



WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

APPLICATION FOR BENEFITS

The application will be considered if it contains a minimum name, address, and signature below. The amount of Supplemental Nutrition Assistance Program (SNAP) benefits will be determined from the date of application. The amount of cash assistance will be determined from the date eligibility requirements are met, including signing the Personal Responsibility Contract (PRC), Self-Sufficiency Plan (SSP), and participating in orientation.

<b>Your Name (first, middle, last)</b>		<b>Birth Date (month, day, year)</b>	
<b>Mailing Address</b>		<b>Street Address (If different from mailing address)</b>	
<b>City</b>	<b>State</b>	<b>Zip Code</b>	<b>Telephone/Message Number During the Day</b>
<b>HEALTH COVERAGE ONLY</b>			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you want to get information about this application by email?	
Email address: _____		County: _____	
<b>Health Care and SNAP: Preferred spoken or written language (if not English):</b>			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had a Presumptive Eligibility Period in the last 12 months?	
If yes, what is your temporary MAID Number (can be found on your card): _____			
<b>AUTHORIZED REPRESENTATIVE/LEGAL GUARDIAN/PROTECTIVE PAYEE (HEALTH COVERAGE, SNAP, WV WORKS)</b>			
You may appoint someone outside your household to act for your household to make an application and to be interviewed. This person should know your household's situation well enough to give any information needed to determine your eligibility and will include information from your tax returns. You are still responsible for the information that anyone acting as your authorized representative gives, including any information that may be incorrect. If you want to appoint someone for this, write his/her name and address here. For health coverage only, complete Appendix C.			
Name: _____		Address: _____	
<b>SNAP EXPEDITED SERVICES</b>			
<b>You may receive SNAP benefits within 7 calendar days if your SNAP household has less than \$150 in monthly gross income and liquid resources such as cash, checking or savings accounts are less than or equal to \$100; or your rent/mortgage and utilities are more than your household's combined monthly income and liquid resources; or a member of your household is a migrant or seasonal farm worker.</b>			
1. How much money do the members of your household have in cash or a bank account?		\$ _____	
2. What is the <b>total</b> amount of income you expect your household to receive this month?		\$ _____	
3. What is your <b>current</b> monthly rent/mortgage payment? \$ _____		Utilities \$ _____	
4. Is anyone in your household a migrant or seasonal farm worker? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If <b>yes</b> , answer these questions: Did all of your household income stop recently? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Does anyone in your household expect to receive income from a new source this month? <input type="checkbox"/> Yes How: _____ <input type="checkbox"/> No			
Have you or anyone in your household received or do you expect to receive SNAP benefits from any other state this month?			
<input type="checkbox"/> Yes Where: _____		<input type="checkbox"/> No	
<b>Your Signature</b>			<b>Date</b>

HEALTH COVERAGE		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is anyone listed on this application incarcerated, detained or jailed? If yes, who?

HEALTH COVERAGE			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	1.	Is anyone enrolled in health coverage now from the following: If <b>yes</b> , check the type of coverage and write the person(s) name(s) next to the coverage they have.
			<input type="checkbox"/> Medicaid: _____ <input type="checkbox"/> Employer Insurance: _____ <input type="checkbox"/> CHIP: _____ <input type="checkbox"/> Name of Health Insurance: _____ <input type="checkbox"/> Medicare: _____ <input type="checkbox"/> Policy Number: _____ <input type="checkbox"/> TRICARE (don't check if you have direct care or Line of Duty): _____ Is this COBRA coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Is this a retiree health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> VA Health Care Programs: _____ <input type="checkbox"/> Other: Name of Health Insurance: _____ Policy Number: _____ Is this a limited-benefit plan (like a school accident policy)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Peace Corps: _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	2.	Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone's else's job, such as a parent or spouse. If <b>yes</b> , you'll need to complete and include Appendix A. Is this a state employee benefit plan? <input type="checkbox"/> Yes <input type="checkbox"/> No

If you want to register to vote, you can complete a voter registration form at [www.sos.wv.gov](http://www.sos.wv.gov).

USDA NONDISCRIMINATION STATEMENT	
<p>In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.</p> <p>Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.) should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.</p> <p>To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at <a href="http://www.ascr.usda.gov/complaint_filing_cust.html">http://www.ascr.usda.gov/complaint_filing_cust.html</a>, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:</p> <ol style="list-style-type: none"> <li>1) Mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, S.W. Washington, D.C. 20250-9410</li> <li>2) Fax: (202) 690-7442; or</li> <li>3) Email: <a href="mailto:program.intake@usda.gov">program.intake@usda.gov</a></li> </ol> <p>USDA is an equal opportunity provider.</p>	

**IMPORTANT INFORMATION ABOUT SNAP**

I understand that DHHR will obtain income and eligibility information from the Systematic Alien Verification and Eligibility (SAVE) System, and U.S. Citizenship and Immigration Services (USCIS) about each member of my group. This information will be obtained by the use of the SSN of each applicant/recipient.

I understand if an individual:

- a. Is found guilty in a federal, state, or local court of trading SNAP benefits for firearms, ammunition, explosives, or controlled substances; is a convicted felon, for possession, use or distribution of a controlled substance(s); or is found guilty of trafficking \$500 or more in SNAP benefits, the guilty party will be permanently disqualified from participating in the SNAP Program.
- b. Makes a false statement or misrepresentation of identity and/or residence or receives duplicate benefits at the same time, the responsible party will be disqualified from the SNAP program for 10 years.
- c. Is found guilty of using or receiving benefits in a transaction involving the sale of a controlled substance, the guilty party will not be eligible for benefits for two years for the first offense and permanently for the second offense.

I understand if any member of my assistance group is found (by court action or an administrative disqualification hearing) to have committed an act of intentional program violation, including trafficking, the individual will not receive SNAP benefits as follows: First Offense – one year; Second Offense – two years; Third Offense – permanently. In addition, I understand my assistance group will have to repay any benefits received for which it was not eligible.

I also understand that any person who obtains benefits from the DHHR by means of a willfully false statement, impersonation, misrepresentation, or any other fraudulent device can be charged with fraud. Upon a conviction, punishment may be a fine up to \$5,000 and/or sentence of 5 years in jail. Federal penalties may include a maximum fine of \$250,000 and a jail sentence of up to 20 years.

I certify by signing my name below, under penalty of perjury, that I have correctly listed the citizenship or alien status of the individuals applying for benefits on this application. This declaration of United States Citizenship or alien in lawful immigration status is a condition of eligibility for WV WORKS, Health Coverage, and SNAP. Any household member for whom citizenship is not declared is not eligible to receive benefits. However, their income and assets will be considered available to the remaining members of the household.

I understand that it is a criminal violation of federal and state law to provide false or misleading information for the purpose of receiving benefits to which I am not entitled. I understand it is my responsibility to provide complete and truthful information.

For questions or information regarding the SNAP program, you may call the State Information/Hotline Number at (800) 642-8589.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Co-Applicant's Signature  
(WV WORKS only)

\_\_\_\_\_  
Date