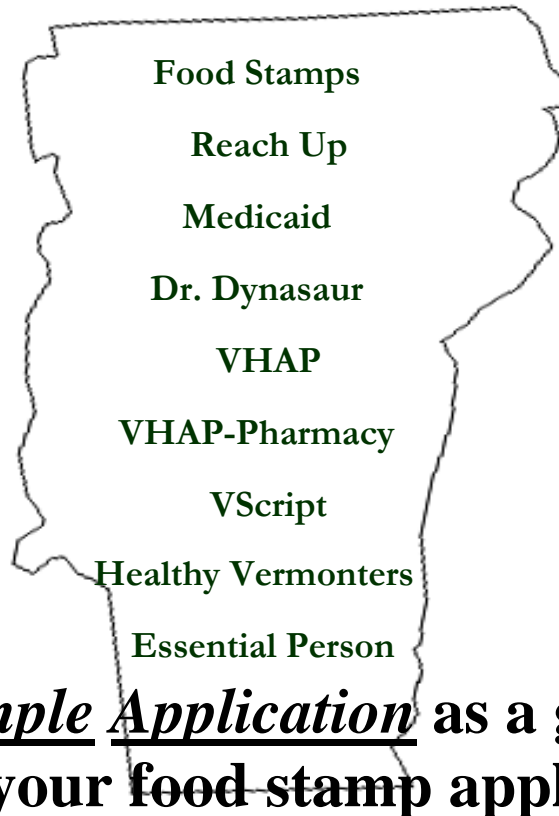


**Welcome to the Economic Services Division of the
Vermont Department for Children and Families (DCF)**

Application for:



**Use this Sample Application as a guide for filling
out your ~~food stamp~~ application.**

**If you do not speak English, we can provide free translation for our services.
Please tell us if you need an interpreter for any language.**

Si usted no habla inglés, podemos proveer traducción gratis para nuestros servicios. Favor de dejarnos saber si necesita un intérprete. (Spanish)

Ako ne govorite engleski, mi vam mozemo za nase usluge obezbjediti besplatnu pomoc prevodioca. Molimo vas da nas obavijestite ako vam je potrebna ova pomoc. (Serbo-Croatian)

Si vous ne parlez pas anglais, nous pouvons vous fournir un traducteur gratuitement pour nos services. Veuillez nous signaler si vous avez besoin d'un interprète. (French)

Nều bạn không biết nói Tiếng Anh, chúng tôi có thể cung cấp sự thông dịch miễn phí cho những dịch vụ của chúng tôi. Xin vui lòng nói cho chúng tôi biết nếu bạn cần thông dịch viên. (Vietnamese)

How to Use this Guide

The application is in faded print. Tips to help you answer the questions are in black.

Read the question and the tip together, because the tip doesn't always restate the question in full.

10 things to know before you get started

1. The application is long, so to get things started, you can just fill out the page that says “**Application**” at the top with your name, address, and signature. Tear off this page and take it to the food stamp office or mail it to the food stamp office as soon as possible. You will need to answer the rest of the questions before you can get food stamps, but you can do this later with the help of a friend, Community Action Agency, your local Agency on Aging, or your food stamp worker. If you are found eligible for food stamps, you will get food stamps going back to the date the office got this page of your application.
2. If you need food right away, you can ask for emergency food stamps. Be sure to fill out page 3 of the application.
3. If you are not sure how to answer a question, leave it blank. The food stamp office can explain the question and help you answer it later.
4. You can write notes in the margins or add paper to explain your answers.
5. If you are applying for food stamps and none of the other programs, you only have to answer the questions marked with the picture of the apple 🍏.
6. Be sure you understand the Rights and Responsibilities page. You can ask someone at the food stamp office or your local Community Action Agency or Agency on Aging to go over this page with you.
7. If you can, make a copy of your application and keep it. The food stamp office cannot make a copy for you, so try to do this before you turn in your application. If you get food stamps, it will be helpful to have a copy to look at anytime you call the food stamp office to discuss your case.
8. The questions on the application ask about the people in your household, how much money everyone gets every month, and how much your household spends for things like rent, day care, and child support. The questions also ask about your household's resources, which are things like money in the bank, land, or cars anyone in your household owns.
9. When you tell the food stamp office about money you make or things you own, it does not always mean those things will count against you or that you will not be able to get food stamps. Some of the questions ask for information that can help you get more food stamps each month.
10. If you have any questions about the application, there are places you can go for help. Community Action Agencies, your local Agency on Aging (for people 60 years and older), and the food stamp office can answer your questions. You can also check out www.vermontfoodhelp.com for information about food stamps.

Information for Applicants

Social Security Numbers. Everyone applying for benefits must provide a social security number. If you don't have one, DCF will help you apply for one. People not applying for benefits do not have to give a social security number; however, they will have to provide all other information such as income and resources.

Important Information for Immigrants. Only U.S. citizens and certain legal aliens can get benefits. If your household includes people who are not eligible because of immigration status, you can still apply for and get benefits for other eligible members. DCF will verify with the Immigration and Naturalization Service the immigration status of noncitizens who apply for benefits. People not applying for benefits do not have to give immigration information.

If you get assistance from us, it may affect your sponsor or your immigration status. Before you apply, you may want to talk with Vermont Legal Aid at 1-800-889-2047 or an agency that helps immigrants with legal questions.

Americans with Disabilities Act. If you think you might have a physical or mental condition that considerably limits a major life activity, like moving, seeing, hearing, or thinking, let us know. The Americans with Disabilities Act gives people with disabilities certain rights. We will make reasonable changes and accommodations in our requirements to help you take part in our programs. Tell your worker if you think there is something that you need.

Rights and Responsibilities. When you sign this form, it means you have read and understand your rights and responsibilities on the back of this form. You will get a copy of these to keep. You may ask for a copy in larger print if you would like. If you do not understand your Rights and Responsibilities, ask your worker to explain them to you.

Confidentiality. DCF will not share any information from this application except for purposes directly connected with program administration. We will keep all information about you, your family, your application, or any benefits you receive confidential unless you clearly allow release of this information, or a court orders it. DCF takes strict precautions to safeguard social security numbers and other confidential information transmitted via the internet or fax machine.

The Application Process

Answer each question as completely as you can. Sign the application and give it to the receptionist or mail it to your local DCF office. Please print. If you have questions or need help with this form, your local office can help you. See the back of this form for the addresses and telephone numbers. If you need more room for your answers, please attach another piece of paper.

If you only want food stamps, you just need to answer the questions with the apple (🍏) symbol.

If you are applying for food stamps or Reach Up, an interview will be scheduled for you. In certain situations, your food stamp interview can be by phone. At your appointment, your worker will go over this form with you. It is your responsibility to give your worker all the information needed. If you are not able to get this information, ask your worker for help.

This page is your application. You may tear it off and give it to your local DCF office now without the rest of the form. It must have your name, address, and signature. You may mail the rest of the form or bring it to your interview. Please complete the entire form when possible. This information helps us determine if you qualify for emergency benefits. The completed form and all required verification are needed to see if you are eligible.

Applicant _____ Social security no. _____ Birthdate ____/____/____

Home address _____

Mailing address if different _____ Town _____ Zip _____

Phone number where you can be reached (_____) _____ Town where you live _____

Directions to your home _____


Do you have an authorized representative or legal guardian? ● Yes ● No

If yes, check one ● Authorized representative ● Legal guardian – name of court _____ Date appointed _____

Name _____ Telephone number (_____) _____

Address _____

Someone in my household is applying for the following programs (check one or more boxes):

-  **Food Stamps** – Help to buy more and better food. If you are eligible, you get benefits from the date DCF gets this application. If you have little or no money for food, you may be able to get emergency help.
- **Reach Up** – Services and cash to help families with children become more independent. If eligible, benefits begin 30 days from the date DCF gets this application or the date it is approved, whichever is earlier.
- **Medicaid/Dr. Dynasaur** – Help to pay medical expenses for people 65 or older, people who are blind or have a disability, children under 21, pregnant women, parents, or caretaker relatives. Medicaid may also help pay Medicare premiums, deductibles, and coinsurance.
Ask for a “health care only” application if you want help only with medical expenses.
- **VHAP or pharmacy programs – VHAP** (Vermont Health Access Plan) helps pay medical expenses for adults without insurance for doctors and hospitals. **VHAP-Pharmacy and VScript** help pay prescription costs for people who are blind, have a disability, or are 65 or older and who have no prescription insurance. **Healthy Vermonters** helps these people and those who have a cap on their prescription insurance. Your worker will enroll you in the best program that you qualify for.
Ask for a “Pharmacy Application” if you want help only with prescription costs.
- **Essential Person** – For people who are blind, have a disability, or are age 65 or older, to help meet expenses for someone who lives with and provides care for them so they can live at home.

I have read and I understand the Rights and Responsibilities on the back of this application. I was given a copy of these statements and I agree to them.

Signature of applicant _____ Date _____

Signature of person helping fill out this form _____ Date _____

Rights and Responsibilities

You may request a copy of this page in larger print.

True and Complete information. I understand the information I provide to DCF to apply for assistance will be subject to verification by federal and state officials to determine if it is correct. This means that sources other than members of my household may be contacted to verify my eligibility for assistance. I understand that if any information is not true, DCF may deny assistance to me.

Reporting changes. I understand when I get assistance, I must report changes in my situation. The changes I must report may be different depending on the benefits I get. If I am not sure which changes I must report, I will ask my worker. I understand changes may affect the amount of benefits I get. I also understand I must report changes within 10 days from when they happen.

Social security number. I understand that, when I apply for assistance from DCF, I must give the social security number of everyone in my household who wants assistance. Federal law requires this as a condition of eligibility. If I am a member of a religious organization that objects to furnishing a social security number, DCF may disregard this requirement. (42 U.S.C. §1320b-7)

DCF uses the social security number: 1) for computer processing of program benefits, support enforcement, fraud investigation, audits, and Lifeline identification; 2) to verify social security and supplemental security income; 3) to prevent individuals from receiving duplicate benefits; 4) to identify groups of cases that must have benefits changed; 5) to exchange information with agencies such as the Social Security Administration, Department of Employment and Training, Internal Revenue Service, or private claims collection agencies to verify income, determine eligibility and benefit amounts, and collect claims; 6) to determine the accuracy and reliability of information given to DCF; and 7) to make medical assistance payments.

No Discrimination. Federal and state law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, prohibit DCF from discriminating based on race, color, national origin, sex, age, or disability. The Food Stamp Act, USDA policy, and state law also prohibit DCF from discriminating based on religion or political beliefs.

To file a discrimination complaint, 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, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). USDA and HHS are equal opportunity providers and employers. Under Vermont law and rules, DCF may not discriminate based on marital status, sexual orientation or place of birth. To file a discrimination complaint, write: Deputy Commissioner, Department for Children and Families, Economic Services Division, 103 S. Main St., Waterbury, VT, 05671.

Decision on application. DCF must make a decision on my application within 30 days (or 90 days if my Medicaid application is based on disability) unless delay is caused by examining physicians, an administrative emergency, or me. If I do not get a decision within 30 (or 90) days, I may call the DCF office or request a fair hearing.

Fair hearing. I may ask for a fair hearing when my claim for assistance, benefits, or services is denied in whole or in part, or not responded to with reasonable promptness by contacting a DCF office or writing to the DCF Deputy Commissioner. (3 V.S.A. §3091)

Quality control review. DCF may select my application for a quality control review. If so, I agree to give proof of required information. If I am unable to give the proof needed, I authorize DCF to get it.

Release of tax records. I give permission to the Vermont commissioner of taxes to disclose information from my state income tax returns to the commissioner of DCF. (33 V.S.A. §112 (c))

Release of medical records. I agree that my health care providers may release my medical records when necessary for the purpose of administering DCF health care or Reach Up programs.

Assignment of medical support. As a condition of eligibility for health care assistance, I agree to assign to DCF or its designee all rights to medical support and to third party payments (such as insurance) for medical care. I agree to

enroll in a group health plan if DCF requires me to, and I understand DCF could pay the premiums. I also agree to cooperate in pursuing any actual or potential source of support or payments, including establishing paternity for my dependent children, if necessary. I understand that if I do not cooperate, my benefits will end.

Recovery of Medicaid payments. DCF must file a claim against my estate when I die to recover Medicaid payments made for me for services I received at age 55 or older while in a nursing facility or a home-and- community-based waiver program, and for related hospital and prescription drug services. DCF will not seek adjustment or recovery against my estate if, at the time of death, my spouse is still alive, I have surviving children who are blind, disabled, or under age 21, or DCF determines that adjustment or recovery would cause undue hardship. I understand I may find out more about recovery from my worker. (42 U.S.C. §1396p)

Medicare part B payments. If I get Medicare part B benefits while getting Medicaid, I want DCF to make any payments for future Medicare part B medical and other health services directly to physicians and medical suppliers. This means I will not have to sign a separate form each time I get a service.

Assignment of support rights. As a condition of eligibility for public assistance, I agree to assign all my rights to support to DCF. I understand this includes all current support owed to me while I get public assistance; all arrears owed to me that are collected during this assignment, and all arrears collected through federal tax offset during or after this assignment, up to the total amount I get or have ever gotten. The noncustodial parent (NCP) will owe me amounts over the total amount of public assistance. Arrears include, but are not limited to, unpaid support obligations, debts, and court-ordered and administrative judgments. While I am on assistance, I understand the NCP will pay all support directly to the Office of Child Support (OCS). While I am waiting for DCF to grant me assistance, I will tell DCF of any support the NCP pays directly to me. After I have been granted assistance, I will immediately turn over to OCS any support the NCP pays me directly.

Take part in Reach Up activities. I understand that I and members of my household may have to participate in certain Reach Up activities and that my worker will tell us what we have to do and what the penalty is if we do not.

Not fleeing prosecution. I certify that neither I nor any member of my household is fleeing prosecution or confinement for a felony or an attempt to commit a felony, or is violating a condition of probation or parole under a federal or state law. I understand DCF must disclose information to law enforcement agencies to apprehend fleeing felons.

No benefits from another state. If any member of my household gets duplicate Food Stamp benefits, Medicaid, or cash assistance from another state or has been convicted in the past ten years of fraudulently misrepresenting residence to get benefits from two or more states, I must tell DCF immediately.

Fraud penalties. I or any member of my household will be subject to prosecution for fraud or some other criminal offense for knowingly giving false, incorrect, incomplete, or misleading information in order to get, try to get, or help someone else get Reach Up, Food Stamp, or health care benefits. If convicted, penalties may include up to three years of imprisonment and/or a fine of up to \$1,000, or an amount equal to the benefits wrongfully received. Federal and other state penalties may also apply. (42 U.S.C. §§1320a-7, 1320a-7a, 1320a-7b, 1396a, 1396r-6; 33 V.S.A. §§141, 143)

Food Stamp fraud penalties. I or any household member cannot trade or sell Food Stamp benefits, use them to buy ineligible items such as alcohol or tobacco, or use someone else's food stamps. If convicted, the member may be barred from the Food Stamp program for one year for the first offense, two years for the second offense, or permanently for the third offense, and be fined up to \$250,000, imprisoned up to 20 years, or both. If convicted of buying or selling illegal drugs in exchange for food stamps, a member may be barred for two years or barred permanently for a second offense. If convicted of purchasing firearms, explosives, or ammunition with food stamps or of trafficking in Food Stamp benefits of \$500 or more, a member may be barred permanently. If convicted of falsely representing identity or residence, a member may be barred for 10 years and may be prosecuted under other federal and state laws. (7 C.F.R. §273.16(b).)

Emergency Needs

If you have little or no money for food, you may be able to get food stamp benefits within 7 days. Answer the questions in the box below to see if you can get expedited service.

Expedited Food Stamps

Have you received food stamps this month in any state?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is anyone in your household a migrant or seasonal farm worker?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
What is your household's total income for this calendar month? (The food stamp office wants to know all the income the household will receive during the current calendar month.)		\$ _____
How much money does your household have in cash, checking, and savings accounts? Give your best guess if you're not sure.		\$ _____
What is your monthly rent or mortgage?	\$ _____	
How much are your monthly utilities? (Utilities are heat, hot water, cooking, lights and phone.)		\$ _____

General Assistance

You may also be able to get general assistance to help meet your emergency needs. Ask your worker for a general assistance application if you need emergency help.

Head of Household for Food Stamp Benefits

If your household has adult parents with children or adults with parental control of children, you may choose the head of household for food stamp benefits.



- DCF sends notices, forms, and benefits to the head of household.
- If you leave this line blank, DCF will make the selection.
- You may change the head of household when your case is reviewed or when the people in your household change.

Head of household _____

 **Have you visited the Food Stamp website at www.vermontfoodhelp.com? Yes No**

For DCF use only

Interview date	<input type="checkbox"/> Application <input type="checkbox"/> Review	<input type="checkbox"/> Reach Up <input type="checkbox"/> Health care	<input type="checkbox"/> Food Stamps <input type="checkbox"/> Essential person	Worker
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 1. List anyone living in your home including people not asking for assistance. Members of your household who are not applying do not have to give their social security number or citizenship information but must provide all other information. If you are applying for food stamps only, answer just the questions with the apple ().

MEMB

List everyone you live with, even the people who do not want food stamps or other help.			Check everything you want to apply for and also the assistance you are currently receiving.			If there are people in your house who do not want help, you do not have to give their social security number or citizenship information.	
First name	Initial	Last name	Assistance applying for		Sex	Social security number	Citizenship status
1.			<input type="checkbox"/> Reach Up	<input type="checkbox"/> Medicaid/Dr. Dynasaur	<input type="checkbox"/> Female		<input type="checkbox"/> U.S. citizen
			<input type="checkbox"/> Food Stamps	<input type="checkbox"/> VHAP or pharmacy	<input type="checkbox"/> Male		<input type="checkbox"/> Refugee
			<input type="checkbox"/> Essential Person	<input type="checkbox"/> None			<input type="checkbox"/> Asylee
			Marital status		Birthdate	Last grade completed	<input type="checkbox"/> Legal alien
			<input type="checkbox"/> Single	<input type="checkbox"/> Civil union			<input type="checkbox"/> Other
			<input type="checkbox"/> Married	<input type="checkbox"/> Separated			
			<input type="checkbox"/> Divorced/dissolved	<input type="checkbox"/> Widowed			
	Relationship to you						
	Self						

First name	Initial	Last name	Assistance applying for		Sex	Social security number	Citizenship status
2.			<input type="checkbox"/> Reach Up	<input type="checkbox"/> Medicaid/Dr. Dynasaur	<input type="checkbox"/> Female		<input type="checkbox"/> U.S. citizen
			<input type="checkbox"/> Food Stamps	<input type="checkbox"/> VHAP or pharmacy	<input type="checkbox"/> Male		<input type="checkbox"/> Refugee
			<input type="checkbox"/> Essential Person	<input type="checkbox"/> None			<input type="checkbox"/> Asylee
			Marital status		Birthdate	Last grade completed	<input type="checkbox"/> Legal alien
			<input type="checkbox"/> Single	<input type="checkbox"/> Civil union			<input type="checkbox"/> Other
			<input type="checkbox"/> Married	<input type="checkbox"/> Separated			
			<input type="checkbox"/> Divorced/dissolved	<input type="checkbox"/> Widowed			
	Relationship to you						

First name	Initial	Last name	Assistance applying for		Sex	Social security number	Citizenship status
3.			<input type="checkbox"/> Reach Up	<input type="checkbox"/> Medicaid/Dr. Dynasaur	<input type="checkbox"/> Female		<input type="checkbox"/> U.S. citizen
			<input type="checkbox"/> Food Stamps	<input type="checkbox"/> VHAP or pharmacy	<input type="checkbox"/> Male		<input type="checkbox"/> Refugee
			<input type="checkbox"/> Essential Person	<input type="checkbox"/> None			<input type="checkbox"/> Asylee
			Marital status		Birthdate	Last grade completed	<input type="checkbox"/> Legal alien
			<input type="checkbox"/> Single	<input type="checkbox"/> Civil union			<input type="checkbox"/> Other
			<input type="checkbox"/> Married	<input type="checkbox"/> Separated			
			<input type="checkbox"/> Divorced/dissolved	<input type="checkbox"/> Widowed			
	Relationship to you						

First name	Initial	Last name	Assistance applying for		Sex	Social security number	Citizenship status
5.			<input type="checkbox"/> Reach Up	<input type="checkbox"/> Medicaid/Dr. Dynasaur	<input type="checkbox"/> Female		<input type="checkbox"/> U.S. citizen
			<input type="checkbox"/> Food Stamps	<input type="checkbox"/> VHAP or pharmacy	<input type="checkbox"/> Male		<input type="checkbox"/> Refugee
			<input type="checkbox"/> Essential Person	<input type="checkbox"/> None			<input type="checkbox"/> Asylee
			Marital status		Birthdate	Last grade completed	<input type="checkbox"/> Legal alien
			<input type="checkbox"/> Single	<input type="checkbox"/> Civil union			<input type="checkbox"/> Other
			<input type="checkbox"/> Married	<input type="checkbox"/> Separated			
			<input type="checkbox"/> Divorced/dissolved	<input type="checkbox"/> Widowed			
	Relationship to you						

Please answer the following questions about the people listed above

You do not have to answer this question if you are applying for food stamps only. Yes No

1a. Has anyone moved to Vermont in the past 12 months?

List anyone in your household who moved to Vermont from another state or country in the last 12 months.

First name	Initial	Date arrived in Vermont	State or country moved from


You do not have to answer this question if you are applying for food stamps only.

Yes No

1b. Has anyone received cash assistance from any other state since 1996?

List anyone in your household who got cash assistance from any other state since 1996. Cash assistance is a payment from the state to help you pay for things you need to live, such as housing. If anyone in your household got benefits in another state, bring the paperwork about those benefits when you meet with your caseworker.

First name	Initial	State or country	Date started	Date ended

 1c. Did anyone receive a Vermont earned income tax credit (EITC) in the past 12 months?

Yes No

List anyone in your household who got the Vermont Earned Income Tax Credit. The Vermont Earned Income Tax Credit is a tax refund for working Vermonters.

First name	Initial	Date received

 2. Is anyone living outside your home in a facility that is not a school or college?
 hospital correctional facility residential care home
 nursing home treatment facility group home

Yes No

INST

List anyone who usually lives with you but who is in the hospital, jail, a nursing home, etc.

First name	Initial	Name of facility	Date of admission

 3. Is anyone in high school, college, vocational school, or a training program?

Yes No

SCHL

List anyone living with you who is a student or in a training program.

First name	Initial	Name of school	Expected completion date	Status
				<input type="checkbox"/> full-time <input type="checkbox"/> half-time <input type="checkbox"/> less than half-time
				<input type="checkbox"/> full-time <input type="checkbox"/> half-time <input type="checkbox"/> less than half-time
				<input type="checkbox"/> full-time <input type="checkbox"/> half-time <input type="checkbox"/> less than half-time

You do not have to answer this question if you are applying for food stamps only.


Yes No

ALIA

4. Is anyone known by any other name, such as a maiden name or alias?


If anyone in your household has ever been known by another name, list the other name. (Example: You used to get benefits under your maiden name. In this example, you would need to list your current name and your maiden name.)

First name	Current name	Last name	First name	Other name	Last
	Initial			Initial	

 5. Does anyone have a physical, mental, or emotional condition that limits activities such as working, going to school, or taking care of the children? Yes No DISA

You only need to give a general description of the condition, for example, mental health, arthritis, back problems, or drug addiction. The food stamp office may ask you for a doctor's note to explain the condition.

First name	Initial	Caused by an accident?	Applied for SSI/AABD?	Condition
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

 6. Is anyone living with you who is a parent to your minor child? Yes No PARE
Do not list your husband, wife, or civil union partner.


The food stamp office wants to know if there is someone living in your house who is the parent to your child/children under 18 and is not your husband, wife, or civil union partner.

First name	Initial	Name of child	Name of child

 7. Did anyone leave a job in the last 60 days or go on strike? Yes No QUIT

The food stamp office wants to know if anyone you live with left a job or went on strike in the last 2 months. Give the reason for leaving, such as laid off, seasonal work, etc.

First name	Initial	Reason for leaving	Date left

 8. Does anyone live with you who does not share your food? Yes No EATS

The food stamp office wants to know if there is anyone living with you who does not buy food with you and eat meals with you. Usually, you get food stamps with the people you live with if you buy food and make meals together. If you live with other people but do not share food, you may be able to get separate food stamps.

First name	Initial	Last	First name	Initial	Last	First name	Initial	Last

Answer question 9 only if you are applying for the Essential Person program.

You do not have to answer this question if you are applying for food stamps only. Yes No

9. Does anyone live with you to provide care so you can live at home? Yes No ESSP
Do not list your husband, wife, or civil union partner.

This question asks if there is anyone living with you who cares for you so that you can live at home. For example, a hired person or a relative (someone other than your spouse or civil union partner).

First name	Initial	Last name	Kind of care	Is this paid for by another agency?
				<input type="checkbox"/> Yes <input type="checkbox"/> No

 10. Is anyone pregnant? Yes No PREG

List the name of anyone living with you who is pregnant. If someone in your household is pregnant, the food stamp office may ask for a doctor's note.

First name	Initial	What is the expected due date?	Does this prevent her from working?
			<input type="checkbox"/> Yes <input type="checkbox"/> No

You do not have to answer this question if you are applying for food stamps only.

Yes No ABSP

11. Are there children in your home who do not have both parents living with them?

This question asks if there are children living with you who are not living with both parents. If there are children living with you without one or both parents, write the name of the parent(s) who is not living in the home.

1.	Absent parent's full name and address	Social security number (optional)	Date of birth	Children of absent parent
			/ /	1
Your relationship to absent parent		Absent parent's current marital status		2
<input type="checkbox"/> Married <input type="checkbox"/> Civil Union <input type="checkbox"/> Dissolved civil union		<input type="checkbox"/> Married <input type="checkbox"/> Civil Union <input type="checkbox"/> Dissolved civil union		3
<input type="checkbox"/> Never married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		<input type="checkbox"/> Never married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		4
2.	Absent parent's full name and address	Social security number (optional)	Date of birth	Children of absent parent
			/ /	1
Your relationship to absent parent		Absent parent's current marital status		2
<input type="checkbox"/> Married <input type="checkbox"/> Civil Union <input type="checkbox"/> Dissolved civil union		<input type="checkbox"/> Married <input type="checkbox"/> Civil Union <input type="checkbox"/> Dissolved civil union		3
<input type="checkbox"/> Never married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		<input type="checkbox"/> Never married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		4

12. If there are two parents who are able to work, please list the parent who is most likely to meet a work requirement? _____

You do not have to answer this question if you are applying for food stamps only.

Yes No MEDI

12. Is anyone who is applying covered by Medicare?

This question asks if you or anyone applying with you has Medicare.

First name	Initial	Medicare claim number	Premium amount	Date hospital coverage, Part A, began	Date medical coverage, Part B, began	Medicare drug discount card?
			\$ per month			<input type="checkbox"/> Yes <input type="checkbox"/> No

You do not have to answer this question if you are applying for food stamps only.

13. Does anyone have health or dental insurance, such as group insurance, veteran's or military benefits?

Yes No

INSU

Do not include Medicare or DCF health care programs.

List anyone in your household who has health or dental insurance other than Medicare, Medicaid, Dr. Dynasaur, VHAP, VScript, or Healthy Vermonters.

1.	Name of policy holder		Type of coverage (check all that apply)	Names of people covered	Name, address, and phone number of insurance company
	Policy number	Group number			
	Premium amount	Date coverage began			
\$ per			<input type="checkbox"/> Doctors <input type="checkbox"/> Prescriptions* <input type="checkbox"/> Hospitals <input type="checkbox"/> Major Medical <input type="checkbox"/> Dental <input type="checkbox"/> Outpatient <input type="checkbox"/> Other _____		

* Does your prescription coverage have an annual limit? Yes No

You do not have to answer this question if you are applying for food stamps only.

Yes No

14a. Has health insurance ended for anyone in the past 12 months?

List anyone in your household who used to have health insurance but **does not** anymore, and give the reason the insurance ended. For example, health insurance may end when someone loses a job or gets divorced.

First name	Initial	Date ended	Reason

You do not have to answer this question if you are applying for food stamps only.

Yes No

14b. Does anyone have unpaid medical or dental bills from the past 3 months?

If yes, Medicaid may be able to help you pay them.

List anyone in your household who has medical or dental bills from the past 3 months that have not been paid. The next question asks about unpaid medical bills that are older than 3 months.

First name	Initial	First name	Initial	First name	Initial

You do not have to answer this question if you are applying for food stamps only.

Yes No


14c. Does anyone have unpaid medical bills older than 3 months?

If yes, we may be able to use them to help you qualify for Medicaid.

List any unpaid medical bills that you or anyone who lives with you has had for more than 3 months. For example, chiropractor visits, dental surgery, or doctor or hospital visits.

First name	Initial	First name	Initial	First name	Initial

Questions 15 – 18 are about your household’s resources. Resources are cash, money in the bank, and some things you own. If you answer “Yes” to any of these questions, you may still be able to get food stamps, because not all resources count against you.

 14. Does anyone, including children, have cash that is not in a bank, such as at home, on hand, or held by others?


Yes No

Include accounts that are co-owned.

CASH

List anyone in your household who has cash that is **not** in the bank and how much cash they have.

First name	Initial	Amount	First name	Initial	Amount
		\$			\$

 16. Does anyone, including children, have money in a bank, credit union, or other institution?

Yes No

Include accounts that are co-owned.

BANK


For this question, the food stamp office wants to know about any money you or anyone in your household has in the bank. Include money that is in an account shared with someone else. Some of these accounts may not count as a resource, but you need to put this information on your application.

Type	Name of owner and co-owner	Name of bank, credit union, or other institution	Identifying number	Balance or value
Savings account				\$
Checking account				\$
Certificate of deposit (CD)				\$
Other _____				\$

 17. Does anyone own any vehicles? Yes No CARS

For this question, write down information about any vehicles you or anyone in your household owns. Most people can get food stamps, no matter how much their vehicle(s) is worth. Leased vehicles will not count against you.

Type of vehicle	Name of owner and co-owner	Year, make, and model	Leased?	Amount owed	For PATH use only Value
Car, truck, or van			<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Car, truck, or van			<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Car, truck, or van			<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Motorcycle or ATV				\$	\$
Snow machine or jet ski				\$	\$
Trailer or boat				\$	\$
Camper or RV				\$	\$
Other _____				\$	\$

 18. Does anyone own or jointly own land, mobile homes, buildings, or other real estate? Yes No PROP
Do not list the home you live in.


If you answer yes to this question, you may still be able to get food stamps. The food stamp office does not count things like farmland or property you are trying to sell, but you should still list these in your answer.

Name of owner and co-owner, if any	Type of property	Location	Assessed value	Amount owed
			\$	\$
			\$	\$

 19. Does anyone, including children, own any other resources? (includes resources owned by children) Yes No STOK


This question asks if anyone in your household has life insurance, stocks, bonds, etc. If you answer yes, you may still be able to get food stamps, depending on the type of fund and how much it is worth.

Type of Resource	Name of owner and co-owner, if any	Value
Life insurance <input type="checkbox"/> term <input type="checkbox"/> whole		Face value \$ Cash value \$
Account set up for burial expenses Is this irrevocable? <input type="checkbox"/> Yes <input type="checkbox"/> No		\$
Burial Plot		
Promissory notes		\$
Other _____		\$

 20. Has anyone sold, traded, or given away anything of value in the last two years? Yes No TRAN
If you are applying only for food stamps, list only those in the last three months.

List the name of anyone who sold, traded, or gave away anything: what it was, when, and the sale price or how much the item is worth. If you are only applying for food stamps, answer this question for the last 3 months. If you are applying for other programs, answer this question for the last 2 years. A household cannot give things away in order to get food stamps, but can give things away for other reasons or sell things for a fair price.

First name	Initial	Type of resource	Date transferred	Sale price or value
				\$

 21. Does anyone, including children, have income from a job or training program? Yes No

List income before any deductions, such as taxes, insurance, child support, or union dues. *If income has ended in the last month, or you expect it to change in the next month, please attach a note explaining the change.*

JINC

This question is about your household's income. When you meet with the food stamp office, bring pay stubs for anyone who has income from a job or training program. If anyone just got a job or lost a job or might start a job in the next month, let the food stamp office know. You can explain on another piece of paper.

First name	Initial	Date paid	Hours worked	Income before taxes	Tips and commissions
				\$	\$
How often paid?				\$	\$
<input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Every two weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____				\$	\$
Name and phone number of employer				\$	\$
				\$	\$

If anyone else has this kind of income, please list it on a separate sheet.

You do not have to answer this question if you are applying for food stamps only.

22. Does anyone get food, housing, clothing, or anything else instead of or in addition to being paid for work? Yes No INKD

This question is asking if anyone gets food, a place to live, clothes, or anything else through their job.

First name	Initial	Item received	Value
			\$ per


 23. Does anyone get paid for taking care of children? Yes No

List income before deductions and list the number of meals you provide each month that you are not paid for.

DCIN

This question asks if anyone gets paid for taking care of children. Include licensed childcare providers as well as people who get paid for watching kids on a casual basis.

First name	Initial	Income before deductions	Breakfast	Lunch	Dinner	Snacks
		\$ per				


 24. Does anyone get payment for room or meals? Yes No

Include payments from children.

RBIN

This question asks if anyone gets paid for renting out a room or cooking meals. If anyone gets paid for providing foster care, include that here. If you answer yes, write the name of the person who gets paid, the payment amount, the names of the people who pay, and what they pay for (for example, room, 1-2 meals a day, or 3 meals a day, etc.). This question is different from question #34, which asks if anyone in the household pays for their room or meals.

First name	Initial	Payment	Names of people paying	Check all that apply
		\$ per		<input type="checkbox"/> room <input type="checkbox"/> 1-2 meals per day <input type="checkbox"/> 3 meals per day

-  25. Does anyone have income from self-employment, such as farming, home party sales, logging, or property rental? Yes No

If yes, provide your most recent federal tax forms, including forms and schedules.

BUSI

This is a question about your household's income from self-employment. The food stamp office needs your federal tax forms in order to figure out your past income and estimate your future income. Let the food stamp office know if your most recent federal tax forms are different from your current situation.


First name	Initial	Type of business	Annual income before deductions	Annual expenses Do not include depreciation	Depreciation
			\$	\$	\$
			\$	\$	\$

-  26. Does anyone have income from work study, a student grant, or loan? Yes No

STIN

If anyone in your household is a student, list any financial aid from work-study, grants, or loans.

First name	Initial	Grant or loan amount	Tuition and fees amount	Period covered month/year to month/year
		\$	\$	

-  27. Does anyone have unearned income? Some examples are: Yes No

Social Security unemployment compensation pensions or retirement dividends or interest
SSI/AABD worker's compensation trusts or annuities refugee stipend
child support veteran's compensation money from others insurance settlement

List income before any deductions, such as Medicare premiums, taxes, insurance, child support, or union dues.

UNEA

This question asks if anyone in your household gets income from somewhere other than a job. If you answer yes, bring proof of this income with you when you meet with the food stamp worker.

First name	Initial	Income before deductions	Type of income	Due to disability?
		\$ per		<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$ per		<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$ per		<input type="checkbox"/> Yes <input type="checkbox"/> No

-  28. Does anyone pay child support or alimony? Yes No

DCEX

Write the name of anyone in your household who pays child support or alimony, how much they pay, and the name of the child who gets support. Write the actual amount paid if different from the court ordered amount.

First name	Initial	Alimony paid	Child support paid	Children for whom support is paid
		\$ per	\$ per	

-  28a. Does anyone pay for day care? Yes No

This question is about how much money your household pays for day care. Day care can be for children or adults. Write down how much your household pays. If the amount your household pays changes every week or month, use another piece of paper to explain.

First name	Initial	Amount	Names of children or adults in day care	Reason
		\$ per		<input type="checkbox"/> working <input type="checkbox"/> looking for work <input type="checkbox"/> going to school

 29. Does anyone 60 or older or with a disability pay for medical expenses not covered by insurance? Some examples are:


Yes No

pain relievers antacids insurance premiums hearing aid batteries
 eyeglasses dental care copayments vitamins

FMED

This question asks if anyone in your household who is 60 or over or has a disability pays for medical costs not covered by insurance. Medical costs are the things listed under the question and also over-the-counter medications, medical supplies, dentures, prescriptions, or a home health aid (nurse). If you or someone in your household pays for these items, you may be able to get more food stamps every month.

First name	Initial	Product or service needed	How often	Average monthly cost
				\$
				\$

 29a. Does anyone 60 or older or with a disability pay for trips to medical services? drug stores doctor's office hospital

Yes No

If you or someone in your household who is 60 or older or has a disability pays for trips to the doctor's office, drug store, hospital, or other medical services, you may be able to get more food stamps each month. Paying for trips means buying gas for a car ride, buying a bus ticket, or paying for a taxi or a friend to drive you. If you have to pay to stay overnight, be sure to tell the food stamp office about that, too.

First name	Initial	Type and location of provider	How often do you make these trips?


If you rent only a room, answer "No" to questions 30-32a

 30. Does anyone pay rent for the home you live in?

Yes No RENT

List anyone in the household who pays rent for the home you live in. If you pay rent to live in a room in a house, check "No."

First name	Initial	Amount and how often	What's included?	Type of housing
		\$ per	<input type="checkbox"/> heat <input type="checkbox"/> utilities	Public housing? <input type="checkbox"/> Yes <input type="checkbox"/> No Subsidized housing? <input type="checkbox"/> Yes <input type="checkbox"/> No

 31. Does anyone pay a mortgage payment, property taxes, lot rent, home equity loan, condo fees, or other costs for the home you live in?

Yes No

List each separately

HOME

List anyone in the household who pays any of the above costs for the home you live in.


First name	Initial	Type of payment	Amount and how often	Date due
		Mortgage	\$ per This amount includes taxes <input type="checkbox"/> insurance <input type="checkbox"/>	
			\$ per	

 32. Does anyone pay for fuel or utilities?

Yes No UTIL

List the people in your household who pay for fuel or utilities. If your household gets fuel assistance, be sure to tell the food stamp office, because you can get more food stamps each month.


First name	Initial	Check all that apply			
		<input type="checkbox"/> heat	<input type="checkbox"/> hot water	<input type="checkbox"/> cooking	<input type="checkbox"/> lights

 32a. Do you share any housing expenses?

Yes No

List anyone with whom you share housing expenses. (Example: Your roommate pays the electric bill and you pay the rent.) Housing expenses are fuel, utilities, telephone, insurance, rent, etc.

Names of people who share expenses with you	Shared expenses

 33. Does anyone pay for phone, garbage removal, water, sewer, homeowners insurance, or other household expenses?

Yes No PHON

This is another question about your housing costs. Check off the things anyone in your household pays for. If someone pays for homeowner's insurance, write down how much. The food stamp office does not need to know how much you pay for the other things listed under the question.

First name	Initial	Check all that apply
		<input type="checkbox"/> phone <input type="checkbox"/> homeowner's insurance \$ _____ per _____

 34. Does anyone pay for room or meals?

Yes No RBEX

List anyone in your household who pays for their room or meals, how much and how often they pay, and what they pay for.

First name	Initial	Amount and how often	Check all that apply
		\$ _____ per _____	<input type="checkbox"/> room <input type="checkbox"/> 1-2 meals <input type="checkbox"/> 3 or more meals

To get the most Food Stamp benefits, report all expenses asked for in this application. Deductions for these expenses are only applied after they are reported. Expenses can be reported anytime to get these deductions for future benefits.

The applicant is responsible for the accuracy of information given to ESD, including information about the applicant's husband, wife, or civil union partner.

Make all the information you have provided on the application is accurate before you sign below.

I have provided and reviewed the information on this application. I give my word, under penalty of perjury, that it is correct and complete to the best of my knowledge and belief.

Signature of applicant _____ Date _____

Signature of person helping fill out this form _____ Date _____

Other Information and Referrals

Racial and Ethnic Heritage

If you are willing, please answer the following regarding the racial and ethnic heritage of your head of household. You do not have to give this information. It is not required to determine eligibility for any program or the amount of assistance you get. This information is collected only to be sure everyone gets benefits on a fair basis.

Ethnicity (check one)

Hispanic or Latino

Not Hispanic or Latino

Race (check all that apply)

American Indian or Alaska Native

Asian

Black or African American

Native Hawaiian or other Pacific Islander

White

Children who are members of federally designated American Indian or Alaska Native tribes may not have to pay a Dr. Dynasaur program fee. Call 1-800-250-8427 for more information.

Voter Registration

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

Yes No

If you do not check either box, you will be considered to have decided not to register at this time.

Applying to register or declining to register to vote will not affect your eligibility for benefits or the amount of assistance that PATH will provide you.

If you want help filling out the voter registration application, we will help you. The decision to seek or accept help is yours. You may fill out the application form in private.

If you believe that someone has interfered with your right to register or decline to register to vote, you may file a complaint with the Secretary of State's Office at Redstone Building, 26 Terrace Street, Drawer 09, Montpelier, VT 05609-1101 (telephone 1-802-828-2363).

Referrals to other programs

Lifeline - A monthly credit on your home phone bill. **Link Up** - A payment for part of the installation cost of a new phone. You can get these credits if you are an adult recipient of PATH benefits. The phone must be listed in your name or you must pay part of the bill. We need a copy of your bill. *Call your telephone company for more information.*

If you are not receiving a Lifeline credit now, would you like to?

Yes No

Would you like an application for Link Up?

Yes No

Fuel Assistance - Help paying heating bills. Applications are accepted July 15 through the last day of February. Your local PATH office can give you an application during this time; otherwise you can ask the *Office of Home Heating Fuel Assistance (OHHFA)* to mail you an application in June. *Call OHHFA at 1-800-479-6151 for more information or an application.*

Would you like a brochure about fuel assistance?

Yes No

Weatherization - Help with insulating, caulking, or weatherstripping your home or apartment to lower your heating costs. *Call toll free 1-877-919-2299 for more information about weatherization.*

Would you like a brochure about weatherization services?

Yes No

WIC (Women, Infants and Children Program) - Health screening, nutrition education, and food for pregnant women, nursing women, and children under five. *Call your local health department office for more information about WIC.*

If you are not already receiving WIC, would you like to?

Yes No

Individual Development Account (IDA) - Learn about finances and save money for education, purchasing a home, or developing a small business. Your money in an IDA is matched by state money dollar for dollar up to an annual and lifetime limit. *Call your local Community Action Agency for more information.*

Would you like a brochure about IDAs?

Yes No

Reach Up Assessment

Only answer the following questions if you are applying for Reach Up.

Name _____ Social security number _____

Does anyone have specialized training, a trade license, a certificate, or a degree, such as hairdresser, Licensed Nurse Associate, law enforcement officer, plumber? Yes No

First name	Initial	List training, license, certificate, or degree	Date received

Does anyone have difficulty with transportation? Yes No

First name	Initial	Check all that apply
		<input type="checkbox"/> no valid license <input type="checkbox"/> no vehicle <input type="checkbox"/> vehicle not registered or insured <input type="checkbox"/> vehicle not reliable <input type="checkbox"/> other _____

Have you or your partner, husband, wife, or civil union partner worked in the past 5 years? Yes No

List each job for each person separately, including self-employment.

Names of people who have worked	Job title or type of work	Employer	Start date	End date	Approximate monthly earnings
					\$
					\$
					\$
					\$
					\$
					\$

Are you or your partner, husband, wife, or civil union partner ready to go to work now? Yes No

Names of people ready to go to work	Names of people not ready to go to work and reasons



Take this page with you.
It has information that may be helpful,
and it is your copy of your Rights and Responsibilities.

You must report changes

Reporting requirements for food stamps

If the only benefit I get is food stamps, I must report:

- my household expenses when I am determined eligible for food stamps and when my case is reviewed. If I don't, I lose the right to a deduction of these expenses during this period.
- when my household income in a calendar month reaches 130% of the federal poverty level for my household size. Your worker can tell you this amount. I must report this no later than 10 days after the end of the month it happens.
- when the status of an able-bodied adult without dependents (ABAWD) in my household changes. Some examples are:
 - loses a job
 - reduces hours of work
 - becomes exempt

Reporting requirements for other programs

If I get health care, Reach Up, or PSE benefits, I must report when someone in my household:

- has an increase or decrease in the number of regularly scheduled hours of work;
- gets a job or stops working;
- has a change in the amount of money coming into the household, including winnings;
- moves in, moves out, gets married, becomes pregnant, or has a baby;
- is given money, land, a car, or other property; or
- gets or changes private health insurance, including prescription coverage.

See the Agreement to Report Change for exactly what you must report. You may report changes to your local PATH office in person, by telephone, by writing, or by sending a Change Report form. If you have any questions about what changes you must report, ask your worker.

Contact information

1-800-287-0589
www.path.state.vt.us

People with a hearing impairment can call the statewide relay service at
1-800-253-0191 (TDD) or 1-800-253-0195 (voice)

If you do not speak English, we can provide free translation for our services.
Please tell us if you need an interpreter for any language.

St. Albans

20 Houghton Street
Room 313
St. Albans, VT 05478
Tel: (802)524-7900
Tel: 1-800-660-4513

Burlington

1193 North Avenue, Suite 5
Burlington, VT 05401-2749
Tel: (802) 863-7365
Tel: 1-800-775-0506

White River Junction

224 Holiday Dr., Suite A
White River Jct., VT 05001-2097
Tel: (802)295-8855
Tel: (802)1-800-775-0507

St. Johnsbury

67 Eastern Avenue, Suite 7
St. Johnsbury, VT 05819
Tel: (802)748-5193
Tel: 1-800-775-0514

Brattleboro

232 Main Street
P.O. Box 70
Brattleboro, VT 05302
Tel: (802)257-2820
Tel: 1-800-775-0515

Barre

5 Perry Street, Suite 150
Barre, VT 05641-4270
Tel: (802) 479-1041
Tel: 1-800-499-0113

Newport

100 Main Street, Suite 240
Newport, VT 05855
Tel: (802) 334-6504
Tel: 1-800-775-0526

Rutland

320 Asa Bloomer Building State
Office Building
Rutland, VT 05701
Tel: (802) 786-5800
Tel: 1-800-775-0516

Springfield

100 Mineral Street, Suite 201
Springfield, VT 05156
Tel: (802) 885-8856
Tel: 1-800-589-5775

Bennington

200 Veterans Memorial Drive
Suite 6
Bennington, VT 05201-1918
Tel: (802) 442-8541
Tel: 1-800-775-0527

Morrisville

63 Professional Drive
Morrisville, VT 05661
Tel: (802) 888-4291
Tel: 1-800-775-0525

Middlebury

700 Exchange Street, Suite 103
Middlebury, VT 05753-9943
Tel: (802) 388-3146
Tel: 1-800-244-2035

Rights and Responsibilities

You may request a copy of this page in larger print.

True and Complete information. I understand the information I provide to DCF to apply for assistance will be subject to verification by federal and state officials to determine if it is correct. This means that sources other than members of my household may be contacted to verify my eligibility for assistance. I understand that if any information is not true, DCF may deny assistance to me.

Reporting changes. I understand when I get assistance, I must report changes in my situation. The changes I must report may be different depending on the benefits I get. If I am not sure which changes I must report, I will ask my worker. I understand changes may affect the amount of benefits I get. I also understand I must report changes within 10 days from when they happen.

Social security number. I understand that, when I apply for assistance from DCF, I must give the social security number of everyone in my household who wants assistance. Federal law requires this as a condition of eligibility. If I am a member of a religious organization that objects to furnishing a social security number, DCF may disregard this requirement. (42 U.S.C. §1320b-7)

DCF uses the social security number: 1) for computer processing of program benefits, support enforcement, fraud investigation, audits, and Lifeline identification; 2) to verify social security and supplemental security income; 3) to prevent individuals from receiving duplicate benefits; 4) to identify groups of cases that must have benefits changed; 5) to exchange information with agencies such as the Social Security Administration, Department of Employment and Training, Internal Revenue Service, or private claims collection agencies to verify income, determine eligibility and benefit amounts, and collect claims; 6) to determine the accuracy and reliability of information given to DCF; and 7) to make medical assistance payments.

No Discrimination. Federal and state law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, prohibit DCF from discriminating based on race, color, national origin, sex, age, or disability. The Food Stamp Act, USDA policy, and state law also prohibit DCF from discriminating based on religion or political beliefs.

To file a discrimination complaint, 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, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). USDA and HHS are equal opportunity providers and employers. Under Vermont law and rules, DCF may not discriminate based on marital status, sexual orientation or place of birth. To file a discrimination complaint, write: Deputy Commissioner, Department for Children and Families, Economic Services Division, 103 S. Main St., Waterbury, VT, 05671.

Decision on application. DCF must make a decision on my application within 30 days (or 90 days if my Medicaid application is based on disability) unless delay is caused by examining physicians, an administrative emergency, or me. If I do not get a decision within 30 (or 90) days, I may call the DCF office or request a fair hearing.

Fair hearing. I may ask for a fair hearing when my claim for assistance, benefits, or services is denied in whole or in part, or not responded to with reasonable promptness by contacting a DCF office or writing to the DCF Deputy Commissioner. (3 V.S.A. §3091)

Quality control review. DCF may select my application for a quality control review. If so, I agree to give proof of required information. If I am unable to give the proof needed, I authorize DCF to get it.

Release of tax records. I give permission to the Vermont commissioner of taxes to disclose information from my state income tax returns to the commissioner of DCF. (33 V.S.A. §112 (c))

Release of medical records. I agree that my health care providers may release my medical records when necessary for the purpose of administering DCF health care or Reach Up programs.

Assignment of medical support. As a condition of eligibility for health care assistance, I agree to assign to DCF or its designee all rights to medical support and to third party payments (such as insurance) for medical care. I agree to

enroll in a group health plan if DCF requires me to, and I understand DCF could pay the premiums. I also agree to cooperate in pursuing any actual or potential source of support or payments, including establishing paternity for my dependent children, if necessary. I understand that if I do not cooperate, my benefits will end.

Recovery of Medicaid payments. DCF must file a claim against my estate when I die to recover Medicaid payments made for me for services I received at age 55 or older while in a nursing facility or a home-and- community-based waiver program, and for related hospital and prescription drug services. DCF will not seek adjustment or recovery against my estate if, at the time of death, my spouse is still alive, I have surviving children who are blind, disabled, or under age 21, or DCF determines that adjustment or recovery would cause undue hardship. I understand I may find out more about recovery from my worker. (42 U.S.C. §1396p)

Medicare part B payments. If I get Medicare part B benefits while getting Medicaid, I want DCF to make any payments for future Medicare part B medical and other health services directly to physicians and medical suppliers. This means I will not have to sign a separate form each time I get a service.

Assignment of support rights. As a condition of eligibility for public assistance, I agree to assign all my rights to support to DCF. I understand this includes all current support owed to me while I get public assistance; all arrears owed to me that are collected during this assignment, and all arrears collected through federal tax offset during or after this assignment, up to the total amount I get or have ever gotten. The noncustodial parent (NCP) will owe me amounts over the total amount of public assistance. Arrears include, but are not limited to, unpaid support obligations, debts, and court-ordered and administrative judgments. While I am on assistance, I understand the NCP will pay all support directly to the Office of Child Support (OCS). While I am waiting for DCF to grant me assistance, I will tell DCF of any support the NCP pays directly to me. After I have been granted assistance, I will immediately turn over to OCS any support the NCP pays me directly.

Take part in Reach Up activities. I understand that I and members of my household may have to participate in certain Reach Up activities and that my worker will tell us what we have to do and what the penalty is if we do not.

Not fleeing prosecution. I certify that neither I nor any member of my household is fleeing prosecution or confinement for a felony or an attempt to commit a felony, or is violating a condition of probation or parole under a federal or state law. I understand DCF must disclose information to law enforcement agencies to apprehend fleeing felons.

No benefits from another state. If any member of my household gets duplicate Food Stamp benefits, Medicaid, or cash assistance from another state or has been convicted in the past ten years of fraudulently misrepresenting residence to get benefits from two or more states, I must tell DCF immediately.

Fraud penalties. I or any member of my household will be subject to prosecution for fraud or some other criminal offense for knowingly giving false, incorrect, incomplete, or misleading information in order to get, try to get, or help someone else get Reach Up, Food Stamp, or health care benefits. If convicted, penalties may include up to three years of imprisonment and/or a fine of up to \$1,000, or an amount equal to the benefits wrongfully received. Federal and other state penalties may also apply. (42 U.S.C. §§1320a-7, 1320a-7a, 1320a-7b, 1396a, 1396r-6; 33 V.S.A. §§141, 143)

Food Stamp fraud penalties. I or any household member cannot trade or sell Food Stamp benefits, use them to buy ineligible items such as alcohol or tobacco, or use someone else's food stamps. If convicted, the member may be barred from the Food Stamp program for one year for the first offense, two years for the second offense, or permanently for the third offense, and be fined up to \$250,000, imprisoned up to 20 years, or both. If convicted of buying or selling illegal drugs in exchange for food stamps, a member may be barred for two years or barred permanently for a second offense. If convicted of purchasing firearms, explosives, or ammunition with food stamps or of trafficking in Food Stamp benefits of \$500 or more, a member may be barred permanently. If convicted of falsely representing identity or residence, a member may be barred for 10 years and may be prosecuted under other federal and state laws. (7 C.F.R. §273.16(b).)