APPLICATION FOR BENEFITS

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

- Please read the entire application form.
- Print the requested information in the unshaded sections.
- If you need help, another person can help you or you can get help from your county assistance office.
- We will accept your application during normal business hours.

You may apply for cash, medical assistance and/or food stamps using this form. If we deny your application for cash and/or medical benefits, or stop your cash and/or medical benefits, you will not have to file a new application to receive or continue to receive food stamps.

We will start your application if you complete your name, address and signature. However, you need to answer all the questions on this form before we can determine if you are eligible for benefits.

After you fill out the form, sign and date it, then bring it, have someone else bring it, or mail it to the county assistance office. If you return your application by mail, you will receive further instructions on how to complete the application process. We will tell you if you need a face to face interview. You will need to prove your identity. If you need help to prove any information, ask the county assistance office for help.

We will tell you if you are eligible within 30 days of receiving your application. Food stamp eligibility starts from the day we receive your application. If you are applying for cash assistance, and you are eligible, your benefits will begin on the date we receive all the information we requested from you. However, if you need an interview and do not appear for the interview or contact us within 30 days of the date we receive your application, your application will be denied.

If you are applying for cash assistance, you and the caseworker who interviews you will complete an Agreement of Mutual Responsibility. This agreement stresses the temporary nature of cash assistance and explains the steps you must take to support yourself and your family without welfare.

Applications for medical assistance may be submitted by medical assistance providers or other agencies chosen by our department.

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.

PLEASE READ REVERSE SIDE OF THIS PAGE

PLEASE READ AND REMOVE THIS PAGE BEFORE COMPLETING APPLICATION

FOOD STAMPS NOW

DOES YOUR HOUSEHOLD HAVE $100 OR LESS IN AVAILABLE CASH AND BANK ACCOUNTS AND EXPECT TO RECEIVE LESS THAN $150 IN INCOME THIS MONTH?

ARE YOU A MIGRANT OR SEASONAL FARM WORKER?

ARE YOUR MONTHLY GROSS INCOME AND CASH ON HAND LESS THAN YOUR RENT/MORTGAGE AND UTILITY COSTS FOR THIS MONTH?

IF THE ANSWER TO ANY OF THESE QUESTIONS IS YES, YOU MAY HAVE A RIGHT TO **EXPEDITED FOOD STAMPS.** This means you can get Food Stamps within 5 days. Ask for more information by contacting the local County Assistance Office.

FILE YOUR FOOD STAMP APPLICATION TODAY! It is **YOUR RIGHT** to file an application today at **ANY TIME** before 5 p.m. The person at the County Assistance Office should date-stamp your application while you watch.

If you are denied expedited food stamps, you have the right to an agency conference within two working days with a supervisor at the County Assistance Office.

If you feel you are being denied your rights or services, or if the County Assistance Office does not take your application when you hand it in, and date-stamp it while you watch, ask to talk with a supervisor or call the HELPLINE toll free at **1-800-692-7462.**

YOU CAN GET FREE LEGAL HELP AT THE LOCAL LEGAL SERVICES OFFICE.

This is an equal opportunity program. If you believe you have been discriminated against because of race, color, national origin, age, sex, disability, political beliefs, or religion, write immediately to the Secretary of Agriculture, Washington, D.C. 20250.

CHECK WHICH BENEFITS YOU WANT TO RECEIVE

☐ CASH ASSISTANCE ☐ FOOD STAMPS ☐ MEDICAL ASSISTANCE

☐ OTHER _____

☐ YES ☐ NO IF YOU ARE NOT ELIGIBLE FOR MEDICAL ASSISTANCE DO YOU WANT A REFERRAL TO THE CHILDRENS HEALTH, INSURANCE PROGRAM?

☐ YES ☐ NO DO YOU WANT AN INTERPRETER? WHAT LANGUAGE

☐ YES ☐ NO DO YOU NEED YOUR NOTICES IN SPANISH?
~NECESITA SUS AVISOS EN ESPANOL?

☐ YES ☐ NO ARE YOU A MIGRANT OR SEASONAL FARM WORKER?

☐ YES ☐ NO ARE YOU HOMELESS OR WITHOUT A PERMANENT HOME?

☐ YES ☐ NO HAVE YOU EVER BEEN DISQUALIFIED OR AGREED TO BE DISQUALIFIED FOR FOOD STAMPS OR CASH ASSISTANCE IN ANOTHER STATE?

☐ YES ☐ NO IF YOU ARE APPLYING FOR FOOD STAMPS AND ARE ELDERLY DISABLED OR HOMELESS, DO YOU WANT TO USE YOUR FOOD STAMPS TO **PURCHASE MEALS IN RESTAURANTS?**

IF YOU HAVE A WELFARE CASE NUMBER IN PENNSYLVANIA - WRITE IT HERE

ADDRESS | HOW LONG AT THIS ADDRESS YEARS MONTHS

CITY | STATE | ZIP CODE PLUS 4

TELEPHONE NUMBER | SCHOOL DISTRICT | TOWNSHIP

PREVIOUS ADDRESS (Street, City, State)

☐ YES ☐ NO HAVE YOU LIVED IN PENNSYLVANIA FOR THE LAST 12 MONTHS?
IF NO, HOW MANY MONTHS HAVE YOU LIVED IN PENNSYLVANIA? → MONTHS
IF LESS THAN 2 MONTHS, WHEN DID YOU MOVE TO PA? MO DAY YR

☐ YES ☐ NO **HAVE YOU EVER APPLIED FOR OR RECEIVED BENEFITS IN ANOTHER STATE?** IF YES — STATE | COUNTY; RECORD #; DATES RECENED FROM TO

☐ YES ☐ NO **HAVE YOU EVER APPLIED FOR BENEFITS** USING A DIFFERENT NAME OR SOCIAL SECURITY NUMBER?

SIGNATURE OF APPLICANT OR REPRESENTATIVE

X _____ DATE

OTHER PROGRAMS

CHECK ANY YOU ARE INTERESTED IN:

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

PROVIDER USE ONLY

PROVIDER NAME | PROVIDER NUMBER

☐ INPATIENT ☐ OUTPATIENT ☐ EMERGENCY

☐ **NON APPLICABLE**

COUNTY ASSISTANCE OFFICE USE

☐ MAIL ☐ **WALK IN**		**FILE CLEAR BY/ DATE**	**SCREEN BY i DATE**	
COUNTY	**DISTRICT**	**APPLICATION REG #**	**DATE STAMP**	CAT
WORKER ID	**CASELOAD**	**RECORD NUMBER**	**2nd DATE**	**CAT**
NAME				
DD BANK # - CASH	**DD BANK # - FS**	**APPOINTMENT DATE / TIME** A M P		

☐ **APPLICATION** ☐ ADD ON

	AUTHORIZED	NOT AUTHORIZED
DATE		
BY		
CAT		
REASON CODE		

COMPLETE THIS PAGE FOR YOURSELF AND EVERYONE WHO LIVES WITH YOU, EVEN IF THEY ARE NOT APPLYING.

PLEASE STATE WHY YOU **ARE APPLYING:** _____

Name any person who lives with you but is temporarily staying somewhere else
If you are applying for this person, also list the person below

PLEASE PRINT ALL INFORMATION

COUNTY OFFICE USE Line #	File Clearance	PRINT YOUR NAME FIRST: LAST NAME	FIRST NAME	Middle Initial	JR / SR I,II	ARE YOU APPLYING FOR THIS PERSON?	ALIAS MAIDEN NAME FORMER MARRIED NAME	BIRTHDATE MO DAY YR	AGE	SEX M/F	SOCIAL SECURITY NUMBER	HOW IS THIS PERSON RELATED TO YOU?
						☐ YES ☐ NO						SELF
						☐ YES ☐ NO						
						☐ YES ☐ NO						
						☐ YES ☐ NO						
						☐ YES ☐ NO						
						☐ YES ☐ NO						
						☐ YES ☐ NO						
						☐ YES ☐ NO						
						☐ YES ☐ NO						
						☐ YES ☐ NO						

You must sign this statement for each person for whom you are applying who is a citizen of the U.S. or an alien in lawful immigration status. An alien who is applying only for emergency medical assistance is not required to sign this certification

I certify that, subject to penalties provided by law, by signing my name, that these persons are U S citizens or aliens in lawful immigration status.

SIGNATURE | DATE

FOR RACE

USE ONE OF THE FOLLOWING CODES. YOUR BENEFITS WILL NOT BE AFFECTED IF YOU DO NOT ANSWER,

1 BLACK
2 HISPANIC
3 NORTH AMERICAN INDIAN OR ALASKAN NATIVE
4 ASIAN OR PACIFIC ISLANDER
WHITE (NOT HISPANIC)
OTHER

CHECK STATUS OF EACH PERSON	VETERAN STATUS	MARITAL STATUS		MEDICAL INSURANCE			
1 US CITIZEN 2 PERM ALIEN 3 TEMP ALIEN 4 REFUGEE 5 ILLEGAL ALIEN	NON-VETERAN ACTIVE MILITARY NATIONAL GUARD RESERVES	SINGLE MARRIED COMMON-LAW MARRIAGE SEPARATED DIVORCED WIDOWED	RACE CODE	MEDICARE (A) A BLUE CROSS BLUE SHIELD OTHER COMPANY NAME HMO / HIO CHAMPUS AUTO	INSURANCE POLICY NUMBER	MEDICARE CLAIM NUMBER	DOES THIS PERSON HAVE A PA ACCESS CARD YES NO

VOTER REGISTRATION

ARE YOU OR ANY OTHER ADULT(S) IN YOUR HOUSEHOLD INTERESTED IN REGISTERING TO VOTE? LIST ALL ADULT MEMBERS OF YOUR HOUSEHOLD IF YOU DO NOT CHECK A BOX, YOU OR ANY OTHER ADULT(S) WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.
IF YOU OR ANY OTHER ADULT(S) IN YOUR HOUSEHOLD ARE ALREADY REGISTERED TO VOTE WHERE YOU LIVE, PLEASE CHECK THE "ALREADY REGISTERED" BOX.

In order to be qualified to register to vote you must be at least 18 years of age on the day of the next election you must have been a citizen of the United States for at least one month PRIOR TO THE NEXT ELECTION and have resided in Pennsylvania and the election district where you plan to vote for at least 30 days prior to the next election AND YOU MUST NOT HAVE BEEN CONFINED TO A PENAL INSTITUTION FOR A CONVICTION OF A FELONY WITHIN THE LAST FIVE YEARS

LINE No CAO ONLY	YES	NO	ALREADY REGISTERED	LAST NAME	FIRST NAME

LINE NO. CAO ONLY	YES	NO	ALREADY REGISTERED	LAST NAME	FIRST NAME

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency. All information will be used only for voter registration purposes.

If you register to vote, the office at which you submit this registration application will remain confidential. If you decline or do not wish to register to vote, the fact that you have declined to register will remain confidential.

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

DO NOT COMPLETE - COUNTY ASSISTANCE OFFICE USE

☐ **GIVEN TO CLIENT** / / DATE

☐ HAND CARRIED TO **COUNTY VOTER REGISTRATION** / / DATE

☐ MAILED TO COUNTY **VOTER REGISTRATION OFFICE** / / DATE

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 Has anyone in your household ever been issued a summons or a warrant to appear as a defendant at a criminal court proceeding?
   Household member(s) _____

If you are applying only for Medical Assistance, you do not have to answer any further questions in this section.

2. ☐ Yes ☐ No Has anyone in your household ever been convicted of a felony or a misdemeanor offense?
   Household member(s) _____
   ☐ Yes ☐ No If yes, was it a felony conviction after August 22, 1996 for the possession, distribution and/or use of a controlled substance?
   ☐ Yes ☐ No If your answer to # 2 was yes, was the conviction for welfare fraud?
3. ☐ Yes ☐ No Has anyone in your household ever been sentenced for a felony or a misdemeanor offense and charged criminal fines, or costs, or ordered to make restitution related to a criminal conviction?
   Household member(s) _____
4. ☐ Yes ☐ No Has anyone in your household ever been placed on probation or parole?
   Household member(s) _____
5. ☐ Yes ☐ No Are you or anyone in your household currently fleeing from law enforcement officials?
   Household member(s) _____

ANSWER ALL YES AND NO QUESTIONS - FOR YES ANSWERS, COMPLETE THE UNSHADED BLOCKS

RFUG

☐ YES ☐ **NO Is there anyone who is not a United States citizen?**

NAME OF PERSON WHO IS NOT A CITIZEN	DATE ENTERED THE US	FROM WHAT COUNTRY	ALIEN REGISTRATION NUMBER	INS SECTION

☐ YES ☐ **NO Does anyone listed above have a sponsor'?**

SPONSOR NAME (Last, First Middle)	ORGANIZATION NAME	SPONSOR OR ORGANIZATION ADDRESS (Street, City, State, Zip Code)	
SPONSOR'S INCOME / RESOURCES ▶	TYPE / SOURCE	HOW MUCH	HOW OFTEN

SCH

☐ YES ☐ NO **Is anyone who is age 16 or older a student in high school, college, training, or vocational school?**

NAME	NAME OF SCHOOL	TYPE OF SCHOOL	PART TIME OR FULL TIME ✓	EXPECTED GRAD. DATE
			☐ PART TIME ☐ FULL TIME	MONTH DAY YEAR
			☐ PART TIME ☐ FULL TIME	
			☐ PART TIME ☐ FULL TIME	

VET / SVI

List anyone who is a veteran or who is active in the military, national guard, or reserves.

NAME	SOCIAL SECURITY NUMBER	BRANCH OF SERVICE	DATE ENTERED	DATE LEFT	VETERAN CLAIM it
			MONTH DAY YEAR	MONTH DAY YEAR	

☐ YES ☐ NO **Is anyone a widow, parent, spouse, or minor child of a veteran?**

NAME	NAME OF VETERAN	BRANCH OF SERVICE	DATE ENTERED	DATE LEFT	VETERAN CLAIM *
			MONTH DAY YEAR	MONTH DAY YEAR	

DIS / INC

☐ YES ☐ NO Is anyone disabled, blind, seriously ill, or in need of special medical care to help overcome a drug or alcohol problem?

☐ YES ☐ NO Is anyone receiving treatment for a drug or alcohol problem?

☐ YES ☐ NO Is anyone receiving protective services because of domestic violence?

☐ YES ☐ NO Has anyone applied for Social Security or SSI (Supplemental Security Income)?

☐ YES ☐ NO Does a parent have a physical or mental disability, illness or impairment which affects his or her ability to support or care for his or her child?

NAME	DESCRIBE THE DISABILITY	DATE DISABILITY BEGAN
		MONTH DAY YEAR

IF YOU ARE APPLYING FOR ONLY FOOD STAMPS, SKIP PAGES 6 AND 7

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 THIS PERSON IS RELATED TO YOU
		☐ MALE ☐ FEMALE				

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 IT IS 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 THIS PERSON IS RELATED TO YOU
		☐ MALL ☐ FEMALE				

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 it 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 IT IS PAID	DATE OF ORDER (MO DAY YR)	WHAT ARE THE SPECIAL TERMS IF ANY	COURT NAME
FOR COURT ORDERED SUPPORT		$				

ENTER INFORMATION FOR ADDITIONAL PARENTS AND/OR A SPOUSE NOT LIVING IN YOUR HOUSEHOLD ON THE NEXT PAGE.

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

3

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

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

4

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

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

IF YOU HAVE MORE RELATIVES TO LIST - ASK THE RECEPTIONIST FOR AN EXTRA PAGE

ANSWER ALL YES AND NO QUESTIONS - FOR YES ANSWERS, COMPLETE THE UNSHADED BLOCKS

WRK HST

☐ YES ☐ NO 1. Are you or anyone else in your household currently employed?
☐ YES ☐ NO 2. Did you or anyone else in your household have a reduction in the number of hours of work to less than 30 hours per week?
☐ YES ☐ NO 3 Have you or anyone else in your household been employed in the last five years?

If "yes" complete the unshaded blocks

NAME	HIGHEST SCHOOL GRADE COMPLETED	EMPLOYER S NAME	EMPLOYER S ADDRESS (Street City State Zip)	PHONE	START DATE MO /DAY YR	END DATE MO / DAY/ YR	# OF HOURS WORKED PER WEEK

☐ YES ☐ NO Is anyone on strike? If yes, who? When did the strike start? MO DAY YR

HIPP

☐ YES ☐ NO If you or anyone else in your household is 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 or seriously ill?

NAME	ILLNESS	PREGNANCY DUE DATE

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

MISC

Does anyone have any of the following resources?

☐ YES ☐ NO Cash-on-hand (01)
☐ YES ☐ NO Savings Account (02)
☐ YES ☐ NO Checking Account (03)
☐ YES ☐ NO Certificate of Deposit (26)
☐ YES ☐ NO Savings Certificate (26)
☐ YES ☐ NO U.S. Savings Bonds (05)
☐ YES ☐ NO Christmas or Vacation Club (04)
☐ YES ☐ NO Stocks or Bonds (05)
☐ YES ☐ NO Trust Fund (06)
☐ YES ☐ NO Boat / Snowmobile / Camper (14)
☐ YES ☐ NO Individual Development Account (Educational Savings Account) (1 6)
☐ YES ☐ NO IRA, KEOGH or other retirement plan (27)
☐ YES ☐ NO Other (99)

NAME OF OWNER	TYPE ACCOUNT 4 / LOCATION OF THE RESOURCE	CURRENT VALUE	NAME OF OWNER	TYPE / ACCOUNT # / LOCATION OF THE RESOURCE	CURRENT VALUE
		$			$
		$			$
		$			$

☐ YES ☐ **NO Is anyone expecting money or any type of resource such as an accident settlement, inheritance, trust fund or other resource?**

If yes, type of property **Value** **When to be received, date**

☐ **YES** ☐ **NO Has anyone sold, transferred, or given away a home, land, or personal property or other resources in the past 36 months?**

If yes, describe the type of resource **Value** **Date**

ANSWER ALL YES AND NO QUESTIONS - FOR YES ANSWERS, COMPLETE THE UNSHADED BLOCKS

MV

☐ YES ☐ **NO Does anyone own or is anyone buying a car, truck, motorcycle?** If you have a recreational vehicle such as a camper, boat or motor home list it as a **MISC RESOURCE** on page 8

NAME(S) OF OWNER	YEAR	MAKE	MODEL	LICENSED	LICENSE PLATE NUMBER	AMT OWED	MONTHLY CAR PAYMENT	INSURANCE POLICY #
				☐ YES ☐ NO				
				☐ YES ☐ NO				
				☐ YES ☐ NO				
				☐ YES ☐ NO				
				☐ YES ☐ NO				
				☐ YES ☐ NO				

INS

☐ **YES** ☐ **NO Does anyone have a life insurance policy? (SKIP THIS BLOCK IF YOU ARE APPLYING FOR FOOD STAMPS ONLY)**

POLICY OWNER	NAME OF INSURANCE COMPANY / POLICY NUMBER	FACE VALUE	CASH VALUE	WHO IS COVERED
			$	
			$	
			$	
			$	

☐ YES ☐ NO **Is anyone covered by an accident policy? (Do not list medical or car insurance here)**

BRL

☐ **YES** ☐ **NO Does anyone own a burial space or plot?**

OWNER OF SPACES	NUMBER OF SPACES	VALUE	AMOUNT OWED	NAME OF CEMETERY
		$	$	
		$	$	

☐ YES ☐ NO Does anyone have a burial or trust agreement with a bank or funeral home?

OWNER OF AGREEMENT	BANK FUNERAL HOME NAME	BANK FUNERAL HOME ADDRESS (Street, City, State, Zip)

ANSWER ALL YES AND NO QUESTIONS - FOR YES ANSWERS, COMPLETE THE UNSHADED BLOCKS

PROP

YES ☐ **NO** ☐ **Does anyone own or is anyone buying a home, land, or nonresident property?**

YES ☐ NO ☐ **Does anyone listed as an absent relative on page 6 or 7 own a home, land, or non-resident property?**

NAME	DATE PURCHASED	MARKET VALUE	NAMES ON DEED / AGREEMENT
	MONTH DAY YEAR	$	

PROPERTY ADDRESS (Street, Township, City, State, Zip)

NAME	DATE PURCHASED	MARKET VALUE	NAMES ON DEED / AGREEMENT
	MONTH DAY YEAR	$	

PROPERTY ADDRESS (Street, Township, City, State, Zip)

MOBL HOME

YES ☐ NO ☐ **Does anyone own or is anyone buying a mobile home?**

Complete the above section if you also own or are buying the land for the mobile home

NAME	YEAR	MAKE	DATE PURCHASED
			MONTH DAY YEAR

NAMES ON THE TITLE	PROPERTY ADDRESS (Street, Township, City, State, Zip)

M ED EXP

List any UNPAID medical bills.

NAME OF PERSON WITH BILL	FREQUENCY	AMOUNT TO BE PAID	WHO PROVIDED SERVICE	TYPE OF BILL (Dr., Hospital, Prescriptions, etc.)	DATE OF SERVICE
		$			MONTH DAY YEAR
		$			
		$			

List any medical bills PAID in the last three months prior to the month of application and/or any PAID in the month of application.

NAME OF PERSON WHO PAID BILL	FREQUENCY	AMOUNT	WHO PROVIDED SERVICE	TYPE OF BILL (Dr., Hospital, Prescriptions, etc.)	DATE PAID
		$			MONTH DAY YEAR
		$			
		$			
		$			

ANSWER ALL YES AND NO QUESTIONS - FOR YES ANSWERS, COMPLETE THE UNSHADED BLOCKS

SHEL

☐ YES ☐ NO Do you pay for heat or cooling?

☐ YES ☐ NO Are you billed separately for your heating or cooling?

☐ YES ☐ NO Did you get Energy Assistance (LIHEAP) since October 1st?

☐ YES ☐ NO Do you have utility costs other than heating, cooling, or phone?

☐ YES ☐ NO Are your meals included in your rent?

☐ YES ☐ NO Do you live in subsidized housing?

☐ YES ☐ NO Do you share expenses?

If yes, with whom?

What expenses are shared (rent/utilities or both) ▶

How much is contributed?

LIST YOUR HOUSEHOLD EXPENSES

EXPENSE	HOW MUCH	HOW OFTEN	EXPENSES	HOW MUCH	HOW OFTEN	EXPENSES	HOW MUCH	HOW OFTEN
RENT OR MORTGAGE	$		TELEPHONE	$		WATER	$	
PROPERTY TAXES (City, County, School)	$		ELECTRIC	$		SEWERAGE	$	
HOMEOWNER'S PROPERTY INSURANCE	$		GAS	$		GARBAGE	$	
OTHER SUCH AS LOT RENT, CONDO FEES KEROSENE, ETC.	$		OIL/C0AL/WOOD	$		UTILITY INSTALLATION	$	

☐ Yes ☐ No Is there anyone outside your household who pays any expenses? If so what? How much? $ To whom?

INCOME

☐ YES ☐ **NO DOES ANYONE HAVE ANY INCOME?** If yes, list any income you have already received this month or expect to receive this month.

Income includes, but is not limited to:

WAGES, SELF EMPLOYMENT, BABYSITTING, ROOM AND BOARD, RENT, SOCIAL SECURITY, SSI, SUPPORT, SICK BENEFITS, UNEMPLOYMENT OR WORKERS 'COMPENSATION, MONEY FOR COLLEGE OR TRAINING, DIVIDENDS OR INTEREST, PENSIONS, COMMISSIONS, UNION PAY

NAME	TYPE / SOURCE OF INCOME	HOW MUCH	HOW OFTEN	DATE RECEIVED
		$		
		$		
		$		

List benefits anyone has applied for but has not received such as Unemployment Compensation, Worker's Compensations, Social Security, or SSL

NAME	TYPE / SOURCE OF INCOME	DATE APPLIED MONTH DAY YEAR	HOW MUCH	WHEN YOU EXPECT IT
		/ /	$	
		/ /	$	

For anyone who has care of a child or a disabled adult, list the expenses to be able to work, look for work, or go to school or training.

NAME OF PERSON WHO NEEDS CARE	NAME OF CARE GIVER	HOW MUCH	HOW OFTEN
		$	
		$	

List information about child support which you or another household member pays to a person who does not live with you.

NAME OF PERSON WHO PAYS	NAME OF CHILD	AMOUNT OF SUPPORT ORDER	AMOUNT ACTUALLY PAID	HOW OFTEN
		$	$	
		$	$	

List the expenses anyone has in order to receive income, such as transportation or legal fees.

NAME	ROUND TRIP MILES TO WORK	OTHER TRANSPORTATION COSTS	LEGAL FEES

COUNTY OFFICE USE ONLY

1 ☐ YES ☐ NO **Is anyone in the application group receiving food stamps and not in a certified shelter for battered women and children?**

2 ☐ YES ☐ NO **Is there any postponed verification from a previous expedited issuance that the household must provide?**

3 ☐ YES ☐ NO Are the household liquid resources equal to or less than $1 00?

4 ☐ YES ☐ NO Is the countable monthly gross Income less than $150?

5 ☐ YES ☐ NO Is this a migrant or seasonal farm worker household'?

6 ☐ YES ☐ NO Is the household destitute?

7 ☐ YES ☐ NO Are combined monthly gross income and liquid resources less than monthly shelter expenses?

EXPEDITED REVIEW	INITIALS	DATE

☐ ELIGIBLE ☐ DENIED CLIENT NOTIFIED

REASON FOR DENIAL

REGISTERED FOR CATEGORIES

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. It 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 PS. Section 483).
The CAD, 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 fall to provide certain verification. It 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 -- You must report changes in the number of people in your household, address, income, real property, or other resources (such as bank accounts or life insurance). You must report new employment or changes in your employment. You also must report any plans to leave the state, even temporarily.

If you receive cash and/or medical assistance benefits, you must report changes within 7 days.

If you are proven to have failed to report earned income in a timely manner, you will not receive an earned income deduction on the unreported income. This will reduce the amount of cash assistance and/or food stamps to which you are entitled and increase the amount of the overpayment claim.

For food stamps, you must report changes within 10 days unless you are in the Monthly Reporting System. You also must report any change in your residence and the resulting change, if any, in shelter costs.

If you are not sure if you must report a particular change, you should report the change. You can report to a member of the county assistance office staff in person, by telephone, 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 the amount of, your benefits (42 U.S.C. § 1320b-7).

PROHIBITIONS AND PENALTIES

You must <u>not:</u>

- 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 1 0 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 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 the 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.

If you need someone outside your household to apply for food stamps for you, complete this section.

FOOD STAMP AUTHORIZED REPRESENTATIVE NAME	SOCIAL SECURITY NUMBER
ADDRESS	PHONE NUMBER

If you need someone outside your household to **obtain food stamps or use them to buy food for you, complete this section.**

FOOD STAMP AUTHORIZED REPRESENTATIVE NAME	SOCIAL SECURITY NUMBER
ADDRESS	PHONE NUMBER

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 7 days for cash and medical assistance, and within 10 days for food stamps (unless in monthly reporting).
- 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 every 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, 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.

CLIENT OR AUTHORIZED REPRESENTATIVE SIGNATURES	DATE	ID	PROVIDER i 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

I WISH TO WITHDRAW MY APPLICATION FOR ☐ CASH ☐ FOOD STAMPS ☐ MEDICAL ☐ OTHER

SIGNATURE _____ DATE _____

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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.

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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 ($1 00), or to undergo imprisonment, not exceeding six months, or both (62 PS. Section 483).

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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.

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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 the amount of, your benefits (42 U.S.C. § 1320b-7).

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- 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 every 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, the information I gave is true, correct and complete to the best of my knowledge.

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- 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.

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.

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

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- jailed up to 20 years to food stamps and up to 7 yea s to cash

and/or

- required lo 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 the 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.