APPLICATION FOR ASSISTANCE
FOOD STAMPS, CASH ASSISTANCE, HEALTH COVERAGE

State Form 30465 (R11 / 11-10) / FI 2400

FOR LOCAL OFFICE USE ONLY
Date of application *(month, day, year)*

PLEASE READ THESE INSTRUCTIONS CAREFULLY

These instructions tell you how to apply for assistance. If you do not understand the instructions or any other information contained in this packet, please ask for help.

1. *Fill out the application which is the next page of this packet. Provide as much of the information as possible. However, your application will be valid if you provide your name and address and sign the form.*
2. *Keep the "Rights and Responsibilities" sheets that were given to you with the application form. Read these pages carefully. They explain what you must do to help us determine your eligibility.*
3. *After you have filled out the application, give it to the office receptionist, or mail it to the County Office of Family Resources.*
4. *If you are married, you need to file only one application for yourself and your spouse who lives in a long term care facility.*
5. *If more than eight people live in the household, please ask for another application.*

ADDITIONAL IMPORTANT INFORMATION

6. *Food Stamps are provided from the date we receive your application. Medicaid benefits can begin no earlier than three months prior to the month of application. Therefore, you should file your application as soon as possible.*
7. *Your application for Food Stamps may receive special expedited processing if your household has little or no income, or you are a migrant or seasonal farm worker. This means that you may be entitled to receive your Food Stamps within seven days after the date we receive your application. To see if you qualify for expedited processing, you must complete Section E on the back of the application.*
8. *The County Office of Family Resources must determine your eligibility for Food Stamps within thirty (30) days if you are not entitled to expedited service, and your eligibility for Cash and Medicaid within forty-five (45) days, with one exception. If your Medicaid eligibility is being determined under the Disability category, your eligibility must be determined within ninety (90) days.*
9. *Once your application is received by the County Office of Family Resources, an appointment will be made for you to be interviewed by a caseworker. At the interview you will complete Part II and sign Part III of the application. If your interview is by phone, the Application for Assistance - Part II and III will be mailed to you for signature. If you cannot keep this appointment, you must contact:*

   _____ *at* _____ .

   If you miss your interview appointment, you must reschedule it. If you do not reschedule your appointment within thirty (30) days after you filed your application, your application will be denied.

Your appointment is set for:

_____, _____, at _____ ☐AM ☐PM
Day of week *Month, day, year* *Time*

at _____ .
Location

INFORMATION AND VERIFICATION

As stated on the rights and responsibilities form you received, you must provide us with the information and verification needed to determine your eligibility. Listed below are some of the papers, records and other types of information and verification that may be needed to determine your eligibility. It will speed up this process if you bring these to your interview for everyone in your assistance group.

1. Record of Social Security number such as Social Security card, Railroad Retirement number or Veteran's Claim number.

2. Record showing age, such as birth certificate, baptismal record, insurance policy or school record.

3. Record of place of birth or, if foreign born, record of naturalization or alien status.

4. Name(s), address(es), employer(s), Social Security number(s) and Military Service number(s) of the absent parent(s) of all children; the names and addresses of the absent parent's parents.

5. Marriage certificate if you are presently married.

6. Life and medical insurance policy and premium payment book.

7. Bank statement, record of stocks, bonds and other assets.

8. Make, model, age and amount owed on any automobile, truck, boat, camper or trailer; registration or title.

9. Record of all income:
   a. Social Security, Railroad Retirement and Veteran's benefits and military allotment such as letter of entitlement or notification.
   b. Child Support *(record of total amount received last month and the current month).*
   c. Contribution *(such as statement from person giving contribution).*
   d. Earnings: pay stubs; name(s) and address(es) of employer(s); employer(s) statement.
   e. Any other income you receive from any other source.

10. Receipts for all expenses:
    a. Child care costs.
    b. Shelter costs such as rent, utilities, tax statement.
    c. Medical costs such as doctor bills, prescription receipts, insurance premium book, insurance reimbursement statement.
    d. Child Support and court-order showing amount ordered.

THE SOONER WE RECEIVE ALL OF THE INFORMATION AND VERIFICATION REQUESTED, THE SOONER WE WILL BE ABLE TO DETERMINE YOUR ELIGIBILITY.

IMPORTANT INFORMATION

In accordance with Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs. To file a complaint alleging discrimination, contact the USDA or HHS:

FOOD STAMPS:

Write: United States Department of Agriculture
Director, Office of Civil Rights
1400 Independence Avenue, S.W.
Washington, D.C. 20250-9410

Call: Toll Free - (866) 632-9992 (voice)

TDD users can contact USDA through local relay or Federal relay at (800) 877-8339 (TDD) or (866) 377-8642 (relay voice users)

CASH ASSISTANCE OR HEALTH COVERAGE:

Write: Department of Health and Human Services
Director, Office of Civil Rights
200 Independence Avenue, S.W. Room 506-F
Washington, D.C. 20201

Call: (202) 619-0403 (voice)
(202) 619-3257 (TDD)

USDA and HHS are equal opportunity providers and employers.

KEEP THIS PAGE

APPLICATION FOR ASSISTANCE - PART I
Food Stamps, Cash Assistance, Health Coverage

State Form 30465 (R11 / 11-10) / FI 2400

FOR OFFICE USE ONLY
Date of application (*month, day, year*)
Case number

*PLEASE **PRINT** NEATLY. Give all information possible. Your application will be valid if you at least provide your name and address, and sign the form on the back in Section F. We will provide the help you need to complete this application process. If you need help, please ask.*

IMPORTANT INFORMATION

The information obtained on this form is confidential under state and federal regulations, including 470 IAC 1-2-7, 470 IAC 1-3-1, 470 IAC 6-1-1, 405 IAC 1-1-12, 45 CFR 205.50, 7 CFR 272.1(c), and 42 CFR 431.300. This information will not be released except as permitted or required by law or with the consent of the applicant/recipient.

SECTION A - AUTHORIZATION

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

I want _____ to apply on my behalf.
(*Name of individual*)

Signature of applicant	Date (*month, day, year*)

SECTION B - FILING FOR BENEFITS

If you are eligible for Food Stamps, benefits will be provided from the day we receive the application. To qualify for expedited Food Stamps, you must complete Section "E" on the back.

Name of person filing application (*first, middle, last*)	Telephone number ( )

Address of person filing application (*number and street, city, state, and ZIP code*)

Do you live with the person(s) needing assistance?
☐ Yes ☐ No

SECTION C - HOUSEHOLD INFORMATION FOR PERSON(S) REQUESTING ASSISTANCE

Household address - if different from above (*number and street, city, state, and ZIP code*)

Mailing address - if different from above (*number and street, city, state, and ZIP code*)

Telephone number ( )	E-mail address

COMPLETE THIS SECTION FOR ALL PERSONS WHO LIVE AT THIS ADDRESS

List the legal name, date of birth and Social Security number of all persons who live at the above address. If you want Temporary Assistance for Needy Families (TANF) for any child, you have to apply for all of the child's sisters, brothers and parents who live with the child.

Does everyone listed below wish to apply for all programs of assistance?
☐ Yes ☐ No (*If No, mark the program(s) requested with a **X***)

NO.	FIRST NAME	MI	LAST NAME	DATE OF BIRTH (*month, day, year*)	SOCIAL SECURITY NUMBER	PROGRAMS REQUESTED		
						CASH	HEALTH COVERAGE	FOOD STAMPS
1								
2								
3								
4								
5								
6								
7								
8								

SECTION D - INSTITUTIONAL INFORMATION

Is the person needing assistance in a Long Term Care Facility?
☐ Yes ☐ No (*If Yes, complete the following*)

NAME OF NURSING FACILITY	ADDRESS (*number and street*)	CITY	STATE	ZIP CODE

(*Continued on the reverse side*)

SECTION E - EXPEDITED SERVICE FOR FOOD STAMPS

You may get Food Stamps within seven (7) days of filing a completed application if the answer to one of the following questions is Yes.

1. Is any individual a migrant or seasonal farm worker? ☐ Yes ☐ No
   If Yes,
   (a) Will you receive income from your former employer after today? ☐ Yes ☐ No
   (b) Will you receive more than $25 income from your new employer within 10 days? ☐ Yes ☐ No
   (c) Will your liquid resources, such as cash, checking / savings, be $100 or less? ☐ Yes ☐ No

2. Are your monthly rent / mortgage and utilities more than your gross monthly income and liquid resources? ☐ Yes ☐ No

3. Is your gross monthly income less than $150 and your liquid resources, such cash, checking / savings accounts, $100 or less? ☐ Yes ☐ No

SECTION F - HEALTH PLAN SELECTION

Please complete this section if anyone is applying for health coverage.

We will check your eligibility for all of our health coverage categories. Children under age 19, low-income families, and pregnant women who are approved for Hoosier Healthwise will be enrolled in one of our health plans. If you have made your selection, please mark the box next to your chosen plan.

☐ Anthem Blue Cross Blue Shield ☐ MHS-Your Family Health Plan ☐ MDWise

Provider directories for Hoosier Healthwise are available on the health plan websites. If you have given us your e-mail address, we will send an electronic copy to you. Do you need a paper copy instead? ☐ Yes ☐ No

If you have questions about how to choose your health plan or would like the provider directory before being assigned to a health plan, please call the Hoosier Healthwise Helpline at 1-800-889-9949.

Applicants approved for Medicaid under the aged, blind, or disabled categories will not be enrolled in one of the above health plans. You will receive information about our traditional health plan with your Hoosier Health Card.

SECTION G - SIGNATURE

I affirm under the penalty of perjury that my answers are complete and correct to the best of my knowledge.

Signature of applicant	Date signed (*month, day, year*)
Signature of witness if signed with an "X"	Date signed (*month, day, year*)

OFFICE USE ONLY

ADDITIONAL INFORMATION	FS EXPEDITED SERVICE / WORKER	INTERVIEW(S)			
Case number	**PRESCREENER**	**DATE**	**TIME**	**CWID**	**PROGRAM**
Denial:	☐ Entitled ☐ Not entitled ☐ Unit refused expedited service	___ / ___ / ___	:		☐ FS ☐ Cash ☐ MA
Program: ☐ FS ☐ Cash ☐ MA	Prescreener initials				
Date (*month, day, year*)	**INTERVIEWER**				
Reason:	☐ Entitled ☐ Not entitled ☐ Unit refused expedited service	___ / ___ / ___	:		☐ FS ☐ Cash ☐ MA
	Interviewer ID number				
	Continuing worker ID number	___ / ___ / ___	:		☐ FS ☐ Cash ☐ MA
	☐ FS ☐ Cash ☐ MA				