ACCESS Florida **Application**

Do you have a reason that makes it difficult for you to come to the office for an interview?
☐ Illness ☐ Transportation ☐ Work or Training ☐ Live in a Rural Area ☐ Care for a sick or Disabled Household Member ☐ Other (explain):

Date Stamp:_____

Case Number:

I would like to apply for: ☐ **Food Assistance** ☐ **Cash** ☐ **Relative Caregiver** ☐ **OSS/Optional State Supplementation** ☐ **Medical** ☐ **Medicaid Waiver/Home & Community Based Services** ☐ **Hospice** ☐ **Nursing Home Care –** Living address prior to entering Nursing Home:

Welcome to the Florida Department of Children and Families (DCF). **If you need help in completing this application or need interpreter services, please contact ACCESS Florida at 1-866-762-2237.** We need at least your name, address, and a signature. Processing begins the day we receive your signed application. House-hold members who are ineligible, or who are not applying for benefits, may be designated as non-applicants. Non-applicants, or persons applying only for Emergency Medicaid, Refugee Cash Assistance, or Refugee Medical Assistance, are **NOT** required to provide a Social Security Number (SSN) based on the Food Stamp Act. If you are not eligible for an SSN because of your immigration status, you may be eligible for a non-work SSN to receive the benefits that require one. If you need an SSN, we can help you apply for one. Non-applicants are **NOT** required to provide proof of immigration status. Noncitizens who are applying for benefits will have their immigration status verified with the United States Citizenship and Immigration Services (USCIS). We will not tell USCIS about the immigration status of those living in your household who are not applying for benefits. Under no circumstances will individuals who are not applying for benefits be reported as not lawfully residing in the United States. If you are completing this application for someone else, answer the questions based on their circumstances.

EXPEDITED FOOD ASSISTANCE – Eligible households may receive food assistance benefits within 7 days

Is your household's gross income less than $150?	☐ YES ☐ NO	Do you pay to heat or cool your home?	☐ YES ☐ NO
Are your total liquid assets (such as cash, bank accounts, etc) less than $100?	☐ YES ☐ NO	What is the monthly amount of your rent or mortgage?	$
Is your household's monthly gross income plus your total liquid assets less than your monthly rent or mortgage plus utilities?	☐ YES ☐ NO	Has all of your household's income recently stopped? **If yes, WHEN?**	☐ YES ☐ NO
Check the bills you pay: ☐ Electricity ☐ Gas ☐ Water ☐ Sewage ☐ Phone		Is anyone in your household a migrant or seasonal farmworker? **If yes, WHO?**	☐ YES ☐ NO

APPLICANT INFORMATION

Name: First Middle Last		Home or Message Phone Number:	E-Mail Address:
Home Address: Street	Apt. No. City State Zip Code		Work Phone Number:
Address where you get your mail (if different from where you live): Street/P. O. Box	City State Zip Code		Cell Phone Number:

INFORMATION FOR ALL PROGRAMS

Is anyone in your home fleeing the law due to a felony or a probation or parole violation? ☐ YES ☐ NO **If yes, who?**	Has anyone in your home been convicted of a drug trafficking felony? ☐ YES ☐ NO **If yes, who?**	Has anyone in your home ever been convicted of receiving food assistance, temporary cash assistance, or Medicaid in more than one state at the same time? ☐ YES ☐ NO **If yes, who?**
Has anyone in your home sold or given away any property or assets in the last 5 years? ☐ YES ☐ NO **If yes, who?**	Did anyone in your home quit a job in the last 60 days or is anyone on strike? ☐ YES ☐ NO **If yes, who?**	Has anyone in your home received food, cash, or medical assistance from another state or source in the last 30 days? ☐ YES ☐ NO **If yes, who?**

STATEMENT OF UNDERSTANDING

I understand that information that I provide with this application, interview, or when requesting other benefits, including computer information matches with other agencies, is subject to verification by DCF and other Federal and State agencies including Division of Public Assistance Fraud (DPAF). I understand and agree to the following: DCF, DPAF, and authorized Federal Agencies may verify the information I give on this form, interview, or when requesting other benefits. Information may be obtained from my past or present employers. My signature authorizes release of such information to DCF and/or DPAF. As a condition of participation in Medicaid, I consent to review and release of all medical records deemed necessary by Medicaid under its auditing and investigatory powers. If any information is incorrect, benefits may be reduced or denied and I may be subject to criminal prosecution or disqualified from the program for knowingly providing incorrect or false information or hiding information. I have read my Rights and Responsibilities. I certify under penalty of perjury that the information on this form is true to the best of my knowledge, including the citizen or noncitizen status of those who are applying for benefits. I hereby acknowledge receipt of the Florida DCF CFOP 60-17, Chapter 1, Attachment 2, Management and Protection of Personal Health Information Policy.

SIGNATURES

_____
Signature of Adult Household Member Date Signed

_____
Signature of Witness if signed with an "X"

Authorized/Designated Representative – Print Name, Address, and Phone

_____

_____

_____
Signature of Authorized/Designated Representative

Application continues on page 2. Please provide as much information as you can to help us determine your eligibility quickly.

FOR OFFICE USE ONLY	**Community Access Site Participant Name/Phone Number:**	**Date Stamp:**

HOUSEHOLD INFORMATION: If you need extra space in the following sections, please use extra pages. Please provide as much information as you can to help us determine your eligibility quickly.

List yourself and all those living in your home even if you are not applying for them. If you are not applying for a member, you do not have to give their SSN or citizenship status.
If living in a nursing home or other institutional arrangement, list only self, spouse and dependents.
OPTIONAL INFORMATION – *ETHNICITY:* **A** = Hispanic or Latino; **B** = Not Hispanic or Latino
RACE: You may choose one or more numbers: **1** – American Indian or Alaskan Native, **2** – Asian, **3** – Black or African American, **4** – Native Hawaiian, **5** – White

Section A – List All Adults Living At Your Address

Legal Name First, Middle, Last	Relationship to you	Want to Apply?	Sex	Social Security Number (see instructions above)	Date and Place of Birth	U.S. Citizen	Ethnicity (see above)	Race (see above)	Marital Status	Attends School/ # Hours/Week/ Last Grade Completed	Buys and Eats Food with You
	SELF	☐ YES ☐ NO	☐ F ☐ M			☐ YES ☐ NO USCIS #	☐ A ☐ B	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5		☐ YES ☐ NO # hours per week:______ Last Grade Completed:______	☐ YES ☐ NO
		☐ YES ☐ NO	☐ F ☐ M			☐ YES ☐ NO USCIS #	☐ A ☐ B	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5		☐ YES ☐ NO # hours per week:______ Last Grade Completed:______	☐ YES ☐ NO
		☐ YES ☐ NO	☐ F ☐ M			☐ YES ☐ NO USCIS #	☐ A ☐ B	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5		☐ YES ☐ NO # hours per week:______ Last Grade Completed:______	☐ YES ☐ NO
		☐ YES ☐ NO	☐ F ☐ M			☐ YES ☐ NO USCIS #	☐ A ☐ B	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5		☐ YES ☐ NO # hours per week:______ Last Grade Completed:______	☐ YES ☐ NO

Section B – List All Children Living At Your Address. If anyone is pregnant, list "unborn" as the name and the due date as the date of birth.

Legal Name First, Middle, Last	Relationship to you	Want to Apply?	Sex	Social Security Number (see instructions above)	Date and Place of Birth	U.S. Citizen	Ethnicity (see page 2)	Race (see page 2)	Child under Age 5 Immunized	Attends School/ School Name	Date To Graduate	Buys and Eats Food with You
Child 1 Would you like this child to get child health checkup services? ☐ YES ☐ NO		☐ YES ☐ NO	☐ F ☐ M			☐ YES ☐ NO USCIS #	☐ A ☐ B	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	☐ YES ☐ NO	☐ YES ☐ NO If yes, school name:		☐ YES ☐ NO
Child 2 Would you like this child to get child health checkup services? ☐ YES ☐ NO		☐ YES ☐ NO	☐ F ☐ M			☐ YES ☐ NO USCIS #	☐ A ☐ B	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	☐ YES ☐ NO	☐ YES ☐ NO If yes, school name:		☐ YES ☐ NO

Section B – List All Children Living At Your Address. If anyone is pregnant, list "unborn" as the name and the due date as the date of birth.												
Child 3 Would you like this child to get child health checkup services? ☐ YES ☐ NO		☐ YES ☐ NO	☐ F ☐ M			☐ YES ☐ NO USCIS #	☐ A ☐ B	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	☐ YES ☐ NO	☐ YES ☐ NO If yes, school name:		☐ YES ☐ NO
Child 4 Would you like this child to get child health checkup services? ☐ YES ☐ NO		☐ YES ☐ NO	☐ F ☐ M			☐ YES ☐ NO USCIS #	☐ A ☐ B	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	☐ YES ☐ NO	☐ YES ☐ NO If yes, school name:		☐ YES ☐ NO

Medicaid: For children under age 16, if no other proof of identity is available such as school records or photo ID, read and sign below:

I certify under penalty of perjury that all the children listed above are who I claim them to be.

_____
Signature

Section C – Absent Parent Information: Provide the following information for each child in Section B whose mother and/or father is not in the home.

Child 1	Absent Parent's Name and Last Known Address		Date of Birth	Social Security No.	Race	Reason for Absence	
	Mother				(see pg.2)		
	Is this the child's legal parent? ☐ YES ☐ NO	Do you want Child Support Enforcement services if not approved for benefits? ☐ YES ☐ NO	Mother's Place of Birth	Mother's Phone Number	Medical Insurance Information: Carrier Name:	Policy Number:	
	Mother's Employer's Name:	Employer's Address:				Employer's Phone #:	
	Absent Parent's Name and Last Known Address		Date of Birth	Social Security No.	Race	Reason for Absence	
	Father				(see pg.2)		
	Is this the child's legal parent? ☐ YES ☐ NO	Do you want Child Support Enforcement services if not approved for benefits? ☐ YES ☐ NO	Father's Place of Birth	Father's Phone Number	Medical Insurance Information: Carrier Name:	Policy Number:	
	Father's Employer's Name:	Employer's Address:				Employer's Phone #:	
Child 2	Absent Parent's Name and Last Known Address		Date of Birth	Social Security No.	Race	Reason for Absence	
	Mother				(see pg.2)		
	Is this the child's legal parent? ☐ YES ☐ NO	Do you want Child Support Enforcement services if not approved for benefits? ☐ YES ☐ NO	Mother's Place of Birth	Mother's Phone Number	Medical Insurance Information: Carrier Name:	Policy Number:	
	Mother's Employer's Name:	Employer's Address:				Employer's Phone #:	
	Absent Parent's Name and Last Known Address		Date of Birth	Social Security No.	Race	Reason for Absence	
	Father				(see pg.2)		
	Is this the child's legal parent? ☐ YES ☐ NO	Do you want Child Support Enforcement services if not approved for benefits? ☐ YES ☐ NO	Father's Place of Birth	Father's Phone Number	Medical Insurance Information: Carrier Name:	Policy Number:	
	Father's Employer's Name:	Employer's Address:				Employer's Phone #:	

Section C – Absent Parent Information: Provide the following information for each child in Section B whose mother and/or father is not in the home.

		Absent Parent's Name and Last Known Address	Date of Birth	Social Security No.	Race	Reason for Absence
Child 3	Mother				(see pg.2)	
		Is this the child's legal parent? ☐ YES ☐ NO / Do you want Child Support Enforcement services if not approved for benefits? ☐ YES ☐ NO	Mother's Place of Birth	Mother's Phone Number	Medical Insurance Information: Carrier Name: / Policy Number:	
		Mother's Employer's Name: / Employer's Address:				Employer's Phone #:
	Father	Absent Parent's Name and Last Known Address	Date of Birth	Social Security No.	Race (see pg.2)	Reason for Absence
		Is this the child's legal parent? ☐ YES ☐ NO / Do you want Child Support Enforcement services if not approved for benefits? ☐ YES ☐ NO	Father's Place of Birth	Father's Phone Number	Medical Insurance Information: Carrier Name: / Policy Number:	
		Father's Employer's Name: / Employer's Address:				Employer's Phone #:
Child 4	Mother	Absent Parent's Name and Last Known Address	Date of Birth	Social Security No.	Race (see pg.2)	Reason for Absence
		Is this the child's legal parent? ☐ YES ☐ NO / Do you want Child Support Enforcement services if not approved for benefits? ☐ YES ☐ NO	Mother's Place of Birth	Mother's Phone Number	Medical Insurance Information: Carrier Name: / Policy Number:	
		Mother's Employer's Name: / Employer's Address:				Employer's Phone #:
	Father	Absent Parent's Name and Last Known Address	Date of Birth	Social Security No.	Race (see pg.2)	Reason for Absence
		Is this the child's legal parent? ☐ YES ☐ NO / Do you want Child Support Enforcement services if not approved for benefits? ☐ YES ☐ NO	Father's Place of Birth	Father's Phone Number	Medical Insurance Information: Carrier Name: / Policy Number:	
		Father's Employer's Name: / Employer's Address:				Employer's Phone #:

Section D – General Information: Answer the following questions about those listed in Sections A and B who are applying for assistance.

1. Is everyone a resident of the state of Florida?	☐ YES	☐ NO	If no, who is not?
2. Is anyone in the household pregnant?	☐ YES	☐ NO	Who? Due Date: # Babies Due:
* 3. **Has anyone attended a school conference for any of the children who are ages 6-18?**	☐ YES	☐ NO	Who? When?
4. Has anyone or their parent (if still a child) or deceased spouse (if applicable) served in the U.S. military?	☐ YES	☐ NO	Who? When?
5. Is anyone in your household a sponsored noncitizen?	☐ YES	☐ NO	Who?
6. Is anyone living in a special setting such as a homeless shelter, drug treatment center, nursing home, assisted living facility, adult family care home, mental health residential treatment facility, or other institution?	☐ YES	☐ NO	Who? Facility Name and Type:
7. Is anyone a foster child?	☐ YES	☐ NO	Who?
* 8. **Are any of the children limited or prevented in any way in his or her ability to do the things most children of the same age can do?**	☐ YES	☐ NO	Who?
* 9. **Do any of the children need to get special therapy, such as physical, occupational or speech therapy, or treatment or counseling for an emotional, developmental, or behavioral problem?**	☐ YES	☐ NO	Who?
*10. **Do any of the children need or use more medical care, mental health, or educational services than is usual for most children of the same age?**	☐ YES	☐ NO	Who?
11. If you are applying for nursing home type services, do you have a child (of any age) living in your home who is blind or disabled?	☐ YES	☐ NO	Who? What is their relationship to you?
12. Has anyone been determined disabled by Social Security or the State of Florida?	☐ YES	☐ NO	Who?

Section D – General Information: Answer the following questions about those listed in Sections A and B who are applying for assistance.			
13. Is anyone claiming to be disabled who has not already been determined disabled by Social Security or the State of Florida?	☐ **YES**	☐ **NO**	Who?
14. Has anyone been denied Supplemental Security Income (SSI) in the past 90 days?	☐ **YES**	☐ **NO**	Who? When?
*15. **Does anyone in your household need help with Medicare premiums or medical bills from the past three (3) months?**	☐ **YES**	☐ **NO**	Who?
*16. **Does anyone who was denied for disability have a new medical condition not considered by the Social Security Administration?**	☐ **YES**	☐ **NO**	Who?
17. Is anyone in your household a victim of human trafficking? (Victims of human trafficking are people taken, kept, or moved by force or fraud for sexual exploitation or forced labor.)	☐ **YES**	☐ **NO**	Who?

If you need extra space in the following sections, please use extra pages.

Section E – Assets & Insurance: Answer the following questions about those listed in Sections A and B who are applying for assistance.

1. Does anyone that you are applying for own all or part of any assets, such as: vehicles, bank accounts, tax sheltered accounts, property, Certificates of Deposit (CDs), cash, mortgage notes, promissory notes, ***loans**, ***IRAs**, ***401Ks**, bonds, annuities, stocks, real estate, life estate, trusts, ***Keogh plans**, ***continuing care retirement community or life care community contracts**, burial contracts/plots, prepaid funeral expenses, savings bonds or certificates, business assets, large sums of money received in last 3 months, health/long-term care/life/auto insurance, HMOs, Medicare or Medicare supplements, etc? Include the assets/insurance of parents of minor child applicants if living in the home and assets/insurance of spouses of applicants if living in the home. ☐ **YES** ☐ **NO** **If yes, list below:**

IMPORTANT INFORMATION FOR OWNERS OF AN ANNUITY: In accordance with Public Law 109-171, individuals (and their spouses) who are applying for or receiving Medicaid Institutional Care Program (nursing home care), Hospice, Home and Community Based Services waiver programs, or the Program of All-Inclusive Care for the Elderly must list all annuities they own. Certain annuity purchases (or other transactions) made on or after 11/01/2007 will be considered a transfer of an asset for less than fair market value unless the annuity names the State of Florida, Agency for Health Care Administration, as the first remainder beneficiary (or second remainder beneficiary after the community spouse or minor or disabled child) for the total amount of Medicaid funds paid on the Medicaid recipient's behalf.

Individual	Type of Asset or Insurance	Vehicles Year, Make, Model	Amount Owed on Vehicle/Property	Location of Asset/Insurance Bank/Company Name and Address	Account # or Insurance ID #	Amount or Value

2. Are any of the above assets set aside to cover burial expenses?	☐ **YES**	☐ **NO**	Which?	What Amount?
3. Has anyone closed bank accounts or other investments, added anyone to the title of an asset, given away assets or property, or liquidated assets greater than $3,000 to buy another asset or service in the last 5 years?	☐ **YES**	☐ **NO**	Who? What?	When? Value?

Section F – Income: Answer the following questions about those listed in Sections A and B who are applying for assistance.

1. Does anyone that you are applying for receive any type of income, such as: wages, tips, self-employment, Social Security/Railroad Retirement or Disability, SSI, other disability, VA income, pension, Civil Service, unemployment, child support, alimony, dividends, interest, stipend, money from another person, annuity, rent, workers' compensation, estate/trust, public assistance, grants, scholarships, student loans, reparations payments, training allowances, etc? (Include the income of parents living at home with minor child applicants and income of spouses and dependents of applicants if living in the home.) ☐ **YES** ☐ **NO** **If yes, list below:**

Individual	Type of Income	Name of Employer or Source of Income	Phone Number of Employer	Monthly Amount Before Deductions	How Often Received (weekly/biweekly/monthly)	Pay Day on What Day of the Week	Weekly # of Work Hours

2. Has anyone's income in the household ended in the last 60 days?	☐ **YES**	☐ **NO**	Who? When?	Source?

Section F – Income: Answer the following questions about those listed in Sections A and B who are applying for assistance.				
3. Will anyone in your household receive additional income from the source that ended?	☐ **YES**	☐ **NO**	Who? When?	Gross amount (before deductions) received in this month only? $
4. Does anyone have a pending application for Social Security or Unemployment Compensation benefits?	☐ **YES**	☐ **NO**	Who?	Which Benefit?
5. Have deposits been made to Income or Miller Type Trusts in any of the past 3 months?	☐ **YES**	☐ **NO**	Whose Trust?	Date(s) and Amount(s) of Deposit(s):

Section G – Expenses: Answer the following questions about those listed in Sections A and B who are applying for assistance.

1. Is anyone that you are applying for required to pay expenses, such as: rent, mortgage, property tax, homeowner's insurance, condo/maintenance fees, gas, electric, fuel, LIHEAP, medical bills such as but not limited to: prescriptions, glasses, transportation, doctor visits, dental, health aides, hospitalization, or insurance or Medicare premiums not covered by insurance or another third party, telephone, day (child) care, or court ordered child support for a child not in your household? Include the expenses of parents of minor child applicants if living in the home and expenses of spouse of applicants if the spouse is living at home. ☐ **YES** ☐ **NO** **If yes, list below:**

Type of Expense	Who is Obligated to Pay This Expense	If a Medical Expense, Who Received the Medical Service?	Monthly Amount	Paid to Whom	Date Paid	Still Owed?	For Court Ordered Child Support Only, Name of Child for Whom Support is Paid
						☐ **YES** ☐ **NO**	
						☐ **YES** ☐ **NO**	
						☐ **YES** ☐ **NO**	
						☐ **YES** ☐ **NO**	

2. How do you heat or cool your home?

3. Does anyone help you pay expenses? ☐ **YES** ☐ **NO** **If yes, explain:**

YOU CAN APPLY TO REGISTER TO VOTE HERE

If you are not registered to vote where you live now, would you like to register to vote here today? Check YES if you would like to apply to register to vote or update your voter registration information. If you check the NO box or do not check a box, you will be considered to have decided not to apply to register to vote or update your voter registration information. Checking YES, NO, or leaving this question blank will not affect your receipt of benefits. ☐ **YES** ☐ **NO**

NOTICE OF RIGHTS

Help: If you would like help in filling out your voter registration application, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration application in private.

Benefits: If you are applying for public assistance from this agency, applying to register, or declining to register to vote will not affect the amount of assistance you will be provided by this agency.

Privacy: Your decision not to register or update your record and the location where you applied to register or update your voter registration record is confidential and may only be used for voter registration purposes.

Formal Complaint: If you believe someone has interfered with either your right to apply to register or to decline to register to vote, your right to privacy in deciding whether to apply to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with: Florida Secretary of State, Division of Elections, NVRA Administrator, R.A. Gray Building, 500 S. Bronough Street, Tallahassee, Florida 32399-0250. Forms for filing a complaint are available at http://election.dos.state.fl.us/nvra/index.shtml or call 1-850-245-6200.

[Authority: National Voter Registration Act (42 U.S.C. 1973 gg); ss. 97.023, 97.058 and 97.0585, F.S.]

YOU MAY BE ELIGIBLE FOR REDUCED TELEPHONE RATES

Check YES if you would like DCF to release your Name, SSN, Phone Number, and the fact that you receive food assistance, Temporary Cash Assistance, or Medicaid to the local telephone company so you may receive a reduced telephone rate through the Lifeline Program. ☐ **YES** ☐ **NO**

NOTICE OF PENALTIES

You may be subject to prosecution for knowingly providing incorrect information to receive public assistance benefits.

REPORTING REQUIREMENTS

You must report any change in your situation according to program requirements to DCF. Food assistance households are required to report changes that increase benefits and food assistance households with a member disqualified for breaking program rules, felony drug trafficking, running away from a felony warrant, or not participating in a work program must report when the household's monthly income exceeds the food assistance gross income limit for the household size. Households receiving Medicaid or Temporary Cash Assistance must continue to report changes that could affect eligibility within 10 days.

IMPORTANT INFORMATION FOR IMMIGRANTS

Applying for or receiving food assistance benefits or Medicaid will not affect you or your family members' immigration status or ability to get permanent resident status (green card). Receiving Temporary Cash Assistance or long–term institutional care such as nursing home benefits might create problems with getting that status, especially if the benefits are your family's only income.

NOTICE OF PENALTIES – Food Assistance:

If you are found guilty (by a state or federal court, or an administrative disqualification hearing, or sign a hearing waiver) of intentionally making a false or misleading statement, concealing or withholding facts in order to receive or in an attempt to receive food assistance or committing any act that violates the Food and Nutrition Act, food assistance regulations, or any state statute for purposes of using, presenting, transferring, acquiring, receiving, or possessing food assistance benefits, you will be disqualified. You will be ineligible for food assistance for 12 months for the first violation, 24 months for the second violation and permanently for the third violation. If you are convicted of trafficking in food assistance benefits of $500 or more, you will be disqualified permanently. If you are convicted of these acts, depending on the severity, you may be fined up to $250,000, imprisoned for up to 20 years, or both.

If you are convicted by a state or federal court of making a fraudulent statement with respect to identity or residency in order to receive food assistance in more than one state at the same time, you will be ineligible to participate in the Food Assistance Program for a period of 10 years.

If you are fleeing to avoid prosecution, custody, or confinement, after conviction for a crime or an attempt to commit a crime, which is a felony, or are in violation of probation or parole imposed under a federal or state law, you are ineligible for food assistance. 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 you are found guilty of a drug-trafficking felony, or convicted by a federal, state, or local court of trading firearms, ammunition, or explosives for food assistance benefits, you are ineligible for food assistance.

NOTICE OF PENALTIES – Temporary Cash Assistance:

If you intentionally give false information or hide information to receive or continue to receive Temporary Cash Assistance and are convicted by a state or federal court or by an administrative disqualification hearing, or sign a hearing waiver, you may be disqualified for 12 months for the first violation, 24 months for the second violation and permanently for the third violation.

If you are found guilty of a drug-trafficking felony, or fleeing to avoid prosecution, custody or confinement, after conviction for a crime or an attempt to commit a crime which is a felony, or are in violation of probation or parole imposed under a federal or state law, you are ineligible for Temporary Cash Assistance. If you are convicted by a state or federal court of making a fraudulent statement with respect to identity or residency in order to receive Temporary Cash Assistance in more than one state at the same time, you will be ineligible to participate in the Temporary Cash Assistance program for a period of 10 years.

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES NON-DISCRIMINATION STATEMENT

No person shall, on the basis of race, color, religion, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to unlawful discrimination under any program or activity receiving or benefiting from federal financial assistance and administered by the Department. To file a complaint, alleging violations of this policy, contact the Office of Civil Rights, Florida Department of Children and Families, 1317 Winewood Boulevard, Tallahassee, Florida 32399-0700 or call 1-850-487-1901, or TDD 1-850-922-9220.

USDA-HHS NON-DISCRIMINATION STATEMENT

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 of discrimination, contact USDA or HHS. Write USDA, Director, Office of Adjudication, 1400 Independence Avenue, S. W., Washington, D. C. 20250-9410 or call toll free (866) 632-9992 (voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201or call (202) 619-0403 (voice) or (202) 619-3257 (TTY). USDA and HHS are equal opportunity providers and employers.

SUBMITTING THE APPLICATION FOR ASSISTANCE

An Application for Assistance may be submitted to any Department of Children and Families Economic Self-Sufficiency Services office in the State of Florida by you, or by someone acting for you, in person, by mail, by facsimile (FAX), or electronically through the internet. Applications received during normal business hours are considered received the same day. When an application is received after normal business hours, it will be considered received on the first business day following its receipt.