STATE OF HAWAII
Department of Human Services

BENEFIT, EMPLOYMENT, AND SUPPORT SERVICES DIVISION
Application for Financial and SNAP Assistance

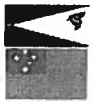
IMPORTANT INFORMATION WHEN APPLYING FOR PUBLIC ASSISTANCE PROGRAMS

IF YOU ARE APPLYING FOR:	**SIGNATURES REQUIRED ON PAGES:**
Financial Assistance only	1, 3 and 11
Supplemental Nutrition Assistance Program (SNAP) only (formerly the Food Stamp Program)	1, 3 and 11
Financial Assistance and SNAP	1, 3 and 11

If any member of your household receives SNAP or TANF benefits, then all children in your household are eligible for free school meals if their school participates in the USDA meal program. Please **call the child's school** if you have questions about the School Lunch Program including:

- You think your child should get free meals but does not receive them;
- You do not want your child to receive free school meals; or
- You have questions about the USDA meal programs.

Information about TANF and other public assistance programs can be found on the Department of Human Services website: http://humanresources/hawaii.gov/bessd/

This is an important letter from the Department of Human Services (DHS). Please call the phone number indicated on the letter. When you call, you will be asked what language you speak and your call will be put on hold for an interpreter. You can also call **1-888-764-7586** for all DHS services.	**English** 
這是一封從人類服務部門發出的重要信件。請撥打信上的電話號碼。當你打電話時，你將會被詢問你講什麼語言，您的通話將被擱置直到接通翻譯服務。其他人類服務部門的服務, 您可以致電到 **1-888-764-7586.**	**Cantonese** 
Ei taropwe mi auchea seni ewe putain tumwunun aramas Department of Human Services (DHS). Kose mwochen kokkori na nampan foon won na taropwe. Nupwen omw kokko, repwe eisinuk menni kapas ke sine pwe repwe kutta ngonuk emon choon chiaku. Ka pwan tongeni kokkori **1-888-764-7586** ren meinisin aninnis seni DHS.	**Chuukese** 
Ceci est une lettre importante du Department of Human Services (DHS). Merci d'appeler le numéro indiqué dans la lettre. Lorsque vous téléphonez, vous serez demandé(e) quelle langue vous parlez, et votre appel sera mis en attente afin de vous mettre en relation avec un interprète. Vous pouvez aussi appeler le **1-888-764-7586** pour tous les services de DHS.	**French** 
Dies ist ein wichtiges Schreiben des Departements for Human Services (DHS). Bitte wählen Sie die unten stehende Telefonnummer. Sie werden gefragt, welche Sprache Sie sprechen. Daraufhin werden Sie mit einem Dolmetscher verbunden. Es können auch alle weiteren DHS-Dienste unter der Telefonnummer **1-888-764-7586** erreicht werden.	**German** 
He leka ko'iko'i keia mai ka 'Oihana Lawelawe Kanaka (Department of Human Services). E kelepona mai i ka helu kelepona ma luna o ka leka. Ke kelepona 'oe, e ninau 'ia ana 'oe he aha kau 'olelo 'oiwi a laila e kali 'oe a loa'a ke kanaka mahele 'olelo. Hiki pu ia 'oe ke kelepona i 1-888-764-7586 no na lawelawe a pau a ka 'Oihana Lawelawe Kanaka (DHS).	**Hawaiian** 
Daytoy ket importante a surat nga aggapu iti Department of Human Services (DHS). Pangngaasiyo koma ta awaganyo ti numero a nailanad iti surat. No umawagkayo, madamag kadakayo no ania ti lengguaheyo ket maiyallatiw ti awagyo iti maysa a paraitarus. Mabalinyo pay ti umawag iti **1-888-764-7586** para kadagiti amin a servisio ti DHS.	**Ilokano** 
ハワイ州人道的奉仕局からの大切なお知らせです。 この紙面に書かれている番号にお電話ください。 電話をされた時に、貴方がどの言語を話されているかを聞かれます、 通訳に接続 されるまでしばらくお待ち ください。 ＤＨＳのどのサービスにも、 この電話番号 **1-888-764-7586** で対応いたします.	**Japanese** 
인간 서비스 부서에서 보내는 중요한 편지 입니다. 이편지에 기재된 전화번호로 전화를 하시요. 당신이 전화를 할때 당신이 사용하는 언어를 물을것이고 그언어의 통역인에게 연결할것 입니다. 당신은 모든 인간 서비스 부서(디에이치에스)에 도움을 받기 위해서 **1-888-764-7586** 로 전화 할수 있읍니다	**Korean** 
这是一封从人类服务部门发出的重要信件。请拨打信上的电话号码。当你打电话时，你将会被询问你讲什么语言，您的通话将被搁置直到接通翻译服务。其他人类服务部门的服务, 您可以致电到 **1-888-764-7586。**	**Mandarin** 
Juon in kojela im elap an aurok im ej itok jen ra eo an department of human services. Jouij im call e nomba in im ej bed ilo pepa in ak letta in. Ne koj call, renej kajitok ibbem kin kain kajin eo am im elikin am ba renej ba kwon kottar bwe ren lewoj juon am ri okok. Komaron call **1-888-764-7586** non aolepen ra ko kajojo ilo DHS services.	**Marshallese** 
O se fa'asilasilaga ta'ua lenei mai le Ofisa o le Human Services. Fa'amolemole, vala'au mai i le numera lea o lo'o i luga o lenei tusi. A e vala'au mai, o le a fesili atu po'o le a le gagana e te mo'omia, ona tu'u sa'o lea o lau telefoni i se tagata e mafai ona fesoasoani ia oe. E mafai fo'i ona e vala'au i le number **1-888-764-7586** mo nisi 'au'aunaga mai lenei Ofisa.	**Samoan** 
Esta es una carta importante del Departamento de Servicios Humanos (DHS). Por favor llame al número de teléfono indicado en la carta. Cuando usted haga la llamada, se le preguntara el idioma que habla y su llamada se pondrá en espera de un intérprete. Usted también puede llamar al **1-888 -764-7586** para acceder a los servicios de DHS.	**Spanish** 
Ito ay mahalagang sulat mula sa Department of Human Services (DHS). Mangyaring tawagan ang numero ng teleponong nakalista sa sulat. Sa inyong pagtawag, itatanong sa inyo ang wikang nais ninyong gamitin. Hintaying sumagot ang tagasalin. Maaari din kayong tumawag sa **1-888-764-7586** para sa lahat nang serbisyo ng DHS.	**Tagalog** 
Ko e tohi mahu'inga eni mei he Potungaue Ngaue Ma'ae Kakai. Kataki 'o telefoni ki he fika 'oku ha 'i he tohi ni. 'E fehu'i atu pe ko e ha e fa'ahinga lea 'oku ke lea'aki 'i he taimi te ke ta mai ai pea tnitokoe ke tali kae 'oua kuo ma'u ha toko taha fakatonu lea. Te ke lava 'o ta ki he ki he ngaahi tokoni kotoa 'a e DHS.	**Tongan** 
Đây là lá thơ quang trọng từ các Bộ Phục Vụ Nhân Dân (DHS). Làm ơn gọi xố điện thoại nằm trên lá thơ. Khi bạn gọi, bạn sẻ được hỏi ngôn ngữ nào bạn nói và cú điện thoại của bạn sẻ chờ người thông dịch. Đồng thời bạn củng có thể gọi số **1-888-764-7586** cho các phục vụ DHS.	**Vietnamese** Việt Nam
Importante kini nga sulat gikan sa Department of Human Services (DHS). Palihug tawagi ang numero nga anaa sa sulat. Sa imong pagtawag, pangutan-on ka kung unsa ang imong pinulongan ug pahulaton ka samtang nangita sila ug maghuhubad. Mahimo usab nga tawagan nimo ang **1-888-764-7586** alang sa tanang serbisyo sa DHS.	**Visayan (Cebuano)** 

STATE OF HAWAII
Department of Human Services
BENEFIT, EMPLOYMENT, AND SUPPORT SERVICES DIVISION

APPLICATION FOR FINANCIAL AND SNAP ASSISTANCE

FOR OFFICIAL USE ONLY			
CASE NAME			
CATEGORY/CASE NUMBER		BRANCH	UNIT
WORKER CODE	WORKER'S NAME		PHONE
☐ FORM MAILED ☐ GIVEN		DATE	

APPLICATION FILING: The day your application is received is the date from which your eligibility for benefits will be determined. Benefits will be paid from that filing date if you are eligible. If you are unable to fill out the application now, just complete your name, address and signature below and turn it in. You must still answer the rest of the questions on the application form before benefits are issued. If you cannot complete the application the eligibility worker will help you. If you are currently residing in a public institution and will be released within 30 days, you may file your application today but the date of application will be the day of release from the institution.

DATE SIGNED FORM RETURNED

PLEASE PRINT CLEARLY

I would like to apply for the following types of benefits: ☐ Money ☐ Supplemental Nutrition Assistance Program (SNAP)

YOUR NAME (Last, First, M.I.)		YOUR SOCIAL SECURITY NO.	BIRTHDATE	PHONE NO.
SPOUSE'S NAME (Last, First, M.I.)		SPOUSE'S SOCIAL SECURITY NO.	SPOUSE'S BIRTHDATE	MESSAGE PHONE NO.
ADDRESS WHERE YOU LIVE (NUMBER AND STREET OR DIRECTIONS TO YOUR HOME)	APT/SPACE NO.	CITY & STATE	ZIP CODE	MILITARY BASE (IF RESIDING IN BASE HOUSING)
YOUR MAILING ADDRESS (IF DIFFERENT FROM ABOVE NUMBER AND STREET)	APT/SPACE NO.	CITY & STATE	ZIP CODE	

HOW MANY PERSONS PURCHASE FOOD AND PREPARE MEALS WITH YOU? (INCLUDE YOURSELF)	HOW MANY PERSONS DO NOT PURCHASE FOOD AND PREPARE MEALS WITH YOU?	ARE THEY RELATED TO ANYONE IN YOUR HOUSEHOLD? ☐ YES ☐ NO	HOW MANY CHILDREN LIVE WITH YOU?
IS ANYONE IN YOUR HOME PREGNANT? ☐ YES ☐ NO	IF YES, INDICATE WHO NAME:		WHEN IS THE BABY DUE? DATE:

SIGNATURE OR MARK OF ADULT APPLICANT _____ DATE _____

SIGNATURE OR MARK OF SPOUSE OR OTHER ADULT APPLICANT _____ DATE _____
(This signature is required for Money Assistance only)

WITNESS IF SIGNATURES ARE "X" _____ DATE _____

APPOINTMENT NOTICE: When your application is received, an Appointment Notice for your interview will be sent or given to you. You must be interviewed before you can receive benefits. A telephone interview may be conducted in lieu of an office interview for aged, disabled or working individuals or for others in hardship situations. To shorten the processing time, you should bring to the interview written proof of information and verification as noted on your appointment letter. You may be asked at the interview to bring more information. If you miss your appointment, or need to change it, you must call the local office to reschedule. The following action will be taken if you miss your appointment:

- For SNAP, if you do not reschedule by the 30th day from the day you filed your application or the last day of your certification, your application will be denied. If your application is denied, you may be required to reapply to receive benefits. You may lose benefits for failing to appear at your interview.
- For cash benefits, if you do not reschedule your appointment date, your application will be denied within the time limits specified by our policies. If you are currently receiving benefits, they may be stopped if you do not reschedule the missed appointment. If benefits are denied or stopped, you may reapply if you still want benefits.

AFTER YOUR INITIAL INTERVIEW WE ENCOURAGE YOU TO REPORT CHANGES AS SOON AS THEY HAPPEN, THIS MAY PREVENT ANY DELAYS IN BENEFITS TO YOU.

INTERVIEW INFORMATION: An interview must be completed before you can receive help. A single interview is sufficient when applying for SNAP and financial benefits. Appointments are scheduled according to the date you apply, with the earliest application given the first available appointment. You will be notified of the date and time of your appointment. **EXCEPTION:** If you meet the **EMERGENCY ASSISTANCE** requirements, you will be interviewed and provided financial benefits within two (2) working days and/or SNAP within seven (7) calendar days from the date of application. Answer the EMERGENCY ASSISTANCE questions below only if you need help right away.

YOU MAY GET SNAP WITHIN SEVEN (7) CALENDAR DAYS IF YOUR HOUSEHOLD:

- Monthly rent/mortgage and utilities are more than your household's gross monthly income and liquid resources; or
- Gross monthly income is less than $150 and your household's liquid resources, such as cash or checking/savings accounts, are $100 or less; or
- Is a seasonal farmworker household whose income terminated prior to applying, is not expecting income of $25 within the next 10 days and has liquid assets of less than $100.

CHECK THE BOX FOR EACH TYPE OF EMERGENCY ASSISTANCE YOU ARE APPLYING FOR: ☐ Financial ☐ SNAP

YES	NO	
☐	☐	Is anyone in your home a seasonal farm worker whose only source of income for the month terminated before applying and income of less than $25 is expected within the next 10 days?
☐	☐	Does anyone in your home have cash or savings or bank accounts? If yes, how much? _____
☐	☐	Has anyone in your home received money this month? If yes, how much? _____
☐	☐	Does anyone in your home expect to receive any money this month? If yes, how much? _____ When? (Date) _____
☐	☐	Are you currently paying any of the following shelter expenses? If yes, list the amounts: Rent/Mortgage _____ Electric _____ Gas _____ Water _____ Phone _____
☐	☐	Have you been served court papers to get out of your present living arrangements? (Attach papers)
☐	☐	Are you living in an agency temporary facility and have to get out in five days? If yes, name of facility? _____

Refer to codes below for responses to questions marked with the corresponding asterisk symbols (*)

1. HOUSEHOLD MEMBERS

On line #1, enter the name of the primary person who will receive the money and/or SNAP benefits for your household. If spouse is in the household, list spouse on line #2. Then list the other household members who are applying for assistance. For money assistance applicants, if anyone in the home is pregnant, list "unborn child" as a household member. All other household members not applying for assistance shall be listed under section #2.

Last Name, First, M.I.	SEX M/F	(*) RELATIONSHIP TO PERSON #1	BIRTHDATE MO/DAY/YR	SOCIAL SECURITY NUMBER (42 USC 1320b-7 requires that SSN's be provided for each household member applying for assistance.)	(**) ETHNIC	(***) RACE	(****) MARITAL	STATUS	YES or NO DISABLED	HIGHEST GRADE COMPLETED	NAME OF CHILD'S PARENT(S) IF NOT IN THE HOME	Was child's mother married to child's father at time of birth? (Check one) Yes	No
1.													
OTHER NAMES USED			AGE:										
2.													
OTHER NAMES USED			AGE:										
3.													
OTHER NAMES USED			AGE:										
4.													
OTHER NAMES USED			AGE:										
5.													
OTHER NAMES USED			AGE:										
6.													
OTHER NAMES USED			AGE:										
7.													
OTHER NAMES USED			AGE:										
8.													
OTHER NAMES USED			AGE:										

2. HOUSEHOLD MEMBERS WHO DO NOT WANT HELP

Write in the names of others in your home who do not want assistance (include yourself if you do not need help.) These people do not need to give us information about their citizenship, immigration status or social security number. These people will not be considered applicants and will not be eligible, however, they may need to tell us about their income and answer the other questions on this form.

1.			AGE:
2.			AGE:
3.			AGE:
4.			AGE:

3. Is anyone temporarily out of the home? ☐ Yes ☐ No

Name	Date Left	Date to Return	Where Person Went

(*) Relationship Codes to Person #1:

SP - Spouse	GR - Grandparent	EX - Ex-Spouse
PA - Parent	GC - Grandchild	SS - Step Sibling
CH - Child	NR - Not Related	ST - Step Parents
SI - Sibling	OR - Other Related	CL - Common Law
AU - Aunt/Uncle	UB - Unborn	CO - Cousin
NN - Niece/Nephew	FC - Foster Child	SC - Step Child

(**) Ethnic Codes - Select only one code

HI - Hispanic
NH- Not Hispanic

(***) Race Codes - Select one or more codes below

WH - White	JA - Japanese
BL - Black	KO - Korean
AI - American Indian or Alaskan Native	CH - Chinese
	FI - Filipino
HA - Hawaiian	OA - Other Asian
SA - Samoan	OP - Other Pacific Islanders

(This question is optional to answer. Failure to answer will not affect eligibility)

(***) Marital Status Codes:

NM	- Never Married
ML	- Married, Living With Spouse
DI	- Divorced
LS	- Legally Separated
MS	- Separated
MI	- Married, Involuntary Separation
WI	- Widowed
CL	- Common Law

FINANCIAL APPLICANT'S REPRESENTATIVE

I permit the following individual to be my representative TO APPLY FOR FINANCIAL (CASH) ASSISTANCE on my behalf, as I am unable to do so myself (elderly, handicapped, foster child, etc.). Enter the name and address of applicant's representative below.

Representative's Name (Last, First, M.I.)	Representative's Address (Number, Street, Apt., City, State, Zip Code)	Phone No.

SNAP AUTHORIZED REPRESENTATIVES

I permit the following individual to be my representative TO APPLY FOR SNAP assistance on my behalf.
(Include individual's name or the licensed alcohol or drug treatment facility or group living arrangement representative.)

Representative's Name (Last, First, M.I.)	Representative's Address (Number, Street, Apt., City, State, Zip Code)	Phone No.

ELECTRONIC BENEFIT TRANSFER AUTHORIZED REPRESENTATIVE

I permit the following individual to HAVE ACCESS TO MY CASH ASSISTANCE. [ ] Yes [ ] No
I permit the following individual to HAVE ACCESS TO MY SNAP BENEFITS and to purchase my food. [ ] Yes [ ] No
This representative will be issued an EBT card and PIN (personal identification number). (Include the individual's name or the licensed alcohol or drug treatment facility or group living arrangement representative. The date of birth and social security number will be used for security purposes only.)

Representative's Name (Last, First, M.I.)	Date of Birth	Social Security Number

Representative's Address (Number, Street, Apt., City, State, Zip Code)	Phone No.

QUESTIONS 4 THROUGH 35 ARE TO BE ANSWERED FOR ONLY THOSE WHO ARE APPLYING FOR ASSISTANCE.

4. Is anyone a disabled U.S. veteran or a disabled spouse or a child of a deceased U.S. veteran? ☐ Yes ☐ No
If yes, name: _____

5. Is anyone (including children) disabled? ☐ Yes ☐ No If yes, name of disabled person(s):
_____
They could be eligible for Supplemental Security Income (SSI) or SSA Disability or Blindness benefits.

6. Is anyone in the household fleeing a felony warrant for arrest; a parole/probation violator; or been convicted of a Federal or State felony for possession, use or distribution of illegal drugs? ☐ Yes ☐ No If yes, name(s): _____

7. CITIZEN STATUS DECLARATION. Pursuant to 42 USC 1320b-7, one applicant household member must certify under penalty of perjury the citizenship status of each applicant household member. If you are not applying for benefits, we will not share your name and information with the Immigration and Naturalization Service (INS). However, information may be shared with the INS to verify the immigration status of persons applying for aid.

(CHECK ONE)					COMPLETE IF YOU ARE A NON-U.S. CITIZEN						
Name	US	US Nat'l	Non-US Cit.	Birthplace	Date of Entry	Immigration Status	Effective Date Of Status	INS Form or Alien Registration Number	Do you, your spouse, or parent have 40 qtrs. of work? (Y/N)	Veteran or Active Military? (Y/N)	Spouse or Dep. Child of Veteran or Act. Military? (Y/N)

NOTE: If you are a permanent alien, you will be required to provide verification of work history.

8. If sponsored non-U.S. citizen or refugee, give name, address, and phone number of the sponsor(s).

Name	Address	Phone

9. What is the primary language spoken in your home? _____

How well is English spoken in the home? (Check only one box)

- ☐ Does not speak or understand English
- ☐ Limited understanding
- ☐ Speaks well, does not read or write English
- ☐ Speaks well, limited reading and writing skills
- ☐ Speaks well, adequate reading and writing skills

Do you need an interpreter? If needed, an interpreter will be provided free of charge.

- ☐ Yes. What language: _____
- ☐ No. I will provide my own interpreter or have a family member or friend who can interpret for me.

10. Has anyone ever received financial or SNAP assistance? ☐ Yes ☐ No

NAME	Type of Assistance	Date Last Received	County/State Last Received

11. Has any household member been disqualified from the SNAP or financial assistance programs? ☐ Yes ☐ No If yes, list name, program, disqualification period, county and state.

NAME	PROGRAM	DISQUALIFICATION PERIOD	COUNTY/STATE

12. For SNAP applicants/recipients only: if you are age 18 through 49, and are an able-bodied adult without dependents (ABAWD), you will only be eligible for three months of assistance in a 36-month period unless you meet additional work/training requirements. You must be employed or participating in an eligible work/training program for 20 hours weekly. Have you participated in a job training program under the Employment and Training (E&T) program, Workforce Investment Act or Trade Adjustment Assistance Act? ☐ Yes ☐ No

NAME	Job or Training Program	Participation Dates

13. Is anyone on strike? ☐ Yes ☐ No If yes, name? _____

14. List the person(s) who is needed in the home to care for a disabled person. _____

15. Does any household member have private health, dental insurance, vision insurance, long-term care insurance, Medicare, TRICARE, VA benefits or prescription drug coverage?

PERSON'S NAME	Insurance Name, Type and Policy Number

16. Does any household member have medical problems or need medical treatment due to an accident or incident?

PERSON'S NAME	Date of Accident / Incident

17. Does anyone have any of the items listed below? Include assets owned as of the first of the month and assets which are co-owned with anyone who does not live with you. Check "Yes or No" for each item. Include other assets not listed in blank spaces provided below.

FINANCIAL ACCOUNTS

YES	NO	ASSETS	NAME OF PERSON(S) ON ACCOUNT	NAME OF FINANCIAL INSTITUTION & BRANCH	ACCOUNT NO.	AMOUNT
		Checking Accounts: Personal/Business				$
		Savings Accounts				$
		Credit Union Accounts				$
		Christmas Savings				$
						$
						$
						$

LIQUID ASSETS

YES	NO	ASSETS	NAME OF PERSON(S) ON ACCOUNT	NAME OF FINANCIAL INSTITUTION & BRANCH	ACCOUNT NO.	AMOUNT
		Cash on Hand				$
		Tax Refund/Tax Credit				$
		Stocks/Bonds (savings bonds)				$
		Money Market/ Time Certificate				$
		IRA/KEOGH Deferred Comp.				$
						$
						$

OTHER ASSETS

YES	NO	ASSETS	PERSON(S) LISTED AS OWNERS	LOCATION/ADDRESS OF ITEM	MARKET VALUE	AMOUNT OWED	EQUITY
		Your Home/Mobile Home			$	$	$
		Other Houses/Land/ Buildings			$	$	$
		Agreement of Sale of Real Property			$	$	$
		Burial Plans/Cemetary Plot			$	$	$
		Life Insurance-List all Policies			$	$	$
		Other (Specify, i.e. Jewelry, TV, Radio, Stereo, Musical Instruments, Hobby Items, Etc.)			$	$	$
					$	$	$

TRANSFER OF PROPERTY

18. Has anyone sold, traded, transferred or given away money, vehicles, property, or other resources/assets in the last 3 months (if applying for SNAP only), or in the last 24 months (if applying for financial assistance)?
☐ Yes ☐ No If yes, complete below:

ITEM SOLD, TRADED, ETC.	DATE	REASON FOR SELLING, TRANSFERRING, ETC.	ACTUAL VALUE OF ITEM	AMOUNT OWED	AMOUNT RECEIVED
			$	$	$
			$	$	$
			$	$	$
			$	$	$
			$	$	$

STUDENT INFORMATION

19. Is anyone aged 16 years and older a student? ☐ Yes ☐ No If yes, complete below:

NAME OF STUDENT	NAME OF SCHOOL	FULL TIME?	PART TIME?	START DATE MO./DAY/YR.	END DATE MO./DAY/YR.

20. Has anyone applied for admission to a college, training, or vocational school? ☐ Yes ☐ No Name: _____

UNEARNED INCOME

21. Is anyone receiving, expect to receive, or have an application pending for any type of income listed below? Check "Yes or No" for each source of income. If "Yes" is checked, complete the information about the item.

YES	NO	PEND-ING	SOURCE OF INCOME	PERSON WHO RECEIVES INCOME	MONTHLY AMOUNT	HOW OFTEN RECEIVED? (MONTHLY/WEEKLY)
			Social Security		$	
			Supplemental Security Income (SSI)		$	
			Assistance Payments from Another State		$	
			Unemployment Benefits		$	
			Housing Authority (HUD, Section 8), Energy Assistance		$	
			Child Support, Alimony		$	
			Money from friends, relatives, charities, contributions, gifts, etc.		$	
			Blood/Plasma income		$	
			Interest/Dividends/Royalties		$	
			Veteran's Benefits, Railroad Retirement, other Governmental Benefits		$	
			Retirement/Pension, Profit Sharing, Annuity Pmts.		$	
			Temporary Disability Insurance/Worker's Compensation		$	
			Training Allowance, Vocational Rehabilitation, JTPA		$	
			Foster Care Payments		$	
			Strike Pay		$	
			Military Enlistment Bonus		$	
			Military Allotment		$	
			Money from land/building sales, rentals or leases (to include agreement of sales)		$	
			Prizes, Cash, Gifts, Awards		$	
			Insurance Settlements		$	
			Reapplication or Appeal of a Denied Benefit (such as SSI or Unemployment benefits, etc.)		$	
			Other (Specify)		$	

EARNED INCOME

22. Give record of all places where you have worked. (Begin with most recent job)

Name, Address, and Phone Number of Employer	From: Mo/Day/Yr.	to: Mo/Day/Yr.	Reason for Leaving	Date(s) Last Paid
Applicant: 1.				
2.				
3.				
Spouse: 1.				
2.				
3.				

23. Is anyone working? ☐ Yes ☐ No If Yes, complete and bring verification to the interview.

PERSON EMPLOYED	JOB TITLE
EMPLOYER	DATE STARTED
ADDRESS	PHONE

HOW OFTEN PAID	PAYDAY	HOURS WORKED PER WEEK	HOURLY RATE OF PAY	GROSS PAY PER CHECK	TIPS PER MONTH
				$	$

PERSON EMPLOYED	JOB TITLE
EMPLOYER	DATE STARTED
ADDRESS	PHONE

HOW OFTEN PAID	PAYDAY	HOURS WORKED PER WEEK	HOURLY RATE OF PAY	GROSS PAY PER CHECK	TIPS PER MONTH
				$	$

PERSON EMPLOYED	JOB TITLE
EMPLOYER	DATE STARTED
ADDRESS	PHONE

HOW OFTEN PAID	PAYDAY	HOURS WORKED PER WEEK	HOURLY RATE OF PAY	GROSS PAY PER CHECK	TIPS PER MONTH
				$	$

24. Is anyone self employed, earning money from a business, baby-sitting, out of home sales, repairing cars, swap meets, garage sales, arts,crafts, etc? ☐ Yes ☐ No If Yes, complete the following and bring verification to the interview.

SELF-EMPLOYED PERSON	TYPE OF BUSINESS	HOURS WORKED PER WEEK	MONTHLY GROSS	MONTHLY EXPENSES
			$	$
			$	$

25. Does anyone receive money from roomers or boarders? ☐ Yes ☐ No If Yes, complete the following:

ROOMER'S/BOARDER'S NAME	MONTHLY AMOUNT RECEIVED	
	ROOM	BOARD
	$	$
	$	$
	$	$

26. Does anyone expect a change in income (such as a new job, a change in wages, etc.)? ☐ Yes ☐ No If Yes, complete the following:

NAME OF PERSON	EXPLAIN	DATE OF CHANGE

COMPLETE FOR SNAP ONLY
DEDUCTIBLE EXPENSES

EXPENSES ARE USED AS A DEDUCTION IN THE DETERMINATION OF THE AMOUNT OF SNAP YOUR HOUSEHOLD MAY BE ENTITLED TO RECEIVE. FAILURE TO REPORT OR VERIFY EXPENSES WILL BE SEEN AS A STATEMENT BY YOUR HOUSEHOLD THAT YOU DO NOT WANT TO RECEIVE A DEDUCTION FOR THE UNREPORTED OR UNVERIFIED EXPENSE. TO CLAIM EXPENSES IN THE FUTURE YOUR HOUSEHOLD WILL NEED TO REPORT AND VERIFY EXPENSES.

SHELTER EXPENSES

27. Does any person or agency outside your household help pay for or provide, at no cost to you, any of the expenses listed below?
☐ Yes ☐ No If Yes, (✓) the expense(s):
☐ Rent ☐ Utilities ☐ Taxes ☐ Mortgages ☐ Personal Supplies ☐ Food ☐ Household Supplies
☐ Medical Care ☐ Clothing ☐ Other _____
If Yes, what person or agency helps pay or provide the expense(s)? _____
Do you need to pay them back? ☐ Yes ☐ No

28. Is anyone in your household working off any part of the rent? ☐ Yes ☐ No If Yes, indicate amount $ _____
29. Do you live in Public Housing? ☐ Yes ☐ No
30. Check Yes or No and complete information for each item:

YES	NO	ITEM	HOW OFTEN BILLED (Monthly, Weekly)	CURRENT BILLED AMOUNT	YES	NO	ITEM	HOW OFTEN BILLED (Monthly, Weekly)	CURRENT BILLED AMOUNT
		Rent					Gas		
		Boat Slip					Propane, Kerosene, Coal, Wood		
		Mortgage/2nd Mortgage					Telephone		
		Sales/Local Property Tax/ Assessments					Utility Installation Fees		
		Homeowner's Insurance					Unoccupied Home Expenses		
		Water					Car Payment (If car is used as a home)		
		Garbage, Sewer, Trash Collection					Car Insurance (If car is used as a home)		
		Electricity					Other (Specify)		

LIST YOUR LANDLORD'S NAME, ADDRESS AND PHONE NUMBER

31. Are you billed separately for utility cost? ☐ Yes ☐ No If Yes, (✓) check the utilities:
☐ Electric/Gas ☐ Water ☐ Sewer/Trash
If yes, choose one of the following options **"A" or "B"** for each utility billed separately:
Electricity/Gas_____ Water _____ Sewer/Trash _____

A. Standard Utility Allowance (SUA)
The SUA is an amount which reflects the average statewide amount spent for specific utilities and other mandatory fees. You may choose to have either the actual cost or the SUA for each utility cost used in determining the SNAP shelter cost deduction amount.

B. Actual Utility Costs
If you Choose to use ACTUAL COSTS, you will need to verify these costs.

ANY QUESTIONS REGARDING THESE OPTIONS CAN BE DISCUSSED WITH YOUR WORKER. ONCE YOU SELECT AN OPTION, YOU CAN CHANGE IT ONLY ONE TIME IN 12 MONTHS.

32. Does your room or rent payment include meals? ☐ Yes ☐ No If Yes, complete the following:

PAYMENT ROOM/MEALS	NO. OF MEALS PROVIDED PER DAY	MONTHLY AMOUNT
$		$

ALIMONY/CHILD SUPPORT EXPENSES

33. Does anyone pay alimony, child support, or make payments for those whom you claim as tax dependents and do not live in your home? ☐ Yes ☐ No If Yes, complete the following:

TYPE OF PAYMENT	AMOUNT	HOW OFTEN PAID	NAME OF PERSON PAID
	$		
	$		

DEPENDENT CARE EXPENSES

34. Does anyone pay or is anyone billed for the care of a child or disabled adult so someone can work, attend school or training, or look for work? ☐ Yes ☐ No If Yes, complete the following:

NAME OF PERSON RECEIVING CARE	NAME OF PERSON PAYING CARE	BILLING		NAME AND ADDRESS OF PERSON PROVIDING CARE
		YOUR SHARE MONTHLY	TOTAL DUE MONTHLY	

MEDICAL EXPENSES

35. MEDICAL EXPENSES. List current medical bills and estimate for anticipated medical expenses for the next 12 months for members of your household who are: (1) age 60 or older, (2) receiving Supplemental Security Income (SSI), Social Security Disability or Blindness payments, Railroad Retirement or other government disability payments, (3) entitled to, but not receiving SSI or Social Security Disability or Blindness Benefits, (4) a disabled veteran, or (5) a disabled spouse or a child of a deceased Veteran. Medical bills/expenses include Medicare premiums, health and hospitalization insurance premiums, prescription drugs, doctor and dental bills, medical transportation costs, glasses, dentures, hearing aids, service of a nurse, or attendant, etc.

NAME OF PERSON THE EXPENSE IS FOR	ACTUAL AMT. BILLED	ESTIMATED EXPENSE	HOW OFTEN BILLED (MONTHLY, WEEKLY)	NAME OF DOCTOR, HOSPITAL PHARMACY, INSURANCE COMPANY
	$	$		
	$	$		
	$	$		
	$	$		
	$	$		
	$	$		
	$	$		

(1) SOCIAL SECURITY NUMBER(SSN):
Pursuant to 42 USC 1320b-7, the SSNs of persons applying for and receiving help in the Financial and SNAP will be used to check identities of household members prevent duplicate participation, verify income/asset amounts and to do mass changes. SSNs will also be used in program reviews or audits and in computer matching with the Internal Revenue Service, State Department of Labor, and Social Security Administration to make sure your household is eligible. This may result in criminal or civil action of administrative claims against persons fraudulently participating in the Financial Program and SNAP.

(2) YOU HAVE THE RIGHT:

- **To discuss any action** regarding your case with your worker or the supervisor if you are dissatisfied.
- **To be notified in advance** before your benefits are reduced or discontinued.
- To ask for a hearing in writing, or orally for SNAP, if you are dissatisfied with any action by the DHS, and to ask the Legal Aid Society of Hawaii, or anyone you want, to help get a hearing. Your case may be presented at the hearing by any person you choose.
- **To have your record kept confidential.**
- **To have a bilingual or sign-language interpreter.** All our oral and written communication to you will be in English. If you do not understand what you hear or read, please contact your worker right away.
- 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 and Nutrition Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs. To file a complaint of discrimination with the Department, contact the Civil Rights Compliance office at 1390 Miller Street Room 214, or call (808) 586-4955, or contact USDA or HHS Write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, SW., Washington, D.C. 20201 or call (202) 614-0403 (voice) or (202) 619-3257 (TDD). USDA and HHS are equal opportunity providers and employers.

(3) YOUR RESPONSIBILITIES:
All households (Simplified and Change Reporting) must apply for and accept all potential sources of income and assets. Failure to do so may result in benefits stopping and ineligibility.

SIMPLIFIED REPORTING HOUSEHOLDS

If your household is determined to be a Simplified Reporting household you are required to complete a Six Month Report form. You are only required to report the following items on your Six Month Report: any change in residence; new employment; earned income verification and self-employment expenses all other sources of income; changes in household composition; and any changes in resources. For the SNAP, you must also report a change in shelter cost if you have moved and any changes in legal obligation to pay child support. For the medical program, you must also report changes in private health insurance, the offer of health insurance by an employer, and the occurrence of any accident.
In addition to the Six Month Report, you will have to report the following within 10 days of the change for the financial assistance programs: any change in household composition and when the household's total gross income exceeds 100% of the Federal Poverty Limit (FPL). For the SNAP, you are required to report when the household's total gross income exceeds 130% of the FPL. For SNAP households that include a member who is considered an able-bodied adult without dependents (ABAWD), you must report when work or training hours decrease below 20 hours a week or termination of employment or training. Households receiving assistance from more than one program shall report the changes as required for each program. Changes may be reported in writing, in person or by telephone.

REPORTING CHANGES FOR ALL OTHER HOUSEHOLDS

Households who are not simplified reporting households shall be required to report the following changes within ten days of the date the change becomes known; or if the change involves income, the change must be reported within ten days of the date that the first payment is received.

- Unearned Income: A change in the source of unearned income and a change of more than $50 in the amount of unearned income, except changes related to the financial assistance grant. Examples of unearned income: Supplemental Security Income (SSI); Unemployment Compensation (UIB); Veteran's Benefits (VA); Tax Refunds; Insurance Settlements; Inheritance, gifts or contributions from relatives; dividends pensions, retirement or Social Security benefits, child support and alimony, etc.
- Earned Income: All changes in earned income, including starting, stopping or changing a job. Receipt of irregular earned income, for example, commissions, lumpsum payments, etc.
- Household Composition: All changes in household composition, such as the addition or loss of a household member.
- Assets: When cash on hand, stocks, bonds, and money in a bank account or savings institution reaches or exceeds the program's asset limit.
- Changes in Residence and Shelter Costs: A change in residence, and for the SNAP the resulting change in shelter costs.
- Child Support Obligations: For the SNAP, any change in legal obligation to pay child support.

ELECTRONIC BENEFITS TRANSFER (EBT) You are responsible to report lost, stolen, or misused EBT CARDS immediately by calling the EBT toll-free customer service number, or by accessing the EBT website at www.ebtaccount.JPMorgan.com. There will be no replacement of any benefits accessed with an EBT card prior to the card being reported lost, stolen or misused. You are responsible to report immediately any changes in the status of your alternate payee. There will be no replacement of any benefits accessed by alternate payees or any other individuals using an EBT card and a valid PIN. Benefits not withdrawn for 90 days for cash assistance accounts and for 365 days for SNAP accounts will be returned to the state.

(4) PENALTY WARNING:

- **Do not make any false statements or hide any information.**
  Sanctions and court prosecution may be pursued under applicable state and federal laws.
- **Do not do anything dishonest to get money and SNAP benefits which you are not supposed to get.**
- **Do not give, trade or sell your SNAP benefits or EBT card to anyone else.**
- **Do not alter or use someone else's SNAP or EBT card for your household.**
- **Do not use your SNAP benefits or EBT card to buy ineligible items such as alcoholic drinks and tobacco.**
- **For the financial assistance program, an intentional program violation disqualification penalty is twelve months for the first violation, twenty-four months for the second violation and permanently for the third or more violations.**
- **For the SNAP, any household or family member who intentionally breaks SNAP rules, can be fined up to $250,000, imprisoned up to 20 years or both. A member of your household can be barred from SNAP for one year for the first violation; two years for a second violation and permanently for the third or any subsequent violation and an additional 18 months if court ordered. The individual may also be subject to further prosecution under other applicable Federal laws. A member convicted of using or receiving SNAP benefits in a transaction involving the sale of firearms, ammunition or explosives is permanently ineligible to participate in SNAP. Individuals convicted of trafficking SNAP benefits of $500 or more are permanently ineligible.**

  Individuals found guilty to have used or received SNAP benefits in a transaction involving the sale of controlled substance are ineligible to participate for two years for first violation and permanently for the second violation. Individuals who have committed and been convicted of Federal or State felonies after 8/22/96 for possession, use or distribution of illegal drugs and who refused to comply with treatment or with a treatment program are ineligible for the program. An individual is ineligible to participate in the financial and SNAP for 10 years if found to have filed more than one application at the same time and have given false identification or residence information. Fleeing felons and probation/parole violators are ineligible for the financial and SNAP.

(5) YOUR AUTHORIZATION:

- I agree that the information I provide to the Department will be subject to verification by Federal, State and local officials to determine if such information is factual; and if any information is incorrect, SNAP benefits may be denied; and I may be subject to criminal prosecution for knowingly providing incorrect information.
- I authorize the Department to check with any financial institution, including, but not limited to, banks, savings and loan associations, thrift companies and credit unions, to verify that I am eligible for help. I authorize any financial institution to provide the Department information, including information on the existence and nature of and amount in any account I may have with the financial institution.
- I agree to provide the necessary documents to verify the statements I have made. If documents are not available, I agree to give the name of person or organization (such as doctor, employer, State or Federal agency) whom the Department may contact for information about me which may be needed to show that I am eligible for help.
- I agree to cooperate with the Department, Federal Quality Control reviewers and/or auditors if my case is selected for a review.
- I understand that the Department may need to release information about me for purposes connected with the administration of the Department's assistance program, or the administration of federally assisted programs which provides assistance on the basis of need.
- I understand that the Department will obtain and exchange information about me to verify my income and eligibility from the Internal Revenue Service and exchange information about me with the Social Security Administration, Department of Labor for wages and Unemployment Compensation, and agencies in all states administering the Income Eligibility Verification System.
- I understand that if SNAP benefits are issued before a determination of financial eligibility is made, that the amount of SNAP benefits may be reduced without further notice as long as I am notified of this possibility on the notice approving SNAP benefits.
- I understand that my residence and business address may be released to law enforcement officers if needed for an official administrative, civil, or criminal law enforcement purpose, or to identify a recipient as a fugitive felon or a parole violator.
- I understand that if my EBT account becomes inactive because I failed to access my benefits, the balance in my EBT account may be used to offset any outstanding overpayments that my household owes the Department.
- I authorize the Department to release information from my case to the social security (SS) advocate contracted by the Department. This information will be used to help get SS benefits for me. The type of information which may be released shall include medical, income and asset information and work history. I also authorize the advocate to release information to the Department regarding the status of my claim for SS and any failure to comply with appointments and requests for information. I understand that release of this information may affect my public assistance benefits. This consent is good until a final determination of eligibility for SS has been reached or the consent is withdrawn in writing.

(6) ASSIGNMENTS AND AGREEMENT:

- **ASSIGNMENT OF RIGHTS:** I understand that as a condition of eligibility for financial assistance, I am assigning to the State of Hawaii any rights to child and spousal support that I may have from another person, for myself or any person for whom I am applying or receiving assistance. This assignment includes rights to support from previous as well as present and future support. Such payments will be used to reimburse the State up to the amount of assistance granted. You may be exempt from this requirement if you fear physical or mental harm to yourself or your children. As a condition of eligibility for financial assistance I understand that by applying, I am assigning to the State of Hawaii my rights to any third party payments for medical care. I will cooperate in obtaining third party payments. I also understand that when I assign child and spousal support to the State I must have the State's permission to negotiate or seek a new court order or otherwise change the existing status of my child or spousal support agreement. I agree to cooperate with the State in establishing paternity for the minor children in my application.
- **REAL PROPERTY AGREEMENT:** I give the Department permission to verify information on my property. I also agree to report to the Department within five days any money received from the sale, lease, exchange or transfer of such property. If I assign or transfer any property for less money than what I get in the open market, my dependents and I will become ineligible for further assistance.
- **THIRD PARTY LIABILITY:** As a condition of eligibility for financial and medical assistance I understand that by applying, I am assigning to the State of Hawaii my rights to any third party payments for medical care. I will cooperate in obtaining third party payments. I will give the State of Hawaii any health insurance payments or other money received for medical care for the time anyone in my household receives assistance. If I do not cooperate because I believe it may not be in the best interest of my household, I must provide information to support this. Without good cause, it will not affect my children's medical benefits, however I may not be eligible for medical benefits unless I am pregnant.

(7) SNAP PRIVACY ACT STATEMENT:

Collection of information for this application, including the social security number (SSN) of each household member is authorized under the Food and Nutrition Act of 2008, as amended, 7 U.S.C. 2011-2036.

- The information will be used to determine whether your household is eligible or continues to be eligible to participate in the SNAP.
- Information may be disclosed to other Federal and State agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law.
- If a SNAP claim arises against your household, the information on the application, including all SSNs, may be referred to Federal and State agencies, as well as to private claims collections agencies for claims collection action.
- The providing of the requested information, including the SSN of each household member, is voluntary. However, failure to provide this information will result in the denial of SNAP benefits to your household.

(8) YOUR CERTIFICATION (MUST BE SIGNED TO BE CONSIDERED A VALID APPLICATION):

Before signing this application, go back and check that you have answered each question. Make sure you understand your rights and responsibilities, the penalty warning, your authorization, your consent, your assignments and agreements.

- I certify under penalty of perjury, that my answers are correct and complete to the best of my knowledge.
- I understand the questions on this application and the penalty for hiding or giving false information.
- I certify that I have been informed of my rights and responsibilities by the worker and I agree to heed these responsibilities.
- I understand the assignments and agreements and agree to fulfill them as a condition of eligibility.
- I certify under penalty of perjury that the information provided on the Citizen Status Declaration on each applicant household member is correct.

SIGNATURE (OR MARK) OF APPLICANT	DATE	SIGNATURE (OR MARK) OF SPOUSE OR OTHER ADULT APPLICANT (Required for money assistance only)	DATE	WITNESS IF SIGNATURE IS "X"

(9) CERTIFICATION BY AUTHORIZED REPRESENTATIVE ☐ OR OTHER PERSON ASSISTING IN FILLING OUT APPLICATION ☐ : (Please check off one box.)

I helped the applicant fill out this form. I understand that anyone helping another person in dishonestly getting benefits is subject to criminal penalties.
I certify that the answers given by me on this form ☐ is what I know personally about him/her; or ☐ was provided by the applicant/recipient.

SIGNATURE	RELATIONSHIP	DATE

HOME ADDRESS	PHONE NO.

(10) IN CASE OF EMERGENCY OR DEATH, THE PERSON TO CONTACT IS: (Please Print)

NAME	RELATIONSHIP	PHONE NO.	ADDRESS

(11) CERTIFICATION BY ELIGIBILITY WORKER:

I certify that the applicant/recipient has been informed of his/her rights and responsibilities and the possibility of criminal charges for misrepresenting or concealing facts which determine eligibility.

PRINT ELIGIBILITY WORKER'S NAME	SIGNATURE OF ELIGIBILITY WORKER	DATE