Esta es una solicitud de beneficios combinados. Si solicita únicamente SNAP (estampillas), conteste solo las preguntas relacionadas a SNAP.

Commonwealth of Virginia
Department of Social Services
APPLICATION FOR BENEFITS

Return your completed application to:
_____ County/City DSS
_____

GENERAL INFORMATION

With this application, you may apply for one or more of the following assistance programs:

- Auxiliary Grants (AG)
- Refugee Cash Assistance (RCA)
- Temporary Assistance for Needy Families (TANF)
- General Relief – Unattached Child (GR)
- Supplemental Nutrition Assistance Program (SNAP)
- TANF Diversionary Assistance (TANF DA)
- TANF Emergency Assistance (TANF EA)

Note that an application for TANF will be treated as an application for SNAP. Be sure to mark **TANF-No SNAP** in the **Household Composition** section if you only want to apply for TANF.

COMPLETING THE APPLICATION

If you need help completing this application, a friend or relative or your eligibility worker can help you. If you are completing this application for someone else, answer each question as if you were that person. If you need to change an answer or make a correction, write the correct information nearby and put your initials and date next to the change. If there are more than 6 people living in your home and you need more space to list everyone, tell the agency you need extra pages. If you have a disability or have difficulty with English, you may receive extra help to make sure you get the assistance or services you are eligible to receive.

COMPLETE AND ACCURATE INFORMATION

You must give complete, accurate, and truthful information. If you do not give needed information, we may not be able to determine your eligibility for assistance. If you knowingly give false, incorrect, or incomplete information, or fail to report changes, you could lose your benefits and be arrested, prosecuted, fined and/or imprisoned. If you knowingly give false, incorrect, or incomplete information to help someone else receive benefits, you could be arrested and prosecuted for fraud.

Cualquier persona en quien confie puede ayudarle a solicitar beneficios.
El Departamento de Servicios Sociales (DSS) y
los asesores de beneficios legítimos NUNCA te pedirán dinero por ayudarte con la solicitud.
Si alguien se ofrece a cargarle dinero para prepararle la solicitud,
probablemente no se debe confiar.

FILING THE APPLICATION

You may apply for benefits by leaving a completed application at the agency or by leaving a partially completed application with at least your name, address, and signature, or, for SNAP only, by tearing off and leaving the half-sheet on Page iii with your name, address, and signature. You must complete the rest of this application before your eligibility can be determined. For some programs, including SNAP, you must also be interviewed, but you may turn in your application before your interview. You may turn in your application any time during office hours the same day as you contact your local agency. You have the right to turn in your application even if it looks like you may not be eligible for benefits. This is important because, if you are eligible for the month in which you apply, your benefit amount will be based on the date you turn in your application.

No es necesario que complete la solicitud totalmente.
El Departamento de Servicios Sociales (DSS)
está obligado a ayudarle a completar el resto de la solicitud
siempre cuando entregue una copia con su nombre completo, dirección y firma.

VERIFICATION AND USE OF INFORMATION

Information you give on this application, including Social Security numbers (SSN), may be matched against federal, state, and local records. These records include:

- Virginia Employment Commission (VEC)
- Internal Revenue Service (IRS)
- Social Security Administration (SSA)
- Department of Motor Vehicles (DMV)
- US Citizenship and Immigration Services (USCIS)
- Income and Eligibility Verification System IEVS)

Cuando firme una solicitud para beneficios de SNAP,
usted también da su consentimiento para que el DSS busque registros en estas agencias
y comparta la información que recopile con ellas.

Any difference between the information you give and these records will be investigated. Information from these records may affect your eligibility and benefit amount. Information may be used to:

- determine the correctness, accuracy, and truthfulness of the application;
- verify your identity and citizenship; verify wages and salary, unemployment benefits, and unearned income, such as Social Security and Supplemental Security Income (SSI) benefits; verify quarters of coverage under Social Security for an alien, or to verify the status of aliens;
- prevent receipt of benefits from more than one social service agency at the same time;
- make required program changes;
- allow disclosure for official examination and to law enforcement officials to assist in apprehending persons fleeing to avoid the law; or
- assist in SNAP claims collection actions.

La información que el DSS recopila de otras agencias debe coincidir razonablemente
con la información que usted proporciona en esta solicitud.
Si existe alguna discrepancia entre las dos fuentes,
se le pedirá que presente pruebas que la expliquen.
Si no presenta pruebas que expliquen la discrepancia, existe el riesgo de que el DSS inicie
una investigación por fraude.
Las investigaciones por fraude que concluyan que un solicitante ha compartido
información falsa o engañosa de forma intencionada podrían resultar en la descalificación
del programa (se le notificará que ya no puede solicitar beneficios) o incluso en un proceso penal.

Your information may also be used or disclosed to study public benefit programs, such as SNAP or TANF.

Information regarding your race and ethnicity is not required and will not affect your eligibility or benefit amount. This information is requested to be sure that program benefits are provided without regard to race, color, or national origin.

NONDISCRIMINATION STATEMENT

In accordance with federal civil rights laws and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Programs that receive federal financial assistance from the U.S. Department of Health and Human Services (HHS), such as Temporary Assistance for Needy Families (TANF), and programs HHS directly operates are also prohibited from discrimination under federal civil rights laws and HHS regulations.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or who have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

CIVIL RIGHTS COMPLAINTS INVOLVING USDA PROGRAMS

USDA provides federal financial assistance for many food security and hunger reduction programs such as the Supplemental Nutrition Assistance Program (SNAP), the Food Distribution Program on Indian Reservations (FDPIR) and others. To file a program complaint of discrimination, complete the Program Discrimination Complaint Form, (AD-3027) found online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1. **mail**: Food and Nutrition Service, USDA
   1320 Braddock Place, Room 334, Alexandria, VA 22314; or
2. **fax**: (833) 256-1665 or (202) 690-7442; or
3. **phone**: (833) 620-1071; or
4. **email**: FNSCIVILRIGHTSCOMPLAINTS@usda.gov.

For any other information regarding SNAP issues, persons should either contact the USDA SNAP hotline number at (800) 221-5689, which is also in Spanish, or call the state information/hotline numbers (click the link for a listing of hotline numbers by state); found online at: SNAP hotline.

CIVIL RIGHTS COMPLAINTS INVOLVING HHS PROGRAMS

HHS provides federal financial assistance for many programs to enhance health and well-being, including TANF, Head Start, the Low Income Home Energy Assistance Program (LIHEAP), and others. If you believe that you have been discriminated against because of your race, color, national origin, disability, age, sex (including pregnancy, sexual orientation, and gender identity), or religion in programs or activities that HHS directly operates or to which HHS provides federal financial assistance, you may file a complaint with the Office for Civil Rights (OCR) for yourself or for someone else.

To file a complaint of discrimination for yourself or someone else regarding a program receiving federal financial assistance through HHS, complete the form on line through OCR's Complaint Portal at https://ocrportal.hhs.gov/ocr/. You may also contact OCR via mail at: Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201; fax: (202) 619-3818; or email: OCRmail@hhs.gov. For faster processing, we encourage you to use the OCR online portal to file complaints rather than filing via mail. Persons who need assistance with filing a civil rights complaint can email OCR at OCRMail@hhs.gov or call OCR toll-free at 1-800-368-1019, TDD 1-800-537-7697. For persons who are deaf, hard of hearing, or have speech difficulties, please dial 7-1-1 to access telecommunications relay services. We also provide alternative formats (such as Braille and large print), auxiliary aids and language assistance services free of charge for filing a complaint.

This institution is an equal opportunity provider.

INSTRUCTIONS FOR COMPLETING THE APPLICATION

1. Do not write in shaded areas. These areas are for agency use only.
2. Complete **SECTION A: APPLICANT INFORMATION.** Complete the grid in **SECTION B: Household Composition** for everyone who lives in your home, even if you are not applying for that person. You may leave questions about citizenship, immigration and Social Security Number blank for anyone for whom you are NOT requesting assistance.
3. Answer the questions in **SECTION C: INCOME** for everyone for whom you are applying. In addition, if you are applying for **TANF,** also provide income information for children age 18 or under, even if you are not applying for that child, and for the stepparent of the children for whom you are applying.
4. Answer the questions in **SECTION D: RESOURCES** for everyone for whom you are applying unless you are applying only for TANF.
5. After completing Sections A through D, answer the questions in the sections indicated below, depending on the type of assistance you are requesting.

TANF	**Section E,** page 5	**TANF Diversionary/Emergency Assistance**	**Section F,** page 6
SNAP	**Section G,** page 6	**Auxiliary Grants**	**Section H,** pages 7-8

6. Complete **SECTION I** for all programs if you want to have an Authorized Representative act on your behalf.
7. Read **CHANGE REPORTING AND PENALTIES** on pages 9-10.
8. Read and complete the last page of this application. Be sure to sign and date the application.

Debe incluir en esta solicitud a todas las personas que viven en su casa.
Si hay alguna persona que no solicita beneficios para sí misma
(porque no los desea o sabe que no cumple con los requisitos),
debe incluir su nombre y otros datos básicos,
pero NO es necesario que proporcione información sobre su ciudadanía,
estatus migratorio o número de seguro social.

No es obligatorio llenar esta sección,
pero puede se la recomiende llenar si necesita beneficios urgentemente.
Se utiliza para que el DSS determine quién califica para el procesamiento acelerado.

EXPEDITED SERVICE FOR SNAP BENEFITS

Your household may qualify for Expedited Service and receive SNAP benefits within 7 days if you are eligible. To qualify for Expedited Service: 1) your gross monthly income must be less than $150 and liquid resources $100 or less; 2) your monthly shelter bills must be higher than your household's gross monthly income plus your liquid resources; or 3) someone in your household must be a migrant or seasonal farm worker with little or no income and resources. **GIVE THE INFORMATION BELOW SO YOUR ELIGIBILITY FOR EXPEDITED SERVICE CAN BE DETERMINED.**

En esta casilla, debe incluir los datos del "jefe de familia".
El jefe de familia es la persona que usted
designe como contacto principal para
el Departamento de Servicios Sociales (DSS).
Debe nombrar a un adulto como jefe de familia,
incluso si no solicita beneficios para esa persona.

Name: Household Sample

Date of Birth: 01/01/1901

Address: 1000 Sample Road
Apt. 100 Richmond, VA 23219

Social Security Number: 555-55-5555 (Child A.)

Telephone Number: _____

_____ Signature:

_____ Date

Si el jefe de familia no tiene un número de seguro social,
entonces puede (1) omitir esta línea,
o (2) indicar el número de seguro social
del miembro de mayor edad del hogar
para el que solicita beneficios e
indicar el nombre de esa persona; vea el ejemplo.

Total income received/expected this month before deductions $_____

Incluya aquí todos los ingresos, ANTES de impuestos

Total cash, money in checking/savings accounts, CDs, etc. $_____

Total rent or mortgage for this month $

Utility expenses for this month $_____

Sume todos los gastos mensuales
de cada uno de los servicios públicos enumerados.

Which utilities do you pay? (check all that apply)

❑ Heat ❑ Lights ❑ Telephone ❑ Electricity for Air Conditioning
❑ Water ❑ Sewer ❑ Garbage ❑ Other

Is anyone in your household a migrant or seasonal farm worker? ❑ YES ❑ NO

El Departamento de Servicios Sociales (DSS) está obligado
a ayudarle a registrarse para votar, si usted lo desea,
pero no es obligatorio registrarse.

COMMONWEALTH OF VIRGINIA VOTER REGISTRATION AGENCY CERTIFICATION

If you are not registered to vote where you live now, would you like to apply to register to vote here today?
(Please check only one)

❑ I am already registered to vote at my current address, or I am not eligible to register to vote and do not need an application to register to vote.
❑ Yes, I would like to apply to register to vote. (Please fill out the voter registration application form)
❑ No, I do not want to register to vote.

Si no es ciudadano estadounidense, seleccione
"No, no quiero registrarme para votar".
Intentar registrarse para votar si no es ciudadano
estadounidense podría resultar en un proceso penal.

If you do not check any box, you will be considered to have decided **not to** register to vote at this time. Applying to register to vote or declining to register to vote will not affect the assistance or services that you will be provided by this agency.

If you decline to register to vote, this fact will remain confidential. If you do register to vote, the office where your application was submitted will be kept confidential, and it will be used only for voter registration purposes.

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 if you desire.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, you may file a complaint with: Secretary of the Virginia State Board of Elections, Washington Building, 1100 Bank Street, Richmond, VA 23219-3497, Telephone (804) 864-8901.

Applicant Name | **Signature** | **Date**

for agency use only

Voter Registration form completed: ❑ Yes ❑ No
Voter Registration form given to applicant for later mailing (at applicant's request) ❑ Yes ❑ No

Agency Staff Signature | Date:

No responda a las preguntas
que aparecen en la sección de color gris.

No responda a estas preguntas; esta sección es para DSS.

AGENCY USE ONLY		
CASE NAME		
CASE NUMBER		
LOCALITY	**SCREENER**	**DATE**

EXPEDITED SERVICE DETERMINATION

Income < $150 + resources ≤ $100 ❑ YES ❑ NO

Income + resources < shelter bills ❑ YES ❑ NO

For migrant or seasonal farm workers:

Resources ≤ $100 and ≤ $25 is expected in next 10 days from new income; ❑ YES ❑ NO

OR

Resources ≤ $100 and $0 income is expected from a terminated source for the rest of this month or next month. ❑ YES ❑ NO

EXPEDITE IF YES TO ANY OF THE ABOVE.

En esta sección, debe incluir información sobre la persona que desea nombrar el "jefe de familia".
El jefe de familia será a quien el DSS se comunique para obtener más información sobre el caso y será responsable de responder a cualquier solicitud del DSS.

Commonwealth of Virginia
Department of Social Services

APPLICATION FOR BENEFITS

Return your completed application to:
_____ County/City DSS
_____
_____

A. APPLICANT INFORMATION

Your Contact Information

Your Name (last, first, middle initial)

Your Street Address (include apartment number) | **City, State, ZIP**

Your Mailing Address (if different from your street address) | **City, State, ZIP**

In what city or county do you live? | **Email Address**

No es necesario que proporcione una dirección de correo electrónico.

Primary Telephone Number | **Alternate Telephone Number**

What is the primary language spoken in your household?

Todas las comunicaciones se realizarán en inglés a menos que usted indique que habla o lee otro idioma.

❑ English	❑ Vietnamese	❑ Laotian	❑ Somali	❑ French	❑ Other (specify):
❑ Spanish	❑ Farsi	❑ Chinese	❑ Kurdish	❑ German	_____
❑ Cambodian	❑ Haitian-Creole	❑ Korean	❑ Arabic	❑ Japanese	

Primary Method of Correspondence

Registrarse para recibir correspondencia electrónica no implica recibir notificaciones por correo electrónico. Simplemente recibirá una notificación de que hay una notificación disponible. Para acceder a la notificación, debe tener una cuenta de CommonHelp vinculada a esta aplicación. Si no desea recibir correos electrónicos, simplemente omita esta sección.

If you would like to receive either text or email messages notifying you that some notices about your benefits may be accessed electronically through CommonHelp (www.CommonHelp.Virginia.gov), select one of the choices below. List either a cell telephone number or an email address. Once you choose a preferred electronic method of correspondence, it will be used for all programs on the case for which you have applied. If you do not choose to be notified by text or email, you will receive all written correspondence through the U.S. mail. If you are completing this application on behalf of another individual as an authorized representative, all correspondence to you will be mailed. The applicant may contact the local department of social services to learn how to change the method of correspondence.

❑ **Text** ❑ **Email** **Cell Phone Number** _____ **Email Address** _____

Si ya tiene un caso registrado para otro programa de beneficios (por ejemplo, Medicaid o TANF), incluya aquí el número de identificación del caso.

❑ YES ❑ NO 1. Have you or anyone for whom you are applying ever applied for, or received, or are currently receiving any benefits from a social services agency, including SNAP (Food Stamps), TANF, Medicaid, General Relief, Auxiliary Grant, Foster Care, Adoption Assistance, or Refugee Cash Assistance? If **YES,** enter the information below.
Name:_____ Type of Benefit Received:_____
When:_____ From What County, City, or State:_____

Esta pregunta solo se refiere a personas que buscan beneficios para sí mismas.

❑ YES ❑ NO 2. Have you or anyone for whom you are applying ever been convicted of making false or misleading statements about your identity or address to receive TANF, SNAP, or Medicaid in two or more states at the same time? If **YES**, give date and place of conviction._____

La "descalificación" no es lo mismo que que le digan que no cumple los requisitos. Si le han comunicado que no puede solicitar prestaciones durante un período determinado, es posible que esté descalificado.

❑ YES ❑ NO 3. Have you or anyone for whom you are applying ever been disqualified from participating in TANF, SNAP, or Medicaid? If **YES**, give date and place of all disqualifications._____

❑ YES ❑ NO 4. Are you or anyone for whom you are applying in violation of parole or probation or fleeing capture to avoid prosecution or punishment of a felony? If **YES,** explain _____

Si la respuesta a esta pregunta es "no", indique igualmente "no" junto a cada subsección de la lista. Si la respuesta a alguna de las subsecciones es "sí", también debe indicar "sí" junto a la número 5.

❑ YES ❑ NO 5. Have you or anyone for whom you are applying ever been convicted of a felony as an adult on or after February 8, 2014 for the following:

a. Aggravated sexual abuse under Title 18 United States Code (USC), Section 2241 or a similar state offense? ❑ YES ❑ NO
b. Murder under Title 18 USC, Section 1111 or a similar state offense? ❑ YES ❑ NO
c. An offense under Title 18 USC, Chapter 110 (sexual exploitation and other abuse of children) or a similar state offense? ❑ YES ❑ NO
d. A federal or state offense involving sexual assault, as defined in Section 40002(a) of the Violence Against Women Act of 1994 (42 USC 13925(a)) ? ❑ YES ❑ NO

If **YES** to any of the above, who? _____.
If **YES** to any of the above, are you in compliance with the terms of the sentence? ❑ YES ❑ NO

Si tiene antecedentes penales pero no está seguro de si se ajustan a estas categorías, consulte sus documentos judiciales, que deberían enumerar las secciones legales correspondientes a los cargos.

B. HOUSEHOLD COMPOSITION: This section includes information about everyone living in your home, even if you are not applying for that person. You may leave the Social Security Number blank if you are not applying for assistance for the person. List yourself first.

La primera parte de esta sección debe enumerar a la persona que desea que sea el "Jefe de Familia".
Esta información debe ser sobre la misma persona que enumeró en la Sección A.

Debe proporcionar la fecha de nacimiento del cabeza de familia/jefe de familia, incluso si no solicita beneficios para esa persona.

1 APELLIDO, NOMBRE, H. | **Relationship to You**: Self | **Birth Date** (mm-dd-yyyy): 01/01/1901

Name (last, first, middle initial)

Social Security Number: --------

City, State, Country of Birth: -------

Gender: ☒ Male ☐ Female

Are you a U.S. citizen? ☐ Yes ☐ No

Marital Status: ☐ Married ☒ Never Married ☐ Separated ☐ Divorced ☐ Widowed

If No, immigration status: _____

US Residency Date: __/____/____

No es necesario que proporcione información sobre el lugar de nacimiento, la ciudadanía u otro estatus de una persona si no solicita beneficios para ella. Debe proporcionar esta información si solicita beneficios para esta persona.

No es necesario proporcionar información de su educación para poder participar en el programa SNAP.

Highest Grade Completed: ____

School Name if a Student: _____

Alien Registration Number: _____

Are you disabled or pregnant? ☐ Yes ☒ No

No está obligado a proporcionar un número de Seguro Social a menos que solicite beneficios para esa persona.

Are you a veteran or dependent? ☐ Yes ☒ No :

Are you temporarily living away from home? ☐ Yes ☒ No

Si esta persona es veterana o dependiente, marque "si" y rodee con un círculo la categoría que corresponda.
Si la persona tiene una discapacidad o está embarazada, marque "si" y rodee con un círculo la categoría que corresponda.
Si ninguna de estas categorías aplica, marque "no" en cada pregunta.

Program(s) Requested:

Si no desea solicitar beneficios para esta persona, seleccione "Ninguno".
Si desea solicitar beneficios para esta persona, seleccione "SNAP".
No marque ninguna otra casilla a menos que desee solicitar dichos beneficios.

☒ None ☐ AG ☐ GR ☐ RCA ☐ SNAP
☐ TANF ☐ TANF DA or EA ☐ TANF--No SNAP

Date Left___/___/_____ **Expected Return Date**___/____/____

Reason for being away:

Providing the following information is voluntary and will not affect eligibility. Please check all that apply.

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Racial Heritage: ☐ White ☐ Black/African American ☐ Asian ☐ Asian & Black/African American ☐ Asian & White ☐ American Indian/Alaskan Native ☐ Black/African American & White ☐ American Indian/Alaskan Native & White ☐ Native Hawaiian/Other Pacific Islander ☐ American Indian/Alaskan Native & Black ☐ Other/Unknown

No es necesario contestar preguntas sobre etnia para calificar para SNAP.

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2 EJEMPLO, niño, A. | **Relationship to Applicant**: hija | **Birth Date** (mm-dd-yyyy): 02/02/2011

Name (last, first, middle initial)

Social Security Number: 555-55-5555

City, State, Country of Birth: RICHMOND, VA USA

Gender: ☐ Male ☒ Female

Is this person a U.S. citizen? ☒ Yes ☐ No

Marital Status: ☐ Married ☒ Never Married ☐ Separated ☐ Divorced ☐ Widowed

If No, immigration status: _____

US Residency Date: __/____/____

Highest Grade Completed: ____

School Name if a Student: _____

Alien Registration Number: _____

Is this person disabled or pregnant? ☐ Yes ☒ No

Is this person a veteran or dependent? ☒ Yes ☐ No :

Is this person temporarily away from home? ☐ Yes ☒ No

Marque "si" para discapacidad si la persona recibe beneficios por discapacidad de la Administración del Seguro Social, la Administración de Jubilación Ferroviaria, la Administración de Veteranos o ha sido certificada como discapacitada por una agencia gubernamental.

Program(s) Requested:

☐ None ☐ AG ☐ GR ☐ RCA ☒ SNAP
☐ TANF ☐ TANF DA or EA ☐ TANF--No SNAP

Date Left___/___/_____ **Expected Return Date**___/____/____

Reason for being away:

Providing the following information is voluntary and will not affect eligibility. Please check all that apply.

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Racial Heritage: ☐ White ☐ Black/African American ☐ Asian ☐ Asian & Black/African American ☐ Asian & White ☐ American Indian/Alaskan Native ☐ Black/African American & White ☐ American Indian/Alaskan Native & White ☐ Native Hawaiian/Other Pacific Islander ☐ American Indian/Alaskan Native & Black ☐ Other/Unknown

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3 EJEMPLO, niño, B. | **Relationship to Applicant**: hijo | **Birth Date** (mm-dd-yyyy): 03/03/2013

Name (last, first, middle initial)

Social Security Number: 777-77-7777

City, State, Country of Birth: LIMA, PERU

Gender: ☒ Male ☐ Female

Is this person a U.S. citizen? ☐ Yes ☒ No

Marital Status: ☐ Married ☒ Never Married ☐ Separated ☐ Divorced ☐ Widowed

If No, immigration status: Residente Permanente

US Residency Date: 05/05/2015

Si esta solicitando beneficios para una persona con un estatus de no ciudadano que le permite calificar, indique la fecha en que se aprobó dicho estatus.

Alien Registration Number: A2222222

Highest Grade Completed: ____

School Name if a Student: _____

Is this person disabled or pregnant? ☒ Yes ☐ No

Is this person a veteran or dependent? ☒ Yes ☐ No :

Is this person temporarily away from home? ☐ Yes ☒ No

Program(s) Requested:

☐ None ☐ AG ☐ GR ☐ RCA ☒ SNAP
☐ TANF ☐ TANF DA or EA ☐ TANF--No SNAP

Date Left___/___/_____ **Expected Return Date**___/____/____

Reason for being away:

Providing the following information is voluntary and will not affect eligibility. Please check all that apply.

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Racial Heritage: ☐ White ☐ Black/African American ☐ Asian ☐ Asian & Black/African American ☐ Asian & White ☐ American Indian/Alaskan Native ☐ Black/African American & White ☐ American Indian/Alaskan Native & White ☐ Native Hawaiian/Other Pacific Islander ☐ American Indian/Alaskan Native & Black ☐ Other/Unknown

Si no está solicitando beneficios para otras personas, marque con una X las secciones por abajo para que nadie más pueda modificarla fácilmente.

Si necesita más de 6 espacios, incluya toda la información requerida en una hoja aparte y adjúntela a la solicitud.

Recuerde: Debe incluir en la solicitud a todas las personas que viven en el hogar y comparten las comidas. No es necesario que solicite beneficios para esas personas, pero deben estar incluidas en el hogar.

HOUSEHOLD COMPOSITION (continued)
If you need more space to list your household members, please ask for another form or write the information on a separate sheet.

4
Name (last, first, middle initial) **Relationship to Applicant** **Birth Date** (mm-dd-yyyy)
Social Security Number: **City, State, Country of Birth:**
Gender: ❑ Male ❑ Female **Is this person a U.S. citizen?** ❑ Yes ❑ No
Marital Status: ❑ Married ❑ Never Married If No, immigration status:
❑ Separated ❑ Divorced ❑ Widowed **US Residency Date:** __/____/____
Highest Grade Completed:____ **Alien Registration Number:**
School Name if a Student: **Is this person disabled or pregnant?** ❑ Yes ❑ No
Is this person a veteran or dependent? ❑ Yes ❑ No : **Is this person temporarily away from home?** ❑ Yes ❑ No
Program(s) Requested: **Date Left**___/___/____ **Expected Return Date**___/___/____
❑ None ❑ AG ❑ GR ❑ RCA ❑ SNAP **Reason for being away:**
❑ TANF ❑ TANF DA or EA ❑ TANF--No SNAP
Providing the following information is voluntary and will not affect eligibility. Please check all that apply.
Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino
Racial Heritage: ❑ White ❑ Black/African American ❑ Asian ❑ Asian & Black/African American ❑ Asian & White
❑ American Indian/Alaskan Native ❑ Black/African American & White ❑ American Indian/Alaskan Native & White
❑ Native Hawaiian/Other Pacific Islander ❑ American Indian/Alaskan Native & Black ❑ Other/Unknown

5
Name (last, first, middle initial) **Relationship to Applicant** **Birth Date** (mm-dd-yyyy)
Social Security Number: **City, State, Country of Birth:**
Gender: ❑ Male ❑ Female **Is this person a U.S. citizen?** ❑ Yes ❑ No
Marital Status: ❑ Married ❑ Never Married If No, immigration status:
❑ Separated ❑ Divorced ❑ Widowed **US Residency Date:** __/____/____
Highest Grade Completed:____ **Alien Registration Number:**
School Name if a Student: **Is this person disabled or pregnant?** ❑ Yes ❑ No
Is this person a veteran or dependent? ❑ Yes ❑ No : **Is this person temporarily away from home?** ❑ Yes ❑ No
Program(s) Requested: **Date Left**___/___/____ **Expected Return Date**___/___/____
❑ None ❑ AG ❑ GR ❑ RCA ❑ SNAP **Reason for being away:**
❑ TANF ❑ TANF DA or EA ❑ TANF--No SNAP
Providing the following information is voluntary and will not affect eligibility. Please check all that apply.
Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino
Racial Heritage: ❑ White ❑ Black/African American ❑ Asian ❑ Asian & Black/African American ❑ Asian & White
❑ American Indian/Alaskan Native ❑ Black/African American & White ❑ American Indian/Alaskan Native & White
❑ Native Hawaiian/Other Pacific Islander ❑ American Indian/Alaskan Native & Black ❑ Other/Unknown

6
Name (last, first, middle initial) **Relationship to Applicant** **Birth Date** (mm-dd-yyyy)
Social Security Number: **City, State, Country of Birth:**
Gender: ❑ Male ❑ Female **Is this person a U.S. citizen?** ❑ Yes ❑ No
Marital Status: ❑ Married ❑ Never Married If No, immigration status:
❑ Separated ❑ Divorced ❑ Widowed **US Residency Date:** __/____/____
Highest Grade Completed:____ **Alien Registration Number:**
School Name if a Student: **Is this person disabled or pregnant?** ❑ Yes ❑ No
Is this person a veteran or dependent? ❑ Yes ❑ No : **Is this person temporarily away from home?** ❑ Yes ❑ No
Program(s) Requested: **Date Left**___/___/____ **Expected Return Date**___/___/____
❑ None ❑ AG ❑ GR ❑ RCA ❑ SNAP **Reason for being away:**
❑ TANF ❑ TANF DA or EA ❑ TANF--No SNAP
Providing the following information is voluntary and will not affect eligibility. Please check all that apply.
Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino
Racial Heritage: ❑ White ❑ Black/African American ❑ Asian ❑ Asian & Black/African American ❑ Asian & White
❑ American Indian/Alaskan Native ❑ Black/African American & White ❑ American Indian/Alaskan Native & White
❑ Native Hawaiian/Other Pacific Islander ❑ American Indian/Alaskan Native & Black ❑ Other/Unknown

Complete esta sección para todos los miembros del hogar que reciben un salario por su trabajo. No incluya aquí beneficios gubernamentales, jubilación, desempleo, etc. Eso se incluirá en la siguiente sección.

C. INCOME

1. Do you or anyone who lives with you receive or expect to receive any of the following types of money from working? Include money from all jobs that you have now or expect to begin, full time, part time, seasonal, temporary, self-employment. Answer Yes or No below and provide the requested information:

Yes	No		Yes	No		Yes	No	
❑	❑	Wages/Salary	❑	❑	Earned Sick Pay	❑	❑	Domestic Work
❑	❑	Contract Income	❑	❑	Babysitting/Adult or child care	❑	❑	Self-employment
❑	❑	Vacation Pay	❑	❑	Farming/Fishing	❑	❑	Any other money from working
❑	❑	Commissions, Bonuses, Tips	❑	❑	Odd jobs			

a.

Name (last, first, middle initial) — Puede ser un rango, si cambia cada semana

Employer Name, Address and Telephone Number

Number of Hours Per Week

Rate of Pay

Pay Schedule
❑ Weekly ❑ Monthly ❑ Biweekly ❑ Twice a Month ❑ Other

Date Job Started

Next Pay Date (mm-dd-yyyy)

Sea lo más detallado posible. Si cobra por hora o recibe un salario, asegúrese de incluir esa información con la "tarifa de pago" (por ejemplo: $16 por hora o $250 por semana).

Si es posible, incluya sus ingresos brutos (ingresos antes de impuestos). Tenga a mano la documentación que lo acredite. Algunos ejemplos de documentación son:

- Recibos de nómina (al menos de un mes; dos meses si sus ingresos varían).
- Carta de su supervisor donde se indique su jornada laboral y sus ingresos.
- Declaración jurada donde se indique su jornada laboral y sus ingresos.

Si no tiene ingresos porque está desempleado, prepárese para presentar una declaración jurada que confirme cuánto tiempo lleva sin trabajo.

Si está desempleado y tiene entre 18 y 64 años, prepárese para explicar cómo cumple o está exento del requisito de trabajo (ver más abajo).

b.

Name (last, first, middle initial)

Employer Name, Address and Telephone Number

Number of Hours Per Week

Rate of Pay

Pay Schedule
❑ Weekly ❑ Monthly ❑ Biweekly ❑ Twice a Month ❑ Other

Date Job Started

Next Pay Date (mm-dd-yyyy)

❑ YES ❑ NO 2. Has anyone been fired, laid off, gone on sick or maternity leave, gone on strike, quit a job, or reduced hours worked in the last 60 days? If **YES**, give name and explain: _____

3. Do you or anyone who lives with you (including children) receive or expect to receive any of the following? Answer yes or no below and provide the requested information.

Esta sección es para fuentes de ingresos distintas al trabajo remunerado. Si recibe alguno de los ingresos enumerados, debe indicar "si" y especificar cuánto recibe mensualmente.

Yes	No		Yes	No		Yes	No	
❑	❑	Social Security	❑	❑	Cash gifts or contributions	❑	❑	Strike benefits
❑	❑	SSI	❑	❑	Unemployment benefits	❑	❑	Prize winnings
❑	❑	VA benefits	❑	❑	Room/board income	❑	❑	All food, clothing, utilities, or rent
❑	❑	Child support, alimony	❑	❑	Black Lung benefits	❑	❑	Other retirement
❑	❑	Public Assistance (TANF, GR etc)	❑	❑	Worker compensation	❑	❑	Interest, dividends
❑	❑	Military Allotment	❑	❑	Rental Income	❑	❑	Insurance settlement
❑	❑	Training allowances (WIA, etc.)	❑	❑	Inheritance	❑	❑	Refugee Matching Grant
❑	❑	Loans	❑	❑	Railroad retirement	❑	❑	Any other type of money

a. _____ **Name of Person**	$ _____ **Amount**	**Type of Money or Help**	**How Often Received?**
b. _____ **Name of Person**	$ _____ **Amount**	**Type of Money or Help**	**How Often Received?**
c. _____ **Name of Person**	$ _____ **Amount**	**Type of Money or Help**	**How Often Received?**

Requisitos de empleo/laboral de SNAP

Toda persona entre 18 y 64 años debe demostrar que participa en un trabajo, voluntariado o programa educativo elegible durante 80 horas al mes (aproximadamente 20 horas a la semana). Normalmente, se lo comproba a traves de talones de pago, u otros documentos que acrediten la actividad laboral.

Si está desempleado, puede estar exento del requisito laboral si:

-Tiene un certificado de discapacidad de la SSA, la VA o la Junta de Jubilación Ferroviaria.
-Su médico confirma que está incapacitado/a y no puede trabajar (debe indicar cuánto tiempo prevé que estará sin trabajar, hasta 12 meses seguidos).
-Está embarazada.
-Tiene hijos menores de 14 años.
-Participa en un programa de trabajo para otro programa de beneficios (por ejemplo, TANF VIEW).

❑ YES ❑ NO 4. Does anyone <u>besides the people on your case</u> pay directly for you, help you pay, or lend you money to pay rent, utilities, medical bills or any other bills? <u>OR</u> does anyone totally supply food, shelter or clothing for you or someone else on a regular basis? If **YES**, give name, amount, and explain: _____

Incluya aquí cualquier ayuda que cubra por completo los gastos de vivienda, alimentación y servicios públicos, su relación con la persona que le proporciona esta ayuda y si vive con ella.

❑ YES ❑ NO 5. Does anyone have a day care expense for a child, an elderly person, or an adult with a disability? If **YES**, give name, amount and explain: _____

Si tiene gastos de guardería para poder trabajar, indique aquí quién paga dichos gastos, con qué frecuencia, el importe pagado y quién está al cuidado de la persona.

❑ YES ❑ NO 6. Does anyone pay legally obligated child support to someone who is not in the household? If **YES**, give name of person paying, person supported, and amount: _____

Esto se aplica a las obligaciones de ordenas formales del departamento de Manutención de los Hijos (DCSE), o por tribunal. Si existe un acuerdo informal entre los padres, no es necesario incluirlo aquí.

Proporcione aquí toda la información posible, ya que esto ayuda a determinar la velocidad de procesamiento de su solicitud.

D. RESOURCES

You do not have to complete this section if you are only applying for TANF. Otherwise, answer for everyone for whom you are applying. Include any resources anyone owns, or that are jointly owned with someone else, even if that person does not live with you. List the names of all joint owners.

1. Do you or anyone who lives with you have any of the following resources or assets?

Yes	No		Yes	No		Yes	No	
❑	❑	Cash $	❑	❑	Checking, Savings	❑	❑	Credit Union
❑	❑	401K, 403B, etc	❑	❑	Promissory notes	❑	❑	Money Market Funds
❑	❑	Individual Retirement Account (IRA)	❑	❑	Christmas Club	❑	❑	Deeds of Trust
❑	❑	Deferred Compensation Plan	❑	❑	Uniform Gift to Minor Account	❑	❑	Retirement accounts
❑	❑	Keogh Plan	❑	❑	Certificate of Deposit (CD)	❑	❑	Trust funds
❑	❑	Stocks or bonds	❑	❑	Pension plans	❑	❑	ABLE Account
❑	❑	Other						

Nota: Debe proporcionar respuestas completas y verdaderas a estas preguntas. Si la información aquí presentada no coincide con las respuestas que proporcionó para otro programa de Medicaid que lleva un limite de recursos financieros, se le solicitará información adicional para ambos programas.

— If **Yes to any of the above**, please provide the following information:

No es necesario que proporcione números de cuenta bancaria ni direcciones. Debe ser suficiente proporcionar el titular de la cuenta, el saldo y el tipo de cuenta.

a.

Owner Name (last, first, middle initial) _____ **Co-Owner Name** (last, first, middle initial) _____

Name of Bank or Institution _____ **Account Type** _____ **Account Number** _____ **$ Balance** _____

Address of Bank or Institution _____

b.

Owner Name (last, first, middle initial) _____ **Co-Owner Name** (last, first, middle initial) _____

Name of Bank or Institution _____ **Account Type** _____ **Account Number** _____ **$ Balance** _____

Address of Bank or Institution _____

❑ YES ❑ NO 2. Has anyone received or expect to receive winnings of $4,250 or more from lottery or gambling? If **YES**, explain: _____

❑ YES ❑ NO 3. Has anyone sold, transferred or given away any resources in the last 3 months (for SNAP) or in the last 3 years (for Auxiliary Grants)? If **YES**, explain: _____

E. TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) (ASK FOR AN EXTRA PAGE IF YOU NEED MORE SPACE)

1. CHILD/PARENT INFORMATION List each child for whom you are applying. Then, list the names of both parents. **You must identify both parents in order to receive TANF. If you intentionally misidentify a parent, you shall be prosecuted**	**2. IMMUNIZATION** (Answer **only if applying for TANF.**) Has the child received **ALL** of the immunizations required according to the child's age? Check (√) **Yes** Or **No** Or **Unknown**
Child's Name	Yes ( ) No ( ) Unknown ( )
Mother	
Father	
Child's Name	Yes ( ) No ( ) Unknown ( )
Mother	
Father	
Child's Name	Yes ( ) No ( ) Unknown ( )
Mother	
Father	
Child's Name	Yes ( ) No ( ) Unknown ( )
Mother	
Father	

No complete esta sección si solo solicita beneficios SNAP.

F. TANF DIVERSIONARY ASSISTANCE/EMERGENCY ASSISTANCE

❑ YES ❑ NO 1. Does your household have an emergency need related to basic needs (food, shelter, shelter items, potential eviction, medical expenses, childcare expenses or the costs associated with getting or keeping employment including transportations costs)? If **YES**, give date and explain below.

❑ YES ❑ NO 2. Does anyone have emergency needs that result from a natural disaster or fire such as replacement of clothing, or the repair or replacement of household equipment and supplies which were destroyed? If **YES**, explain below.

❑ YES ❑ NO 3. Has your household experienced an involuntary loss or reduction of income (except TANF/Refugee Cash Assistance) in the six months prior to the date of application?

❑ YES ❑ NO 4. Does your household have a delay in starting to receive income resulting in the current emergency? (The income must start within 60 days following the application date.) If **YES**, who? _____

Date, description, and cause of emergency:

No complete esta sección
si solo solicita beneficios SNAP.

Si en su hogar hay alguien con quien prepara
y comparte comidas (aunque no sea familiar o tenga sus propios ingresos),
debe incluirse como parte de su hogar y en la Sección B de la solicitud.

G. SNAP BENEFITS

1. List the name of the person who is the head of your household: _____.

❑ YES ❑ NO 2. Is anyone living in your home NOT included in your SNAP application? If **YES**, do you and everyone for whom you are applying usually purchase and prepare meals apart from these people? Or, do you intend to do so if your application for SNAP benefits is approved? Check (✓) ❑ YES ❑ NO

❑ YES ❑ NO 3. Is anyone living in your home renting a room from you (a roomer) or being provided a room and food (a boarder)? If **YES**, list names: _____

❑ YES ❑ NO 4. Is anyone age 60 or older **or** approved to receive Medicaid because of a disability **or** receiving any type of disability payment? If **YES**, list all current medical expenses for these people.

Household Member with Medical Expense	Type of Expense	Amount	Name of Doctor, Hospital, Pharmacy

Si compartes tu hogar con alguien con quien no cocinas,
escribe al margen cuál es tu relación con esa persona y confirma que
no compartirás comidas con ella.

Esta sección solicita información sobre gastos médicos no cubiertos por el seguro (por ejemplo, facturas de atención especializada, copagos, facturas hospitalarias, costos de medicamentos, atención médica domiciliaria, transporte médico).

❑ YES ❑ NO 5. Do you have any of the following shelter expenses? If **YES**, list your current expenses.
Check (✓) here ❑ if these expenses are for a house you do not live in.

Expense	Amount Billed	How Often Billed?	Who is Responsible for the Bill?
Rent/Mortgage			
Taxes/ Insurance			
Electricity			
Gas/Oil/Kerosene/Coal/Wood			
Water/Sewage/Garbage			
Telephone			
Installation			

Complete toda esta sección; cuanta más información proporcione, más precisos serán los beneficios.
Tenga a mano copias de sus facturas o un recibo de pago con esta solicitud para justificar sus gastos.

El DSS utilizará estas respuestas para determinar qué porcentaje de sus ingresos
debe incluirse al determinar su elegibilidad y, en última instancia, sus beneficios mensuales.

Estas preguntas también determinan su nivel de beneficios;
respóndalas todas.

6a How do you heat your home? _____ ¡No falte contestar esta pregunta!

❑ YES ❑ NO 6b Do you have air conditioning in your home?

❑ YES ❑ NO 6c Did you receive energy/fuel assistance during this past year while living in your current home?

❑ YES ❑ NO 6d Are you staying temporarily in someone else's home, an emergency shelter, welfare hotel, other halfway house, or a place not usually used for sleeping? If **YES**, how much does it cost to stay there during the month?

_____

If you are staying temporarily in someone else's home, when did you move there? _____

H. AUXILIARY GRANTS (AG)

❑ YES ❑ NO 1 Do you live in an Assisted Living Facility, an Adult Foster Care Home, a Nursing Facility, or other institution?
If **YES**, Date Applicant Entered_____
City/County and State where you lived before entering the institution _____.
If outside Virginia, was placement made by a government agency? ❑ YES ❑ NO

❑ YES ❑ NO 2 Have you applied for or are you applying for supportive housing?

❑ YES ❑ NO 3 Do you have a spouse who does not live in the home? If **YES**, enter the Spouse's Name and address
_____

❑ YES ❑ NO 4. Have you lived in Virginia for the past 90 days?

❑ YES ❑ NO 5 Do you owe or did you pay any bills you had in the month of entry into an assisted living facility or adult foster care?

❑ YES ❑ NO 6. Do you have any unpaid medical bills for the three months before the application month?

Description of Bills	Dates of Bills	Dates Bills Paid

❑ YES ❑ NO 7. Do you own any household goods or personal effects worth more than $500, such as silver, fine china, furs, artwork, jewelry, or other items held for their value or as an investment?

Description and Value of Items

❑ YES ❑ NO 8. Do you have any burial plots, burial arrangements or trust funds for burial?

Owner(s)	Number of Plots Type of Arrangement:	Where	Value $ Amount Owed $	Date Acquired
Owner(s)	Burial contract/agreement type: ❑ Irrevocable ❑ Revocable	Trustee/Authority/Funeral Home:	Funds Required $	Amount Paid $
Other information:				

❑ YES ❑ NO 9. Does anyone own any personal property, such as campers/trailers, non-motorized boats, utility trailers, tools, equipment, supplies, or livestock?

Owner(s)	Type	Is this property used in your business or trade, including farming? YES ( ) NO ( )	Value	Amount Owed	Date Acquired

❑ YES ❑ NO 10. Does anyone own any real property, including life estates, inherited property, land, buildings, or mobile homes?
If YES, do you live there? Check (✓): ❑ YES ❑ NO

Owner(s)	Type	YES ( ) NO ( ) Currently rented? YES ( ) NO ( ) Income-producing? YES ( ) NO ( ) Currently for sale?	Value $	Amount Owed $	Date Acquired

❑ YES ❑ NO 11. Does anyone own vehicles, such as cars, trucks, vans, motorboats, motor homes, recreational vehicles, or motorcycles/mopeds?

Owner(s)	Type, Make, Model, Year	Currently Licensed?	Vehicle ID# License #	Value Amount Owed	How Used	Date Acquired
		❑ YES ❑ NO	# #	$ $		

No complete esta sección
si solo solicita beneficios SNAP.

H. AUXILIARY GRANTS (AG) (continued)

❑ YES ❑ NO 12. Does anyone have any life insurance? If **YES,** provide information about each policy. List each policy separately. Attach a separate sheet if necessary.

Owner	Person Insured	Type of Insurance ❑ Whole Life ❑ Term	Face Value $	Cash Value $
Company Name	Policy Number			
Owner	Person Insured	Type of Insurance ❑ Whole Life ❑ Term	Face Value $	Cash Value $
Company Name	Policy Number			
Owner	Person Insured	Type of Insurance ❑ Whole Life ❑ Term	Face Value $	Cash Value $
Company Name	Policy Number			

An application for AG is also an application for Medicaid. The following questions will help determine Medicaid eligibilty through the Department of Social Services or possible eligibility for Advanced Premium Tax Credits (APTC) for private health insurance through the Federal Marketplace (Healthcare.gov).

❑ YES ❑ NO 13. Does anyone have health insurance? If **Yes**, complete the following:

Policy Holder:	Person(s) Insured:
Company Name, Address, Phone:	
Coverage Type:	Begin Date: / / End Date: : / /
ID Number:	Premium Amount: $

❑ YES ❑ NO 14. Does anyone have Medicare?

Person Insured	Claim Number	Coverage
		❑ Part A ❑ Part B
		❑ Part A ❑ Part B

15. List the names of everyone expected to be included on the same tax return as you for this year, whether or not they live in the same home as you. For anyone in the home that does not file taxes and does not expect to be on anyone else's tax return, list those names under "Non-filer(s)".

Tax Filer:	
Joint Taxpayer:	
Tax Dependent(s):	
Non-filer(s):	

I. Authorized Representative

An authorized representative may apply for benefits on your behalf or receive copies of your program notices. Your representative may also receive and use your SNAP benefits on your behalf. If you want to name an authorized representative, please give the information below about the representative and what you want the representative to do on your behalf. Note that you may have only one representative who can access your benefits.

Name, Address and Telephone Number of the Authorized Representative	Check (✓) each duty authorized for that person
	❑ Apply for benefits ❑ Receive correspondence ❑ Access or use SNAP benefits
	❑ Apply for benefits ❑ Receive correspondence ❑ Access or use SNAP benefits

No complete esta sección
si solo solicita beneficios SNAP.

Aquí puede indicar las personas que desea que puedan comunicarse con el Departamento de Servicios Sociales (DSS) sobre sus beneficios de SNAP. Incluya solo a personas de su confianza y debe indicar los limites/preferencias de su acceso (por ejemplo, pueden recibir notificaciones, pero no usar los beneficios).

CHANGE REPORTING, RESPONSIBILITIES, AND PENALTIES
(READ THIS SECTION CAREFULLY BEFORE SIGNING THIS APPLICATION)

REPORTING CHANGES

You must report changes that occur. What you need to report and when you need to report it varies by each program as listed below or on the next page for SNAP.

TANF/Refugee Cash Assistance: Report within 10 days, but no later than the 10th day of the month after a change occurs. Report these changes:

- Your household income goes over 130% of the Federal poverty level. See the Change Report or the Notice of Action for the amount or visit www.dss.virginia.gov.
- Your address changes.
- An eligible individual leaves or enters the home.
- Changes that may affect your participation in VIEW such as, changes in income, employment, education, training, transportation, and child care.

General Relief-Unattached Child: Report the day the change occurs or the first day that the agency is open after the change occurs. Report these changes:

- Your address changes.
- The amount of your monthly income changes.
- There are other changes that may affect eligibility.

Auxiliary Grants: Report changes within 10 days. Report these changes:

- Your address changes.
- The amount of your monthly income changes.
- There are changes in your resources, including transferring assets/property or in any motor vehicles owned.

PENALTIES FOR TANF AND REFUGEE CASH ASSISTANCE (RCA) VIOLATIONS

You must not knowingly give false information, hide information, or fail to report changes on time in order to receive TANF or RCA, or to receive supportive or transitional services such as child care or assistance with transportation.

If you are found guilty of intentionally breaking these rules, you will be ineligible to receive TANF or RCA for yourself for 6 months (1st violation), 12 months (2nd violation), or permanently (3rd violation). In addition, you may be prosecuted under Federal or State law.

Anyone convicted of misrepresenting his or her residence to get TANF, Medicaid, SNAP benefits or SSI in two or more states is ineligible for TANF for 10 years.

DOMESTIC VIOLENCE INFORMATION

Domestic violence information and services are available to anyone experiencing violence or abuse from their partner. If you are in immediate danger, call 911. If you would like to speak with, text or chat with someone who understands these issues or to learn about services and safety options, contact the Virginia Statewide Hotline.

- Call and speak with an advocate toll-free at 1-800-838-8238. (Note: Interpreters are available for more than 200 languages via the Language Line.)
- Text with an advocate at 804-793-9999.
- Chat with an advocate at https://www.vadata.org/chat/. (Chat feature works best on a computer or tablet.)
- Call and speak with an advocate - LGBTQ Helpline: 1-866-356-6998

SNAP CHANGE REPORTING, RESPONSIBILITIES, AND PENALTIES
(READ THIS SECTION CAREFULLY BEFORE SIGNING THIS APPLICATION)

You must report changes that occur for SNAP but, what you must report is tied to how long you are determined eligible for benefits, the certification period. You must report changes that occur during the certification period within 10 days, but no later than the 10th day of the month after the change occurs.

Changes that you need to report during the certification period for SNAP will depend on the length of the certification period. "Simplified Reporting" applies to households that are eligible for SNAP benefits for five (5) months or longer. "Change Reporting" applies to households that are eligible for one (1) month to four (4) months. Changes that need to be reported for each category are listed below.

INTERIM REPORT FILING

In addition to reporting changes when they occur during the SNAP certification period, Simplified Reporting households may be required to submit an Interim Report in the sixth or twelfth month. The Interim Report is used to determine the amount of SNAP benefits households will receive for the second half of the certification period. The Interim Report provides a snapshot of household circumstances that were presented at the time of application. We will ask for proof of income changes and changes in legal obligations to pay child support. If households fail to return the completed Interim Report by the fifth of the month, SNAP benefits for the seventh or thirteenth month may be delayed or closed. Assistance for filing the Interim Report is available by calling the telephone number printed on the form.

REPORTING REQUIREMENTS – SIMPLIFIED REPORTING HOUSEHOLDS

Certified five months or longer, households must report:

- The number of work hours goes under 20 per week for anyone between the ages of 18-49 if there are no children in your SNAP household;
- You have lottery or gambling winnings of $4,250 or more; or
- All the income for your household, before taxes, goes over 130% of the Federal poverty level. See the Change Report or the Notice of Action for the amount or visit www.dss.virginia.gov.

REPORTING REQUIREMENTS – CHANGE REPORTING HOUSEHOLDS

Certified four months or less), households must report:

- There is a change in the number of people in your household;
- Your address changes, including shelter expenses that change resulting from the move;
- The obligation to pay child support changes or the amount paid to someone outside the household changes;
- Your liquid resources, such as bank accounts, cash, bonds, etc. are $2,750 or $4,250 or more;
- You have lottery or gambling winnings of $4,250 or more;
- The number of work hours goes under 20 per week for anyone between the ages of 18-50 if there are no children in the home; or
- There are changes in income:
  - There are income changes of more than $125 except, you do not have to tell us if your TANF income changes if your TANF case is in Virginia;
  - The source of your income changes, including if you start or stop a job; or
  - Your job switches from full-time to part-time or part-time to full-time.

SNAP RESPONSIBILITIES AND PENALTIES FOR VIOLATIONS

You must not:

- **give false information or hide information to get SNAP benefits;**
- **trade or sell EBT cards or attempt to trade or sell EBT cards;**
- **use SNAP benefits to buy non-food items, such as alcohol, tobacco or paper products;**
- **use someone else's EBT card for your household;**
- **buy an item and discard the contents in order to get the return deposit for the container;**
- **resell a purchased product for cash or exchange a purchased product for consideration other than eligible food; or**
- **purchase food on credit.**

If you intentionally break any of these rules, you could be barred from getting SNAP benefits for 12 months (1st violation), 24 months (2nd violation), or permanently (3rd violation); fined up to $250,000, imprisoned up to 20 years, or both; and suspended for an additional 18 months and further prosecuted under other Federal and State laws.

If you intentionally give false information or hide information about identity or residence to get SNAP benefits in more than one locality at the same time, you could be barred for 10 years.

If you are convicted in court of trading or selling SNAP benefits of $500.00 or more, you could be barred permanently.

If you are convicted in court of trading SNAP benefits for a controlled substance, you could be barred for 24 months for the 1st violation, permanently for the 2nd violation.

If you are convicted in court of trading SNAP benefits for firearms, ammunition, or explosives, you could be barred permanently for the first violation.

Al firmar la solicitud, usted da su consentimiento para que se compartan todos estos datos y acepta cumplir con todas estas normas.

BY MY SIGNATURE BELOW, I DECLARE:

- I read the information at the beginning of this application and the Change Reporting and Penalties section of this application.
- I understand that if I refuse to cooperate with any review of my eligibility, including a review by Quality Assurance, my benefits may be denied until I cooperate.
- I understand that if my application is for SNAP benefits, failure to report or verify any of my expenses will be seen as a statement by my household that I do not want to receive a deduction for these expenses.
- I have given true and correct information on this application to the best of my knowledge and belief. I understand that if I give false information, withhold information, or fail to report a change promptly or on purpose, I may be breaking the law and could be prosecuted for perjury, larceny, and/or welfare fraud. I understand that if I help someone complete this form in order to get benefits he or she is not entitled to receive, I may be breaking the law and could be prosecuted.
- As a condition of receiving TANF, I agree to assign all of my rights to financial support paid to me and to anyone for whom I am receive TANF. After my application for TANF is approved, I agree to give any support payments I receive to the Division of Child Support Enforcement.
- I authorize the Department of Social Services and refugee service contractors to obtain any verification necessary to both determine and review financial assistance eligibility. This authorization is valid for one year from the date of my signature below. I understand that this time limit does not apply as long as my medical assistance case is open or to investigations regarding possible fraud.
- As an applicant for Auxiliary Grants, I understand that my application will be evaluated for Medicaid. I agree to assign my rights to medical support and other third-party payments to the Department of Medical Assistance Services (DMAS). I also agree to assign the rights of anyone for whom I am applying for Auxiliary Grants to medical support and other third-party payments to DMAS. If I do not agree to assign these rights, I will be ineligible for Medicaid.
- I understand that, to the extent allowed by federal law, information about this application may be shared with agencies under the Secretary of Health and Human Resources for Virginia. Informatin about applicants for and recipients of services may be shared to: 1) streamline administrative processes and reduce administrative burdens on the agencies; 2) reduce paperwork and administrative burdens on appllicants and recipients; and 3) improve access to and the quality of services provided by the agencies.
- I understand that different state agencies provide different services and benefits. Each agency must have specific information to determine eligibility services and benefits.
  ❑ **I allow** ❑ **I do not allow** the Department of Social Services to disclose certain information about me to other state agencies, including information in electronic databases, for the purpose of determining my eligibility for benefits/services provided by that agency. This disclosure will make it easier for agencies to work together efficiently to provide or coordinate services and benefits. Agencies include, but are not limited to, the Department of Health, and the Department for Aging and Rehabilitative Services. I can withdraw this authorization at any time by notifying my eligibility worker.

I filled in this application myself ❑ **YES** ❑ **NO.** If **NO**, it was read back to me when completed. ❑ **YES** ❑ **NO.**

Al marcar "Autorizo", permitirá que el DSS comparta información sobre su caso con otras agencias.
Si no desea que se comparta información más allá de la mínima requerida, marque "No autorizo".

Cualquier persona puede ayudarte con esta solicitud.

_____ _____ _____ _____
Applicant's Signature or Mark **Date** **Witness To Mark or Interpreter** **Date**

_____ _____
Signature of the Spouse or Authorized Representative **Date**

No necesita un testigo si usted mismo puede firmar la solicitud.
Si utilizó un intérprete o si otra persona firma en su nombre,
incluya la firma de un testigo para confirmar que la información aquí contenida es verdadera y precisa,
y que la solicitud se preparó de acuerdo con sus instrucciones.

Complete thesection below if this application was completed for the applicant by someone else.

Aquí debe indicar la información de la persona que le ayudará con la solicitud.
Omita esta pregunta si usted mismo completó la solicitud.

_____ _____ _____
Name of Person Completing Application **Date** **Address**

_____ _____ _____
Primary Telephone **Alternate Telephone** **Relationship to Applicant**

AGENCY USE ONLY	
Case Name	Case Number
Locality	Date Received
Date of Interview:	❑ In office ❑ Telephone
Interviewer	Program (s)