Massachusetts Department of Transitional Assistance

Application for Transitional Assistance Benefits

Grantee/Assessed Person Name *Social Security Number*

Provide the following information for all household members. (Also include household members not applying for assistance and dependent children who are temporarily absent from the home.) Attach separate sheet if needed.

Household/AU Members

1.

Last Name First Name MI	Social Security Number	**Relationship to Grantee/Assessed Person**

Gender ❒ M ❒ F	Date of Birth / /	Marital Status	Present in Household ❒ Yes ❒ No	Purchase & Prepare Together ❒ Yes ❒ No	Telephone Number

Who is financially responsible for this household member?	Country of Citizenship	Preferred Language

Your **ethnicity/race**: This information is collected to make sure everyone is treated fairly. Your answer is voluntary and it will not affect your eligibility or benefit amount.

Ethnicity: ❒ Hispanic or Latino ❒ Yes ❒ No

Race: (check all applicable)

❒ American Indian or Alaskan Native ❒ Asian ❒ Black or African American

❒ Native Hawaiian or Other Pacific Islander ❒ White

Is this person applying? ❒ Yes ❒ No

If **yes**, is this person a U.S.Citizen? ❒ Yes ❒ No

I certify, under penalty of perjury that I am a U.S. Citizen. (Grantee signs his/her name for any member under age 18.) Anyone older than 18 must sign his/her own name.

'X' ___________________________________

Program(s) person is applying for? ❒ TAFDC ❒ EAEDC ❒ FS ❒ EA ❒ None

Is the person included in the AU by mandate? ❒ Yes ❒ No

If **yes**, Reason: ___________________________

Is the **other** parent in the home? ❒ Yes ❒ No

Alternate Name:	Name Type:	Alternate SSN:

2.

Last Name First Name MI	Social Security Number	**Relationship to Grantee/Assessed Person**

Gender ❒ M ❒ F	Date of Birth / /	Marital Status	Present in Household ❒ Yes ❒ No	Purchase & Prepare Together ❒ Yes ❒ No	Telephone Number

Who is financially responsible for this household member?	Country of Citizenship	Preferred Language

Your **ethnicity/race**: This information is collected to make sure everyone is treated fairly. Your answer is voluntary and it will not affect your eligibility or benefit amount.

Ethnicity: ❒ Hispanic or Latino ❒ yes ❒ no

Race: (check all applicable)

❒ American Indian or Alaskan Native ❒ Asian ❒ Black or African American

❒ Native Hawaiian or Other Pacific Islander ❒ White

Is this person applying? ❒ Yes ❒ No

If **yes**, is this person a U.S.Citizen? ❒ Yes ❒ No

I certify, under penalty of perjury that I am a U.S. Citizen. (Grantee signs his/her name for any member under age 18.) Anyone older than 18 must sign his/her own name.

'X' ___________________________________

Program(s) person is applying for? ❒ TAFDC ❒ EAEDC ❒ FS ❒ EA ❒ None

Is the person included in the AU by mandate? ❒ Yes ❒ No

If **yes**, Reason: ___________________________

Is the **other** parent in the home? ❒ Yes ❒ No

Alternate Name:	Name Type:	Alternate SSN:

3.

Last Name	First Name	MI	Social Security Number	**Relationship to Grantee/Assessed Person**

Gender ❒ M ❒ F	Date of Birth / /	Marital Status	Present in Household ❒ Yes ❒ No	Purchase & Prepare Together ❒ Yes ❒ No	Telephone Number

Who is financially responsible for this household member?	Country of Citizenship	Preferred Language

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Ethnicity: ❒ Hispanic or Latino ❒ Yes ❒ No

Race: (check all applicable)

❒ American Indian or Alaskan Native ❒ Asian ❒ Black or African American

❒ Native Hawaiian or Other Pacific Islander ❒ White

Is this person applying? ❒ Yes ❒ No

If **yes**, is this person a U.S.Citizen? ❒ Yes ❒ No

I certify, under penalty of perjury that I am a U.S. Citizen. (Grantee signs his/her name for any member under age 18.) Anyone older than 18 must sign his/her own name.

'X' ____

Program(s) person is applying for? ❒ TAFDC ❒ EAEDC ❒ FS ❒ EA ❒ None

Is the person included in the AU by mandate? ❒ Yes ❒ No

If **yes**, Reason: ___________________________

Is the **other** parent in the home? ❒ Yes ❒ No

Alternate Name:	Name Type:	Alternate SSN:

4.

Last Name	First Name	MI	Social Security Number	**Relationship to Grantee/Assessed Person**

Gender ❒ M ❒ F	Date of Birth / /	Marital Status	Present in Household ❒ Yes ❒ No	Purchase & Prepare Together ❒ Yes ❒ No	Telephone Number

Who is financially responsible for this household member?	Country of Citizenship	Preferred Language

Your **ethnicity/race**: This information is collected to make sure everyone is treated fairly. Your answer is voluntary and it will not affect your eligibility or benefit amount.

Ethnicity: ❒ Hispanic or Latino ❒ Yes ❒ No

Race: (check all applicable)

❒ American Indian or Alaskan Native ❒ Asian ❒ Black or African American

❒ Native Hawaiian or Other Pacific Islander ❒ White

Is this person applying? ❒ Yes ❒ No

If **yes**, is this person a U.S.Citizen? ❒ Yes ❒ No

I certify, under penalty of perjury that I am a U.S. Citizen. (Grantee signs his/her name for any member under age 18.) Anyone older than 18 must sign his/her own name.

'X' ____

Program(s) person is applying for? ❒ TAFDC ❒ EAEDC ❒ FS ❒ EA ❒ None

Is the person included in the AU by mandate? ❒ Yes ❒ No

If **yes**, Reason: ___________________________

Is the **other** parent in the home? ❒ Yes ❒ No

Alternate Name:	Name Type:	Alternate SSN:

Family Cap

Do you want to apply for an exception and/or waiver of the Family Cap rule? ❒ Yes ❒ No

If yes, go to page 25 and record the information and complete the *EX/WVREQ* and *FCWCH* forms.

Dept. Use Only

What **program(s)** is the AU applying for? ❒ TAFDC ❒ EAEDC ❒ FS ❒ EA

Categorically Eligible for Food Stamps? ❒ Yes ❒ No

Assistance Unit (AU) Composition Q&A Navigator

*(Record answers in the **AU Composition Details** section and **attach sheet if needed**.)*

Pregnant

Are there any household members who are pregnant? ❐ Yes ❐ No
If **yes**, complete the following section.

Member's Name for which "yes" applies	Due Date	How many babies do you expect?	Date Reported
	/ /		/ /

Temporary Absence

Are there any household members who are temporarily absent? ❐ Yes ❐ No
If **yes**, complete the following section.

Member's Name for which "yes" applies	Date Reported	Expected End Date	Reason(s) for Temporary Absence
	/ /	/ /	

TAFDC Care and Control

Is there a child(ren) in the household who is not under the care and control of the TAFDC grantee? ❐ Yes ❐ No
If **yes**, complete the following section.

Name of Member for which "yes" applies	Name of Person Exercising Parental Control	Gender	SSN

Food Stamp Parental Control

Is there a child(ren) in the household who is not under parental control of the food stamp grantee? ❐ Yes ❐ No
If **yes**, complete the following section.

Name of Member for which "yes" applies	Name of Person Exercising Parental Control	Gender	SSN

EAEDC Unrelated Child

Is someone a caretaker for all the children applying for EAEDC? ❐ Yes ❐ No
If **yes**, complete the following section.

Name of Member for which "yes" applies	Caretaker's Name	Gender	SSN

Guardian

Does anyone in the household have a legal guardian? ❐ Yes ❐ No
If **yes**, complete the following section.

Name of Member for which "yes" applies	Name of Legal Guardian	Gender	SSN

Assistance Unit (AU) Composition Q&A Navigator

(Record answers in the AU Composition Details section)

Caretaker

Does anyone in the household have a Caretaker? ❒ Yes ❒ No
If yes, complete the following section.

Name of Member for which "yes" applies	Gender	SSN	Date Reported
			/ /

Boarders

Are there any boarders in the household? ❒ Yes ❒ No
If yes, complete the following section.

Name of Boarder	How Many Meals Per Week	Date Reported
		/ /

Foster Care

Is there anyone in the household who is in foster care? ❒ Yes ❒ No
If yes, complete the following section.

Name of Foster Parent	Expected End Date	Date Reported
	/ /	/ /

Interview Question & Answer Navigator

Nonfinancials

(*Record answers in the **Assessed Person Nonfinancial Statement** section*)

Resident Information

Are you or is anyone in your assistance unit(s) NOT a resident of Massachusetts, or intending to leave the state?
❒ Yes ❒ No

If **yes**, complete the following section.

Name of Member for which "yes" applies	Massachusetts Resident?	Do you Intend to Leave?	Reason for Leaving	Departure Date
	❒ Yes ❒ No	❒ Yes ❒ No		/ /

Residential Facility

Are you or is anyone in your assistance unit(s) living in a residential facility? ❒ Yes ❒ No

If **yes**, complete the following section.

AU Member Name	Type of Facility	Date of Entry	Date of Exit	Facility Name and Address
		/ /	/ /	

Interview Question & Answer Navigator

Nonfinancials

(*Record answers in the **Assessed Person Nonfinancial Statement** section*)

Teen Parent

Is there a teen parent in the household? ❐ Yes ❐ No If **yes**, go to page 22 and record the information.

Prior Assistance

Have you or has anyone in your assistance unit(s) been in receipt of Public Assistance in another state since August, 1996? ❐ Yes ❐ No

If **yes**, complete the following section.

AU Member Name	Program Name	State Granting Assistance	Start Date	End Date	Date Last Benefit Received	Number of Months Received
			/ /	/ /	/ /	
			/ /	/ /	/ /	
			/ /	/ /	/ /	

Citizenship

Are you or anyone in your assistance unit(s) NOT a U.S. Citizen? ❐ Yes ❐ No

Is this member claiming 40 quarters of work experience? ❐ Yes ❐ No

If **yes**, go to page **23** and record the information.

Voter Registration

Is anyone 18 or older in your assistance unit(s) who is a United States citizen and a Massachusetts resident currently NOT registered to vote at your current address? ❐ Yes ❐ No

If **yes**, complete the following section and the *Voter Registration Form*.

AU Member Name	Registration Status	Wants to Register	Voter Register Form Completed	Declination Form Completed
		❐ Yes ❐ No	❐ Yes ❐ No	❐ Yes ❐ No
		❐ Yes ❐ No	❐ Yes ❐ No	❐ Yes ❐ No

Interview Question & Answer Navigator

Nonfinancials

(*Record answers in the **Assessed Person Nonfinancial Statement** section*)

Absence

Do any of the children in your assistance unit (including any Family Cap child(ren)) have a parent(s) who is continuously absent or deceased? ❒ Yes ❒ No

If **yes**, go to page **17/18** and record the information for each absent/deceased parent. Complete the *T-A34/36*.
If more than one absent/deceased parent attach a separate sheet and *T-A34/36*.

Disability

Are you or is anyone in the assistance unit(s) physically or mentally disabled? ❒ Yes ❒ No
Has this disability lasted and/or is expected to last at least 12 months? ❒ Yes ❒ No

If **yes**, go to page **19** and record the information.

Accident and Incident

Have you or has anyone in your assistance unit had an accident, injury, illness or any other incident that resulted in a lawsuit, workers' compensation or insurance claim? ❒ Yes ❒ No

If **yes**, go to page **20** and record the information.

Immunization

Are there any children in your TAFDC assistance unit who are NOT up to date with their immunizations?
❒ Yes ❒ No

If **yes**, complete the following section.

AU Member Name	Date of Birth	Reason Not Immunized
	/ /	
	/ /	
	/ /	

Interview Question & Answer Navigator

Nonfinancials

(*Record answers in the **Assessed Person Nonfinancial Statement** section*)

Felony Convictions and/Violations

Have you or has anyone in the household been convicted in court for making fraudulent statements about his/her place of residence in order to receive assistance from two or more states at the same time?

❒ Yes ❒ No

If **yes**, complete the following section.

AU Member Name	Date of Conviction
	/ /

Are you or is anyone in the household fleeing to avoid prosecution, custody or confinement after a conviction for a felony or a high misdemeanor in the State of New Jersey?

❒ Yes ❒ No

If **yes**, complete the following section.

AU Member Name	Date of Conviction
	/ /

Are you or is anyone in the household in violation of a condition of probation or parole?

❒ Yes ❒ No

If **yes**, complete the following section.

AU Member Name	Date Probation or Parole Imposed
	/ /

Have you or has anyone in the household been convicted under federal or state law of a felony related to the possession, distribution or use of a controlled substance for a crime committed after 8/22/96?

❒ Yes ❒ No

If **yes**, complete the following section.

AU Member Name

Do you or does anyone in the household have an outstanding warrant issued by a court in Massachusetts?

❒ Yes ❒ No

If **yes**, complete the following section.

AU Member Name

Interview Question & Answer Navigator

Income and Expenses

(Record answers in the ***Assessed Person Income & Expense Statement*** *section)*

Employment

Are you presently employed or have you been employed in the last 90 days? ❐ Yes ❐ No

If **yes**, complete the following section. (Enter employment information for all household members and attach separate sheet, if needed.)

AU Member Name & Telephone #			Employer Name and Address & Telephone #			
Job Title	Start Date / /	End Date / /	Hourly Wage $	Weekly Hours	How Often Paid?	Permanent Job ❐ Yes ❐ No
If Not Employed, What Is the Reason?		Employed Last 12 Months? ❐ Yes ❐ No Total income earned last 12 months? $ __________			Business Expenses	
Health Insurance Offered Last 12 Months? ❐ Yes ❐ No			Job Held Thirty Days? ❐ Yes ❐ No			
Earnings Countable for Cash? ❐ Yes ❐ No			Earnings countable for Food Stamp Benefits ? ❐ Yes ❐ No			
If working, put applicant on Monthly Reporting.			Federal Identification Number (FEIN) for employer________________________			

Earnings

Record wage information here:

Date From - To	Gross Amount	Hrs	Date entered
/ / - / /	$ __________	_____	/ /
/ / - / /	$ __________	_____	/ /
/ / - / /	$ __________	_____	/ /
/ / - / /	$ __________	_____	/ /
/ / - / /	$ __________	_____	/ /

Is any of the earned income lump sum? ❐ Yes ❐ No

Other Income

Are you or is anyone in your asssitance unit(s) eligible to receive or receiving any other types of income? ❐ Yes ❐ No

If **yes**, complete the following section.

AU Member Name	Type of Income/ Amount	Claim Number	How Often Received ?	Start Date	Countable for
				/ /	❐ TAFDC ❐ FS
				/ /	❐ TAFDC ❐ FS
				/ /	❐ TAFDC ❐ FS

Is any of the other income lump sum? ❐ Yes ❐ No

Interview Question & Answer Navigator

Income and Expenses

*(Record answers in the **Assessed Person Income & Expense Statement** section)*

Support Expenses

Do you or does anyone in your assistance unit(s) have a legal obligation to pay child support to someone outside the household? ❒ Yes ❒ No

If **yes**, complete the following section.

AU Member Name with Legal Obligation and Making Regular Child Support Payments	Type	How Much Paid?	How Often Paid?

Dependent Care Expense

Do you or does anyone in your assistance unit(s) have any dependent care expenses or are they authorized or receiving IECC through EECor a CCRA? ❒ Yes ❒ No

If **yes**, complete the following section.

AU Dependent Member Name	Type	Eligible for	Start Date	How Often Paid?
	❒ IECC ❒ Non IECC	❒ TAFDC Deduction ❒ FS Deduction	/ /	
	❒ IECC ❒ Non IECC	❒ TAFDC Deduction ❒ FS Deduction	/ /	

Record dependent care information here:

Date From	Date To	Expense Amount	Date entered
/ /	- / /	$ ___________	/ /
/ /	- / /	$ ___________	/ /
/ /	- / /	$ ___________	/ /
/ /	- / /	$ ___________	/ /
/ /	- / /	$ ___________	/ /

Interview Question & Answer Navigator

Income and Expenses

*(Record answers in the **Income & Expense Statement** section)*

Health Insurance Expenses

Do you or does anyone in your assistance unit have health insurance? ❒ Yes ❒ No

If **yes**, complete the following section.

AU Member Name	SSN	Relationship	Monthly Premium Amount $
Start Date / / End Date / /	Premium Effective Date / /	Premium Payer/Subscriber Name	Benefit Type
Insurer Name	Policy Number	Group Number	

Medical Expenses

Do you or does anyone in your assistance unit who is 60 years old or older or who has a certified disability have medical expenses? ❒ Yes ❒ No

If **yes**, complete the following section.

AU Member Name	Type	Other Type	Frequency	Amount $	Start Date / /
Third Party Liability Amount $			Third Party Liability Frequency		
Countable for Cash ❒ yes ❒ no Countable for Food Stamps ❒ yes ❒ no		Countable Amounts: TAFDC __________ EAEDC __________ FS _____________ EA ____________			

Shelter Expenses

What type of housing expense do you have? (If possible, verify using the *LL/VER* or *VLA* form.)

	Amount	Frequency
Rent (amount you are responsible for)		
Mortgage (Principal)		
Mortgage (Interest)		
Property Taxes		
Homeowner's Insurance		
Residence Loan		
State & Local Assessments		
Other (specify)		

Are the above expenses allowable for cash? ❒ Yes ❒ No

Are the above expenses allowable for food stamp benefits? ❒ Yes ❒ No

Interview Question & Answer Navigator

Income and Expenses

*(Record answers in the **Income & Expense Statement** section)*

Standard Utility Allowance

What is the number of food stamp assistance units that are sharing expenses?_________________

Will the standard utility allowance be used? ❐ Yes ❐ No What is the start date? / /

What are the allowable types? ***(check all that apply)*** ❐ Heat ❐ Nonheating utility ❐ Phone ❐ None amount_______

Utilities Expenses

What type of utility expenses do you have?

	Amount	Frequency	Start Date
Gas			
Electric			
Phone/Utility Installation			
Water and Sewerage			
Oil			
Garbage/Trash Collection			
Other			

Are the above expenses allowable for cash? ❐ Yes ❐ No

Are the above expenses allowable for food stamp benefits? ❐ Yes ❐ No

What are the allowable amounts forTAFDC ________ EAEDC ________ FS _______ EA ________

Interview Question & Answer Navigator

Asset Statement

*(Record answers in the **Assessed Person Asset Statement** section)*

Liquid Assets

Do you or does anyone in your assistance unit(s) have either cash on hand or any type(s) of bank account?

❐ Yes ❐ No If **yes**, complete the following section.

AU Member Name	Type	Account #	% Owned	% Accessible	Institution Name	Amount	Start Date
							/ /
							/ /
							/ /

Do you want to receive your cash benefits through Direct Deposit? ❐ Yes ❐ No

If **yes**, complete the *Direct Deposit (CA/DD)* form.

Interview Question & Answer Navigator

Asset Statement

*(Record answers in the **Assessed Person Asset Statement** section)*

Financial Holdings

Do you or does anyone in your assistance unit(s) have either stocks, bonds or securities? ❒ Yes ❒ No

If **yes**, complete the following section.

AU Member Name	Type	Unit Value	Number Owned	Beneficiary/ Third Party	Trust Type	Tradeable	Purpose	Amount
					❒ Irrevocable ❒ Revocable	❒ Yes ❒ No		
					❒ Irrevocable ❒ Revocable	❒ Yes ❒ No		
					❒ Irrevocable ❒ Revocable	❒ Yes ❒ No		

Insurance

Do you or does any member of your assistance unit(s) have either life insurance, burial insurance or pre-paid funeral? ❒ Yes ❒ No

If **yes**, complete the following section.

AU Member Name/ Policy Owner	Type	Policy Number	Face Value	Prepaid Funeral Amount	Carrier/ Undertaker	Current Cash Surrender Value	Start Date
							/ /
							/ /
							/ /

Vehicle

Do you or does any member of your assistance unit(s) have a vehicle or vehicles? ❒ Yes ❒ No

If **yes**, complete the following section.

AU Member Name/ Owner	Type	Year/Make Model	Registered	Vehicle Use	VIN Number	Fair Market Value	Amount Owed	Equity Value	Plate/ State
			❒ Yes ❒ No						
			❒ Yes ❒ No						
			❒ Yes ❒ No						

Interview Question & Answer Navigator

Asset Statement

*(Record answers in the **Assessed Person Asset Statement** section)*

Real Property

Do you or does any member of your assistance unit have any building(s), land, real estate or burial plots? ❐ Yes ❐ No

If **yes**, complete the following section.

AU Member Name/Owner	Type/Description/Location	Fair Market Value	Lien Amount	Equity Value

Pensions

Do you or does any member of your assistance unit(s) have any pension(s) or retirement account(s)? ❐ Yes ❐ No

If **yes**, complete the following section.

AU Member/Owner	Type	Name of Institution	Account Number	Amount	Start Date
					/ /
					/ /
					/ /

Refunds

Have you or has any member of your assistance unit received a tax refund or an Earned Income Credit (E.I.C.)? ❐ Yes ❐ No

If **yes**, complete the following section.

AU Member Name	Type	Retained E.I.C. amount	Amount
	❐ Earned Income Credit ❐ Federal Income Tax ❐ State Income Tax		
	❐ Earned Income Credit ❐ Federal Income Tax ❐ State Income Tax		

Interview Question & Answer Navigator

Asset Statement

*(Record answers in the **Assessed Person Asset Statement** section)*

Transfer of Assets

Have you or has anyone in your assistance unit(s) sold, traded, given away or transferred anything of value?

❒ Yes ❒ No

If **yes**, complete the following section.

AU Member Name & Relationship	Type	Date of Transfer	Reason	Gross Value
		/ /		
		/ /		
		/ /		

Other Assets

Do you or does anyone in your assistance unit have any "OTHER" assets? ❒ Yes ❒ No

If **yes**, complete the following section.

AU Member Name	Type	Is Asset Inaccessible?	Value
		❒ Yes ❒ No	
		❒ Yes ❒ No	
		❒ Yes ❒ No	

Interview Question & Answer Navigator

Work Requirements

*(Record information in the **Work Requirements** section)*

TAFDC

Exemption Status for TAFDC AU ❒ Exempt ❒ Nonexempt **Reason** _______________

AU Member Name ____

Is AU Member exempt from **Work Program**? ❒ Yes ❒ No **Start Date** / / **Reason** _______________

Is AU Member **complying** with Work Program requirements? ❒ Yes ❒ No **Start Date** / / **Reason** _______________

(Complete for Other Parent in AU)

Other Parent Name ____

Is Other Parent **exempt**? ❒ Yes ❒ No **Start Date** / / **Reason** _______________

Is Other Parent exempt from **Work Program**? ❒ Yes ❒ No **Start Date** / / **Reason** _______________

Is Other Parent **complying** with Work Program requirements? ❒ Yes ❒ No **Start Date** / / **Reason** _______________

ESP

If AU Member is Work Program required, what is the ESP Participation start date? **Start Date** / /

Is AU Member **complying** with Work Program requirements? ❒ Yes ❒ No **Start Date** / / **Reason** _______________

(Complete for Other Parent in AU)

If Other Parent is Work Program required, what is the ESP Participation start date? **Start Date** / /

Is Other Parent **complying** with Work Program requirements? ❒ Yes ❒ No **Start Date** / / **Reason** _______________

WORK SEARCH

Work Search Begin Date	Work Search End Date	Orientation Date
/ /	/ /	/ /

(Complete for Other Parent in AU)

Work Search Begin Date	Work Search End Date	Orientation Date
/ /	/ /	/ /

EAEDC

AU Member Name ____

Is AU Member **Work Program** required for EAEDC? ❒ Yes ❒ No **Start Date** / / **Reason** ________________

Is AU Member **complying** with Work Program requirements? ❒ Yes ❒ No **Start Date** / / **Reason** ________________

Interview Question & Answer Navigator

Work Requirements

*(Record information in the **Work Requirements** section)*

Food Stamps

AU Member Name ____

Is AU Member **Work Program** required for Food Stamps? ❒ Yes ❒ No **Start Date** / / **Reason** ____________________

Is AU Member **complying** with Work Program requirements? ❒ Yes ❒ No **Start Date** / / **Reason** ____________________

(Complete for Other Parent in AU)

Other Parent Name ____

Is Other Parent **Work Program** required for Food Stamps? ❒ Yes ❒ No **Start Date** / / **Reason** ____________________

Is Other Parent **complying** with Work Program requirements? ❒ Yes ❒ No **Start Date** / / **Reason** ____________________

Food Stamp Employment &Training (FS/ET)

Is AU Member meeting requirements for FS/ET? ❒ Yes ❒ No **Start Date** / / **Reason** ____________________

Is AU Member **complying** with FS/ET requirements? ❒ Yes ❒ No **Start Date** / / **Reason** ____________________

(Complete for Other Parent in AU)

Other Parent Name ____

Is Other Parent meeting requirements for FS/ET? ❒ Yes ❒ No **Start Date** / / **Reason** ____________________

Is Other Parent **complying** with FS/ET requirements? ❒ Yes ❒ No **Start Date** / / **Reason** ____________________

Reminder: For all work required AUs the ESP Workflow must be completed.

Interview Question & Answer Navigator

Nonfinancials

(*Record answers in the* ***Assessed Person Nonfinancial Statement*** *section.*)

Absence *(If more than one absent/deceased parent attach a separate sheet and T-A34/36.)*

Absent/Deceased Parent Name	SSN	Is Parentage Issue Identified? ❒ Yes ❒ No
Reason for Absence	Absence Start Date / /	Absence End Date / /

Child Support Cooperation

Will You Cooperate with Child Support Proceedings? ❒ Yes ❒ No	Date of Cooperation / /	Date of Referral / /	Start Date / / End Date / / Scheduled End Date / /

Has good cause been claimed? ❒ Yes ❒ No If **yes**, check reason. ❒ Conceived as a result of incest/rape ❒ Adoption proceedings pending ❒ Adoption decision pending ❒ Physical/emotional or Domestic Violence risk ❒ Other(specify) ___________________________________

How is absent parent related to the child? ***(check one)*** ❒ Adoptive Father ❒ Natural Mother ❒ No Relationship
Child's Name ________________________________ ❒ Adoptive Mother ❒ Natural Father
Child's D.O.B. ____/____/______ ❒ Other____

How is absent parent related to the child? ***(check one)*** ❒ Adoptive Father ❒ Natural Mother ❒ No Relationship
Child's Name ________________________________ ❒ Adoptive Mother ❒ Natural Father
Child's D.O.B. ____/____/______ ❒ Other____

Absent Parent Personal Information

Absent Parent Last/Alias Name	Alias First Name	Alias Middle Name	Date of Birth / /
Place of Birth (include city, state and country)			
Physical description (for example, race, height, weight, eye color, hair color, other identifying characteristics)			

Absent Parent Location

Current Address	Telephone Number	Date Last Lived Together / /
Last Known Address (if you do not know current address)		Date / /
City	State	

Absent Parent Marital Status

❒ For Absent Parent to Mother **Status Date** / /	❒ Divorced ❒ Annulled	❒ Married ❒ Never Married	❒ Separated ❒ Legally Separated	❒ Widowed ❒ Unknown
❒ For Absent Parent to Other (current) **Status Date** / /	❒ Divorced ❒ Annulled	❒ Married ❒ Never Married	❒ Separated ❒ Legally Separated	❒ Widowed ❒ Unknown
❒ For Absent Parent to AU Member **Status Date** / /	❒ Divorced ❒ Annulled	❒ Married ❒ Never Married	❒ Separated ❒ Legally Separated	❒ Widowed ❒ Unknown

Interview Question & Answer Navigator

Nonfinancials

(*Record answers in the **Assessed Person Nonfinancial Statement** section*)

Court Location for Legal, Separated or Divorce

City State

Marriage Location

City State Date / /

Did you ever file a joint tax return with the Absent Parent? ❐ Yes ❐ No If **yes**, when ____________________________

Absent Parent Records

Motor Vehicle

Driver's License Number		License State	Vehicle Identification Number (VIN)	
Make	Model	Model Year	License Plate Number	Plate State

Military

Military Branch ***(check all that apply)*** ❐ Air Force ❐ Army ❐ Coast Guard ❐ Marine Corps ❐ Navy ❐ Unknown

Current Status
(check one) ❐ Absent Without Leave (AWOL) ❐ Active ❐ Dishonorable Discharge ❐ Reserve
❐ Jailed by Uniformed Services ❐ Honorable Discharge ❐ Unknown ❐ Retired

Benefits

Veterans' Administration ❐ Yes ❐ No Social Security Administration ❐ Yes ❐ No

Criminal Record

Criminal Record ❐ Yes ❐ No Currently Incarcerated ❐ Yes ❐ No Where ______________________________

Employment

Affiliation ❐ Employment Name ____ Local #_______________

Address ____ Telephone___________________________________

Affiliation Status ❐ Current ❐ Last Known ❐ Unknown Start Date / / End Date / /

Agreement

Is there an agreement? ❐ Yes ❐ No Agreement Type ❐ Court Ordered ❐ Voluntary ❐ Child Support Type
❐ Spousal Support ❐ Alimony

Pay on a reqular basis? ❐ Yes ❐ No Start Date / / End Date / / Obligation Amount$_____________

Frequency *(check one)* ❐ Monthly ❐ Weekly ❐ Biweekly ❐ SemiMonthly ❐ Quarterly ❐ SemiAnnually ❐ Annually

Health Insurance

Is there Health Insurance? ❐ Yes ❐ No Court Ordered/Responsible ❐ Yes ❐ No Paternity Acknowledged ❐ Yes ❐ No

Absent Parent Affidavit

I, the custodial parent, certify under penalty of perjury that ____ has been continuously absent since ___/___/___________ and that all other information provided by me is true to the best of my knowledge.

Signature____ Date __________________

Witness Signature_____________________________________ Date __________________

Interview Question & Answer Navigator

Nonfinancials

(*Record answers in the* ***Assessed Person Nonfinancial Statement*** *section*)

Disability

Name of Disabled AU Member		Determination Source
Date of Determination / /	Duration Declaration ❒ Yes ❒ No	Is there another party responsible? ❒ Yes ❒ No

Physical/Mental Disability

Is review required? ❒ Yes ❒ No Type of Review *(check one)* ❒ Medical Report ❒ PRO Disability Supplement

Date Report given to Applicant? / / Date Report Returned / / Is Report Complete? ❒ Yes ❒ No

Date of Completion / /

Report Results

Duration ❒ Less than 30 days ❒ 30 - 45 days ❒ 60 - 89 days

❒ 90 - 119 days ❒ 4 - 6 months ❒ 7 - 9 months

❒ 10 - 12 months ❒ One year or more ❒ Permanent

Exam Date / / Onset Date / / End Date / / Signed Date / /

Provider Number_________________________________ Is person able to work? ❒ Yes ❒ No Number of Hours per Week________

Review Tracking

Is this a priority? ❒ Yes ❒ No Date Sent / / Date Returned / /

❒ Approval ❒ Denial ❒ Incomplete

Disposition Reason ***(check one)*** ❒ Improvement not demonstrated ❒ Vocational allowance ❒ Equals criteria listing

❒ Meets criteria ❒ Other **(specify)** ____

Disposition Date / / Expiration Date / /

Conclusion

MRC Referral Date / / AP-SSI-1 form signed ❒ Yes ❒ No

AP-SSI-1 Referral Date / / AP-SSI-1 form returned date / /

Interview Question & Answer Navigator

Nonfinancials

*(Record answers in the **Assessed Person Nonfinancial Statement** section)*

Accident and Incident

AU Member Name ____

Episode

❒ Accidental Injury ❒ Auto Accident ❒ Dog Bite ❒ Employment Related Accident ❒ Employment Related - Discrimination

❒ Employment Related - Sexual Harassment ❒ Employment Related - Wrongful Termination ❒ Lead Paint ❒ Malpractice ❒ Slip/Fall

❒ Wrongful Death ❒ Other (specify) ____________________

Description of Injury

❒ Ankle/Foot ❒ Arm ❒ Back ❒ Burn ❒ Elbow ❒ Hand

❒ Knee ❒ Leg ❒ Neck ❒ Wrist/Hand ❒ Other (specify) ___________________________

Location of accident/incident____ Accident Date / /

Assignment

Is this accident/incident reason for application? ❒ Yes ❒ No Will you cooperate in the assignment? ❒ Yes ❒ No

Is the assignment form (A16/17) signed? ❒ Yes ❒ No

Name of the person who signed the assignment form? ____

What is the relationship to the assessed person? *(check one)* ❒ Grantee ❒ Injured Person ❒ Authorized Representative ❒ Attorney

Is a Workers' Compensation claim required? ❒ Yes ❒ No

Lawsuit Claim

Did you file a lawsuit? ❒ Yes ❒ No If yes, what kind of action did you file? ❒ Lawsuit ❒ Claim Claim filed date / /

Is settlement pending?❒ Yes ❒ No

Did you receive a settlement? ❒ Yes ❒ No If yes, provide the following information.

Date of Settlement / /

____
Court Name City State

Third Party

Is a Third Party/Employer involved? ❒ Yes ❒ No If yes, complete the following.

____
Third Party/Employer Name Address City State Telephone #

____
Contact person's name for Third Party/Employer

For Insurance Companies, complete the following.

____
Insurance Company Name Address Telephone #

Interview Question & Answer Navigator

Nonfinancials

(*Record answers in the Assessed Person Nonfinancial Statement section*)

Education *(Attach separate sheet if needed.)*

Complete the following section for all adult AU members who are over 5 and under 60 years of age.

1.

AU Member Name			School Name/Address			
Enrollment Status	Date Entered / /	End Date / /	Graduation Date / /	Degree Type	Total Credit Hours	Attendance %
Employment Objective	Health Insurance Offered ❒ Yes ❒ No		Current Grade Level	**Highest Grade Level Completed**		

2.

AU Member Name			School Name/Address			
Enrollment Status	Date Entered / /	End Date / /	Graduation Date / /	Degree Type	Total Credit Hours	Attendance %
Employment Objective	Health Insurance Offered ❒ Yes ❒ No		Current Grade Level	**Highest Grade Level Completed**		

3.

AU Member Name			School Name/Address			
Enrollment Status	Date Entered / /	End Date / /	Graduation Date / /	Degree Type	Total Credit Hours	Attendance %
Employment Objective	Health Insurance Offered ❒ Yes ❒ No		Current Grade Level	**Highest Grade Level Completed**		

4.

AU Member Name			School Name/Address			
Enrollment Status	Date Entered / /	End Date / /	Graduation Date / /	Degree Type	Total Credit Hours	Attendance %
Employment Objective	Health Insurance Offered ❒ Yes ❒ No		Current Grade Level	**Highest Grade Level Completed**		

5.

AU Member Name			School Name/Address			
Enrollment Status	Date Entered / /	End Date / /	Graduation Date / /	Degree Type	Total Credit Hours	Attendance %
Employment Objective	Health Insurance Offered ❒ Yes ❒ No		Current Grade Level	**Highest Grade Level Completed**		

Interview Question & Answer Navigator

Nonfinancials

(*Record answers in the **Assessed Person Nonfinancial Statement** section*)

Teen Parent *(Complete only if household includes a teen parent.)*

Teen Parent Name & Address	**Date of Birth** / /

With whom do you live? ❐ Responsible Adult ❐ Foster Parent ❐ Guardian ❐ Other Responsible Adult ❐ Spouse
❐ None (living independently) ❐ Other (**specify**) ____________________

Teen Parent Referral

Is DSS referral required? ❐ Yes ❐ No If yes, state reason.	❐ Other Reason **(specify)**

Was DSS referral refused? ❐ Yes ❐ No	Was an authorization release received? ❐ Yes ❐ No Relationship	Date request sent to Central Office? / /

Teen Parent Assessment

Date referral sent to DSS / /	Date assessment returned / /

TLP Priority ❐ Yes ❐ No	Disposition Date Results sent to TAO / /	Open DSS case ❐ Yes ❐ No Graduated from DSS TLP ❐ Yes ❐ No	Health and Safety ❐ Yes ❐ No

Teen Parent Referral

Name of Program	Date of Availability / /	Date Assessment Results Sent / /

Teen Parent agrees with assessment? ❐ Yes ❐ No	Teen Parent appealing assessment results? ❐ Yes ❐ No	51A filed? ❐ Yes ❐ No

Action Taken Date Update sent to Central Office / /

Teen Parent Placement Record

Date of Placement / /	If delay in placement state reason.
Date of Discharge / /	Reason for Discharge

Other Reason

Teen Parent Outreach

Reason for Referral *(check one)*

- ❐ No visible means of support
- ❐ Disability exempt no appointment
- ❐ No Open DSS case
- ❐ Diagnosed mental disability
- ❐ May be victim of Domestic Violence
- ❐ Jeopardy of losing housing
- ❐ Housing may be unsafe
- ❐ Failed SJS requirement
- ❐ Open DSS case
- ❐ Refused Vocational Assessment
- ❐ Need Fuel Assistance and is not eligible
- ❐ Participating in Education and Training activities
- ❐ Substance Abuse Treatment
- ❐ Other (specify)____________________

High Priority ❐ Yes ❐ No Date of Referral / /

Interview Question & Answer Navigator

Nonfinancials

(*Record answers in the* ***Assessed Person Nonfinancial Statement*** *section*)

Noncitizen *(Attach separate sheet if needed.)*

1.

Last Name	First Name	MI	Alien Registration Number	**Date of Entry** / /	Sponsored Noncitizen ❒ Yes ❒ No **If yes, fill out Sponsor section on page 24**
INS Designation	Section Reference	Other Section Reference	Country of Birth		
Date of Massachusetts Residency / /	Status Start Date / /	Expiration Date / /	Pursuing Citizenship ❒ Yes ❒ No	Do you have 50% American Indian blood? ❒ Yes ❒ No	
Country of Citizenship	Other Country of Citizenship	Ten or more years of work? ❒ Yes ❒ No			
Reason if not Military Experience					

2.

Last Name	First Name	MI	Alien Registration Number	**Date of Entry** / /	Sponsored Noncitizen ❒ Yes ❒ No **If yes, fill out Sponsor section on page 24**
INS Designation	Section Reference	Other Section Reference	Country of Birth		
Date of Massachusetts Residency / /	Status Start Date / /	Expiration Date / /	Pursuing Citizenship ❒ Yes ❒ No	Do you have 50% American Indian blood? ❒ Yes ❒ No	
Country of Citizenship	Other Country of Citizenship	Ten or more years of work? ❒ Yes ❒ No			
Reason if not Military Experience					

3.

Last Name	First Name	MI	Alien Registration Number	**Date of Entry** / /	Sponsored Noncitizen ❒ Yes ❒ No **If yes, fill out Sponsor section on page 24**
INS Designation	Section Reference	Other Section Reference	Country of Birth		
Date of Massachusetts Residency / /	Status Start Date / /	Expiration Date / /	Pursuing Citizenship ❒ Yes ❒ No	Do you have 50% American Indian blood? ❒ Yes ❒ No	
Country of Citizenship	Other Country of Citizenship	Ten or more years of work? ❒ Yes ❒ No			
Reason if not Military Experience					

Interview Question & Answer Navigator

Nonfinancials

(*Record answers in the* ***Assessed Person Nonfinancial Statement*** *section*)

Sponsor ***(Attach separate sheet if needed.)***

1.

Sponsor Name		Sponsor's Spouse's Name
Organization Name		Type of Sponsor
Affidavit of Support Date / /	Affidavit of Support End Date / /	TAFDC Deeming Required ❒ Yes ❒ No
Food Stamp Deeming Required ❒ Yes ❒ No	EA Deeming Required ❒ Yes ❒ No	If Deeming not required state reason.

2.

Sponsor Name		Sponsor's Spouse's Name
Organization Name		Type of Sponsor
Affidavit of Support Date / /	Affidavit of Support End Date / /	TAFDC Deeming Required ❒ Yes ❒ No
Food Stamp Deeming Required ❒ Yes ❒ No	EA Deeming Required ❒ Yes ❒ No	If Deeming not required state reason.

3.

Sponsor Name		Sponsor's Spouse's Name
Organization Name		Type of Sponsor
Affidavit of Support Date / /	Affidavit of Support End Date / /	TAFDC Deeming Required ❒ Yes ❒ No
Food Stamp Deeming Required ❒ Yes ❒ No	EA Deeming Required ❒ Yes ❒ No	If Deeming not required state reason.

Interview Question & Answer Navigator

Nonfinancials

(*Record answers in the* ***Assessed Person Nonfinancial Statement*** *section*)

Family Cap

Do you want to apply for an exception and/or waiver of the Family Cap rule? ❐ Yes ❐ No

If **yes**, complete the following sections and the *Family Cap Exception Waiver* and *Case History* forms.

AU Member Name	Name of Pregnant/Parenting AU Dependent	Pregnant AU Member Due Date? / /
Is AU a two-parent Household? ❐ Yes ❐ No	Is there an existing,TAFDC case? ❐ Yes ❐ No	
What is the **expected** Family Cap Date? / /	What are the child(ren) of records name(s) and date of birth(s)? **(1)** ____________ / /	
What is the **grantee** Family Cap Date? / /	**(2)**____________ / /	
What is the name(s) of the dependent child(ren)? (1) ____________ (2)____________	What is the name (s) of the dependent child(ren) not in the pregnant case? (1) ____________ (2)____________	

What is the reason for the dependent child(ren) not being in the pregnancy case? ______________________________

____

____

Family Cap

Prior TAFDC AU Closing Date ? / /	Central Office NOB Unit Reported Date of Birth? / /	Date Dependent Children Closed on TAFDC AU ? / /
Reported Birth Date of Dependent Child(ren) ? / /	Date **Family Cap** Appointment Letter Sent? / /	**Waiver Denial Date** / /
Family Cap Exception Requested? ❐ Yes ❐ No	What is the **Exception** Reason?	What is the **Waiver** Reason?

Blank Page

I certify under penalty of perjury that I have read, or have had read to me, the information given/displayed in this document and that such information is true to the best of my knowledge. I understand that giving false or misleading statements or misrepresenting, hiding or withholding facts, either orally or in writing, to establish eligibility for Transitional Aid to Families with Dependent Children (TAFDC), MassHealth and Children's Medical Security Plan (CMSP), Emergency Aid to the Elderly, Disabled and Children (EAEDC), Emergency Assistance (EA) and the Food Stamp Program (FSP) is fraud, an Intentional Program Violation (IPV), and is punishable by civil and criminal penalties.

If I am eligible for TAFDC or EAEDC from the Department of Transitional Assistance (DTA), I may receive MassHealth automatically. If I am not eligible for TAFDC, both MassHealth, which is run by MassHealth, and CMSP, which is run by the Department of Public Health (DPH), will use the information on my application to determine if I am eligible for MassHealth or CMSP.

I am aware of my responsibility to report (within 10 days) in person, by phone or by mail to the worker representing the appropriate agency any changes in income, assets, address, living arrangement, family size, employment, health insurance coverage and health insurance premiums, or any other circumstances of all members of my TAFDC, MassHealth, CMSP, EAEDC or EA filing unit or my FSP assistance unit that may affect their/my eligibility for these programs.

I understand that for food stamp benefits, to receive a deduction for child care expenses, rent or mortgage payments, utility or shelter expenses, child support paid to a non-household member, or medical expenses, I must report and provide verification to DTA. Failure to report or verify, the above-listed expenses(s), could mean that I will receive less food stamp benefits each month, and will be seen as my statement that the household does not want to receive a deduction for the unreported or unverified expense(s).

I understand that by signing below, all FSP household members between the ages of 16 and 60 are automatically work registered and enrolled in the Food Stamp Employment and Training Program (FS/E&T). The automatic FS/E&T enrollment allows household members to easily access FS/E&T services. Nonexempt FSP household members will be notified of work requirements, have exemptions and penalties for noncompliance explained and be referred to an employment activity, if appropriate.

I know that I must also report if I or any member of my TAFDC or EAEDC filing unit, FSP assistance unit or MassHealth/CMSP household files a claim or sues someone for damages or settles a lawsuit or legal claim. I understand that a violation of the duty to report within 10 days may be found an indication of fraud for which I may be prosecuted.

I authorize any and all health care providers to release to DTA and MassHealth and their medical agents any medical records of mine or my dependents that may be pertinent to receiving benefits and services.

By signing below, I give permission to DTA and MassHealth to verify and investigate the information I have given that relates to the determination of my eligibility for assistance.

I understand that if I or any members of my family are in an accident or are injured in some other way, in consideration of public assistance benefits provided to me and/or other members of my family, as a result of such an incident, under any program of assistance administered by either MassHealth or DTA, including the programs of MassHealth, TAFDC, EAEDC, I do hereby agree to pay and I do assign to MassHealth and DTA an amount of money equal to the amount of public assistance provided by such agencies. This money will be paid from any money that I or any other member of my family or heirs or legal representatives receive as a result of such accident/incident from any person, insurer, or other source, including but not limited to, any liability insurance carrier including my own or another's insurer, or workers' compensation carrier even if the name of the person, insurer, or other source is not known as of this date.

I understand that if I were already eligible for medical benefits at the time of the accident/incident, MassHealth and DTA will recover only medical expenses and any financial assistance provided as a result of the accident/incident. I also understand that if I applied for public assistance benefits as a result of the accident/incident, MassHealth and DTA will recover all public assistance benefits, both financial and medical, provided to me and other members of my family.

I agree to notify MassHealth and DTA as soon as any insurance claim, civil action, or other proceeding is begun to recover damages arising out of this incident, and to provide any new information as it becomes available.

I agree to cooperate fully with MassHealth and DTA and to provide any information and file claims necessary to establish liability and recover damages. I understand that failure to cooperate with MassHealth and DTA may be grounds for terminating or denying medical benefits and/or financial assistance.

I give MassHealth and DTA the right to release any information about assistance provided in order to assist in the recovery of such assistance.

I give MassHealth and DTA permission to review all records at the Department of Industrial Accidents and any other records that other entities or persons may have pertaining to liability and damages.

I have read "Your Right to Know," the appropriate program brochure(s) and the MassHealth booklet or have had them read to me, and understand their contents and my rights and responsibilities. If I have any questions about the brochures or any of this information, I will ask my worker. I can also call Recipient Services at 1-800-445-6604 if I have trouble reading or understanding any of this information.

I authorize DTA to contact federal and state agencies, local housing authorities, providers under contract with DTA, welfare departments of other states and financial institutions, concerning my eligibility for assistance and services, and schools/institutions regarding my children's attendance records.

I give permission for the above-mentioned agencies, schools and institutions to release information to DTA to be used in the determination of my eligibility and the amount of benefits.

I understand that by signing below I authorize DTA and the Massachusetts Executive Office of Health and Human Services to share information about my eligibility for public assistance benefits with electric distribution companies, gas distribution companies and eligible telecommunications carriers pursuant to confidentiality agreements executed by these companies and carriers for the sole purpose of certifying my eligibility for discount utility service rates. I also authorize DTA to share my information with the Department of Housing and Community Development (DHCD) for the purpose of enrolling me in the Heat & Eat Program.

I understand that by signing below I authorize DTA to share information about me and my dependents under age 19 with the Department of Education (DOE) for the purpose of automatically certifying my dependents for school nutrition programs and information about me, my dependents under age 5 and any pregnant woman in my assistance unit with DPH for the purpose of providing referrals for Woman, Infants and Children (WIC) Program nutrition services.

I certify under penalty of perjury that my answers are correct and complete to the best of my knowledge and that all members of the food stamp household are either U.S. citizens or aliens in satisfactory immigration status.

I give permission for my current and former employers and health insurers to release to the MassHealth and/or to DPH any and all information they have about my or my family's health insurance coverage. This includes, but is not limited to, information about policies, premiums, coinsurance, deductibles and covered benefits that are, may be, or should have been available to me or members of my family group.

I also understand that by signing below, I give permission to MassHealth to go after and collect third-party payments for medical care and medical support from the parent of any child under age 19 who is applying for benefits.

If I or any member of my family is eligible for MassHealth, CommonHealth, MassHealth Family Assistance or CMSP, I understand that I may have to pay a premium set by the MassHealth or DPH.

I have read and understood the AP-SSI authorization form. I hereby authorize the Commonwealth to withhold an amount from my retroactive lump sum SSI check equivalent to the cash benefits paid to me by the EAEDC program.

Food Stamp Penalty Warning

I understand that if I or any member of my food stamp household intentionally breaks any of the rules listed below, that person will be barred from the FSP for **one year** after the first violation, **two years** after the second violation and **permanently** after the third violation. The person may also face criminal prosecution under applicable state and federal laws. These rules are:

- Do not give false information or hide information to get food stamp benefits.
- Do not trade or sell food stamp benefits.
- Do not alter EBT cards to get food stamp benefits you are not entitled to receive.
- Do not use food stamp benefits to buy ineligible items, such as alcoholic drinks and tobacco.
- Do not use someone else's food stamp benefits or EBT card, unless you are an "authorized representative."

I also understand the following penalties:

- Individuals who commit a TAFDC or EAEDC IPV that is confirmed in an Administrative Disqualification Hearing (ADH), will be barred from the FSP for the same period the individual is barred from TAFDC or EAEDC.
- Individuals who make a fraudulent statement or representation about their identity or place of residence to receive multiple food stamp benefits simultaneously, will be barred from the FSP for **ten years**.
- Individuals who trade (buy or sell) food stamp benefits for a controlled substance/illegal drug(s), will be barred from the FSP for a period of two years for the first finding, and **permanently** for the second finding.
- Individuals who trade (buy or sell) food stamp benefits for firearms, ammunition or explosives, will be barred from the FSP **permanently**.
- Individuals who trade (buy or sell) food stamp benefits having a value of $500 or more, will be barred from the FSP **permanently**.
- Individuals who are fleeing to avoid prosecution, custody or confinement after conviction for a felony or are violating a condition of probation or parole, are ineligible to participate in the FSP.
- Individuals who fail to comply without good cause with Food Stamp Work Requirements, will be disqualified from the FSP for a period of three months for the first finding, six months for the second finding and twelve months for the third finding. If the individual found to have failed to comply for a third time is the head of the food stamp household, the entire household shall be ineligible to participate in the FSP for a period of six months.

I have read and signed the Food Stamp Penalty Warning in my primary language.

Right to an Interpreter

I understand that I have a right to an interpreter provided by DTA if neither I nor any adult member of my household is able to speak or understand English. I also understand that I can get an interpreter for any DTA fair hearing or bring one of my own. If I need an interpreter for a hearing, I must call the Division of Hearings (DOH) at least one week before the date of my hearing.

Nondiscrimination Statement

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

To file a complaint of discrimination, contact USDA or HHS. Write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TTY). USDA and HHS are equal opportunity providers and employers.

______________________________	_____/_____/________
Your Signature	Date
______________________________	_____/_____/________
Witness (when mark is used for signature)	Date
______________________________	_____/_____/________
Assistance Unit Manager Signature	Date

Yo certifico bajo pena de perjurio que he leído, o que me han leído la información provista en este documento y que tal información es cierta en según mi conocimiento. Yo entiendo que el proveer información falsa o engañar o representar en forma errónea o cubrir hechos, ya sea oralmente o por escrito, para establecer la elegibilidad para la Asistencia Transicional para Familias con Hijos Dependientes (TAFDC), MassHealth y el Plan de Beneficios de Seguridad Médica para Niños (CMSP), Asistencia de Emergencia para Ancianos, Incapacitados y Niños (EAEDC), Asistencia de Emergencia (EA) y el Programa de "Food Stamp" (cupones de alimentos) es fraude, una Violación Intencional del Programa (IPV), y es penable bajo penas civiles y criminales.

Si soy elegible para TAFDC o EAEDC a través del Departamento de Asistencia Transicional (DTA), yo posiblemente recibiré MassHealth automáticamente. Si no soy elegible para TAFDC, tanto MassHealth cuál se dirigida por MassHealth y el Plan de Seguridad Médica para Niños (CMSP), cuál se dirigida por el Departamento de Salud Pública (DPH), usarán la información en mi aplicación para determinar si yo soy elegible para MassHealth o CMSP. Recibiré un aviso por separado sobre mi elegibilidad para estos programas.

Yo tengo conocimiento de mi responsabilidad para reportar (dentro de los 10 días) en persona, por teléfono o por correo al empleado que representa la agencia apropiada cualquier cambio en cuanto al ingreso económico, dirección, arreglos de vivienda, número de miembros de familia, trabajo, seguro médico y primas del seguro médico, o todas otras circunstancias para todos los miembros de la TAFDC, MassHealth, CMSP, EAEDC o EA o unidad de ayuda de cupones de alimentos que pueda afectar la elegibilidad para estos programas.

Entiendo que para los beneficios de cupones de alimentos. para recibir una deducción en los gastos para el cuidado de niño, el alquiler o los pagos de renta, de hipoteca, las utilidades, el pago para asistencia de niño a una persona que no es miembro del hogar, o costos medicos, debo de informar y proporcionar la verificación al DTA. El no informar o averiguar cualquier de los gastos mencionados anteriormente, podría significar que recibiría menos beneficios de cupones alimentos cada mes, y sera considerado como mi declaración que la casa no desea recibir una deducción por los gastos no denunciados o no verificados.

Mediante mi firma al pie de este formulario, me doy por notificado que todos los miembros del grupo familiar en el Programa de Cupones de Alimentos que se encuentren las edades de 16 y 60 años serán automáticamente enlistados en el Programa de Cupones de Alimentos y Empleo y Entremamiento (FS/E&T). El enlistado automático en FS/E&T permite a los miembros del grupo familiar el fácil acceso a los servicios de FS/E&T. Los miembros del grupo familiar en el Programa de Cupones de Alimentos no exceptuados serán notificados acerca de requisitios de empleo y se les explicarán las excepciones y penalidades por falta de cumplimiento, y serán referidos a una actividad de empleo, si es apropiado.

Yo sé que también debo de reportar si yo o algún miembro de mi grupo de TAFDC o EAEDC o unidad de ayuda de cupones de alimentos o MassHealth/CMSP establece un reclamo o entabla juicio por daños, o recibe dinero al acordar un juicio o reclamo legal. Yo entiendo que el fallar con el deber de reportar dentro de los 10 días puede determinarse como una indicación de fraude por lo que yo podría ser enjuiciado.

Yo autorizo a cualquier y todos los proveedores de cuidados de salud para que provean al DTA y MassHealth y sus agentes médicos cualquier historial médico mío o de mis dependientes que puedan ser pertinentes al recibo de beneficios y servicios. Al firmar abajo, yo doy permiso al DTA y MassHealth para verificar e investigar la información que yo he provisto con relación a la determinación de mi elegibilidad para asistencia.

Yo entiendo que si yo o algún otro miembro de mi familia están envueltos en un accidente o se lastiman de alguna otra forma, en consideración por los beneficios de asistencia publica otorgados a mi y/u otros miembros de mi familia, como resultado de dicho incidente, bajo cualquier programa de asistencia administrado por MassHealth o por el DTA, incluyendo los programas de MassHealth, TAFDC y EAEDC, por lo mismo yo estoy de acuerdo en pagar y asigno a MassHealth y al DTA una cantidad de dinero igual a la cantidad de asistencia publica que se me otorga a través de dichas agencias. Este dinero será pagado de cualquier dinero que yo o cualquier otro miembro de mi familia o herederos, o representantes legales reciban como resultado de dicho accidente/incidente de cualquier persona, aseguradora, u otro recurso, incluyendo pero no limitado a, cualquier seguro de responsabilidad civil incluyendo mío propio o el seguro de cualquier otra persona, o compensación por accidente de trabajo aunque el nombre de la persona, asegurador, o cualquier otro recurso no sea conocido en esta fecha.

Yo entiendo que si ya yo fuese elegible para beneficios médicos en el momento del accidente/incidente, MassHealth y el DTA recuperaran solo gastos médicos y cualquier asistencia financiera otorgado como resultado del accidente/incidente. Yo también entiendo que si yo solicite para beneficios de asistencia publica como resultado del accidente/incidente, MassHealth y el DTA recuperaran todos los beneficios de asistencia publica, tanto financieros como médicos, otorgados a mi y a otros miembros de mi familia.

Yo estoy de acuerdo en notificar MassHealth y al DTA tan pronto cualquier reclamación de seguro, acción civil, u otro procedimiento comience para recobrar daños provenientes de ese incidente, y otorgare cualquier información nueva según sea disponible a mi.

Yo estoy de acuerdo en cooperar completamente con MassHealth y el DTA y otorgare cualquier información y radicare reclamaciones necesarias para establecer responsabilidad y para recobrar daños. Entiendo que no cooperar con MassHealth y/o el DTA puede ser motivo para terminar o negar beneficios médicos y/o asistencia económica.

Yo le doy permiso a MassHealth y al DTA a compartir información sobre cualquier asistencia otorgada a mí para poder asistir en la recuperación de tal asistencia.

Yo le doy permiso a MassHealth y al DTA para revisar todos los expedientes en el Departamento de Accidentes Industriales y cualquier otro expediente que otras entidades o personas puedan tener pertinentes a la responsabilidad y a los daños.

Yo he leído o me han leído "Su Derecho de Saber," el folleto(s) del programa apropiado y el folleto de MassHealth, y entiendo sus contenidos, mis derechos y responsabilidades. Si tengo cualquier pregunta sobre los folletos o cualquier información contenida aquí, le preguntaré a mi trabajador. También puedo llamar al Servicio del Recipiente 1-800-445-6604 si tengo dificultad en leer o entender cualquier parte de esta información.

Yo autorizo al DTA para que se comuniquen con las agencias federales y estatales, oficinas locales de vivienda autoridades, proveedores bajo contrato con el DTA, departamentos de beneficencia social de otros estados e instituciones financieras con respecto a mi elegibilidad para asistencia y servicios, y escuelas/instituciones con respecto a los registros de asistencia de mis niños.

Les doy permiso a los indicados anteriormente agencias, escuelas e instituciones para proveer información al DTA para su uso en la determinación de mi elegibilidad y la cantidad de los beneficios.

Entiendo que al firmar abajo autorizo al DTA y la Oficina Ejecutiva de Massachusetts de Salud y de Servicios Humanos a revelar la información sobre mi elegibilidad para los beneficios de asistencias públicas con as compañías eléctrica, de gaz y de telecomunicaciones elegibles conforme a los acuerdos para respetar la confidencialidad ejecutados por estas compañías y portadores. También autorizo a DTA para compartir mi información con el Departamento de Vivienda y del Desarrollo de la Comunidad con el fin de alistarme en el Programa de Calefacción y Comida.

Entiendo que al firmar abajo el presente documento autorizo al DTA a ceder información sobre mi persona y mis dependientes menores de 19 años al Departamento de Educación (DOE) con el fin de certificar automáticamente a mis dependientes menores de 5 años y a toda mujer embarazada a mi cargo en mi unidad de asistencia en el DPH con el fin de proporcionar referencias para los servicios de nutrición del Programa Mujeres, Menores y Niños (WIC).

Certifico bajo pena o perjurio que mis respuestas son correctas, las cuales han sido completadas conforme a mi leal saber y entender y que todos los miembros de la unidad familiar de cupones de alimentos son ciudadanos o residentes legales de los Estados Unidos en estado de inmigración satisfactorio.

Yo doy permiso a mi empleador actual y anterior y los seguros médicos para proveer a MassHealth y/o al DPH toda y cualquier información que ellos tengan sobre el seguro médico mío y/o de mi familia. Esto incluye, pero no está limitado, a información sobre pólizas, primas, coasegurador, monto deducible y beneficios que son, podrían ser, o deberían haber estado disponibles para mí o miembros de mi grupo familiar.

Yo también entiendo que al firmar en la parte inferior, yo doy permiso MassHealth para perseguir y colectar los pagos de terceras personas para el cuidado médico y apoyo médico de los padres de cualquier niño menor de 19 años de edad que esté aplicando para beneficios.

Si yo o cualquier miembro de mi familia es elegible para MassHealth, CommonHealth, Asistencia Familiar de MassHealth o CMSP, yo entiendo que podría pagar una prima fijada por la MassHealth o el DPH.

Yo he leído y entiendo el formulario de autorización de AP-SSI. Yo autorizo al Estado a retener una cantidad de la suma retroactiva del cheque de SSI equivalente al beneficio en efectivo pagado por el programa EAEDC.

Aviso Penal Acerca de Los Cupones De Alimentos

Yo entiendo que si yo o cualquier persona de mi hogar que recibe cupones de alimentos rompe intencionalmente cualquiera de las reglas enumeradas abajo, aquella persona va a ser excluida del Programa de Cupones de Alimentos por un año después de la primera violación, por dos años después de la segunda violación, y permanentamente después de la tercera violación. Puede ser que la persona también tendrá que enfrentar procesamiento criminal bajo las leyes estatales y nacionales que se aplican. Estas reglas son:

- No entregue información falsa ni esconda información para conseguir beneficios de cupones de alimentos.
- No cambie ni venda beneficios de cupones de alimentos.
- No modifique las tarjetas EBT para conseguir beneficios de cupones de alimentos a los cuales no tiene derecho.
- No use los beneficios de cupones de alimentos para comprar productos inelegibles, como el alcohol y el tabaco.
- No use los beneficios de cupones de alimentos ni la tarjeta EBT de otra persona, a no ser que usted es representante autorizado.

También yo entiendo las siguientes penas:

- Individuos que cometen una Violación Intencional del Programa (IPV) de un programa de TAFDC o EAEDC que está confirmado en una Audiencia Administrativa de Descalificación(ADH), van a estar excluidos del Programa de Cupones de Alimentos por el mismo período en que está excluido un programa de TAFDC o EAEDC.
- Individuos que hacen una declaración o representación fraudulenta acerca de su identidad o lugar de residencia para recibir beneficios múltiples de cupones de alimentos simultaneamente, van a estar excluidos del Programa de Cupones de Alimentos por diez años.
- Individuos que cambian (compran o venden) beneficios de cupones de alimentos por una sustancia controlada/ drogas ilegales van a estar excluidos del Programa de Cupones de Alimentos por dos años después de la primera instancia y permanentemente después de la segunda instancia.
- Individuos que cambian (compran o venden) beneficios de cupones de alimentos por armas de fuego, municiones o explosivos van a estar excluidos del Programa de Cupones de Alimentos permanentemente.
- Individuos que cambian (compran o venden) beneficios de cupones de alimentos con un valor de $500 o más van a estar excluidos del Programa de Cupones de Alimentos permanentemente.
- Individuos que están huyendo para evitar procesamiento, custodia o encarcelación después de la condena por un delito mayor o los que están violando una condición de libertad condicional, son inelegibles para participar en el Programa de Cupones de Alimentos.
- Individuos que no cumplen los Requisitos de Trabajo del Programa de Cupones de Alimentos sin buena razón, van a estar descalificados del Programa del Cupones de Alimentos por un período de tres meses después de la primera instancia, seis meses en la segunda instancia, y doce meses en la tercera instancia. Si el individuo que se ha determinado que no ha cumplido por tercera vez es la cabeza de la casa que recibe cupones de alimentos, todos los miembros de la casa van a estar inelegibles para participar en el Programa de Cupones de Alimentos por un período de seis meses.

He leído y firmado el formulario Aviso Penal Acerca de Los Cupones De Alimentos en mi idioma primario.

El Derecho a Un Intérprete

Yo entiendo que tengo el derecho a un interprete provisto por DTA si ni yo ningún miembro adulto de mi casa que recibe cupones de alimentos puede hablar o entender inglés. Yo entiendo también puedo conseguir a un interprete por cualquier DTA audiencia o traiga uno mi propio. Si necesito un interprete por una audiencia, debo llamar la División de Audiencias por lo menos una semana antes de la fecha de su audiencia.

Falta de Discriminación Declaración

Conforme a la ley federal y el Ministerio de Agricultura de los Estados Unidos (USDA) y las nórmas del Departamento de la Salud y de los Servicios Humanos (HHS), la discriminación a base de raza, de color, de origen nacional, de sexo, de edad, o de inhabilidad es prohibida. Bajo el Acta de Estampilla para Alimentos (Food Stamp Act) y las nórmas del USDA, también es prohibida la discriminación a base de religión o de creencias políticas.

Para presentar una queja sobre discriminación, entre en contacto con el USDA o HHS. Escriba el USDA, el Director, la Oficina de los Derechos Civiles, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 o llame al (800) 795-3272 (voz) o (202) 720-6382 (TTY). Escriba HHS, el Director, la Oficina de los Derechos Civiles, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 o llame al (202) 619-0403 (voz) or (202) 619-3257 (TTY). El USDA y HHS son proveedores y patrones de igual oportunidad.

____ ______/______/_________

Su Firma Fecha

____ ______/______/_________

Testigo (cuando esté marcado para la firma) Fecha

____ ______/______/_________

Firma del Trabajador(a) de la Unidad de Asistencia Fecha