason for sanction occurs in the first 24 months of receipt of cash assistance, whether consecutive or interrupted, the sanction applies only to the individual.

If the reason for the sanction occurs after the first 24 months of receipt of cash assistance, whether consecutive or interrupted, the sanction applies to the entire assistance group.

In place of the sanctions above, if an employed individual voluntarily, without good cause, reduces his earnings by not fulfilling the 20-hour work requirement during the first 24 months, the cash grant is reduced by the dollar value of the income that would have been earned if the recipient would have fulfilled his 20-hour work requirement, until the 20-hour requirement is met.

If an employed individual voluntarily, without good cause, reduces his earnings by not fulfilling the 20-hour work requirement after having received cash assistance for 24 months, the household is ineligible.

AFFIDAVIT

WHEN I SIGN THIS FORM I AGREE THAT:

- I have read this application in full or someone has read it to me and I understand the questions asked.
- I received a copy of my rights and responsibilities, have read them or someone has read them to me, and I understand them.
- I will provide or cooperate in getting any information needed to prove my statements.
- I must report changes in my circumstances within the first 10 calendar days of the month following the month of the change, unless I am in Semiannual reporting for Food Stamp benefits. (See pages 9 and 10 for reporting requirements.)
- I will cooperate with the requirements of the child support enforcement program as directed by the Department.
- If I receive cash and/or medical benefits, I give the state and/or the Domestic Relations Section the right to pursue and collect cash and/or medical support for me and others for whom I am applying.
- If I receive cash benefits, the worker has read the certification on the back of the check; and ever time I endorse a check, I am signing the certification.
- I am responsible for any fraudulent statements made on this application even if the application is submitted by someone acting on my behalf.
- I consent to, and will fully cooperate in the finger, photo, and signature imaging process. I understand that refusal to cooperate may result in the denial of benefits.
- I certify that, subject to penalties provided by law, that the information I gave is true, correct, and complete to the best of my knowledge.

WHEN I SIGN THIS FORM, I UNDERSTAND THAT:

- The state operates a fraud control program under which local, state, and federal officials may verify the information I have given. Verification will include confirmation through the Pennsylvania State Police Criminal Record Files, the Administrative Office of Pennsylvania Court files, and other records that are available.
- The state may obtain information about my circumstances from other persons or organizations, including computer matches and Immigration and Naturalization.
- My Social Security Number will be used to obtain information to verify my circumstances and eligibility.
- My benefits may be reduced or terminated or I can be penalized (including charged with fraud) for giving false or misleading information or for not reporting changes that would affect my benefits.
- I am giving the state the right to seek, with or without legal action, payment from private or public health insurance or liable third party. The amount recovered will not exceed the amount paid by medical assistance.
- The state and the Domestic Relations Section have the right to review all records of medical services paid for by medical assistance.
- Payment for medical services will be made directly to the provider, not to me. This includes payments from Medicare.
- The law provides for automatic assignment to the state of support rights for myself and others for whom I am accepting cash and/or medical assistance.
- If I receive cash benefits, all support including arrears will be paid to the state. If I receive medical benefits, medical support may be paid to the state. When benefits stop, arrears may be paid to the state to repay the amount of assistance granted. the amount of support retained by the state will not be more than the amount of cash assistance received and/or the amount paid under the medical assistance program.
- Failure to report or provide proof of household expenses will be regarded as my statement that I do not want to receive a deduction for unreported or unproven expenses (Authority; U.S. Department of Agriculture, Food and Nutrition Service, Mid-Atlantic region, Adminstrative Note 6-99, issued Jan. 4, 1999). I understand that I have the right to receive credit for household expenses at the time I report and that I may be asked to provide proof of them at any time during my food stamp certification period.

CLIENT OR AUTHORIZED REPRESENTATIVE SIGNATURES	DATE	ID	EMPLOYEE/WITNESS SIGNATURES	DATE

ADDRESS OF REPRESENTATIVE (STREET, CITY, STATE, ZIP)	PHONE NUMBER

SECOND WITNESS IF AN (X) IS SIGNED ABOVE	ADDRESS OF WITNESS	DATE

CLIENT RIGHTS

RIGHT TO NONDISCRIMINATION

We may not discriminate on the basis of age, sex, race, color, ancestry, disability, religious creed, national origin, sexual preference, life-style, union membership, political belief, or because you applied for and/or received assistance before. If you feel you have been discriminated against by the Department or anyone providing services for the Department, you may file a verbal or written complaint with the Department or the County Assistance Office which will forward the complaint to the appropriate federal or state agency.

RIGHT TO APPEAL

You have the right to ask for a Departmental hearing to appeal a decision of or failure to act by the Department which affects your benefits or that you feel is unfair or incorrect. You may file the appeal at the County Assistance Office. At the appeal hearing, you may represent yourself or someone else, such as a lawyer, friend, or relative may represent you.

RIGHT TO AN AGENCY CONFERENCE

If you appeal, you may have an agency conference before the hearing. If you appeal because the Department decided that you are not eligible for expedited food stamp service, you have a right to an agency conference with a supervisor within 2 work days.

RIGHT TO A WRITTEN NOTICE

We will give you a written notice explaining your benefits. If we deny, change, suspend, or stop benefits, we will explain the reason on the notice. You have 30 days (90 days for food stamps) from the date of the notice to ask for a hearing if you disagree with the action taken and/or the reasons given.

CHILD CARE PROVIDER INFORMATION

You have the right to request a child abuse and criminal background clearance from your child care provider.

RIGHT TO CONFIDENTIALITY

We keep information you give confidential and use it only to administer the programs you apply for and/or may be eligible for, such as the school lunch program. Any person knowingly violating any of the rules and regulations of this Department made in accordance with this article shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay a fine, not exceeding one hundred dollars ($100), or to undergo imprisonment, not exceeding six months, or both (62 P.S. Section 483).

The CAO, when requested, must provide federal, state and local law enforcement officials with the address, Social Security Number, and photograph (if available) of an individual who is fleeing to avoid prosecution, custody, or confinement for a felony or violating probation or parole.

RIGHT TO CLAIM GOOD CAUSE

The law requires you to cooperate in establishing paternity for any child born out of marriage and get any support owed to you and/or any child(ren) for whom you want cash and/or medical assistance. The Department will excuse you from cooperating with the support requirements if you prove that it would not be in the best interest of the child(ren) for whom assistance is claimed.

If you are not exempt from employment and training requirements, you must comply unless you have good cause.

You must meet Monthly Reporting requirements unless you have good cause.

CLIENT RESPONSIBILITIES

RESPONSIBILITY TO ACKNOWLEDGE LIABILITY OF REAL OR PERSONAL PROPERTY

If you are applying for cash assistance and have non-resident real property and/or personal property, we may require you to sign an agreement to repay benefits received by you, your spouse, and minor children.

If you are age 55 or older and receive Medical Assistance to pay for nursing facility services, home and community-based waiver services and any related hospital and prescription drug service, you will be required to repay the cost of these services from your probate estate.

RESPONSIBILITY TO PROVIDE INFORMATION

You must give true, correct and complete information. You must cooperate in documenting or proving the information you give. Cash assistance may be denied if you fail to provide certain verification. If you cannot provide proof, you should ask the County Assistance Office to help. You must cooperate fully with persons or investigators of the Department or the Inspector General's Office conducting investigations.

RESPONSIBILITY TO REPORT CHANGES

For cash assistance and Medical Assistance, you must report changes in: the number of people in your household, address, new unearned income, real property or other resources (such as bank accounts or life insurance). However, for Medical Assistance, if you are pregnant, under 21 years of age or have a dependent child under 21 years of age living with you, you are not required to report changes in resources. You must report any plans to leave the state, even temporarily. If you have no earned income, you must report new employment or new income from self-employment. If you have earned income, you must report if your gross monthly earned income increases by more than $100 than the estimated gross monthly earned income used to determine your benefit. If you have unearned income, you must report if your gross monthly unearned income increases by more than $50 than the amount used to determine your benefit. You must report changes within the first 10 days of the month following the month of the change.

For Food Stamp households that are not participating in Semiannual Reporting (SAR), you must report changes as described for cash assistance with three exceptions. If you have unearned income, you must report increases or decreases in gross monthly unearned income of more than $50. Additionally, changes in life insurance and temporary absences from the state or county do not need to be reported.

For Food Stamp households that are participating in SAR, you must report if your household's total gross monthly income exceeds 130 percent of the Federal Income Poverty Guidelines (FPIGs) for your household size. The report must be made within 10 calendar days from the end of the month in which the gross monthly income exceeds the 130 percent FPIGs. Your caseworker will explain your specific income reporting requirement.

In addition, for Food Stamp households that contain an Able-Bodied Adult Without Dependents (ABAWD) that are participants in SAR, the household must report if the ABAWD work hours fall below an average of 20 hours weekly. An ABAWD means that you are able to work, you are age 18 through 49 and you have no children under age 18 who live with you.

If you are proven to have failed, without good cause, to report earned income in a timely manner, you may not receive an earned income deduction on the unreported income. This may reduce the amount of cash assistance and/or Food Stamps to which you are entitled and increase the amount of the overpayment claim.

You can report changes to the CAO in person, by telephone, by fax or by mail.

RESPONSIBILITY TO LAWFULLY USE THE PA ACCESS CARD

You may use the PA ACCESS card for services only during the period you are eligible. You must use the card only for the person who is eligible and you may get only services that are needed and reasonable.

RESPONSIBILITY TO PROVIDE SOCIAL SECURITY NUMBERS

For cash, medical and/or food stamps benefits, you must provide a Social Security Number (SSN) for each person for whom you are applying. If you do not have an SSN you must apply for one. Refusal or failure to provide an SSN may result in disqualification. For cash and medical benefits, we will also ask you to supply an SSN for anyone else whose income and/or resources affect your eligibility or amount of benefits. We use the SSN to verify identity, administer our programs, prevent duplication in state and federal programs, for computer matches with other programs, and to get information about income and resources to determine eligibility for, and/or he amount of, your benefits (42 U.S.C. § 1320b-7)

AFFIDAVIT

WHEN I SIGN THIS FORM I AGREE THAT:

- I have read this application in full or someone has read it to me and I understand the questions asked.
- I received a copy of my rights and responsibilities, have read them or someone has read them to me, and I understand them.
- I will provide or cooperate in getting any information needed to prove my statements.
- I must report any changes in my circumstances within the first 10 calendar days of the month following the month of change, unless I am in Semiannual Reporting for Food Stamp benefits.
- I will cooperate with the requirements of the child support enforcement program as directed by the Department.
- If I receive cash and/or medical benefits, I give the state and/or the Domestic Relations Section the right to pursue and collect cash and/or medical support for me and others for whom I am applying.
- If I receive cash benefits, the worker has read the certification on the back of the check; and ever time I endorse a check, I am signing the certification.
- I am responsible for any fraudulent statements made on this application even if the application is submitted by someone acting on my behalf.
- I consent to, and will fully cooperate in the finger, photo, and signature imaging process. I understand that refusal to cooperate may result in the denial of benefits.
- I certify that, subject to penalties provided by law, that the information I gave is true, correct, and complete to the best of my knowledge.

WHEN I SIGN THIS FORM, I UNDERSTAND THAT:

- The State operates a fraud control program under which local, state, and federal officials may verify the information I have given. Verification will include confirmation through the Pennsylvania State Police Criminal Record Files, the Administrative Office of Pennsylvania Court files, and other records that are available.
- The state may obtain information about my circumstances from other persons or organizations, including computer matches and Immigration and Naturalization.
- My Social Security Number will be used to obtain information to verify my circumstances and eligibility.
- My benefits may be reduced or terminated or I can be penalized (including charged with fraud) for giving false or misleading information or for not reporting changes that would affect my benefits.
- I am giving the state the right to seek, with or without legal action, payment from private or public health insurance or liable third party. The amount recovered will not exceed the amount paid by medical assistance.
- The state and the Domestic Relations Section have the right to review all records of medical services paid for by medical assistance.
- Payment for medical services will be made directly tot he provider, not to me. This includes payments from Medicare.
- The law provides for automatic assignment tot he state of support rights for myself and others for whom I am accepting cash and/or medical assistance.
- If I receive cash benefits, all support including arrears will be paid to the state. If I receive medical benefits, medical support may be paid to the state. When benefits stop, arrears may be paid to the state to repay the amount of assistance granted. the amount of support retained by the state will not be more than the amount of cash assistance received and/or the amount paid under the medical assistance program.
- Failure to report or provide proof of household expenses will be regarded as my statement that I do not want to receive a deduction for unreported or unproven expenses (Authority; U.S. Department of Agriculture, Food and Nutrition Service, Mid-Atlantic region, Adminstrative Note 6-99, issued Jan. 4, 1999). I understand that I have the right to receive credit for household expenses at the time I report and that I may be asked to provide proof of them at any time during my food stamp certification period.

PROHIBITIONS AND PENALTIES

You must **not:**

- give false, incorrect, or incomplete information;
- trade, sell or alter your food stamps or your Authorization To Participate (ATP), Electronic Benefit Transfer (EBT) Card or your PA ACCESS Card;
- use other people's food stamps, ATP's, EBT, or PA ACCESS Card;
- use your food stamps to buy ineligible items, such as alcoholic drinks or tobacco; **or**
- use your food stamps to buy illegal drugs, firearms, ammunition, or explosives.

Any member of your household who is found guilty by a court or an Administrative Disqualification hearing of breaking any of the above rules or who signs a voluntary disqualification consent agreement or waiver of Administrative Disqualification hearing will be barred from getting cash assistance or food stamps for up to:

- 12 months for the first violation;
- 24 months for the second violation; **and**
- permanently for the third violation.

Any household member found guilty by a court of having used food coupons to buy illegal drugs will be disqualified for:

- 24 months for the first violation; **and**
- permanently for the second violation.

Any household member found guilty by a court of buying or selling food stamp coupons, ATP cards, or other benefit instruments for cash or consideration other than food or the exchange of firearms, ammunition, explosives, or controlled substances in the amount of $500 or more in food stamp coupons will be disqualified permanently.

Any household member found by a court or an administrative disqualification hearing of misrepresenting his identity or residence to receive multiple food stamps will be disqualified for 10 years.

Any household member fleeing to avoid prosecution, custody, or confinement for a felony, or attempted felony, or violating a condition of probation or parole will be ineligible until the situation is rectified.

An individual who has been sentenced for a felony or misdemeanor offense and who has not satisfied the penalty imposed by the court is ineligible for Cash Assistance.

An individual is ineligible for Cash Assistance for a period of 10 years if he is convicted of fraudulent misrepresentation of residence for the purpose of receiving welfare benefits in two or more states.

Cash Assistance will be reduced by amounts received by cashing an assistance check at a gambling casino, race track, bingo hall or other establishment that derives more than 50% of its gross revenues from gambling.

If you do not report changes as required, your benefits may be reduced or stopped. If you purposely fail to give correct information or report changes, you may be fined and/or put in jail. Improper use of the PA ACCESS Card for medical services and/or cash and food stamp electronic benefit transfers may result in a fine or imprisonment, or both.

If you are found guilty of violating these rules, or committing fraud, you also may be:

- fined up to $250,000 for food stamps and up to $15,000 for cash;
- jailed up to 20 years for food stamps and up to 7 years for cash; **and/or**
- required to repay the benefits you received.

FOOD STAMP WORK REQUIREMENTS/SANCTIONS - If you are physically and mentally fit, over 15 years of age and under 60 years of age, and not otherwise exempt, you may not refuse to register for employment; participate in an approved employment and training program unless you have good cause; accept employment unless you have good cause; provide sufficient information to your County Assistance Office about your employment status and job availability unless you have good cause or comply with workfare. Additionally, you must not voluntarily and without good cause quit your job or reduce the number of hours you work if, after the reduction, you are employed less than 30 hours per week.

If you or another member of your household violates any of the above work requirements, you or that person may be disqualified from receiving food stamps. Before a disqualification is imposed, you will receive a notice and will have the right to appeal and have a fair hearing.

The minimum disqualification periods are as follows: for the first violation, 1 month and thereafter until the failure to comply ceases; the second violation is 3 months and thereafter until the failure to comply ceases; and for the third and subsequent violations, 6 months and thereafter until the failure to comply ceases.

CASH ASSISTANCE WORK REQUIREMENTS/SANCTIONS - A mandatory participant who fails to cooperate with the work or work-related activity requirement; participate in ETP; accept a bona fide offer of employment; or who terminates employment; reduces earnings or fails to apply for work; without good cause, is ineligible for cash assistance.

The period of sanction is:

First occurrence - 30 days or until the failure to comply ceases, whichever is longer.

Second occurrence - 60 days or until the failure to comply ceases, whichever is longer.

Third occurrence - permanently.

If the reason for sanction occurs in the first 24 months of receipt of cash assistance, whether consecutive or interrupted, the sanction applies only to the individual.

If the reason for the sanction occurs after the first 24 months of receipt of cash assistance, whether consecutive or interrupted, the sanction applies to the entire assistance group.

In place of the sanctions above, if an employed individual voluntarily, without good cause, reduces his earnings by not fulfilling the 20-hour work requirement during the first 24 months, the cash grant is reduced by the dollar value of the income that would have been earned if the recipient would have fulfilled his 20-hour work requirement, until the 20-hour requirement is met.

If an employed individual voluntarily, without good cause, reduces his earnings by not fulfilling the 20-hour work requirement after having received cash assistance for 24 months, the household is ineligible.