STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES

BENEFIT, EMPLOYMENT, AND SUPPORT SERVICES DIVISION

IMPORTANT INFORMATION WHEN APPLYING FOR FINANCIAL ASSISTANCE AND SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

Signatures are required on pages 1 and 11 of the application.

If any member of your household receives SNAP or Temporary Assistance for Needy Families (TANF) benefits, then all children in your household are eligible for free school meals if their school participates in the United States Department of Agriculture (USDA) meal program. Please call the child's school if you have questions regarding the School Breakfast and Lunch Program. They will be able to provide you information when:

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

Information about TANF and other programs available under the Department of Human Services can be found at the following website: http//humanservices.hawaii.gov/bessd/

DHS - Benefit, Employment and Support Services Division (BESSD) Financial Assistance / SNAP Application

Bilingual and Sign Interpreter Services

BESSD provides free bilingual and sign language interpreters. If you need an interpreter please call 1-888 - 764-7586 and press 7, this is a toll-free telephone number. You can also get help in person at the BESSD office near you.	**English** 
BESSD 提供免費的雙語和手語翻譯。如果你需要口譯員，請致電 **1-888-764-7586** 然後按 1,這是一個免費的電話號碼。 您也可以在您附近的 BESSD 辦公室尋求協助。	**Cantonese** 
BESSD epwe awora choon chiaku non kkapas me pwomw ese kamo. Ika kopwe nounow choon chiaku, kokkori 1-888-764-7586 mwurin ka tikki na nampa 7, lei ei nampa ese kkamo (toll-free). En mei pwan tongeni angei ekkoch aninnis ren omw pwusin chuuno non ofesin BESSD .	**Chuukese** 
BESSD fournit gratuitement des interprètes bilingues et des interprètes de langue des signes. Si vous avez besoin d'un interprète s'il vous plaît téléphonez au 1-888-764-7586 et appuyez sur 7, Ceci est un numéro de téléphone gratuit. Vous pouvez également obtenir de l'aide en personne au bureau de BESSD près de chez vous.	**French** 
BESSD bietet kostenlose zweisprachige und Gebärdendolmetscher. Wenn Sie einen Dolmetscher benötigen, rufen Sie bitte 1-888-764-7586 und 7 drücken. Dies ist eine gebührenfreie Telefonnummer. Sie können auch helfen in Person an der BESSD Büro in Ihrer Nähe.	**German** 
Ho'olako 'o BESSD i ka mahele 'olelo a me ka 'olelo kuhi lima manuahi. 'Ina pono e loa'a ka mahele 'olelo ia 'oe, e 'olu'olu e kelepona i 1-888-764-7586 a e kaomi I ka helu 7. He helu kelepona kaki 'ole keia. E hiki pu ia 'oe ke kokua 'ia 'Ina hele kino 'oe i ke ke'ena BESSD kokoke ia 'oe.	**Hawaiian** 
Iti BESSD ket mangipaay ti libre nga bilingual ken sign language nga intepreter. No kasapulan yo iti intepreter pangngaasi ta awagan yo iti 1-888-764-7586 ken italmeg yo ti 2. Daytoy ket toll-free a numero. Mabalin yo pay ti dumawat iti tulong a personal ti asideg nga opisina iti BESSD.	**Ilocano** 
BESSDでは二ヶ国語併用と手話の通訳を無料で提供します。もしあなたに通訳が必要な場合は、1-888-764-7586 に電話をかけ、そして7の番号を押して下さい。こちらは料金無料の電話番号です。あなたの最寄りのBESSDのオフィスでも、ご自身が援助を受ける事も可能です。	**Japanese** 
BESSD 는 무료통역과 사인언어 통역을 제공 합니다. 통역이 필요하면 **1-888-764-7586** 로 전화해서 3 을 누르십시요. 이전화는 무료로 사용하는 전화번호 입니다. 당신은 **BESSD** 당신이 사는근처 메드 퀘스트 사무실에서 직접 도움을 받을수 있읍니다.	**Korean** 
BESSD 提供免费的双语和手语翻译。如果你需要口译员. 请致电 **1-888-764-7586** 然后按 1。这是一个免费的电话号码。 您也可以在您 附近的 BESSD 办公室寻求协助。	**Mandarin** 
BESSD ej bar lewoj jiban ikejen kajin ko kab sign language ko. Ne koj aikuij jiban kin ikejein okok non kajin eo am juoij im call **1-888-764-7586** im jibed 5 telephone nomba in ej toll-free telephone number. Komaron bar einwot ebok jiban ilo BESSD office ko me rebaak yuk.	**Marshallese** 
E saunia e le ofisa o le BESSD ni tagata e mafai ona fesoasoani ia te oe i le gagana Samoa, e aunoa ma se totogi. Afai e te mana'omiaina lea fesoasoani, fa'amolemole vala'au i le numera 1-888-764-7586, o le numera 7 i luga o lau telefoni. O lenei telefoni e lē tau totogiina e oe, e te vili fua. E maua fo'i nisi 'au'aunaga pe afai e te sūsū atu i so'o se ofisa o le BESSD o	**Samoan** 
El BESSD proporciona sin costo intérpretes bilingües y de idioma de señal. Si usted necesita a un intérprete, por favor llame 1-888-764-7586 y apriete 7. Éste es un número del teléfono de peaje gratis. Usted también puede conseguir personalmente ayuda en la oficina de BESSD cerca de usted.	**Spanish** 
Ang BESSD ay nagbibigay ng libreng bilingual at sign language na tagapagsalin ng wika. Kung kailangan ninyo ng tagapagsalin pakiusap na tawagan ang 1-888-764-7586 at pindutin ang 7. Pwede rin kayong pumunta ng personal sa opisina ng BESSD na malapit sa inyo. Tignan ang pahina 2 para sa opisina na pinakamalapit sa inyo.	**Tagalog** 
'Oku malava 'ehe polokalama BESSD 'o 'oatu ha tokotaha fakatonulea fk-Tonga pe talanoa nima, ta'etotongi. Kapau 'oku ke fiema'u ha tokoni fakatonulea, kataki 'o telefoni ki he fika 1-888-764-7586 pea ke lomi e 7. 'Oku ta'etotongi 'ae ta ki he fika telefoni ko 'eni. 'Oku toe malava pe keke ma'u tokoni hangatonu mei ha 'ofisi 'oe polokalama BESSD 'oku ke nofo ofi ai.	**Tongan** 
BESSD phục vụ thông dịch viên song ngữ và ngôn ngữ ký hiệu miễn phí. Nếu bạn cần người thông dịch viên xin làm ơn gọi 1-888-764-7586 và bấm 4. Đây là số điện thoại miễn phí. Để bạn đồng thời có thể nhận sự giúp đỡ tận BESSD nơi ở văn phòng gần bạn.	**Vietnamese** **Việt Nam**
Ang BESSD maghatag ug libre nga mga taghubad nga duha ang pinulongan ug mga taghubad sa pinasinyas nga pinulongan. Kun ikaw magkinahanglan ug taghubad sa pinulongan palihug tawagi ang 1-888-764-7586 ug ipindot ang 7. Libre ang tawag nianing numero sa telepono. Mahimo usab nga personal ka nga makakuha ug tabang sa opisina sa BESSD nga duol sa inyoha.	**Visayan** 

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. To shorten the processing time, you should submit proof of information and verification as noted on your appointment letter. You may be asked at the interview to submit 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 34 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. Has anyone in the household been found guilty of misrepresenting residence to obtain assistance in two or more states? ☐ Yes ☐ No
If yes, name(s): _____

8. CITIZENSHIP STATUS DECLARATION. One household member must certify under penalty and perjury the citizenship status of each household member. The Department of Human Services (DHS) may validate the alien status/document with the United States Citizenship and Immigration Services (USCIS), the USCIS will furnish information only as allowed by the IRCA legislation, the USCIS is not allowed to institute any adverse action against you based on the DHS inquiry, and the information received from the USCIS may affect your eligibility or amount of benefits from our Department. **I CERTIFY UNDER PENALTY OF PERJURY THAT THE INFORMATION BELOW ON EACH HOUSEHOLD MEMBER IS CORRECT.**

	(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.

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

Name	Address	Phone

10. 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.

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

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

12. 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

13. 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

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

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

16. 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

17. 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

18. 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.

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

UNEARNED INCOME

20. 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

21. 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.				

22. 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
				$	$

23. 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
			$	$
			$	$

24. 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
	$	$
	$	$
	$	$

25. 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

26. 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

27. Is anyone in your household working off any part of the rent? ☐ Yes ☐ No If Yes, indicate amount $ _____
28. Do you live in Public Housing? ☐ Yes ☐ No
29. 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

30. 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.

31. 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

32. 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

33. 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

34. 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.
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.ebtEDGE.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 112 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.
- I agree that I will not access my Temporary Assistance for Needy Families (TANF) financial assistance benefits through any electronic benefit transfer transaction in any liquor store; any casino; gambling casino, or gaming establishment; or any retail establishment which provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment.

(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. 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.

(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

State of Hawaii Processing Centers

Oahu

Kapolei Processing Center 601 Kamokila Boulevard, #117 Kapolei, Hawai'i 96707 Phone: 692-8384 Fax: 692-7783	**Ko'olau Processing Center- Luluku** 45-513 Luluku Road Kane'ohe, Hawai'i 96744 Phone: 233-5325 Fax: 233-5358	**Ko'olau Processing Center- Waikalua** 45-260 Waikalua Road Kane'ohe, Hawai'i 96744 Phone: 233-3621 Fax: 233-3620
KPT Processing Center 1485 Linapuni Street, #122 Honolulu, Hawai'i 96819 Phone: 832-3800 Fax: 832-3392	**OR&L Processing Center** 333 North King Street, #200 Honolulu, Hawai'i 96817 Phone: 586-8047 Fax: 586-8138	**Pohulani Processing Center** 677 Queen Street, #400B Honolulu, Hawai'i 96813 Phone: 587-5283 Fax: 587-5297
Wahiawa Processing Center 929 Center Street Wahiawa, Hawai'i 96786 Phone: 622-6315 Fax: 622-6484	**Wai'anae Processing Center** 86-120 Farrington Highway #A103 Wai'anae, Hawai'i 96792 Phone: 697-7881 Fax: 697-7184	**Waipahu Processing Center** 94-275 Moku'ola Street, #303A Waipahu, Hawai'i 96797 Phone: 675-0052 Fax: 675-0038

Maui County

Maui Processing Center - Lunalilo 35 Lunalilo Street, #300 Wailuku, Hawai'i 96793 Phone: 243-5110 Fax: 243-5114	**Maui Processing Center - State Building** 54 High St. #125 Wailuku, Hawai'i 96793 Phone: 984-8300 Fax: 984-8333
Lanai Sub-Unit 730 Lana'i Avenue Lana'i City, Hawai'i 96763 Phone: 565-7102 Fax: 565-6460 Mailing Address: PO Box 631374 Lana'i City, Hawai'i 96763	**Molokai Unit** 55 Maka'ena Place #1 Kaunakakai, Hawai'i 96748 Phone: 553-1715 Fax: 553-1720 Mailing Address: PO Box 70 Kaunakakai, Hawai'i 96748

Hawaii Island

North Hilo Unit Kulana Na'auao Building 13 Kekaulike Street Hilo, Hawai'i 96720 Phone: 933-0331 Fax: 933-8856	**South Hilo Unit** Kino'ole Plaza 1990 Kino'ole Street, #108 Hilo, Hawai'i 96720 Phone: 981-2754 Fax: 981-2819	**Kamuela-Hamakua Unit** State Office Building 1, #110 45-3380 Mamane Street Honoka'a, Hawai'i 96727 Phone: 775-8854 Fax: 775-8858
Ka'u Sub-Unit Na'alehu Civic Center 95-5669 Mamalahoa Hwy. Na'alehu, Hawai'i 96772 Phone: 939-2421 Fax: 929-9500 Mailing Address: PO Box 6 Na'alehu, Hawai'i 96772	**South Kona Unit** Captain Cook Civic Center 82-6130 Mamalahoa Hwy. Bldg. 2 Captain Cook, Hawai'i 96704 Phone: 323-7573 Fax: 323-4549 Mailing Address: PO Box 225 Captain Cook, Hawai'i 96704	**Kohala Sub-Unit** State Office Building 54-3900 'Akoni Pule Hwy. Kapa'au, Hawai'i 96755 Phone: 889-7141 Fax: 889-7132 Mailing Address: PO Box 249 Kapa'au, HI 96755
North Kona Unit 75-5722 Hanama Pl., Ste. 1105 Kailua-Kona, Hawai'i 96740 Phone: 327-4980 Fax: 327-4684		

Kauai

Kaua'i Processing Center Former Lihu'e Courthouse Building 3059 'Umi Street, #A110 Lihu'e, Hawai'i 96766 Phone: 274-3371 Fax: 335-8446