KEEP THIS BOOKLET FOR YOUR RECORDS

Assistance Application

Information Booklet

Welcome to the State of Michigan Department of Human Services (DHS)

We have programs to help you and/or your household (everyone living in your home) with food, medical care, child care, cash and emergencies. We can also tell you about other programs and resources that may help meet your needs. We look forward to helping you and your household.

If you need help with reading, writing, hearing, etc., please tell us. If you need an interpreter, we will provide one or you may bring your own.

Steps to Assistance

1 - **Read this booklet and keep it.** It tells you about our programs and has important information. **When you sign the assistance application, you agree to the rules in this booklet.**

2 - **Answer the questions on the assistance application.** We need your answers to decide what help you may receive. You can apply for all or some of our programs.

3 - **Bring, mail or fax your assistance application to the DHS office in your area.** You can find the address and phone number to the office in your area in your phone book under the state government section, or online at *www.michigan.gov/dhs-countyoffices*. You may also apply for some assistance programs online at *www.michigan.gov/dhs*.

4 - **For some programs we may need to ask for more information (proof).** We will let you know what we need.

5 - **We will send you a letter** in the mail telling you if you are approved or denied. **Keep this letter.** It has important information including the name, phone number and email address of your DHS specialist.

You have the right to apply for help today. The date DHS receives your assistance application or filing form may affect the date your benefits start. **Exception:** If you are applying for Supplemental Security Income and food assistance benefits before being released from an institution, the filing date for your benefits will be the date you get out of the facility.

If you cannot finish the whole assistance application today, you may either complete the **filing form** (available at the end of this booklet or online at *www.michigan.gov/dhs-forms*) or you may turn in your incomplete assistance application. It must have your: • Name • Date of birth (not needed for food assistance) • Address (unless homeless) • Signature or your representative's signature (someone filing for you).

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

Department of Human Services (DHS) no discrimina contra ningún individuo o grupo a causa de su raza, religión, edad, origen nacional, color de piel, estatura, peso, estado matrimonial, sexo, orientación sexual, identidad de sexo o expresión, creencias políticas o incapacidad. Si usted necesita ayuda para leer, escribir, oír, etc., bajo la Acta de Americanos con Incapacidades, usted está invitado a hacer saber sus necesidades a una oficina de DHS en su área.

لن تميز إدارة الخدمات الإنسانية (Department of Human Services - DHS) ضد أي شخص أو مجموعة بسبب العرق، أو الديانة، أو العمر، أو المنشأ الوطني، أو اللون، أو ا ل، أو الوزن، أو الحا ة الزوجية، أو الجنس، أو التوجه الجنسي، او الهوية الجنسية التي يتصور ا الشخص لنفسه أو التعابير الجنسية التي يعطيها الشخص عن نفسه، أو المعتقدات السياسية، أو الإعاقة والعجز. إن كنت تحتاج إلى مساعدة في القراءة والكتابة والسمع، ...إلخ، ندعوك ان تجعل احتياجاتك معر فة لدى مكتب DHS في ا ا ا التي تعيش فيها عملاً بقانون الأمريكيين المعاقين (Americans With Disabilities Act).

Local office address

DHS specialist name, phone number and email address

Read this information booklet before you sign the assistance application.

Timely Decisions

We must make timely decisions to approve or deny your application for assistance. Below are the program standards we follow:

Program Symbols	DHS Programs	Standards
	Food Assistance	
	• Expedited (seven-day processing)	7 days
	• Food Assistance Program	30 days
	Medical Assistance	45 days
	• With a medical decision on disability	90 days
	• For pregnant women	10 days
	• Refugee Assistance Program Medical (RAPM)	30 days
	Child Development and Care	45 days
	Cash Assistance	
	• Family Independence Program	45 days
	• Refugee Assistance Program	30 days
	• State Disability Assistance	60 days
	State Emergency Relief	10 days

Expedited Food Assistance Program (Seven-Day Processing)

Your household may qualify for seven-day processing of your food assistance application if:

- You have less than $150 in monthly gross income and $100 or less in liquid assets (cash on hand, checking or savings accounts, savings certificates), **or**
- Your combined gross income and liquid assets are less than your monthly rent and/or mortgage payment plus heat and utilities, **or**
- You are a **destitute*** migrant or seasonal farmworker with $100 or less in liquid assets.

If your household qualifies for seven-day processing you must:

- Participate in an interview, **and**
- Provide proof of your identity, **and**
- Complete the entire application form.

To continue receiving food assistance benefits, you will be asked to provide proof of other information (like income, residency, etc.). If you provide the proof when you apply, you may be given a longer food assistance benefit period.

* **Destitute** means that your income **stopped** before the date you applied, or your income **has started** but you expect to receive no more than $25 within the next 10 days.

Food Assistance Program (FAP) Interviews

Most FAP interviews are held by telephone. However, you may request an in-person interview.

If you are also applying for cash assistance, you may be scheduled for an in-person interview.

We May Need Proof

For most programs, DHS will need proof of your household's income. If you have proof, send or bring it with your assistance application. Some ways to prove income are:

- ☐ Check stubs
- ☐ Child support receipts
- ☐ Social Security award letter
- ☐ Self-employment records of income and expenses

If we need proof, we will send you a list of what we need.

For some programs, we **MAY** need proof of:

- ☐ Age and/or identity
- ☐ Immigration status
- ☐ U.S. citizenship
- ☐ Pregnancy
- ☐ Current medical insurance card
- ☐ School enrollment, anyone age 16-18
- ☐ Income that recently started or stopped
- ☐ Assets (cash on hand, checking/savings accounts, credit union accounts, etc.)

If you need help getting proof, ask your DHS specialist.

Read this information booklet before you sign the assistance application.

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Read this information booklet before you sign the assistance application.

Programs

Food Assistance Program (FAP)

FAP provides benefits that can be used to buy food (including seeds and plants to grow your own food) for your household. People of all ages may receive FAP.

You may be eligible for FAP benefits if you have either:

- Low/no income.
- Low/no assets.

Income

FAP eligibility and benefit amounts are based on your household income and the number of people in your FAP group. When we look at your income, we make some **deductions** and consider **allowable expenses** (see below).

Deductions from countable income:

- 20 percent of earned income, and
- A standard deduction based on the number of people in your FAP group.

Allowable expenses:

- Medical expenses over $35 a month not paid by a third party (for persons age 60 or older, veteran with a disability or a person with a disability).
- Some housing and utility costs.
- Some child care costs and costs for care of persons with disabilities.
- Court-ordered child support paid to a non-household member.

I understand that failure to report or verify any listed expenses will be seen as a statement by me that I do not want to receive a deduction for the unreported or unverified expenses. Verifications must be received within 10 days.

If your heat is included in your rent, and you receive or expect to receive the Home Heating Credit, tell us on your assistance application. If you do not tell us about the credit, we will assume you do **not** want to receive a deduction for heat expenses.

Program requirements:

- **Follow Work Rules and Penalties** - see pages 12, 13.
- **Child Support Services** - see page 9.
- **Child Support Actions** - see page 12.

Adult Medical Program (AMP)

AMP helps pay for basic medical care for low-income adults. Additional services may be available through a county health plan.

You may be eligible for AMP if you are not eligible for Medicaid and you have:

- Cash assets of $3,000 or less, and
- Low income.

Limited enrollment. We limit the number of people who can receive AMP in Michigan. When we reach the limit, we must deny your application, even if you meet the eligibility rules.

Resident County Hospitalization (RCH)

RCH helps individuals with low income who cannot pay for medical care when they are in the hospital overnight.

You may be eligible for RCH if you:

- Have low income, and
- Are not eligible for Medicaid, and
- Do not have other insurance to pay for inpatient hospital care.

Each county sets its own financial eligibility rules.

For more information, contact the DHS office in your area.

Medical Assistance (MA)

If you are applying for MA, also known as Medicaid, we must give you a Medicaid Healthcare Coverage brochure with more complete information. Contact the DHS office in your area if you do not receive this brochure.

We have many MA programs for children, families and adults. Our goal is to make essential health care services, including Medicare premiums, available to people who cannot pay for them. Asset and income rules are different for different MA groups and programs.

If you have other health insurance or coverage, you may still qualify. Your medical providers (doctors, hospitals, etc.) will have to bill the other insurance first.

You may be eligible for MA when you are:

- A Supplemental Security Income (SSI) recipient.
- Financially eligible, and:
  - Under age 21.
  - Age 65 or older.
  - Pregnant.
  - Blind or disabled.
  - A parent or close relative living with and acting as a parent for a child.

Assets are counted for some programs. Many children and pregnant women can get MA with no limit on assets.

For persons age 19 and older (except for pregnant women), your assets must be below the limit for at least one day in the month that you ask for medical help. You must provide proof of your assets.

If you are over the asset limit, you may be able to get help if you use the excess assets to pay bills. We may ask for proof of how you used excess assets.

Income. Each Medicaid program has income limits. The limits depend on the program, who lives with you, and where you live. If your income is over the limit:

- You may still get help if you give us proof of your medical expenses.
- We may give you MA with a deductible.

Getting your medical bills paid. Choose a provider who will accept Medicaid – not all providers do. If you are applying for MA, tell your medical providers (doctors, hospital, pharmacy, etc.) before you receive any medical services.

If you are eligible for help, you will be sent a mihealth card**.** Each eligible person in your family will get his/her own card. **Do not throw this card away.** If your mihealth card is lost, stolen or damaged, call: 1-800-642-3195.

Give your medical providers a copy of your mihealth card as soon as you receive it. This information is needed to bill Medicaid for your covered services. Your providers must bill Medicaid within 12 months from the date you received their services, even if you gave the bill to DHS.

If your providers miss the 12-month limit, the bill may not be paid unless the delay is because you asked for a hearing to get MA. DHS determines your eligibility but the Department of Community Health (MDCH) pays for the services covered by Medicaid. MDCH may refund your money if you pay for an MA-covered service between the date your hearing request is received by DHS after an incorrect denial of MA and the date your MA is approved as a result of your hearing.

Help for past months. We may approve MA for up to three months before the month you applied. If we do, ask your providers to bill Medicaid for services you received before we approved your application. If you pay for services before your application is approved, ask your health providers to refund your money and bill Medicaid. Providers do not have to give refunds, but some will. The provider must bill Medicaid even if you gave the bill to DHS.

Program requirements:

- **Child Support Services** - see page 9.
- **Child Support Actions** - see page 12.

Healthy lifestyles. We want all MA clients to live healthy lifestyles. This might include making a commitment to: attend all medical appointments, exercise regularly, not smoke or use illegal drugs, and keep children's shots up-to-date.

For more information on living a healthy lifestyle, you may visit the Michigan Department of Community Health (MDCH) Web site at: *www.michiganstepsup.org* or call the following numbers:

- 1-877-422-4244 - healthy eating habits and tips.
- 1-877-422-4244 - free *Make Health Your Choice* booklet.
- 1-800-480-7848 - quit smoking.

Read this information booklet before you sign the assistance application.

Child Development And Care (CDC)

CDC helps pay for the cost of child care. You may be eligible if you are:

- A family with low income.
- A licensed foster parent requesting care for foster children.
- A member of a DHS protective services case participating in a treatment plan.
- A FIP/EFIP or Supplemental Security Income (SSI) recipient.
- A FIP applicant doing a required work participation program activity.

You must have a child care need because of:

- Work.
- High school completion classes (including general equivalency diploma, adult basic education, and English as a second language).
- Approved education or training.
- Approved treatment activities for a health or social condition.

The child care must be provided in Michigan by a:

- Licensed child care center.
- Licensed group child care home.
- Registered family child care home.
- DHS enrolled* unlicensed child care provider who has completed the Great Start to Quality Orientation and provides care in the child's home or provides care in his/her own home and is related by blood, marriage or adoption as a grandparent, great-grandparent, aunt/great-aunt, uncle/great-uncle, or sibling and must **not** live in the same home as the child.

  * Enrollment is not allowed if the provider, or an adult household member age 18 and older, living with the provider, is:

    - Convicted of certain crimes.
    - On the central registry for child abuse or neglect.

How much money can you make and still be eligible?

FIP/EFIP, SSI recipients, licensed foster parents, and children's protective services families are eligible without an income determination. Eligibility for all other families is based on gross monthly income. Use the table below to get an idea if you may be eligible.

Family Group Size	Gross Monthly Income
1&2	$0-1607
3	$0-1990
4	$0-2367
5	$0-2746
6	$0-3123
7	$0-3500
8	$0-3877
9	$0-4254
10+	$0-4634

What does DHS pay?

DHS child care rates are based on the type of provider you choose, the child's age, and the provider's training if the provider is an unlicensed child care provider. Current rates are available online at www.michigan.gov/childcare.

If you are eligible because you are a low-income family, we pay 70% to 100% of child care costs up to the DHS rate. The percentage depends on your gross monthly income and eligibility.

You are responsible for any child care costs not paid by DHS.

Program requirements:

- **Child Support Services** - see page 9.
- **Child Support Actions** - see page 12.

Resources:

- More information about the CDC program may be obtained online at:
  www.michigan.gov/childcare
- If you need help finding an eligible child care provider, contact your Great Start Regional Child Care Resource Center at 1-877-614-7328 or visit www.greatstartconnect.com.

Read this information booklet before you sign the assistance application.

Family Independence Program (FIP)
Refugee Assistance Program (RAP)

The main goal of cash assistance programs is to help families become self-supporting and independent.

- **FIP** is temporary cash assistance for low-income families with minor children.
- **RAP** is temporary cash assistance for persons recently admitted into the U.S. as refugees.

To qualify for FIP or RAP, you must have:

- Low income, **and**
- Cash assets less than $3,000 and property assets less than $500,000.

You may be eligible for FIP if you are not receiving cash benefits from another state and you are either:

- Pregnant.
- A parent, legal guardian, or relative acting as a parent for a child under the age of 18 (or a high school student age 18). Children ages 16-18 must attend school full time.

48-month lifetime limit:

You cannot receive FIP for more than 48 months in your lifetime unless you qualify for an exception month. This includes any cash assistance you may have received in another state.

It is prohibited to use FIP or RAP to purchase lottery tickets, alcohol, or tobacco or for gambling, illegal activities, adult entertainment or nonessential items.

You may be eligible for RAP if you are:

- A refugee (or someone treated as a refugee) as determined by the United States Citizenship and Immigration Services (USCIS).
- Within eight months of date of entry to the U.S., and
- Not eligible for FIP.

The FIP or RAP grant amount is based on:

- Number of people in your household group.
- Court-ordered child support expenses paid by your household.
- Total income.

Child support payments. Each month you are on FIP, current support we collect on your order is kept by the state. If you get support in a month when you are getting FIP, you must report it to your local DHS office, and you may need to repay it. If the support we collect is more than your FIP grant for at least two months, we may close your FIP case so you can get the child support payments directly.

Program requirements:

- **Follow Work Rules and Penalties** - see pages 12, 13.
- **Child Support Services** - see page 9.
- **Child Support Actions** - see page 12.
- **Immunize Children Under Age Six - Get Shots (FIP)** - see page 11.

State Disability Assistance (SDA)

SDA provides cash assistance to meet the basic needs of a person with a disability, a person caring for a person with a disability, or persons in a special living arrangement.

It is prohibited to use SDA to purchase lottery tickets, alcohol, or tobacco. It is also prohibited for gambling, illegal activities, adult entertainment or nonessential items.

A person is considered disabled if (s)he is one of the following:

- Age 65 or older.
- Unable to work for 90 days or more because of a medical condition.
- Receiving Supplemental Security Income (SSI) or Social Security disability benefits.
- Receiving medical assistance based on disability or blindness.
- Receiving special education services.
- Receiving Michigan Rehabilitation Services.
- Diagnosed as having AIDS.
- Living in an adult foster care home, a home for the aged, a county infirmary or a substance abuse treatment center.

You may be eligible for SDA if you are not eligible for FIP and you are any of the following:

- 65 or older.
- Permanently or temporarily **disabled**.
- Taking care of a person with a disability who lives with you.

AND you have:

- Cash assets less than $3,000 and property assets less than $500,000 **and**
- Low income (different limits for single and married persons).

Read this information booklet before you sign the assistance application.

State Emergency Relief (SER)

SER provides limited help to households with low income who have an emergency. SER helps prevent serious harm to individuals and families who have an emergency that threatens their health or safety.

You may be eligible for SER if:

- You have low income and limited assets.
- The emergency situation is not likely to happen again (example: for help with rent or house payments, you must show you have enough income to pay your housing costs in the future).
- You have made certain required payments on your shelter, heat, electric and/or utility bills.
- The amount you need is within our limits.

Covered services include:

- Relocation payments to avoid or eliminate homelessness.*
- Mortgage, insurance and/or property tax payment, to stop forfeiture, foreclosure or tax sale.*
- Limited home repairs.
- Home heating, electric and utility bills.
- Burial costs.

* *DHS works with the Salvation Army to provide emergency shelter statewide.*

The amount of help you may receive depends on the number of people in your household, income, assets and type of service requested and other factors.

Child Support Services

The Office of Child Support (OCS) is part of DHS and is responsible for the child support program in Michigan. OCS works with the Prosecuting Attorney (PA), Friend of the Court (FOC) and agencies in other states.

The goal of OCS is to ensure that children are supported by their parents. Child support may include:

- Cash for everyday living.
- Health and/or educational benefits.
- Payment for child care costs.

An OCS support specialist can help:

- Locate a child's absent parent(s).
- Establish a child's legal father by:
  - Voluntary paternity papers.
  - Court action for paternity.
- Establish a child support order.

Child support services are available if:

- A child lives in your home whose parent(s) do(es) not live there.
- You receive child care services, food, cash or medical assistance from DHS.

You do not have to receive help from DHS to apply for child support services.

To apply for services, complete the *IV-D Child Support Services Application/Referral* (DHS-1201):

- Print a DHS-1201 from the DHS public Web site at *www.michigan.gov/dhs-forms*.
- Call OCS at **1-866-540-0008** or **1-866-661-0005.**
- Send a written request to:

Office of Child Support
Central Functions Unit
PO Box 30744
Lansing, MI 48909

Return the completed DHS-1201 to the DHS in your area, the local PA or FOC, or the address above.

Early On®

Early On coordinates services for families who have a child age zero (birth) to age three with a disability, developmental delay or a related medical condition.

To find out if your child is eligible, call *Early On* at **1-800-*EarlyOn (327-5966)*** or online at *www.1800earlyon.org.* An *Early On* coordinator in your county will:

- Let you know if your child is eligible.
- Help you decide if you want *Early On* services for your child.

There is no cost for an evaluation of *Early On* eligibility.

***Early On* services can include:** • assessment services • audiology • diagnostic medical services • early identification • family skills training • health services • home visits • nursing services • nutritional counseling • occupational therapy • pathology • psychological services • screening • service coordination • social work services • special equipment • special instruction • speech • transportation • counseling (family, group, individual) • vision services.

Read this information booklet before you sign the assistance application.

Low Income Home Energy Assistance Program (LIHEAP)

LIHEAP consists of federal money given to each state to help low-income individuals and families with heating costs. In Michigan, this money is used for the following programs:

- Home Heating Credit (HHC).
- State Emergency Relief (SER) - see page 8.
- Weatherization Assistance Program (WAP).

There is no separate application for LIHEAP.

Home Heating Credit (HHC)

The HHC is available to **all** low-income households including those with rent that includes heat. The Michigan Department of Treasury determines eligibility and makes the payments.

Applications for the HHC are available at the Department of Treasury and wherever tax forms are available (online at *www.michigan.gov/treasury*, select Income Tax Forms from the Treasury Quick List on the home page). You do not need to file a state income tax return to receive the HHC. Eligibility is based on income, number of tax exemptions and household heating costs.

Weatherization Assistance Program (WAP)

WAP is a federally funded, low-income residential energy conservation program available to low-income Michigan homeowners and renters. These services reduce energy use and lower utility bills. Services may include:

- Attic insulation and ventilation.
- Wall insulation.
- Foundation insulation.
- Smoke detectors.
- Dryer venting.
- Air leakage reduction.

Applications for WAP are available at your local weatherization operator.

To find the local weatherization operator in your area, go to:
www.michigan.gov/dhs-womap

Resources:

- **LIHEAP** - call the toll-free DHS Energy Assistance hotline at 1-800-292-5650.
- **HHC or WAP** - go to:
  www.michigan.gov/heatingassistance

Things You Must Do

By signing the assistance application, you agree to do these things.

Give Correct Information and Report Changes (All Programs)

Correct information. You must give DHS correct and complete information about you and everyone in your household.

If you give us incorrect or incomplete information on purpose, or you do not report a change, you may be prosecuted for perjury or fraud, or denied benefits. (See "Penalties for Intentional Program Violation Or Fraud" for more information.)

Reporting changes. Tell your DHS specialist about changes or report changes online within **10 days** of the change.* If you have any doubt about whether to report a change, contact your DHS specialist. Your DHS specialist will tell you if different reporting rules apply to you.

The types of changes you must report are:

- Employment starts, stops (within 10 days of receiving your first/last payment) or changes.
- Change in rate of pay (within 10 days of receiving the first payment reflecting the change).
- Change of hours worked by more than five hours per week, if it will last more than one month.
- Unearned income starts or stops (like Social Security, unemployment or retirement benefits, etc.).
- Unearned income changes by more than:
  - **$50** per month for most programs.
  - **$25** per month for most MA programs.
- Change in assets.
- Change of address.
- Housing or utility cost stops, starts or changes.
- Anyone moving in or out of your home.
- Changes in child care need, cost or provider.
- Changes in child support amount paid out or received.
- Health or medical insurance premiums or change in coverage.

*Exception: For FIP only you must report a child leaving your home within 5 days of the date you know they will be absent for 30 days or more.

Read this information booklet before you sign the assistance application.

Things You Must Do (continued)

Repay Extra Benefits (All Programs)

If you or anyone in your household receives benefits they are not eligible for, the adults in the household must repay the extra benefits. The benefits must be repaid even if there was no fraud. If DHS makes an error, the adults in the household must repay the extra benefits **except** in medical assistance cases.

For FAP, an authorized representative (someone with access to your food benefits who can shop for you) may also be responsible for repayment of any extra FAP benefits.

Recoupment. DHS may keep part of your future benefits as repayment for extra benefits you received.

Trafficking. FAP benefits that are sold or traded are treated as extra benefits and must be repaid.

Release of information. If you or anyone in your household received extra benefits, the information on your assistance application, including Social Security numbers, may be given to federal, state and private agencies to help with collection.

Provide Social Security Numbers (Most Programs)

For most programs, under federal law 42 USC 1320b-7, you must provide Social Security numbers for everyone **applying**.

Exceptions include:

- When applying for child care **only**, you do not have to provide a Social Security number for adults or children who do not need child care.
- Non-citizens who cannot get a Social Security number may still qualify for medical assistance for emergency services, pregnancy and childbirth. (See "Citizens and Non-Citizens.")

DHS will help you apply for Social Security numbers. Give DHS the Social Security number as soon as you receive it. If you do not, your benefits may be reduced or denied or you may have to repay an overpayment.

DHS will use Social Security numbers to check whether you are eligible and receiving the correct benefits. DHS uses Social Security numbers to check information with other agencies. (See "Information About Your Household That Will Be Shared.")

Pursue Other Benefits (Most Programs)

You must apply for other benefits you may qualify for, such as:

- Unemployment benefits.
- Social Security and Supplemental Security Income (SSI) benefits.
- Veterans Administration benefits.

DHS will tell you if you need to apply for benefits.

If you do not pursue benefits when required, your DHS benefits may be reduced, closed or denied.

Immunize Children Under Age Six - Get Shots (FIP)

Children under age six must be immunized as recommended by the Michigan Department of Community Health.

Your cash benefits may be reduced by $25 per month until your children are up-to-date on their immunizations.

A child is exempt from the immunization requirement if:

- (S)he is under two months of age.
- Immunizations are medically inappropriate for the child.
- Immunizations are against the family's religious beliefs.

Child Support Actions (Most Programs)

If you receive benefits from FIP, FAP, MA or CDC, and you have a minor child in your home whose parent(s) do(es) not live there, you will receive a letter from a support specialist about the child support program. You must contact the support specialist when you receive the letter. You must work with the Office of Child Support, the Prosecuting Attorney and Friend of the Court.

Good cause. DHS will not require you to pursue paternity or support if you have good cause.

To claim good cause, tell your DHS specialist and ask for the "Claim of Good Cause" form. You may be asked to provide proof.

If you do not cooperate with child support actions when required, and do not have a good-cause reason, DHS will do all of the following:

- Remove the food assistance benefits of the person not cooperating for at least one month.
- Deny or stop your medical benefits for at least one month. We will not deny or stop Medicaid for children or pregnant women.
- Deny or stop your child care benefits for at least one month.
- Deny or stop cash assistance for your entire household for at least one month.
- Deny SER for failure to comply with a requirement of FIP.

Read this information booklet before you sign the assistance application.

Assistance Application
Michigan Department of Human Services (DHS)

Instructions

- ***If you answer all the questions on the assistance application, we can determine if you are eligible for ALL programs. Please print your answers.***
- ***Check ALL programs you are applying for.*** *The program symbols below will appear in each section of questions on the application. These symbols tell you which questions you must answer for each program. For more information about programs, see the* ***Information Booklet****.*

☐ **Food Assistance Program (FAP).**

☐ **Medical Assistance (MA, AMP)** (doctor or hospital bills, prescriptions, Medicare premiums).
Retroactive Medical - Do you, or anyone in your household, have paid or unpaid medical expenses in the last three months? ☐ Yes ☐ No

☐ **Child Development and Care (CDC)** (help with child care payments).

☐ **Cash Assistance (FIP - Family Independence Program, RAP - Refugee Assistance Program, SDA - State Disability Assistance)** (help with cash for pregnant women, families with children, refugees, adults with disabilities, live-in caretakers of adults with disabilities or residents of special living arrangements).

☐ **State Emergency Relief (SER)** (utility shut-off, eviction notice, burial or other emergency).
NOTE: You must complete both the assistance application and SER supplemental application (DHS-1514) available from the DHS office in your area or you may also apply online at *www.michigan.gov/dhs-forms*.

If you cannot complete this application now, you may complete the filing form on the last page of the information booklet or online at *www.michigan.gov/dhs-forms*. The date DHS receives your assistance application or filing form may affect the date your benefits start. DHS will still need to receive your completed assistance application before any benefits can be approved.

If you need help filling out this application, DHS must help you. If you are refused help, you may call (855) 275-6424.

1. If you do not speak English or you have a disability, how can we help you?
   ☐ Interpreter ☐ Sign language ☐ Assisted listening device (ALD) ☐ Other _____
2. If you do not speak English, what language do you speak? _____

Si usted necesita ayuda llenando esta solicitud, DHS debe ayudarle. Si ellos se niegan ayuda, usted puede llamar a (855) 275-6424.

1. ¿Si usted no habla inglés o tiene una incapacidad, como podemos ayudarle?
   ☐ Intérprete ☐ Dactilología ☐ Dispositivo vivo asistido (ALD) ☐ Otro _____
2. ¿Si usted no habla inglés, qué idoma habla? _____

إن كنت تتطلّب إلى مساعدة في ملء هذا الطلب، فيجب على DHS تقديم المساعدة لك. وفي حال تمّ رفض تقديم المساعدة لك، فيمكنك الاتصال بالرقم ٣٧٣-٠٧٠٧ (٥١٧)

١. إن كنت لا تتكلم اللغة الإنكليزية أو تعاني من إعاقة، فكيف يمكننا مساعدتك؟

☐ مترجم شفهي ☐ لغة إشارة ☐ أجهزة مساعدة للسمع (ALD) ☐ غير ذلك _____

٢. إن كنت لا تتكلم اللغة الإنكليزية، فما هي اللغة التي تتكلمها؟_____

For office use only	Date application received in local office	Case name	
		Application number	Case number
		Specialist name	
		Specialist phone	Fax
		Specialist email	

This form is issued under authority of the Code of Federal Regulations (CFR) 42 CFR 435.907; 7 CFR 273.2(d); and Sections 25 and 59 of Act 280 of the Public Acts of 1939, as amended, and Public Act 280 of 1939. You must complete this form if you want the department to consider your application for financial, medical or food assistance or for child care services.

A. Address Information

1. **Check where you live:** ☐ House/apartment/mobile home ☐ Homeless ☐ Other _____

If you live in a facility or special living arrangement, or have lived in one in the last three months, check what type below:

- ☐ Home for the aged
- ☐ Children's group home
- ☐ Adult foster care home
- ☐ Commercial boarding house
- ☐ Hospital
- ☐ County infirmary
- ☐ Nursing facility
- ☐ Mental health or psychiatric facility
- ☐ Jail/prison
- ☐ Emergency housing/shelter
- ☐ Drug or alcohol treatment center
- ☐ Juvenile residential facility
- ☐ Community justice center
- ☐ Domestic violence shelter
- ☐ Halfway house
- ☐ Assisted living

What date do you expect to leave, or what date did you leave the facility? __/__/____ ☐ Date unknown ☐ Does not apply

Name of facility _____

2. **Address where you live, or address of facility** (number, street, rural route, apartment/lot number)

City | State | Zip code | County

3. **Mailing address** (if different from above, or PO box)

City | State | Zip code | County

4. Home phone ___-___-____ Cell phone ___-___-____ Work phone ___-___-____

Phone number where we can leave a message ___-___-____ Whose number is it? (name/relationship)

Telephone Typewriter (TTY) number ___-___-____ Email address

5. Have you moved from, or received assistance from another state any time after August 1996? ☐ Yes ☐ No

If yes, what state? _____ What county? _____

Date you moved to Michigan (MI) __/__/____ What was your caseworker's name? _____ Caseworker phone number ___-___-____

6. Do you and your household intend to remain in MI? ☐ Yes ☐ No

7. Did you or someone in your household come to MI with a job commitment or looking for work? ☐ Yes ☐ No

8. If you are a migrant or seasonal farmworker, list your permanent mailing address below.

Permanent mailing address (number, street, rural route, apartment/lot number, PO box)

City | State | Zip code | County

B. Food Assistance Information

1. Does everyone in the household buy food and fix or eat meals together? ☐ Yes ☐ No
   If no, list who does not _____
2. How much are the total cash assets belonging to your household?
   (Include cash, savings, checking, savings bonds, etc.) $_____
3. How much is the total monthly gross income (before any deductions) for your household?
   (Include earnings, unemployment benefits, child support, Social Security benefits, etc.) $_____
4. Does anyone in your household receive tribal food distribution benefits? ☐ Yes ☐ No
   If yes, list who _____

C. Information About You and Your Household

- ***Answer for ALL persons in your household (everyone living in your home). Include persons who are not there all the time, even if you are not applying for them. LIST YOURSELF FIRST.***
- ***If you are an alien with a sponsor who has agreed to financially support you, even if (s)he is not doing so, include your sponsor's information in one of the boxes below.***
- ***If you are filling out the application for a patient in a nursing facility, list:***
  - ***The patient first.*** - ***The patient's spouse.*** - ***Any dependents living at home.***
- ***Spaces for five more persons in your household are available on the next five pages.***
  Do you need more household pages? ☐ ***Yes*** ☐ ***No***

Answer for person 1. Check all boxes that apply.

1. Name (first, middle initial, last; birth name, if different) _____ 2. Date of birth _____ 3. Relationship to you SELF
4. ☐ Male ☐ Female 5. Social Security number* ___-___-____ * (optional if applying ONLY for child care or emergency medical services)
6. Marital status ☐ Married ☐ Never married ☐ Divorced ☐ Widowed ☐ Separated
7. Is this person a U.S. citizen? ☐ Yes ☐ No **If no, and you are a documented alien, what is your date of entry: _____
   Mother's Maiden Name _____ Place of Birth _____ (county, city, state)
8. Pregnant now/last three months ☐ Yes ☐ No If yes, ▸ Due date/pregnancy end date __/__/____
   Number expected/had ☐ One ☐ Twins ☐ Triplets ☐ Other _____
9. Highest grade completed in school _____ ☐ Received GED ☐ Full-time ☐ Half-time ☐ Less than half-time
10. In school now? ☐ Yes ☐ No If yes, ▸ School name _____
    ☐ K-12 ☐ GED ☐ College ☐ Trade school ☐ University ☐ Vocational ☐ Other
11. Ethnicity (optional) ☐ Hispanic/Latino ☐ Not Hispanic/Latino
12. Race (optional) ☐ American Indian/Alaska Native – Enter tribe name _____
    ☐ Asian ☐ Black/African American
    ☐ Native Hawaiian/Other Pacific Islander ☐ White
13. Is this person any of the following? (check all that apply) ☐ Refugee ☐ Sponsor of an alien
    ☐ Migrant farmworker ☐ Foster child ☐ Foster parent ☐ Temporarily absent (college, military, etc.)
    ☐ Seasonal farmworker ☐ Adopted child ☐ Non-parent caregiver ☐ None apply to this person
14. If this person is currently away from the home ▸ Why? _____ Expected return date _____
15. How many days each month does this person stay at the application address?____ at another address?____
    Other address _____ (number, street, rural route, apartment/lot number, city, state, zip code)
16. What kind of help does this person need? ☐ Food ☐ Medical ☐ Emergency help
    ☐ Family Planning Services ☐ Child care ☐ Cash assistance ☐ None (not applying)

**Applies to FIP, Medicaid and RAP applicants only

Answer for person 2. Check all boxes that apply.

1. Name (first, middle initial, last; birth name, if different) _____ 2. Date of birth _____ 3. Relationship to you _____

4. ☐ Male ☐ Female 5. Social Security number* ___-___-____ * (optional if applying ONLY for child care or emergency medical services)

6. Marital status ☐ Married ☐ Never married ☐ Divorced ☐ Widowed ☐ Separated

7. Is this person a U.S. citizen? ☐ Yes ☐ No **If no, and you are a documented alien, what is your date of entry: _____
Mother's Maiden Name _____ Place of Birth _____ (county, city, state)

8. Pregnant now/last three months ☐ Yes ☐ No If yes, ▸ Due date/pregnancy end date __/__/____
Number expected/had ☐ One ☐ Twins ☐ Triplets ☐ Other _____

9. Highest grade completed in school _____ ☐ Received GED ☐ Full-time ☐ Half-time ☐ Less than half-time

10. In school now? ☐ Yes ☐ No If yes, ▸ School name _____
☐ K-12 ☐ GED ☐ College ☐ Trade school ☐ University ☐ Vocational ☐ Other

11. Ethnicity (optional) ☐ Hispanic/Latino ☐ Not Hispanic/Latino

12. Race (optional) ☐ American Indian/Alaska Native – Enter tribe name _____
☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African American ☐ White

13. Is this person any of the following? (check all that apply) ☐ Refugee ☐ Sponsor of an alien
☐ Migrant farmworker ☐ Foster child ☐ Foster parent ☐ Temporarily absent (college, military, etc.)
☐ Seasonal farmworker ☐ Adopted child ☐ Non-parent caregiver ☐ None apply to this person

14. If this person is currently away from the home ▸ Why? _____ Expected return date _____

15. How many days each month does this person stay at the application address? _____ at another address? _____
Other address _____ (number, street, rural route, apartment/lot number, city, state, zip code)

16. What kind of help does this person need? ☐ Food ☐ Medical ☐ Emergency help
☐ Family Planning Services ☐ Child care ☐ Cash Assistance ☐ None (not applying)

17. If this person is under 22, complete this section:
Who paid for this child's birth expenses ☐ State ☐ Parents ☐ Another person
What was the marital status of the mother while pregnant with this child? _____
If Married or Divorced: Marriage Date __/__/____ Separation Date __/__/____ Divorce Date __/__/____
Order/County/State: _____ Order/County/State: _____
If single, this child's Conception Date __/__/____ City: _____ State ____ Country _____
Has an Affidavit of Parentage (AOP) or a court order named someone as the father? ☐ Yes ☐ No
If Yes, Order/AOP# _____ Date __/__/____ City: _____ State ____ Country _____
If No, is there more than one likely father? ☐ Yes ☐ No, If Yes, **Stop**
If not directed to stop, complete the following for each parent:

Father

Name (first, mi, last) Birthdate SSN
_____ __/__/____ _____
Approximate age (if Birthdate not known): _____
Is he in the home? ☐ Yes ☐ No
Is he deceased ☐ Yes ☐ No
Is he the same father described for a previous child?
☐ Yes, name: _____ ☐ No
Is he a single-parent adopter? ☐ Yes ☐ No
Has the court terminated his rights? ☐ Yes ☐ No
If Yes to any of the above, **stop**. Otherwise:
Is there a support order naming him for this child?
Order # _____ County _____ State _____ Country _____
Last known employer & address _____
Month/year last worked __/____
Height ___ Weight ___ Hair color ____ Eye Color ____
Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Race: ☐ American Indian/Alaska Native (Tribe _____)
☐ Asian ☐ Hawaiian Native/Pacific Islander
☐ Black/African American ☐ White
Father's health insurance covering this child:
Carrier _____ Policy # _____

Mother

Name (first, mi, last) Birthdate SSN
_____ __/__/____ _____
Approximate age (if Birthdate not known): _____
Is she in the home? ☐ Yes ☐ No
Is she deceased ☐ Yes ☐ No
Is she the same mother described for a previous child?
☐ Yes, name: _____ ☐ No
Is she a single-parent adopter? ☐ Yes ☐ No
Has the court terminated her rights? ☐ Yes ☐ No
If Yes to any of the above, **stop**. Otherwise:
Is there a support order naming her for this child?
Order # _____ County _____ State _____ Country _____
Last known employer & address _____
Month/year last worked __/____
Height ___ Weight ___ Hair color ____ Eye Color ____
Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Race: ☐ American Indian/Alaska Native (Tribe _____)
☐ Asian ☐ Hawaiian Native/Pacific Islander
☐ Black/African American ☐ White
Mother's health insurance covering this child:
Carrier _____ Policy # _____

**Applies to FIP, Medicaid and RAP applicants only

Answer for person 3. Check all boxes that apply.

1. Name (first, middle initial, last; birth name, if different) _____ 2. Date of birth _____ 3. Relationship to you _____

4. ☐ Male ☐ Female 5. Social Security number* ___-___-____ * (optional if applying ONLY for child care or emergency medical services)

6. Marital status ☐ Married ☐ Never married ☐ Divorced ☐ Widowed ☐ Separated

7. Is this person a U.S. citizen? ☐ Yes ☐ No **If no, and you are a documented alien, what is your date of entry: _____
Mother's Maiden Name _____ Place of Birth _____ (county, city, state)

8. Pregnant now/last three months ☐ Yes ☐ No If yes, ▸ Due date/pregnancy end date __/__/____
Number expected/had ☐ One ☐ Twins ☐ Triplets ☐ Other _____

9. Highest grade completed in school _____ ☐ Received GED ☐ Full-time ☐ Half-time

10. In school now? ☐ Yes ☐ No If yes, ▸ School name _____ ☐ Less than half-time
☐ K-12 ☐ GED ☐ College ☐ Trade school ☐ University ☐ Vocational ☐ Other

11. Ethnicity (optional) ☐ Hispanic/Latino ☐ Not Hispanic/Latino

12. Race (optional) ☐ American Indian/Alaska Native – Enter tribe name _____
☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African American ☐ White

13. Is this person any of the following? (check all that apply) ☐ Refugee ☐ Sponsor of an alien
☐ Migrant farmworker ☐ Foster child ☐ Foster parent ☐ Temporarily absent (college, military, etc.)
☐ Seasonal farmworker ☐ Adopted child ☐ Non-parent caregiver ☐ None apply to this person

14. If this person is currently away from the home ▸ Why? _____ Expected return date _____

15. How many days each month does this person stay at the application address? _____ at another address? _____
Other address _____ (number, street, rural route, apartment/lot number, city, state, zip code)

16. What kind of help does this person need? ☐ Food ☐ Medical ☐ Emergency help
☐ Family Planning Services ☐ Child care ☐ Cash Assistance ☐ None (not applying)

17. If this person is under 22, complete this section:
Who paid for this child's birth expenses ☐ State ☐ Parents ☐ Another person
What was the marital status of the mother while pregnant with this child? _____
If Married or Divorced: Marriage Date __/__/____ Separation Date __/__/____ Divorce Date __/__/____
Order/County/State: _____ Order/County/State: _____
If single, this child's Conception Date __/__/____ City: _____ State _____ Country _____
Has an Affidavit of Parentage (AOP) or a court order named someone as the father? ☐ Yes ☐ No
If Yes, Order/AOP# _____ Date __/__/____ City: _____ State _____ Country _____
If No, is there more than one likely father? ☐ Yes ☐ No, If Yes, **Stop**
If not directed to stop, complete the following for each parent:

Father

Name (first, mi, last) Birthdate SSN
_____ __/__/____ _____
Approximate age (if Birthdate not known): _____
Is he in the home? ☐ Yes ☐ No
Is he deceased ☐ Yes ☐ No
Is he the same father described for a previous child?
☐ Yes, name: _____ ☐ No
Is he a single-parent adopter? ☐ Yes ☐ No
Has the court terminated his rights? ☐ Yes ☐ No
If Yes to any of the above, **stop**. Otherwise:
Is there a support order naming him for this child?
Order # _____ County _____ State _____ Country _____
Last known employer & address _____
Month/year last worked __/____
Height ___ Weight ___ Hair color ____ Eye Color ____
Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Race: ☐ American Indian/Alaska Native (Tribe _____)
☐ Asian ☐ Hawaiian Native/Pacific Islander
☐ Black/African American ☐ White
Father's health insurance covering this child:
Carrier _____ Policy # _____

Mother

Name (first, mi, last) Birthdate SSN
_____ __/__/____ _____
Approximate age (if Birthdate not known): _____
Is she in the home? ☐ Yes ☐ No
Is she deceased ☐ Yes ☐ No
Is she the same mother described for a previous child?
☐ Yes, name: _____ ☐ No
Is she a single-parent adopter? ☐ Yes ☐ No
Has the court terminated her rights? ☐ Yes ☐ No
If Yes to any of the above, **stop**. Otherwise:
Is there a support order naming her for this child?
Order # _____ County _____ State _____ Country _____
Last known employer & address _____
Month/year last worked __/____
Height ___ Weight ___ Hair color ____ Eye Color ____
Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Race: ☐ American Indian/Alaska Native (Tribe _____)
☐ Asian ☐ Hawaiian Native/Pacific Islander
☐ Black/African American ☐ White
Mother's health insurance covering this child:
Carrier _____ Policy # _____

**Applies to FIP, Medicaid and RAP applicants only

Answer for person 4. Check all boxes that apply.

1. Name (first, middle initial, last; birth name, if different) _____ 2. Date of birth _____ 3. Relationship to you _____

4. ☐ Male ☐ Female 5. Social Security number* ___-___-____ * (optional if applying ONLY for child care or emergency medical services)

6. Marital status ☐ Married ☐ Never married ☐ Divorced ☐ Widowed ☐ Separated

7. Is this person a U.S. citizen? ☐ Yes ☐ No **If no, and you are a documented alien, what is your date of entry: _____
Mother's Maiden Name _____ Place of Birth _____ (county, city, state)

8. Pregnant now/last three months ☐ Yes ☐ No If yes, ▸ Due date/pregnancy end date __/__/____
Number expected/had ☐ One ☐ Twins ☐ Triplets ☐ Other _____

9. Highest grade completed in school _____ ☐ Received GED ☐ Full-time ☐ Half-time

10. In school now? ☐ Yes ☐ No If yes, ▸ School name _____ ☐ Less than half-time
☐ K-12 ☐ GED ☐ College ☐ Trade school ☐ University ☐ Vocational ☐ Other

11. Ethnicity (optional) ☐ Hispanic/Latino ☐ Not Hispanic/Latino

12. Race (optional) ☐ American Indian/Alaska Native – Enter tribe name _____
☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African American ☐ White

13. Is this person any of the following? (check all that apply) ☐ Refugee ☐ Sponsor of an alien
☐ Migrant farmworker ☐ Foster child ☐ Foster parent ☐ Temporarily absent (college, military, etc.)
☐ Seasonal farmworker ☐ Adopted child ☐ Non-parent caregiver ☐ None apply to this person

14. If this person is currently away from the home ▸ Why? _____ Expected return date _____

15. How many days each month does this person stay at the application address? _____ at another address? _____
Other address _____ (number, street, rural route, apartment/lot number, city, state, zip code)

16. What kind of help does this person need? ☐ Food ☐ Medical ☐ Emergency help
☐ Family Planning Services ☐ Child care ☐ Cash Assistance ☐ None (not applying)

17. If this person is under 22, complete this section:
Who paid for this child's birth expenses ☐ State ☐ Parents ☐ Another person
What was the marital status of the mother while pregnant with this child? _____
If Married or Divorced: Marriage Date __/__/____ Separation Date __/__/____ Divorce Date __/__/____
Order/County/State: _____ Order/County/State: _____
If single, this child's Conception Date __/__/____ City: _____ State ____ Country _____
Has an Affidavit of Parentage (AOP) or a court order named someone as the father? ☐ Yes ☐ No
If Yes, Order/AOP# _____ Date __/__/____ City: _____ State ____ Country _____
If No, is there more than one likely father? ☐ Yes ☐ No, If Yes, **Stop**
If not directed to stop, complete the following for each parent:

Father

Name (first, mi, last) Birthdate SSN
_____ __/__/____ _____
Approximate age (if Birthdate not known): _____
Is he in the home? ☐ Yes ☐ No
Is he deceased ☐ Yes ☐ No
Is he the same father described for a previous child?
☐ Yes, name: _____ ☐ No
Is he a single-parent adopter? ☐ Yes ☐ No
Has the court terminated his rights? ☐ Yes ☐ No
If Yes to any of the above, **stop**. Otherwise:
Is there a support order naming him for this child?
Order # _____ County _____ State _____ Country _____
Last known employer & address _____
Month/year last worked __/____
Height ___ Weight ___ Hair color ____ Eye Color ____
Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Race: ☐ American Indian/Alaska Native (Tribe _____)
☐ Asian ☐ Hawaiian Native/Pacific Islander
☐ Black/African American ☐ White
Father's health insurance covering this child:
Carrier _____ Policy # _____

Mother

Name (first, mi, last) Birthdate SSN
_____ __/__/____ _____
Approximate age (if Birthdate not known): _____
Is she in the home? ☐ Yes ☐ No
Is she deceased ☐ Yes ☐ No
Is she the same mother described for a previous child?
☐ Yes, name: _____ ☐ No
Is she a single-parent adopter? ☐ Yes ☐ No
Has the court terminated her rights? ☐ Yes ☐ No
If Yes to any of the above, **stop**. Otherwise:
Is there a support order naming her for this child?
Order # _____ County _____ State _____ Country _____
Last known employer & address _____
Month/year last worked __/____
Height ___ Weight ___ Hair color ____ Eye Color ____
Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Race: ☐ American Indian/Alaska Native (Tribe _____)
☐ Asian ☐ Hawaiian Native/Pacific Islander
☐ Black/African American ☐ White
Mother's health insurance covering this child:
Carrier _____ Policy # _____

**Applies to FIP, Medicaid and RAP applicants only

Answer for person 5. Check all boxes that apply.

1. Name (first, middle initial, last; birth name, if different) _____ 2. Date of birth _____ 3. Relationship to you _____

4. ☐ Male ☐ Female 5. Social Security number* ___-___-____ * (optional if applying ONLY for child care or emergency medical services)

6. Marital status ☐ Married ☐ Never married ☐ Divorced ☐ Widowed ☐ Separated

7. Is this person a U.S. citizen? ☐ Yes ☐ No **If no, and you are a documented alien, what is your date of entry: _____
Mother's Maiden Name _____ Place of Birth _____ (county, city, state)

8. Pregnant now/last three months ☐ Yes ☐ No If yes, ▸ Due date/pregnancy end date __/__/____
Number expected/had ☐ One ☐ Twins ☐ Triplets ☐ Other _____

9. Highest grade completed in school _____ ☐ Received GED ☐ Full-time ☐ Half-time

10. In school now? ☐ Yes ☐ No If yes, ▸ School name _____ ☐ Less than half-time
☐ K-12 ☐ GED ☐ College ☐ Trade school ☐ University ☐ Vocational ☐ Other

11. Ethnicity (optional) ☐ Hispanic/Latino ☐ Not Hispanic/Latino

12. Race (optional) ☐ American Indian/Alaska Native – Enter tribe name _____
☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African American ☐ White

13. Is this person any of the following? (check all that apply) ☐ Refugee ☐ Sponsor of an alien
☐ Migrant farmworker ☐ Foster child ☐ Foster parent ☐ Temporarily absent (college, military, etc.)
☐ Seasonal farmworker ☐ Adopted child ☐ Non-parent caregiver ☐ None apply to this person

14. If this person is currently away from the home ▸ Why? _____ Expected return date _____

15. How many days each month does this person stay at the application address? _____ at another address? _____
Other address _____ (number, street, rural route, apartment/lot number, city, state, zip code)

16. What kind of help does this person need? ☐ Food ☐ Medical ☐ Emergency help
☐ Family Planning Services ☐ Child care ☐ Cash Assistance ☐ None (not applying)

17. If this person is under 22, complete this section:
Who paid for this child's birth expenses ☐ State ☐ Parents ☐ Another person
What was the marital status of the mother while pregnant with this child? _____
If Married or Divorced: Marriage Date __/__/____ Separation Date __/__/____ Divorce Date __/__/____
Order/County/State: _____ Order/County/State: _____
If single, this child's Conception Date __/__/____ City: _____ State ____ Country _____
Has an Affidavit of Parentage (AOP) or a court order named someone as the father? ☐ Yes ☐ No
If Yes, Order/AOP# _____ Date __/__/____ City: _____ State ____ Country _____
If No, is there more than one likely father? ☐ Yes ☐ No, If Yes, **Stop**
If not directed to stop, complete the following for each parent:

Father

Name (first, mi, last) Birthdate SSN
_____ __/__/____ _____
Approximate age (if Birthdate not known): _____
Is he in the home? ☐ Yes ☐ No
Is he deceased ☐ Yes ☐ No
Is he the same father described for a previous child?
☐ Yes, name: _____ ☐ No
Is he a single-parent adopter? ☐ Yes ☐ No
Has the court terminated his rights? ☐ Yes ☐ No
If Yes to any of the above, **stop**. Otherwise:
Is there a support order naming him for this child?
Order # _____ County _____ State _____ Country _____
Last known employer & address _____
Month/year last worked __/____
Height ___ Weight ___ Hair color ____ Eye Color ____
Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Race: ☐ American Indian/Alaska Native (Tribe _____)
☐ Asian ☐ Hawaiian Native/Pacific Islander
☐ Black/African American ☐ White
Father's health insurance covering this child:
Carrier _____ Policy # _____

Mother

Name (first, mi, last) Birthdate SSN
_____ __/__/____ _____
Approximate age (if Birthdate not known): _____
Is she in the home? ☐ Yes ☐ No
Is she deceased ☐ Yes ☐ No
Is she the same mother described for a previous child?
☐ Yes, name: _____ ☐ No
Is she a single-parent adopter? ☐ Yes ☐ No
Has the court terminated her rights? ☐ Yes ☐ No
If Yes to any of the above, **stop**. Otherwise:
Is there a support order naming her for this child?
Order # _____ County _____ State _____ Country _____
Last known employer & address _____
Month/year last worked __/____
Height ___ Weight ___ Hair color ____ Eye Color ____
Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Race: ☐ American Indian/Alaska Native (Tribe _____)
☐ Asian ☐ Hawaiian Native/Pacific Islander
☐ Black/African American ☐ White
Mother's health insurance covering this child:
Carrier _____ Policy # _____

**Applies to FIP, Medicaid and RAP applicants only

Answer for person 6. Check all boxes that apply.

1. Name (first, middle initial, last; birth name, if different) _____ 2. Date of birth _____ 3. Relationship to you _____

4. ☐ Male ☐ Female 5. Social Security number* ___-___-____ * (optional if applying ONLY for child care or emergency medical services)

6. Marital status ☐ Married ☐ Never married ☐ Divorced ☐ Widowed ☐ Separated

7. Is this person a U.S. citizen? ☐ Yes ☐ No **If no, and you are a documented alien, what is your date of entry: _____
Mother's Maiden Name _____ Place of Birth _____ (county, city, state)

8. Pregnant now/last three months ☐ Yes ☐ No If yes, ▸ Due date/pregnancy end date __/__/____
Number expected/had ☐ One ☐ Twins ☐ Triplets ☐ Other _____

9. Highest grade completed in school _____ ☐ Received GED ☐ Full-time ☐ Half-time

10. In school now? ☐ Yes ☐ No If yes, ▸ School name _____ ☐ Less than half-time
☐ K-12 ☐ GED ☐ College ☐ Trade school ☐ University ☐ Vocational ☐ Other

11. Ethnicity (optional) ☐ Hispanic/Latino ☐ Not Hispanic/Latino

12. Race (optional) ☐ American Indian/Alaska Native – Enter tribe name _____
☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African American ☐ White

13. Is this person any of the following? (check all that apply) ☐ Refugee ☐ Sponsor of an alien
☐ Migrant farmworker ☐ Foster child ☐ Foster parent ☐ Temporarily absent (college, military, etc.)
☐ Seasonal farmworker ☐ Adopted child ☐ Non-parent caregiver ☐ None apply to this person

14. If this person is currently away from the home ▸ Why? _____ Expected return date _____

15. How many days each month does this person stay at the application address? _____ at another address? _____
Other address _____ (number, street, rural route, apartment/lot number, city, state, zip code)

16. What kind of help does this person need? ☐ Food ☐ Medical ☐ Emergency help
☐ Family Planning Services ☐ Child care ☐ Cash Assistance ☐ None (not applying)

17. If this person is under 22, complete this section:
Who paid for this child's birth expenses ☐ State ☐ Parents ☐ Another person
What was the marital status of the mother while pregnant with this child? _____
If Married or Divorced: Marriage Date __/__/____ Separation Date __/__/____ Divorce Date __/__/____
Order/County/State: _____ Order/County/State: _____
If single, this child's Conception Date __/__/____ City: _____ State ____ Country _____
Has an Affidavit of Parentage (AOP) or a court order named someone as the father? ☐ Yes ☐ No
If Yes, Order/AOP# _____ Date __/__/____ City: _____ State ____ Country _____
If No, is there more than one likely father? ☐ Yes ☐ No, If Yes, **Stop**
If not directed to stop, complete the following for each parent:

Father

Name (first, mi, last) Birthdate SSN
_____ __/__/____ _____
Approximate age (if Birthdate not known): _____
Is he in the home? ☐ Yes ☐ No
Is he deceased ☐ Yes ☐ No
Is he the same father described for a previous child?
☐ Yes, name: _____ ☐ No
Is he a single-parent adopter? ☐ Yes ☐ No
Has the court terminated his rights? ☐ Yes ☐ No
If Yes to any of the above, **stop**. Otherwise:
Is there a support order naming him for this child?
Order # _____ County _____ State _____ Country _____
Last known employer & address _____
Month/year last worked __/____
Height ___ Weight ___ Hair color ____ Eye Color ____
Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Race: ☐ American Indian/Alaska Native (Tribe _____)
☐ Asian ☐ Hawaiian Native/Pacific Islander
☐ Black/African American ☐ White
Father's health insurance covering this child:
Carrier _____ Policy # _____

Mother

Name (first, mi, last) Birthdate SSN
_____ __/__/____ _____
Approximate age (if Birthdate not known): _____
Is she in the home? ☐ Yes ☐ No
Is she deceased ☐ Yes ☐ No
Is she the same mother described for a previous child?
☐ Yes, name: _____ ☐ No
Is she a single-parent adopter? ☐ Yes ☐ No
Has the court terminated her rights? ☐ Yes ☐ No
If Yes to any of the above, **stop**. Otherwise:
Is there a support order naming her for this child?
Order # _____ County _____ State _____ Country _____
Last known employer & address _____
Month/year last worked __/____
Height ___ Weight ___ Hair color ____ Eye Color ____
Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Race: ☐ American Indian/Alaska Native (Tribe _____)
☐ Asian ☐ Hawaiian Native/Pacific Islander
☐ Black/African American ☐ White
Mother's health insurance covering this child:
Carrier _____ Policy # _____

**Applies to FIP, Medicaid and RAP applicants only

D. Household Members Under Age 22

Do you need more pages? ☐ *Yes* ☐ *No*

List person(s) under age 22 in the household	List name of mother/father (first, middle, last)	Check if parent is deceased	If person under age 22 does not live with a parent, who do they live with?	Check box(es) below if: • Parents were ever married to each other. • Paternity was legally established. • Support is court-ordered.
	Mother	☐ Yes	Name	☐ Married ☐ Paternity ☐ Support Order # ________
	Father	☐ Yes	Relationship	
	Mother	☐ Yes	Name	☐ Married ☐ Paternity ☐ Support Order # ________
	Father	☐ Yes	Relationship	
	Mother	☐ Yes	Name	☐ Married ☐ Paternity ☐ Support Order # ________
	Father	☐ Yes	Relationship	
	Mother	☐ Yes	Name	☐ Married ☐ Paternity ☐ Support Order # ________
	Father	☐ Yes	Relationship	
	Mother	☐ Yes	Name	☐ Married ☐ Paternity ☐ Support Order # ________
	Father	☐ Yes	Relationship	
	Mother	☐ Yes	Name	☐ Married ☐ Paternity ☐ Support Order # ________
	Father	☐ Yes	Relationship	
	Mother	☐ Yes	Name	☐ Married ☐ Paternity ☐ Support Order # ________
	Father	☐ Yes	Relationship	
	Mother	☐ Yes	Name	☐ Married ☐ Paternity ☐ Support Order # ________
	Father	☐ Yes	Relationship	
	Mother	☐ Yes	Name	☐ Married ☐ Paternity ☐ Support Order # ________
	Father	☐ Yes	Relationship	
	Mother	☐ Yes	Name	☐ Married ☐ Paternity ☐ Support Order # ________
	Father	☐ Yes	Relationship	

E. Child Development and Care (CDC) Information

Do you need more pages? ☐ *Yes* ☐ *No*

1. Do you need help paying for child care? ☐ **Yes** ▶ ***Check why and complete the table below.*** ☐ **No**

☐ Work ☐ High school or GED ☐ Education/training approved by DHS or the work participation program.

☐ Treatment for health or social condition (explain)______________________________

Name of child needing care	Provider name	Provider ID number (if known)	What time is child in care? Example: 8:00 a.m. - 4:00 p.m.
			Su ____ Wed ____ M ____ Thurs ____ Tu ____ Fri ____ Sat____
			Su ____ Wed ____ M ____ Thurs ____ Tu ____ Fri ____ Sat____
			Su ____ Wed ____ M ____ Thurs ____ Tu ____ Fri ____ Sat____
			Su ____ Wed ____ M ____ Thurs ____ Tu ____ Fri ____ Sat____
			Su ____ Wed ____ M ____ Thurs ____ Tu ____ Fri ____ Sat____
			Su ____ Wed ____ M ____ Thurs ____ Tu ____ Fri ____ Sat____
			Su ____ Wed ____ M ____ Thurs ____ Tu ____ Fri ____ Sat____
			Su ____ Wed ____ M ____ Thurs ____ Tu ____ Fri ____ Sat____
			Su ____ Wed ____ M ____ Thurs ____ Tu ____ Fri ____ Sat____
			Su ____ Wed ____ M ____ Thurs ____ Tu ____ Fri ____ Sat____

F. Medical Information

Do you need more pages? ☐ *Yes* ☐ *No*

1. List anyone in your household who is a victim of domestic violence _____ ☐ None
2. List any children under six years of age who are not up-to-date on their immunizations (shots) _____ ☐ None
3. List any children in an *Early On®* program _____ ☐ None

   Name and phone number of *Early On* coordinator _____
4. List any children who receive Children's Special Health Care Services _____ ☐ None
5. List anyone who is now or has ever been in a special education class _____ ☐ None

   Name and phone number of school _____
6. List anyone going to an alcohol or drug treatment program _____ ☐ None
7. List anyone working with Michigan Rehabilitation Services _____ ☐ None

   Name and phone number of Michigan Rehabilitation counselor _____
8. List anyone caring for a child, spouse or other person with a disability in the home _____ ☐ None
9. Is the caregiver able and available to work in addition to caring for someone? ☐ Yes ☐ No
10. **List anyone applying for assistance who is physically or mentally unable to work full-time.** ☐ **None**

Person	Medical condition	Is this person able to work?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

G. Medical Coverage

Does anyone in your household have, or expect to have, medical coverage (other than Medicaid)?

☐ **Yes** ▸ ***Check which type of coverage and complete the table below.*** ☐ **No**

☐ Health/hospital insurance (employer, parent, etc.)
☐ Medicare
☐ Accident (home or car insurance, etc.)
☐ MIChild
☐ Plan/contract (life care contract, etc.)
☐ Workers' compensation
☐ Health savings account
☐ Other _____

Person covered	Name and address of insurance company	Claim, contract/group numbers, effective date

H. Asset Information

Do you need more pages? ☐ *Yes* ☐ *No*

1. Does anyone in your household have any assets? (include assets owned with another person)

☐ **Yes** ▸ ***Check all types of assets your household has and complete the table below.*** ☐ **No**

- ☐ Checking accounts
- ☐ Certificates of deposit (CD)
- ☐ Cash on hand/in safe deposit box
- ☐ Trust or annuities
- ☐ Life estate
- ☐ Life insurance
- ☐ Burial trust/funeral contract(s)
- ☐ Savings accounts
- ☐ Credit union accounts
- ☐ Money market accounts
- ☐ Christmas club accounts
- ☐ Savings bonds, stocks or mutual funds
- ☐ Land contract, mortgage or other notes payable to household member
- ☐ Burial plot(s), casket, etc.
- ☐ Other (mineral/water/oil rights, etc.)
- ☐ Patient trust fund
- ☐ IRA, KEOGH, 401K or deferred compensation account(s)
- ☐ Real estate/property
- ☐ Real estate/property (not including place you live)
- ☐ Tools and equipment, livestock or crops
- ☐ Lottery/Gambling winning

Owner of asset	Type of asset	Balance (amount or value)	Name and address (bank, insurance company, etc.)	Account or policy number, etc.

2. Has anyone in your household:

- Sold/given away property, land, stocks, bonds, vehicles, savings, checking or credit union accounts, income, cash, etc., or closed any accounts or removed or added a name to any asset within the last 60 months? ☐ Yes ☐ No

  If yes, ▸ Who? _____ ▸ What? _____

  ▸ Date ☐☐/☐☐/☐☐☐☐ ▸ How much? $

- Filed a lawsuit which may bring money, property, etc.? ☐ Yes ☐ No

  If yes, ▸ Who? _____ ▸ What? _____

  ▸ Date ☐☐/☐☐/☐☐☐☐ ▸ How much? $

- Received a one-time payment (such as worker's compensation, lottery winnings, insurance settlement lawsuit award, etc.) within the last 60 months (five years)? ☐ Yes ☐ No

  If yes, ▸ Who? _____ ▸ What? _____

  ▸ Date ☐☐/☐☐/☐☐☐☐ ▸ How much? $

- Acting for another household member put any money, lawsuit settlement, income or assets in a trust, annuity or similar legal device within the last 60 months (five years)? ☐ Yes ☐ No

  If yes, ▸ Who? _____ ▸ What? _____

  ▸ Date ☐☐/☐☐/☐☐☐☐ ▸ How much? $

I. Vehicle Information

Do you need more pages? ☐ *Yes* ☐ *No*

Does anyone in your household have any vehicles?

☐ **Yes** ▸ ***Check all that apply and complete the table below.*** ☐ **No**

☐ Car ☐ Truck ☐ Boat ☐ Camper/trailer ☐ Motorcycle ☐ RV ☐ Other vehicles

Owner(s) on vehicle title or registration	Year	Make / Model	Mileage	Amount owed

J. Migrant or Seasonal Farmworker Income

Do you need more pages? ☐ *Yes* ☐ *No*

Is anyone in your household a ☐ **migrant or** ☐ **seasonal farmworker?**
☐ **Yes** ▸ ***Complete the table below.*** ☐ **No**

		Date	Gross pay amount
Has anyone received any income from the same grower within 30 days before the application date?	☐ Yes ▸ Name of person(s): ☐ No		
Does anyone expect to receive more income this month?	☐ Yes ▸ Name of person(s): ☐ No		
Has anyone received a travel advance?	☐ Yes ▸ Name of person(s): ☐ No		
Has anyone recently lost their only source of income?	☐ Yes ▸ Name of person(s): ☐ No	Last pay date	Gross pay amount

K. Employment Changes

Do you need more pages? ☐ *Yes* ☐ *No*

Did anyone in your household have changes in employment in the last 30 days?
☐ **Yes** ▸ ***Check all that apply and complete the table below.*** ☐ **No**

Check all that apply	Name of person(s)	Name and address of employer	Date of change	Date and gross amount of final pay
☐ Refused work Reason _____				
☐ Voluntarily reduced hours worked Reason _____				
☐ Quit a job Reason _____				
☐ Was laid off Reason _____				
☐ Was fired Reason _____				
☐ Is participating in a strike Reason _____				

L. Self-Employment Income (including odd jobs)

Do you need more pages? ☐ *Yes* ☐ *No*

1. Is anyone in your household self-employed or will anyone be self-employed before the end of the next calendar month? ☐ **Yes** ▸ ***Complete the table below.*** ☐ **No**

Self-employed person	Type of work or business and date business started	Business name and address	Gross monthly income (amount before any expenses)	Monthly self-employment expenses
	☐☐/☐☐/☐☐☐☐			
	☐☐/☐☐/☐☐☐☐			

M. Employment Income

Do you need more pages? ☐ *Yes* ☐ *No*

Is anyone in your household working for wages or salary or will anyone begin working before the end of the next calendar month? ☐ **Yes** ▸ ***Complete the information below for each working person.*** ☐ **No**

Name of working person _____ Start date ☐☐/☐☐/☐☐☐☐

Employer name/address/phone number _____

Type of work _____ Job title _____

If new job, first pay check date ☐☐/☐☐/☐☐☐☐ Will employment continue? ☐ Yes ☐ No

Day of week pay is received _____ Most recent or last pay check date ☐☐/☐☐/☐☐☐☐

Average # of hours expected to work _____ per ☐ Week ☐ Pay period Rate of pay $ _____ ☐ Hourly ☐ Salary ☐ Other _____

How often paid: ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Other _____

Do you receive a ☐ Bonus ☐ Commission or ☐ Overtime? ☐ Yes ☐ No

▸ If yes, amount $ _____ How often? _____

Do you receive tips not included in your check? ☐ Yes ☐ No

▸ If yes, average tips not included $ _____ per ☐ Week ☐ Pay period ☐ Other _____

Name of working person _____ Start date ☐☐/☐☐/☐☐☐☐

Employer name/address/phone number _____

Type of work _____ Job title _____

If new job, first pay check date ☐☐/☐☐/☐☐☐☐ Will employment continue? ☐ Yes ☐ No

Day of week pay is received _____ Most recent or last pay check date ☐☐/☐☐/☐☐☐☐

Average # of hours expected to work _____ per ☐ Week ☐ Pay period Rate of pay $ _____ ☐ Hourly ☐ Salary ☐ Other _____

How often paid: ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Other _____

Do you receive a ☐ Bonus ☐ Commission or ☐ Overtime? ☐ Yes ☐ No

▸ If yes, amount $ _____ How often? _____

Do you receive tips not included in your check? ☐ Yes ☐ No

▸ If yes, average tips not included $ _____ per ☐ Week ☐ Pay period ☐ Other _____

N. Other Income

Do you need more pages? ☐ *Yes* ☐ *No*

1. Does anyone in your household receive, or expect to receive (has applied for), any income other than earnings?

☐ **Yes** ▸ ***Check all boxes that apply and complete the table below.*** ☐ **No**

☐ Social Security benefits (RSDI) ☐ Supplemental Security Income (SSI) ☐ Disability benefits

☐ Pension/retirement benefits ☐ Resettlement Income (FAP only) ☐ Unemployment benefits

☐ Railroad retirement benefits ☐ Workers' compensation ☐ Rental income

☐ Veterans benefits ☐ Money from friends or relatives, etc. ☐ Room and/or board income

☐ Military allotments ☐ Interest/dividend income

☐ Land contract, mortgage or other notes payable to a household member

☐ Income/payments from a tribe (tribal general assistance, land claims, casino profit sharing, per capita, etc.)

☐ Other (mineral/water/oil rights, etc.) ☐ Child support/court order docket # _____

Person receiving/ expecting money	Income source/type	How often received	Amount received	Expected to continue?	Date expecting if not yet received
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

2. If anyone in your household receives Social Security (RSDI) or Railroad Retirement benefits, list the claim number(s) _____

3. Is anyone in your household a veteran? ☐ Yes ☐ No If yes, is person a:

☐ **U.S. veteran with a disability. Who?** _____

☐ **Widow(er) or child of a deceased U.S. veteran? Who?** _____

☐ **Spouse or child with a disability of a U.S. veteran with a disability? Who?** _____

☐ **None of these**

Has anyone in your household applied for VA health care benefits? ☐ Yes ☐ No **Who?** _____

Is anyone in your household receiving VA health care benefits? ☐ Yes ☐ No **Who?** _____

O. Disability Benefits

Do you need more pages? ☐ *Yes* ☐ *No*

1. Has anyone in your household, who is not receiving disability benefits, applied for or been denied disability benefits? ☐ **Yes** ▸ ***Check all disability benefits that apply and complete the table below.*** ☐ **No**

Person	Type of benefit	Benefit status	Date of action (if known)
	☐ Social Security Claim # ______ ☐ Self ☐ Spouse ☐ Parent ☐ Supplemental Security Income (SSI) ☐ Other ______	☐ Applied for benefits. ☐ Denied benefits.* ☐ Appealed the denial. ☐ Requested a hearing.	
	☐ Social Security Claim # ______ ☐ Self ☐ Spouse ☐ Parent ☐ Supplemental Security Income (SSI) ☐ Other ______	☐ Applied for benefits. ☐ Denied benefits.* ☐ Appealed the denial. ☐ Requested a hearing.	
	☐ Social Security Claim # ______ ☐ Self ☐ Spouse ☐ Parent ☐ Supplemental Security Income (SSI) ☐ Other ______	☐ Applied for benefits. ☐ Denied benefits.* ☐ Appealed the denial. ☐ Requested a hearing.	

* *Social Security Administration has decided they are not disabled.*

2. If benefits were denied, have the person's health problem(s) changed? ☐ **Yes** ☐ **No**

If yes, ▸ **List who** ______ **Date of change** ______

☐ **Health problem is worse** ☐ **New health problem** ☐ **Has more than one health problem**

P. Dependent Care Expenses and Court-Ordered Support

Do you need more pages? ☐ *Yes* ☐ *No*

1. Does anyone in work, school, or training pay for the care of a ☐ **child,** ☐ **family member with disabilities?**

☐ **Yes** ▸ ***Complete the table below (DO NOT include amounts paid by DHS or anyone else).*** ☐ **No**

Person paying	Amount paid	How often	Name of person(s) receiving care
	$ ______	☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Other	
	$ ______	☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Other	
	$ ______	☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Other	

2. Does anyone in your household pay court-ordered ☐ **child support** ☐ **spousal support/alimony?**

☐ **Yes** ▸ ***If either of the boxes are checked above, complete the table below.*** ☐ **No**

Person paying	Court-order/docket number and county of order	Order amount	Amount paid per	For whom
		$ ______	$ ______ ☐ Week ☐ Month ☐ Other	
		$ ______	$ ______ ☐ Week ☐ Month ☐ Other	
		$ ______	$ ______ ☐ Week ☐ Month ☐ Other	

Q. Medical Expenses

Do you need more pages? ☐ *Yes* ☐ *No*

1. List anyone who has paid or unpaid medical expenses for services provided in the last three months:

▸ Who?_____ What months?_____

List anyone who has paid medical premiums in the last three months:

▸ Who?_____ What months?_____

2. Does anyone in your household have any ongoing medical expenses?

☐ **Yes** ▸ ***Check all expenses that apply and complete the table below.*** ☐ **No**

- ☐ Medical care
- ☐ Dental care
- ☐ Hospitalization
- ☐ Transportation for medical care (for pregnancy or ongoing care)
- ☐ Emergency room
- ☐ Nursing facility
- ☐ Prescribed over-the-counter drugs
- ☐ Prescription drugs
- ☐ Prescription drug card
- ☐ Dentures
- ☐ Eyeglasses
- ☐ Hearing aids
- ☐ Prosthetics
- ☐ Service animal
- ☐ Guardian/conservator fees
- ☐ Health insurance premium
- ☐ Medicare premium
- ☐ Medical equipment/supplies
- ☐ Personal care/chore services
- ☐ Other

Person with expense	Medical expense (checked above)	Amount person pays	How often (monthly, yearly, etc.)

R. Shelter Expenses

Check the boxes that apply and fill in the amount.*

1. ☐ Rent $ _____ (enter ONLY the amount you pay, NOT the amount paid by HUD, Section 8, MSHDA, etc.)
   ☐ Weekly ☐ Monthly ☐ Other
   ☐ Renter's insurance $_____ per year *(answer ONLY if applying for MA for a nursing facility)*
2. Does anyone pay for:
   Rent that includes meals (room/board) ☐ Yes ▸ $ _____ ☐ Weekly ☐ Monthly ☐ Other ☐ No
   Meals only (board) ☐ Yes ▸ $ _____ ☐ Weekly ☐ Monthly ☐ Other ☐ No
3. ☐ Mobile home lot rent? $ _____ ☐ Weekly ☐ Monthly ☐ Other
4. ☐ Mortgage/mobile home/land contract $ _____ ☐ Weekly ☐ Monthly ☐ Other
5. ☐ Second mortgage or home equity loan $ _____ ☐ Weekly ☐ Monthly ☐ Other
6. Shelter expenses billed separately from rent or mortgage: ☐ Fuel Type (Ex. wood, gas, propane) _____
   - ☐ Heat (gas, electric, propane, wood, etc.)
   - ☐ Cooling (including room air conditioner)
   - ☐ Electricity (non-heat)
   - ☐ Water/sewer
   - ☐ Cooking fuel
   - ☐ Garbage/trash pick-up
   - ☐ Telephone
   - ☐ Homeowner's insurance $ _____ per year
   - ☐ Property taxes $ _____ per year
   - ☐ Special assessments $_____ per _____
   - ☐ Mortgage guarantee insurance $ _____ per _____
   - ☐ Cooperative/condominium/association fee $_____
   - ☐ Other _____ $ _____

7. **Michigan Department of Treasury Home Heating Credit (HHC)** - For the current fiscal year:
   a. Has anyone in your household who is applying for FAP received the HHC for the ***current address***?
   ☐ **Yes** ☐ **No**
   b. Will anyone in your household who is applying for FAP, apply or expect to apply for, the HHC for the ***current address***? ☐ **Yes** ☐ **No**

**If you are applying for medical assistance ONLY and you are in a nursing facility and have a spouse or dependent living at home, complete Section R. If you are applying for OTHER medical assistance ONLY, you may skip Section R.*

S. Receipt of Benefits

1. Did anyone in your household ever apply for or receive benefits from Michigan in the past? ☐ Yes ☐ No

   ▸ If yes, under what name(s)? _____
   (maiden name, alias, former spouse, etc.)

   ▸ If yes, does anyone have a Bridge card? ☐ Yes ☐ No *For more information about these cards, see the **Information Booklet**.*

   If yes, who? _____

   ▸ If yes, does anyone have a mihealth card? ☐ Yes ☐ No

   Who does not have a mihealth card? _____

2. Does anyone in your household receive Women, Infants, Children (WIC) benefits? ☐ Yes ☐ No

   ▸ If yes, who? _____

3. Does anyone in your household receive tribal TANF (cash) benefits? ☐ Yes ☐ No

   ▸ If yes, who? _____

4. Does anyone in your household receive Adoption subsidy/Guardianship Assistance Payments? ☐ Yes ☐ No

   ▸ If yes, who? _____

T. Information DHS Needs to Know

Answer for everyone in your household.

- Has anyone ever been disqualified or had their benefits reduced or stopped because they did not follow program rules? ☐ Yes ☐ No

  ▸ If yes, who? _____

- Has anyone ever been convicted of fraud for receiving cash or food assistance from two or more states for the same time period? ☐ Yes ☐ No

  ▸ If yes, who? _____ What program(s)? _____

- Is anyone fleeing from felony prosecution or jail? ☐ Yes ☐ No

  ▸ If yes, who? _____

- Has anyone ever been convicted of a drug-related felony occurring after August 22, 1996? ☐ Yes ☐ No

  ▸ If yes, who? _____ Convicted more than once? ☐ Yes ☐ No

- Is anyone in violation of probation or parole? ☐ Yes ☐ No

  ▸ If yes, who? _____

U. State of Michigan Voter Registration Application

If you are not already registered to vote at your current address, would you like to register to vote? ☐ Yes ☐ No

NOTE: If you do not check either box, DHS will assume you have decided not to register to vote at this time.

Applying or declining to register to vote will not affect the amount of help that you will be provided by this department. 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 voter registration application form in private.

If you believe that someone has interfered with your right to:

- Register to vote.
- Decline to register to vote.
- Privacy in deciding whether to register or in applying to register to vote.
- Choose your own political party or other political preference.

You may file a complaint with:

Secretary of State
PO Box 20126
Lansing, MI 48901-0726

V. Representative, Guardian, Conservator or Person Helping with Application

1. If you are eligible for food assistance, do you want someone else to have a Bridge card and access to your food benefits to shop for you? ☐ Yes ☐ No

   If yes, enter his/her full name _____
   (This person will be your authorized representative.)

2. Are you filling this application out for someone else? ☐ Yes ☐ No
   Are you representing the person applying? ☐ Yes ☐ No
   Check one or both.

   ▸ ***If Yes is checked for one or both questions above, complete the following information:***

Name | Phone number ___-___-____

Street address (number, street, rural route, apartment/lot number, PO box)

City | State | Zip code

Representative's relationship to applicant *(check all that apply)*
☐ Guardian ☐ Relative (*specify*) _____
☐ Conservator ☐ Other (*specify*) _____

If you are under age 18, are you married? ☐ Yes ☐ No

W. Affidavit

IMPORTANT: Before you sign this application, READ the affidavit.

Under penalties of perjury, I swear or affirm that this application has been examined by or read to me, and, to the best of my knowledge, the facts are true and complete. If I am a third party applying on behalf of another person, I swear that this application has been examined by or read to the applicant, and, to the best of my knowledge, the facts are true and complete.

I certify that I have received a copy, reviewed and agree with the sections in the assistance application **Information Booklet** explaining how to apply for and receive help: Programs, Things You Must Do, Important Things to Know, Repay Agreements, and Information About Your Household That Will Be Shared.

I certify, under penalty of perjury, that all the information I have written on this form or told my DHS specialist or my representative is true. I understand I can be prosecuted for perjury if I have intentionally given false or misleading information, misrepresented, hidden or withheld facts that may cause me to receive assistance I should not receive or more assistance than I should receive. I can be prosecuted for fraud and/or be required to repay the amount wrongfully received. I understand I may be asked to show proof of any information I have given.

Signature of client or representative	Date	When in-person interview completed: Signature of department witness/migrant recruiter	Date

Notes

Notes

Notes

Notes

Child Support Actions (Most Programs) (continued)

If you receive benefits from FIP, FAP, MA or CDC, and you When you get a FIP grant, you give (assign) to DHS any current support for you (spousal support) or minor children in your home (child support). This means when you get FIP, some of the spousal or child support you get from someone else may go to DHS to pay back some of the FIP grant.

You may get a child support payment that is owed to you while on FIP. If you do get a child support payment, call your local DHS office to find out if you can keep it. If your DHS worker tells you the payment was sent to you in error, you must return the money. If you do not return the money, you may lose your FIP grant or your grant may be reduced.

If the amount of support DHS collects is more than your FIP grant for at least two months, DHS may close your FIP case so you can receive support payments directly.

If you get MA for your children, you give (assign) your rights to current and past medical support to the Michigan Department of Community Health (MDCH). This means when you get MA, medical support payments you get from someone else will go to MDCH.

Follow Work Rules and Penalties (FIP or RAP and FAP)

Your work rules will depend on whether you receive FIP or RAP cash assistance, FAP benefits with no cash assistance, or time-limited FAP benefits.

FIP or RAP cash assistance work rules. Your family must complete a Family Automated Screening Tool (FAST) and develop a Family Self-Sufficiency Plan (FSSP). This plan will list the work activities that you must do up to 40 hours per week to receive FIP or RAP. You design this plan with your DHS specialist and the work participation program.

Adults who receive FIP or RAP must (but not limited to):

- Complete the screening tool (FAST).
- Help make and comply with a FSSP.
- Not quit, refuse work or reduce work hours.
- Not get fired from a job due to misconduct or missing work.
- Comply with assigned employment and/or self-sufficiency activities.

Penalties for breaking FIP or RAP work rules. If you break the FIP or RAP work rules without good cause (see "Good Cause" on page 13), DHS will:

- Deny your application (you may reapply).
- Stop FIP for your whole family for three months for the first time, six months for the second time and permanently for the third time.
- Count all penalty months toward your 48-month lifetime limit.
- Stop RAP for you for at least three months (but the rest of your household might be eligible).
- If you receive both FIP and FAP, we may:
  - Stop or reduce your FAP benefits for at least one month if you are not excused from FAP work rules.
  - Count your FIP grant amount as income.

FAP work rules. (NOTE: If you receive both cash and food benefits, you must follow FIP work rules.)

- **If you are working**, you may not:
  - Quit a job of 30 hours or more per week.
  - Voluntarily reduce work hours below 30 hours per week without good cause.
- **If you are not working**, or you work less than 30 hours per week, you may not:
  - Refuse a job offer.
  - Refuse to participate in required employment-related activities that must be done to receive FAP.

Penalties for breaking FAP work rules. If you receive FAP and you break the work rules without good cause, your benefits will stop or be reduced for:

- At least one month for the first time, and
- Six months for any other time after the first time.

Time-limited food assistance rules. (NOTE: Time limits are not always in effect, so check with your DHS specialist.)

Special time limits and work requirements might apply to you if you are:

- A person without a disability.
- At least 18 years old but under the age of 50, and
- Living in a household with no children under age 18 (related or unrelated).

Read this information booklet before you sign the assistance application.

Work Rule Deferrals and Good Cause (FIP or RAP and FAP)

Work rule deferrals (excused). Some people who receive cash or food assistance may be excused from work rules. If you receive FIP and are excused from the work rules, you may have to do other activities. If you think you should be excused from work rules, talk to your DHS specialist. NOTE: Reasons for being excused may change.

You may be excused from FIP or RAP work rules if you are:

- Under the age of 16.
- Age 65 or older.
- A parent of a baby less than two months old. You may be assigned to family strengthening activities once the baby is six weeks old.
- Working 40 hours per week.
- Caring for a child or spouse with a disability (depending on the person's needs and the child's school attendance).
- A person with a disability or medical limitations.
- Experiencing a domestic violence situation (determined by DHS).

You may be excused from FAP work rules if you are:

- Age 60 or older.
- Personally caring for a child under the age of six who is receiving FAP on your case.
- Working 30 hours per week or earning at least minimum wage times 30 hours per week.
- Attending high school, adult education, or a GED program at least half-time.
- Injured, ill or personally caring for a household member with a disability.
- Seven to nine months pregnant.
- Pregnant with medical complications.
- Applying for FAP at a Social Security office.
- In substance abuse treatment or rehabilitation.
- Applying for or receiving unemployment benefits.
- Appealing the denial of unemployment benefits.

Good cause. You have the right to claim good cause if you believe you should be excused from the FIP, RAP and/or FAP work rules. If you think you have a good cause reason, contact your DHS specialist right away. NOTE: Reasons for good cause may change.

FIP or RAP or FAP - Reasons for good cause:

- An unplanned event or factor that does not allow you to meet the work rules (ex., domestic violence, religion, health or safety risk or homelessness).
- Illness or injury.
- You requested child care that was not provided.
- You requested transportation services that were not provided.
- Long commute (more than two hours per day or more than three hours per day with child care).
- You quit a job to take a comparable job.
- Your job required you to commit illegal activities.
- You are physically or mentally unable to do the job.
- Your employer discriminated against you based on age, race, color, sex, national origin, disability, religion, etc.
- You are working 40 hours per week for at least the state minimum wage.
- Reasonable accommodation was not provided.

FAP only - You may have a good cause reason if you/your:

- Are deferred.
- Moved due to another household member's job or education/training.
- Have a job that requires you to retire or to join, resign from, or refrain from joining a labor union or organization.
- Have a job that is on strike or at a lockout site.
- Have unreasonable work conditions.
- Have been offered a job that is outside of your work experience during the **first 30 days** as a mandatory FAP work participant.
- Employer is not able to keep the promise of work.

Important Things To Know

Penalties, Intentional Program Violation Or Fraud (FAP, FIP, SDA, CDC)

Intentional Program Violation (IPV) is when you make a false or misleading statement, hide, misrepresent or withhold facts on purpose to receive or continue to receive extra benefits.

Fraud/IPV - If we think you committed fraud/IPV, we may hold an administrative hearing, bring criminal charges or ask you to voluntarily sign a disqualification agreement.

FAP Trafficking - You may also be guilty of fraud/IPV if you trade or sell your FAP benefits or Bridge card. You may not use FAP benefits or Bridge cards that belong to another household for your household. You may not use FAP benefits or Bridge cards to purchase anything other than food or seeds and plants to grow your own food for your household.

If it is proven in court that you are guilty of **fraud:**

- You are subject to criminal penalties (ex., fines up to $250,000, jail/prison time up to 20 years, or both). You may be charged under other federal laws and a court may prevent you from receiving benefits for an additional 18 months; **and**
- You must repay any extra benefits you received because of the fraud/IPV; **and**
- You will be disqualified from receiving FIP/SDA and/or FAP benefits - see the table below.

If it is proven you are guilty of **IPV** in an administrative hearing, or you voluntarily sign a disqualification:

- You will be disqualified from receiving FIP/SDA and/or FAP benefits - see the table below, **and**
- You will have to repay the extra benefits you received because of the fraud or IPV.

CDC Penalties - Violation of CDC program rules may result in a sanction of 6 months, 12 months or a lifetime.

If you do any of the following:	**You will lose FIP/SDA and/or FAP benefits for:**
• Make a false or misleading statement. • Hide, misrepresent or withhold facts to receive or continue to receive benefits. • Trade or sell less than $500 in FAP benefits or Bridge cards. • Use FAP benefits to buy ineligible items such as alcoholic drinks or tobacco. • Use FAP benefits or Bridge cards that belong to someone else for your household.	• One year for the first violation. • Two years for the second violation. • Life for the third violation.
If you are:	**You will lose FAP benefits for:**
• Convicted by a court or found guilty by administrative hearing of lying about your identity or where you live to receive benefits on two or more cases at the same time.	• 10 years.
If you are:	**You will lose FIP benefits for:**
• Convicted in court of lying about your identity or where you live to receive benefits* in two or more cases at the same time. *Benefits include programs funded under Title IV-A of the Social Security Act, Medicaid and Supplemental Security Income. This penalty will not stop you from receiving MA.	• 10 years.
If any member of the household is found guilty in court of:	**You will lose FAP benefits for:**
• Trading FAP benefits for drugs.	• Two years for the first offense. • Life for the second offense.
If any member of the household is found guilty in court of:	**You will lose FAP benefits for:**
• Trading FAP benefits for firearms, ammunition or explosives. • Trading, buying or selling FAP benefits of $500 or more for anything other than food.	• Life.

Read this information booklet before you sign the assistance application.

Important Things To Know (continued)

General Complaints

Clients have the right to make general complaints about matters other than the right to apply, non-discrimination or hearing issues. Written complaints can be sent to:

Michigan Department of Human Services
Specialization Action Center
235 S. Grand Avenue
PO Box 30037
Lansing, MI 48909
or they may call 1-855-275-9242 or 1-855-ASK-MICH

Hearing Rights

If you do not agree with a decision DHS makes to deny, reduce or terminate benefits, you have the right to request a hearing. In most cases, if you receive a notice reducing or canceling your benefits and you request a hearing within 11 days of the date the action will take place, your benefits will continue until the hearing is held.

Someone else may represent you at the hearing, such as a friend, relative, or lawyer.

To ask for a hearing:

- Bring, mail or fax a signed, written hearing request* to your DHS office.

  ** DHS-18 available online at www.michigan.gov/dhs-forms.*

- For FAP only, you can request a hearing verbally, in person or by telephone.
- The hearing request must be signed by you or by your parent, spouse, attorney, court-appointed guardian or conservator, or by someone else you name in a signed statement.

Michigan Administrative Hearings Service (MAHS) will deny your hearing request if:

- We receive your request more than 90 days after we mailed the notice to deny, terminate, or reduce your benefits.
- The person who signed the hearing request cannot show a court order or signed statement from you and is not your lawyer, spouse or parent.

If You Think We Discriminate

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

To file a complaint of discrimination, contact USDA or HHS. Write USDA, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing-impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). Write HHS, Director, Office for Civil Rights, DHHS, 233 N. Michigan Ave., Suite 240, Chicago, IL 60601 or call (312) 886-2359 (Voice); (312) 353-5693 (TDD); fax (312) 886-1807.

"USDA and HHS are equal opportunity providers and employers."

Race and Ethnicity

Answering questions about race and ethnicity is voluntary. If you do not answer these questions, your eligibility or benefit levels will not be affected.* The information is collected to ensure that program benefits are distributed without regard to race, color or national origin.

** If you choose not to answer these questions, your DHS specialist may choose an answer for you.*

Citizens and Non-Citizens

Social Security numbers and immigration papers are NOT required for a person who is:

- Not applying for help.
- An undocumented non-citizen applying only for medical assistance for emergency services, pregnancy or childbirth.
- Only applying for child care. (You must give a Social Security number for the child and the child must be a U.S. citizen or show immigration papers.)

Other eligible members of your household will still be able to receive help.

You may have to provide information about income and assets of all persons in your household, even if they are not applying.

Receiving food, medical, or emergency assistance will **not** affect your immigration status. If you are here illegally, it may affect your ability to stay in the U.S.

For some programs, **persons claiming U.S. citizenship** must provide proof of citizenship and identity. Acceptable proof of citizenship includes, but is not limited to, a U.S. passport, a certificate of naturalization, a U.S. public birth record showing birth in the U.S. or U.S. territories.

Persons receiving SSI, Social Security, Medicare, or adoption assistance; foster children, and newborn "safe delivery" babies are not required to provide proof of U.S. citizenship for DHS programs.

Read this information booklet before you sign the assistance application.

Important Things To Know (continued)

Persons With Disabilities

You do not have to tell us about disabilities, but some help is only available to persons with disabilities. If you or someone in your household has a disability, we can make exceptions or give you special help.

Tell your DHS specialist if you need help.

If you do not tell us about a disability now, you can tell us about it later.

If you are denied special help or an exception you need because of a disability, and you think the denial was wrong, you may file a complaint of discrimination with:

DHS, Americans with Disabilities Act Coordinator

P.O. Box 30037, Suite 1412
Lansing, MI 48909
(517) 373-8520

Domestic Violence

We may be able to waive some program requirements (such as working, looking for a job, pursuing child support or going to school) if participating would:

- Put you or a family member in danger of physical or emotional harm.
- Subject you to sexual abuse.
- Otherwise be unfair to you.

You are authorized to receive domestic violence comprehensive services. Contact the DHS office in your area or your DHS specialist for more information or to access these services.

Resources:

- Online at: *www.michigan.gov/domesticviolence*.
- DHS Publication 859, Is Someone Hurting You or Your Children? (also available in Spanish) - online at: *www.michigan.gov/dhs-publications*.

If You Receive Tribal Benefits

You cannot receive food benefits from the tribal food distribution program and the food assistance program at the same time.

You cannot receive tribal TANF (cash) from a tribe and FIP cash benefits from DHS at the same time.

Tribal organizations may receive LIHEAP funds from the federal government. Payments are limited to the highest amount available from either DHS or the tribal organization. DHS will ask you to prove any tribal LIHEAP payment you receive.

Bridge Card

Cash and/or food benefits are accessed by using a debit card. This debit card is called the Bridge card or Electronic Benefit Transfer (EBT) card.

You cannot alter or disguise your Bridge card in any way or you may face a penalty.

Call EBT Customer Service toll-free at 1-888-678-8914 to:

- Report a lost, stolen or damaged card.
- Request a replacement card (your benefits may be reduced when replacing your Bridge card).
- Establish/change your personal ID number (PIN).
- Find out your balance.

Repay Agreements

By signing the assistance application, you agree to do these things:

Recovery of Medical Costs (MA, AMP)

If any program run by the Michigan Department of Community Health (MDCH) pays the cost of hospital, surgical or medical services, you agree that the right to recover payments (from insurance, lawsuits, etc.) is transferred to the MDCH. This includes payments from a third person or public or private contractor. Any recovery payment you receive must be paid to the State of Michigan, MDCH.

Exception: Payments are not recovered from Medicare.

Read this information booklet before you sign the assistance application.

Repay Agreements (continued)

By signing the assistance application, you agree to do these things:

Estate Recovery (MA - LTC)

I understand that upon my death the Michigan Department of Community Health (MDCH) has the legal right to seek recovery from my estate for services paid by Medicaid. MDCH will not make a claim against the estate while there is a legal surviving spouse or a legal surviving child who is under the age of 21, blind, or disabled. An estate consists of real and personal property. Estate Recovery only applies to certain Medicaid recipients who received Medicaid services after the implementation date of the program. MDCH may agree not to pursue recovery if an undue hardship exists.

Lump Sums and Accumulated Benefits (SDA, State-Funded FIP)

If you receive SDA, you agree to repay DHS if you receive:

- Lump sum payments such as an inheritance, insurance settlement, etc., or
- Accumulated benefits paid retroactively such as unemployment benefits or workers' compensation.

If you receive SDA or state-funded FIP, you agree to repay DHS if you receive retroactive SSI.

You agree to allow Social Security Administration to pay DHS the amount of state-funded assistance you received while your SSI claim was pending.

If the first accumulated benefit payment is sent to you, you agree to pay DHS right away for the state-funded assistance you received while the claim was pending.

If you disagree with the amount DHS keeps, see "Hearing Rights."

Information About Your Household That Will Be Shared

By signing the assistance application, you agree that DHS can share information about you and your household with others, and that other agencies or people can give us information about you, as stated below:

Information DHS Will Get From Others

Social Security Administration information (all programs) - You agree that the Social Security Administration may give DHS all information needed to determine your eligibility.

Quality Control (QC) investigations (all programs) - DHS might choose your case for a quality control review. If your case is chosen, DHS will contact you, other people, employers and/or agencies for proof of the information provided on your assistance application.

Law enforcement check (FAP, FIP, SER) - DHS receives information from law enforcement officials for the purpose of catching persons fleeing to avoid the law.

Child care billing information (CDC) - DHS will use information from your child care provider and yourself to determine CDC eligibility and payment amounts.

Computer cross-checking (all programs) - DHS will check with federal, state and private agencies to make sure the information you provide on the assistance application is correct. DHS may check wages, income, assets, unemployment benefits, income tax refunds, Social Security benefits and numbers, child support, immigration status, etc.

If you give any information that does not match, DHS will check to find out what is correct. You may be asked for permission to contact employers, banks or other people.

DHS will check records from other states. You may be denied benefits in Michigan if you or other household members were disqualified in another state.

Information About Your Household That Will Be Shared

By signing the assistance application, you agree that DHS can share information about you and your household with others, and that other agencies or people can give us information about you, as stated below:

Information DHS Will Give To Others

Law enforcement check (FAP, FIP, SER) - DHS may give information to law enforcement officials for the purpose of catching persons fleeing to avoid the law.

Eligibility information (FAP) - DHS sends food assistance program (FAP) eligibility information to schools. This information allows your child(ren) to receive free or reduced-cost meals.

CDC - DHS will send information and notices to your child care provider when your CDC:

- Application is denied or withdrawn.
- Payments are approved or changed.
- Case is closed.

Illegal Aliens - DHS may send information about certain illegal aliens to the Department of Homeland Security.

Coordination of Health Care

- **Coordination of health care programs and providers (MA)** - The State's medical assistance program relies on a large number of managed care health programs, mental health and substance abuse programs, and private providers to deliver quality care to persons like you.

  To make sure you receive a high level of care and that your benefits are coordinated, providers in the program may share information about your care (or your child or ward) with other providers in the program when such information and consultation is clinically needed.

- **Information about you, your child or ward (MA)** - Necessary information may be shared between Medicaid managed care health plans and programs in which you participate. Health plans, programs and providers that deliver health care to you may share necessary information in order to manage and coordinate health care and benefits. This information may include, when applicable, information relative to HIV, AIDS, AIDS-related complex (ARC) or other communicable diseases, information about behavioral or mental health services, and referral or treatment for alcohol and drug abuse as permitted by 42 CFR Part 2.

Web Site References

- **Career education and workforce programs:** *www.michigan.gov/mdcd*
- **Earned Income Tax Credit:** *www.michiganeic.org*
- **Energy Assistance Programs:** *www.michigan.gov/heatingassistance*
- **Family Automated Screening Tool (FAST):** *www.michigan.gov/fast*
- **Michigan Assistance and Referral Service (MARS) program eligibility pre-screening tool:** *www.michigan.gov/mars*

  NOTE: To find out if you may be eligible for any of our programs, you may visit the MARS Web site. You will be asked for information about your family and household that will help determine if you might qualify.

- **Michigan Department of Community Health (MDCH):** *www.michigan.gov/mdch*
  - **Healthy lifestyles:** *www.michiganstepsup.org*
  - **Office of Services to the Aging:** *www.michigan.gov/miseniors*
  - **Women, Infants and Children (WIC) program:** *www.michigan.gov/wic*

Read this information booklet before you sign the assistance application.

Web Site References (continued)

- **Michigan Department of Human Services (DHS):** *www.michigan.gov/dhs*
  - **Cash Assistance** *www.michigan.gov/dhs-cash*
  - **Cash Assistance - SSI** *www.michigan.gov/dhs-ssi*
  - **Child Care** *www.michigan.gov/childcare*
  - **Child Support** *www.michigan.gov/childsupport*
  - **Client Application Process** *www.michigan.gov/dhs-applicationprocess*
  - **DHS County Offices** *www.michigan.gov/dhs-countyoffices*
  - **DHS Forms and Applications** *www.michigan.gov/dhs-forms*
  - **DHS Policy and Procedural Manuals** *www.michigan.gov/dhs-manuals*
  - **Emergency Services** *www.michigan.gov/dhs-ser*
  - **Food Assistance** *www.michigan.gov/foodstamps*
  - **Medical Services** *www.michigan.gov/dhs-medical*
- **Michigan Disability Resources:** *www.michigan.gov/disabilityresources*

Publications

Ask your DHS specialist if you would like any of these publications. The following publications are available online at: *www.michigan.gov/dhs-publications*. Some are also available in Spanish (Sp).

- **Child Care**

  Child Development and Care Handbook - (DHS Publication 230). (Only available online at: *www.michigan.gov/childcare*)

- **Child Support**

  Understanding Child Support: A Handbook for Parents (DHS Publication 748) (Sp).

  What Every Parent Should Know About Establishing Paternity (DHS Publication 780) (Sp).

  Fatherhood: Taking Responsibility for Your Child (DHS Publication 806).

  DNA Paternity Testing: Questions and Answers (DHS Publication 865) (Sp).

- **Home Heating Credit** - Notice to Potential Home Heating Credit Recipients (DHS Publication 788) (Sp).

The following publications are available online at: *www.michigan.gov/mdch*. Select MDCH Brochures Available for Download from the Quick Links.

- **Medicaid**

  Healthy Kids (MDCH Publication 655) - explains medical coverage for pregnant women, babies, and children.

  Medicaid Fair Hearings: Rights and Responsibilities (MDCH Publication).

  Your Rights and Responsibilities in a Health Plan (MDCH Publication 201).

  Medicaid Deductible Information (MDCH Publication 617) - explains how your medical costs can be used to get your income at or below the income limits to be eligible for Medicaid.

  Nursing Facility Eligibility (MDCH Publication 726) - explains eligibility for persons in or entering a nursing facility.

  Medicare Savings Program: (MDCH Publication 769) - explains how to get help paying Medicare expenses.

  Medicaid Fee for Service Handbook (MDCH Publication 669).

- **State Emergency Relief**

  State Emergency Relief Program (DHS Publication 563).

  You and Your Energy Bills (DHS Publication 631).

  DHS Can Help With Temporary Assistance (DHS Publication 783).

Filing Form

Michigan Department of Human Services (DHS)

You have the right to apply for help today. If you cannot finish the entire assistance application today, you may complete this filing form and return it to the DHS office in your area to protect your application date. If applying for only FAP, you must fill in your name, address (unless homeless) and signature or your representative signature.* The date DHS receives your filing form may affect the date your benefits start. DHS will still need to receive your completed assistance application before any benefits can be approved.

**Exception: If you are applying for SSI and FAP benefits before being released from an institution, the filing date for your benefits will be the date you get out of the facility.*

If you need help filling out this application, DHS must help you. If you are refused help, you may call (517) 373-0707.

If you do not speak English or you have a disability, how can we help you?

☐ Interpreter ☐ Sign language ☐ Assisted listening device (ALD) ☐ Other _____

If you do not speak English, what language do you speak? _____

1. I received help from Michigan in the past. ☐ **Yes** ☐ **No** **Case/recipient number** _____ (if known)

2. I am applying for:

- ☐ **Food Assistance Program** (seven-day processing can begin today if you complete the back of this form **and** your household qualifies).
- ☐ **Medical Assistance** (doctor or hospital bills, prescriptions, Medicare premiums).
- ☐ **Child Development and Care** (help with child care payments).
- ☐ **Cash Assistance (FIP- Family Independence Program, RAP - Refugee Assistance Program, SDA - State Disability Assistance)** (help with cash for pregnant women, families with children, refugees, adults with disabilities, live-in caretakers of adults with disabilities or residents of special living arrangements).

3. Legal name (first, middle, last; birth name, if different)

4. ☐ Male ☐ Female

5. Date of birth**

__ __ / __ __ / __ __ __ __

**Not needed for food assistance.

6. Social Security number***

__ __ __ – __ __ – __ __ __ __

7. Phone number

__ __ __ – __ __ __ – __ __ __ __

8. Message number

__ __ __ – __ __ __ – __ __ __ __

***Voluntary if applying ONLY for child care or emergency medical.*

9. Address where you live (number, street, rural route, apartment/lot number) ☐ Homeless

City | County | State | Zip code

10. Mailing address (if different from above or PO box)

City | County | State | Zip code

Signature

Under penalties of perjury, I swear or affirm that this filing form has been examined by or read to me, and, to the best of my knowledge, the facts are true and complete. If I am a third party applying on behalf of another person, I swear that this filing form has been examined by or read to the applicant, and, to the best of my knowledge, the facts are true and complete.

Signature of client or representative | **Date**

Read this information booklet before you sign the assistance application.

Expedited Food Assistance Program Seven-Day Processing

1. Does everyone in the household buy food and fix or eat meals together? ☐ Yes ☐ No
   If no, list who does not _____
2. How much are the total cash assets belonging to your household?
   (Include cash, savings, checking, savings bonds, etc.) $ _____
3. How much is the total monthly gross income (before any deductions such as taxes) for your household?
   (Include earnings, unemployment benefits, child support, Social Security benefits, etc.) $ _____
4. Does anyone in your household receive tribal food distribution benefits? ☐ Yes ☐ No
   If yes, list who _____
5. What is the total amount you pay for your monthly rent and/or mortgage payment, property taxes, homeowners insurance, etc.? $ _____
6. Do you pay for heat? ☐ Yes ☐ No
7. Do you pay for cooling (including room air conditioner)? ☐ Yes ☐ No
8. If you do not pay for heating or cooling, check which utilities you pay: ☐ Non-heat electric ☐ Water/sewer ☐ Telephone ☐ Cooking fuel ☐ Garbage/trash

9. Is anyone in your household a ☐ migrant or ☐ seasonal farmworker?
☐ Yes ▸ *Complete the table below.* ☐ No

Has anyone received any income from the same grower within 30 days before the application date?	☐ Yes ▸ Name of person(s): ☐ No	Date	Gross pay amount
Does anyone expect to receive more income this month?	☐ Yes ▸ Name of person(s): ☐ No		
Has anyone received a travel advance?	☐ Yes ▸ Name of person(s): ☐ No		
Has anyone recently lost their only source of income?	☐ Yes ▸ Name of person(s): ☐ No	Last pay date	Gross pay amount

10. Names of all household members	Birth date	Social Security number
	__/__/____	___-__-____
	__/__/____	___-__-____
	__/__/____	___-__-____
	__/__/____	___-__-____
	__/__/____	___-__-____

11. Do you need more pages? ☐ Yes ☐ No

For office use only	Date application received in local office	Case name	
		Application number	Case number
		Specialist name	
		Specialist phone	Fax
		Specialist email	

Read this information booklet before you sign the assistance application.