pennsylvania
DEPARTMENT OF HUMAN SERVICES

Application for Benefits

Provider Instructions:

Before completing this application, access the Eligibility Verification System (EVS) using the individual's date of birth and Social Security number to determine if the individual is already receiving Medical Assistance (MA) benefits. If the individual is not receiving MA benefits, the Department of Human Services (DHS) encourages medical facilities to take applications so that the facility will not bear expenses for medical care for which public funds are available. Delays in applications can mean delays in payments for medical services or total denial of payment. The following forms are needed to apply for MA:

• PA 600 - Application for Benefits, including the Provider Addendum
• MA 314 - Eligibility Determination Form (for inpatient care only)

If the PA 600 (including the Provider Addendum, when needed) contains the necessary information and verification, the County Assistance Office (CAO) can determine eligibility for MA and authorize either partial or full payment for medical services. If the PA 600 and Provider Addendum are not complete, the CAO may require more information from the individual to complete the application process. This may delay payment or result in a denial of the application.

When there is a pregnant woman or child under the age of 21 in the household, the shorter application form, PA 600 HC - Application for Health Care Coverage, may be used.

Complete the application for MA benefits as follows:

1. Remove this page and complete the Provider Addendum on the reverse side.
2. Complete the "MEDICAL PROVIDER USE ONLY" section of the PA 600 Application for Benefits on page v. Give the remaining booklet to the applicant for completion of all information.
3. After the applicant has completed the booklet, review for completeness and have the applicant sign the affidavit on page 15.
4. The applicant's signature must be witnessed by the provider or the provider's employee.
5. Complete and attach the reverse of this page to the back of this booklet.

Who May Apply:

Anyone who wishes to apply for health care coverage must be given the opportunity to do so.

- When an individual requests an application, he or she may request health care coverage for him/herself and other family members who wish to be included. The application is for all medical services covered under the MA program. For this reason, the application must contain information about the applicant and all other family members who wish to apply. In addition, the CAO may use income and resource information from other family members to determine eligibility.
- Any individual, agency, or institution may complete and/or submit an application form for health care coverage on behalf of the applicant. The applicant should, if at all possible, complete and sign the form. If someone else completes and signs the form, the applicant remains responsible for any fraudulent statements made on the application.
- If another individual signs for the applicant, enter the name and address of that person on the address line beneath the signature lines.
- An application for a deceased individual will be accepted if the person died during the month of application or during the three calendar months before the month of application. A relative, friend, or official of the institution or agency which provided the service may complete and sign the application.

When Application Should Be Made:

When an individual indicates that he/she wishes to apply for health care coverage, have the individual immediately sign and date Page 1 and complete the PA 600. After the provider's representative has reviewed the form for completeness, he/she will witness the individual's or representative's signature on page 15. If the application is approved, MA coverage begins on the date of the signature on the front of the booklet. Payment may be available for a service given prior to this date, if the service was given in the month of application or during the three calendar months before the month of application. Delay in obtaining the applicant's signature may cause the applicant to be liable for medical services that may have been covered by the MA program.

If you have any questions about the completion of the application form, call 1-800-692-7462

Retroactive Coverage:

DHS will pay for certain medical services provided up to three months before the calendar month of application if the applicant is eligible. If payment is being requested for medical services provided during this retroactive period, use the provider addendum to provide necessary information.

Verification:

Applications must have necessary verification of income, resources, medical expenses and any other information required to process the application.

PA 600 Completion Checklist

If any sections are left blank or completed inaccurately, the CAO may require additional information which could delay application processing.

The application should include:

Page 1	Name and address of applicant and signature of applicant, or someone on his/her behalf, and date.
Pages 2-12	As much information as possible for the applicant and other family members who are applying. Yes or no answers to all questions. If yes, additional information should be entered.
Affidavit (Page 15)	The date and signature of the applicant or someone on his/her behalf. The form is signed and dated by the provider or the provider's employee.

Provider Addendum

Applicant Name	Date

Third Party Liability Resources Instructions

Complete if anyone in the applicant group (including absent spouse or parent) is covered by health or accident insurance. Use a second addendum if there are more than three sources. Items are self-explanatory except for the following:

Contract/Policy/Agreement Number
Enter the number as shown on the insurance card or other document. This number is often the Social Security number or HIB number of the insured person.

Group Name/Group Number
Enter the Group Name or the Group Number and any designation number (local, shop, etc.)

Income Instructions

Complete this section if anyone in the applicant group had unpaid medical expenses during the three calendar months before the month of application and anyone in the applicant group had income during those three months.

Use a separate line for each type/source of income each person received. If the income from a particular source varied during the period covered (e.g., wages often vary from pay period to pay period), use a separate line for each amount received:

Employer/Source Enter the name of the employer or other source of income (e.g., name of union providing benefits).

Gross Amount Enter the amount earned before deductions or the actual amount received if the income is unearned.

Begin Date Enter the date the income started.

Date Received Enter the last date the income was received. If the income varies, enter each date received. If the income ended, circle the date.

Attach verification of the income, if available.

Third Party Liability Resources

INSURANCE CARRIERS, HMO, PRIMARY CARE PHYSICIAN OF FCN	CLAIM OFFICE ADDRESS (INCLUDE CITY, STATE, ZIP CODE)	CONTRACT/POLICY/ AGREEMENT NO.	GROUP NAME/ GROUP NUMBER

POLICY HOLDER NAME	POLICY HOLDER SSN	POLICY HOLDER ADDRESS (IF NOT APPLICANT)

EMPLOYER NAME	EMPLOYER ADDRESS

Income

NAME (LAST, FIRST, MI)	INCOME CODE	EMPLOYER/SOURCE	GROSS AMOUNT	FREQ CODE	BEGIN DATE	DATE REC'D

Frequency Codes:

01 ONE TIME ONLY
02 WEEKLY
03 BI-WEEKLY
04 SEMI-MONTHLY
05 MONTHLY
06 BI-MONTHLY
07 QUARTERLY
08 SEMI-ANNUALLY
09 ANNUALLY

Type of Income Codes:

01 FULL-TIME EMPLOYMENT
02 PART-TIME EMPLOYMENT
03 ROOM/BOARD OR RENT
04 SELF-EMPLOYMENT
10 UNEMPLOYMENT COMPENSATION
11 WORKER'S COMPENSATION
12 SOCIAL SECURITY RETIREMENT SURVIVORS AND DISABILITY
14 SUPPLEMENTAL SECURITY INCOME
15 VETERANS COMPENSATION
17 UNITED MINE WORKERS BENEFITS
18 BLACK LUNG
19 RAILROAD RETIREMENT
20 ADJUSTABLE PENSION (FEDERAL IRA, KEOGH, ETC.)
21 SICK BENEFITS
22 UNION BENEFITS
23 DIVIDENDS/INTEREST
24 COURT ORDERED SUPPORT
25 SUPPORT FROM RELATIVES (LRR) LIVING IN HOUSEHOLD
26 ALIMONY (SPOUSAL SUPPORT)
31 SCHOLARSHIPS, GRANTS, LOANS
32 VOLUNTARY CHILD SUPPORT
99 OTHER INCOME

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DEPARTMENT OF HUMAN SERVICES

Pennsylvania Application for Benefits

This is an application for cash, health care and the Supplemental Nutrition Assistance Program (SNAP) benefits. If you need this application in another language or someone to interpret, please contact your local county assistance office. Language assistance will be provided free of charge.

Esta es una solicitud de beneficios en efectivo, beneficios de atención médica y del Programa de Asistencia Nutricional Suplementaria (SNAP). Si necesita esta solicitud en otro idioma o un intérprete, comuníquese con la oficina de asistencia de su condado. La asistencia lingüística se proporcionará de forma gratuita.

Đây là đơn xin hưởng các khoản tiền phúc lợi, bảo hiểm y tế và Chương Trình Trợ Cấp Dinh Dưỡng Bổ Sung (SNAP). Nếu bạn cần đơn này bằng ngôn ngữ khác hay cần thông dịch viên thì vui lòng liên hệ với văn phòng hỗ trợ quận tại địa phương mình. Hỗ trợ ngôn ngữ sẽ được cung cấp miễn phí.

此为现金、医疗和补充营养援助计划 (SNAP) 福利申请表。如需其他语言版本或口头翻译，请联系当地的县援助办公室。免费获取语言协助。

В этом приложении будут содержаться данные о ваших денежных пособиях, льготах по медицинскому обслуживанию и пособиях по программе «Программа дополнительной продовольственной помощи» (SNAP). Если вы хотите переключить язык приложения или вам требуются услуги перевода, обратитесь в окружное отделение социальной помощи по месту жительства. Языковые услуги предоставляются бесплатно.

នេះគឺជាពាក្យស្នើសុំប្រាក់ ទំហែទាំសុខភាព និងអត្ថប្រយោជន៍កម្មវិធីជំនួយអាហាររួបត្តម្ភបន្ថែម (SNAP) ។ប្រសិនបើអ្នកត្រូវការជាក់ពាក្យសុំជាភាសាផ្សេង ឬត្រូវការអ្នកបកប្រែ សូមទាក់ទងការិយាល័យជំនួយខោនធីរបស់អ្នក ។ អ្នកនឹងទទួលបានជំនួយបកប្រែភាសាដោយឥតគិតថ្លៃ ។

هذا تطبيق مخصص للمستحقات النقدية، الرعاية الصحية وميزات برنامج مساعدات التغذية التكميلية (SNAP). إذا كنت تريد تصفح هذا التطبيق بلغة أخرى أو كنت تريد مترجماً فوريًا، فالرجاء الاتصال بمكتب المساعدة المحلي التابع للمقاطعة الخاصة بك، وسيتم توفير المساعدة اللغوية مجانًا.

If you have a disability and need this application in large print or another format, please call our helpline at **1-800-692-7462**.

Individuals who are deaf, hard of hearing, or have speech disabilities and wish to communicate with the helpline may call PA Relay Services by dialing **711**.

COMPASS
CLICK. APPLY. BENEFIT.

You can apply online at: **www.compass.state.pa.us**.

Family Safety: Information About Your Benefits and Domestic Violence

Domestic violence happens when someone in your life harms you. Abuse can be physical, sexual or emotional. It includes:

- Physically hurting you or your children
- Threatening or trying to hurt you, your children or your property
- Forcing you to have sex
- Sexually abusing your children
- Controlling where you go and who you see
- Not allowing you or your children to have food, clothing or medical care
- Keeping you from going to work or school
- Following or stalking you

If you are or have been a victim of domestic violence or are at risk of further violence, your caseworker can excuse you from requirements for cash assistance if domestic violence prevents you from complying. Sometimes people cannot safely follow welfare requirements because they fear that they or their children will be abused if they do so. These include:

- Support cooperation
- Time limits
- Work (RESET)
- Requirements that teen parents live at home
- Other requirements on a case-by-case basis
- Verification

If you need to be excused from welfare requirements because of domestic violence, tell your caseworker.

If you or your children are or have been victims of domestic violence, or are at risk of further violence, your caseworker can:

- **Talk** to you if you want to talk. You can ask to talk in private. Your caseworker and the staff will keep your personal information confidential. However, the law says that the Department of Human Services must report child abuse to the Children and Youth Agency.
- **Help** you find local programs where you can get **counseling, safety planning, shelter, legal services** and other help.
- **Help** you understand the rules for applying for cash assistance, and how they affect you if you apply. Certain TANF requirements may be waived based upon domestic violence.

For more information about crisis intervention, counseling, accompaniment to police, medical and court facilities, temporary emergency shelter, and prevention and education programs, call:

The Pennsylvania Coalition Against Domestic Violence
1-800-932-4632 (in PA) 303-839-1852 (National)

PA CareerLink® - Important Information

PA CareerLink® is a program of the Pennsylvania Department of Labor and Industry to help job seekers find jobs. The Labor and Industry staff knows about current labor market conditions and can give you information and resources to help your job search.

It is recommended that you register with PA CareerLink® to get started. You can register with PA CareerLink® at **www.pacareerlink.pa.gov/**.

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DEPARTMENT OF HUMAN SERVICES

Application for Benefits

Pennsylvania receives information from other state and federal agencies to verify the information you give us. If you misrepresent, hide or withhold facts which may affect your eligibility for benefits, you may be required to repay your benefits and you may be prosecuted and disqualified from receiving certain future benefits.

COMPASS
CLICK. APPLY. BENEFIT.

You can apply online at: **www.compass.state.pa.us**.

It's easy to apply!

1. **Fill** out this form.
2. **Sign and date it on page 1 and page 15.**
3. **Bring, fax** or **mail** your form to your county assistance office (CAO).

Are you interested in any other services?

Put a check in the box if you are interested in information on any of these other services:

- ☐ Supplemental Security Income (SSI)
- ☐ Intellectual disability services
- ☐ LIHEAP (energy assistance)
- ☐ Food banks
- ☐ School meals (free or reduced cost)
- ☐ Long Term Care (nursing home care)
- ☐ Well Baby Clinic
- ☐ Immunizations (shots)
- ☐ Veterans' services
- ☐ Employment and training
- ☐ Vocational rehabilitation
- ☐ Housing assistance
- ☐ Child care
- ☐ Head Start (for children ages 3 to 6)
- ☐ Child support services
- ☐ Family planning/birth control
- ☐ Lifeline (reduced cost phone service)
- ☐ WIC (Women, Infants and Children)
- ☐ Home and Community Based Services (Waiver Services)
- ☐ Special allowances for employment and training such as tools
- ☐ Other: _____

Questions?

Call your county assistance office or our CUSTOMER SERVICE CENTER at **1-877-395-8930.**
In Philadelphia, call **1-215-560-7226.**

We are here to help you. Call Monday thru Friday 8:30 a.m. to 5 p.m.
TDD Services are available by calling PA Relay Services at **711**.

Medical Providers Use Only		
PROVIDER NAME	PROVIDER NUMBER	☐ EMERGENCY

CAO Use Only					
APPLICATION REGISTRATION NUMBER	CASELOAD	COUNTY	DISTRICT	RECORD NUMBER	DATE STAMP

Quick SNAP!

Get SNAP Benefits Now!

(SNAP was formerly known as the Food Stamp program.)

- **Does your household have $100 or less in available cash and bank accounts and expect to receive less than $150 in income this month?**
- **Are you a migrant or seasonal farm worker?**
- **Are your monthly gross income and cash and bank accounts less than your rent/mortgage and utility costs for this month?**

If the answer to any of these questions is yes, you may have a right to expedited SNAP benefits.

This means you can get SNAP benefits within five calendar days of the date you apply.
Ask for more information by contacting the local county assistance office.

File your SNAP benefits application today!

It is your right to file an application today at any time before 5 p.m. The person at the county assistance office should date-stamp your application while you watch.

If you are denied expedited SNAP benefits, you have the right to an agency conference within two working days with a supervisor at the county assistance office. If you believe you are being denied your rights or services, or if the county assistance office does not take your application when you hand it in and date-stamp it while you watch, ask to talk with a supervisor or call the Helpline toll free at 1-800-692-7462.

You can get free legal help at the local legal services office.

SIGNATURE REQUIRED

Getting Started

What do you want to apply for?

☐ Cash assistance ☐ Health Care Coverage ☐ SNAP (Supplemental Nutrition Assistance Program)

What language do you prefer? ¿Qué idioma prefiere usted? ☐ English/Inglés ☐ Spanish/Español ☐ Other/Otro (specify/especifique) _____

Do you need an interpreter? ¿Necesita un intérprete? ☐ Yes/Sí ☐ No **If yes,** what language? En caso afirmativo, ¿de qué idioma? _____

Go paperless! Would you like to receive your notices online?
Go to www.compass.state.pa.us and enroll on your MyCOMPASS Account.

- We can start your application as soon as you write your name and address, and sign and return this application.
- We encourage you to answer as many questions as you can unless the instructions tell you that you can choose not to answer. The more complete information we have, the faster we can process your application.
- If you are eligible, SNAP benefits start from the date we receive your application. We will tell you within 30 days if you are eligible or not.

IMPORTANT: All persons applying must provide or apply for a Social Security number (SSN) and answer citizenship questions. Providing an SSN is optional for persons not applying for benefits, but providing it can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with health care coverage costs. If someone wants help getting a SSN, call 1-800-772-1213 or visit www.ssa.gov. TTY users should call 1-800-325-0778.

Note: If you are a non-citizen applying for Emergency Medical Services only, you do not need to provide information about your immigration status or apply for or provide a SSN.

Tell us about you, the applicant: We will need to contact an adult/parent/caretaker.

Name (Include first, middle initial, last, suffix - Jr./Sr./etc.):			
Home address (Include street, apt. number, city, state & ZIP code+4)			
School district:	Township or municipality:	How long have you lived at this address?	
Phone number: ( )	Phone type: ☐ Home ☐ Work ☐ Cell	Second phone number: ( )	Phone type: ☐ Home ☐ Work ☐ Cell
☐ Check here if you do not have a home address. You still need to give a mailing address.	Mailing address (if different from home address):		

Quick SNAP: You may be able to get SNAP within 5 days! Answer these questions, then sign this application and give it to your county assistance office by 5 p.m. today! Your county assistance office will set up an interview with you.

Total monthly **income**, for you and anyone who is applying, **before** taxes are taken out: $	Are you, or anyone you are applying for, getting SNAP now? ☐ Yes ☐ No	Do you pay for utilities other than telephone? ☐ Yes ☐ No **If yes,** which utilities?
Total **resources** (resources are money in cash, checking and savings accounts): $	Do you pay for telephone services? ☐ Yes ☐ No	Are you, or anyone you are applying for, a seasonal or migrant farm worker? ☐ Yes ☐ No
Total monthly **rent** or **mortgage** for you and anyone who is applying: $	Do you pay for heating or the cost to run air conditioning? ☐ Yes ☐ No	Do you, or anyone you are applying for, live in a shelter for abused or battered women and children? ☐ Yes ☐ No

Sign here:

X _____ _____

Your signature or your representative's signature | Date

Tell us about people in your home:

We need to gather information about everyone who lives at your address, even if they are not applying for benefits. **For health care applicants, be sure to include anyone on your federal income tax return, even if they do not live with you.**

Note: You do not need to file a tax return to get benefits.

Person 1 (Start with yourself)

CAO Use Only **Line #:**

Name (Include first, middle initial, last, suffix-Jr./Sr./etc.)	Are you applying for yourself? ☐ Yes ☐ No	Social Security number:

Birthdate (MM/DD/YYYY):	Sex ☐ M ☐ F	Driver's license or state ID number if you have one:	**Marital Status** ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed

Are you in school? ☐ Yes ☐ No	**If yes,** what grade?	Name of school:	Full-time student? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No	**If yes,** due date?	How many babies are expected?

Answer the questions below if you are applying for yourself.

You do not need to answer these questions if you are applying only for SNAP.

☐ Yes ☐ No	If not eligible for full Medical Assistance coverage, do you want to be reviewed for coverage for the Family Planning Services program only?
☐ Yes ☐ No	If you are under 21, we will consider only your income in our determination for the Family Planning Services program. If you wish to be reviewed for full Medical Assistance coverage, we will need to evaluate your household income, including your parent(s)' income. Do you want to be reviewed only for the Family Planning Services program and NOT for full Medical Assistance coverage?
☐ Yes ☐ No	Regardless of age, are you afraid that information you may receive where you live about family planning services could cause physical, emotional, or other harm from your spouse, parents, or other person? **If yes,** do you have another address (other than where you live) where you'd like to get information about family planning services?

Are you a U.S. citizen or national? ☐ Yes ☐ No

If you are not a U.S. citizen or national, answer the following questions:

Do you have eligible immigration status? ☐ Yes	**If yes,** fill in the document type and ID number:	Document type:	Document ID number:
Do you have a sponsor? ☐ Yes ☐ No		Have you lived in the U.S. since 1996? ☐ Yes ☐ No	

RACE (Optional) (Check all that apply)	☐ Black or African American ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native (See Appendix A) ☐ White ☐ Other _____
ETHNICITY (Optional)	☐ Hispanic or Latino ☐ Non Hispanic or Latino

Person 2

CAO Use Only Line #:

Name (Include first, middle initial, last, suffix-Jr./Sr./etc.)

Are you applying for this person? ☐ Yes ☐ No

Social Security number:

Birthdate (MM/DD/YYYY):

Sex ☐ M ☐ F

Driver's license or state ID number if this person has one:

Marital Status ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed

How is this person related to you? ☐ Spouse ☐ Child ☐ Stepchild ☐ Not Related ☐ Other _____

Does this person live with you? ☐ Yes ☐ No

Is this person in school? ☐ Yes ☐ No

If yes, what grade?

Name of school:

Full-time student? ☐ Yes ☐ No

Is this person pregnant? ☐ Yes ☐ No

If yes, due date?

How many babies are expected?

Answer the questions below if you are applying for this person.

You do not need to answer these questions if you are applying only for SNAP.

☐ Yes ☐ No If not eligible for full Medical Assistance coverage, does this person want to be reviewed for coverage for the Family Planning Services program only?

☐ Yes ☐ No If this person is under 21, we will consider only their income in our determination for the Family Planning Services program. If they wish to be reviewed for full Medical Assistance coverage, we will need to evaluate their household income, including their parent(s)' income. Does this person want to be reviewed only for the Family Planning Services program and NOT for full Medical Assistance coverage?

☐ Yes ☐ No Regardless of age, are they afraid that information they may receive where they live about family planning services could cause physical, emotional, or other harm from their spouse, parents, or other person?

If yes, do they have another address (other than where they live) where they'd like to get information about family planning services?

Is this person a U.S. citizen or national? ☐ Yes ☐ No

If this person is not a U.S. citizen or national, answer the following questions:

Does this person have eligible immigration status? ☐ Yes

If yes, fill in the document type and ID number:

Document type:

Document ID number:

Does this person have a sponsor? ☐ Yes ☐ No

Has this person lived in the U.S. since 1996? ☐ Yes ☐ No

RACE (Optional) (Check all that apply) ☐ Black or African American ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native (See Appendix A) ☐ White ☐ Other _____

ETHNICITY (Optional) ☐ Hispanic or Latino ☐ Non Hispanic or Latino

Person 3

CAO Use Only Line #:

Name (Include first, middle initial, last, suffix-Jr./Sr./etc.)

Are you applying for this person? ☐ Yes ☐ No

Social Security number:

Birthdate (MM/DD/YYYY):

Sex ☐ M ☐ F

Driver's license or state ID number if this person has one:

Marital Status ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed

How is this person related to you? ☐ Spouse ☐ Child ☐ Stepchild ☐ Not Related ☐ Other _____

Does this person live with you? ☐ Yes ☐ No

Is this person in school? ☐ Yes ☐ No

If yes, what grade?

Name of school:

Full-time student? ☐ Yes ☐ No

Is this person pregnant? ☐ Yes ☐ No

If yes, due date?

How many babies are expected?

Answer the questions below if you are applying for this person.

You do not need to answer these questions if you are applying only for SNAP.

☐ Yes ☐ No If not eligible for full Medical Assistance coverage, does this person want to be reviewed for coverage for the Family Planning Services program only?

☐ Yes ☐ No If this person is under 21, we will consider only their income in our determination for the Family Planning Services program. If they wish to be reviewed for full Medical Assistance coverage, we will need to evaluate their household income, including their parent(s)' income. Does this person want to be reviewed only for the Family Planning Services program and NOT for full Medical Assistance coverage?

☐ Yes ☐ No Regardless of age, are they afraid that information they may receive where they live about family planning services could cause physical, emotional, or other harm from their spouse, parents, or other person?

If yes, do they have another address (other than where they live) where they'd like to get information about family planning services?

Is this person a U.S. citizen or national? ☐ Yes ☐ No

If this person is not a U.S. citizen or national, answer the following questions:

Does this person have eligible immigration status? ☐ Yes

If yes, fill in the document type and ID number:

Document type:

Document ID number:

Does this person have a sponsor? ☐ Yes ☐ No

Has this person lived in the U.S. since 1996? ☐ Yes ☐ No

RACE (Optional) (Check all that apply) ☐ Black or African American ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native (See Appendix A) ☐ White ☐ Other _____

ETHNICITY (Optional) ☐ Hispanic or Latino ☐ Non Hispanic or Latino

Person 4

CAO Use Only Line #:

Name (Include first, middle initial, last, suffix-Jr./Sr./etc.)

Are you applying for this person? ☐ Yes ☐ No

Social Security number:

Birthdate (MM/DD/YYYY):

Sex ☐ M ☐ F

Driver's license or state ID number if this person has one:

Marital Status ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed

How is this person related to you? ☐ Spouse ☐ Child ☐ Stepchild ☐ Not Related ☐ Other _____

Does this person live with you? ☐ Yes ☐ No

Is this person in school? ☐ Yes ☐ No

If yes, what grade?

Name of school:

Full-time student? ☐ Yes ☐ No

Is this person pregnant? ☐ Yes ☐ No

If yes, due date?

How many babies are expected?

Answer the questions below if you are applying for this person.

You do not need to answer these questions if you are applying only for SNAP.

☐ Yes ☐ No If not eligible for full Medical Assistance coverage, does this person want to be reviewed for coverage for the Family Planning Services program only?

☐ Yes ☐ No If this person is under 21, we will consider only their income in our determination for the Family Planning Services program. If they wish to be reviewed for full Medical Assistance coverage, we will need to evaluate their household income, including their parent(s)' income. Does this person want to be reviewed only for the Family Planning Services program and NOT for full Medical Assistance coverage?

☐ Yes ☐ No Regardless of age, are they afraid that information they may receive where they live about family planning services could cause physical, emotional, or other harm from their spouse, parents, or other person?

If yes, do they have another address (other than where they live) where they'd like to get information about family planning services?

Is this person a U.S. citizen or national? ☐ Yes ☐ No

If this person is not a U.S. citizen or national, answer the following questions:

Does this person have eligible immigration status? ☐ Yes

If yes, fill in the document type and ID number:

Document type:

Document ID number:

Does this person have a sponsor? ☐ Yes ☐ No

Has this person lived in the U.S. since 1996? ☐ Yes ☐ No

RACE (Optional) (Check all that apply) ☐ Black or African American ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native (See Appendix A) ☐ White ☐ Other _____

ETHNICITY (Optional) ☐ Hispanic or Latino ☐ Non Hispanic or Latino

Person 5

CAO Use Only Line #:

Name (Include first, middle initial, last, suffix-Jr./Sr./etc.)

Are you applying for this person? ☐ Yes ☐ No

Social Security number:

Birthdate (MM/DD/YYYY):

Sex ☐ M ☐ F

Driver's license or state ID number if this person has one:

Marital Status ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed

How is this person related to you? ☐ Spouse ☐ Child ☐ Stepchild ☐ Not Related ☐ Other _____

Does this person live with you? ☐ Yes ☐ No

Is this person in school? ☐ Yes ☐ No

If yes, what grade?

Name of school:

Full-time student? ☐ Yes ☐ No

Is this person pregnant? ☐ Yes ☐ No

If yes, due date?

How many babies are expected?

Answer the questions below if you are applying for this person.

You do not need to answer these questions if you are applying only for SNAP.

☐ Yes ☐ No If not eligible for full Medical Assistance coverage, does this person want to be reviewed for coverage for the Family Planning Services program only?

☐ Yes ☐ No If this person is under 21, we will consider only their income in our determination for the Family Planning Services program. If they wish to be reviewed for full Medical Assistance coverage, we will need to evaluate their household income, including their parent(s)' income. Does this person want to be reviewed only for the Family Planning Services program and NOT for full Medical Assistance coverage?

☐ Yes ☐ No Regardless of age, are they afraid that information they may receive where they live about family planning services could cause physical, emotional, or other harm from their spouse, parents, or other person?

If yes, do they have another address (other than where they live) where they'd like to get information about family planning services?

Is this person a U.S. citizen or national? ☐ Yes ☐ No

If this person is not a U.S. citizen or national, answer the following questions:

Does this person have eligible immigration status? ☐ Yes

If yes, fill in the document type and ID number:

Document type:

Document ID number:

Does this person have a sponsor? ☐ Yes ☐ No

Has this person lived in the U.S. since 1996? ☐ Yes ☐ No

RACE (Optional) (Check all that apply) ☐ Black or African American ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native (See Appendix A) ☐ White ☐ Other _____

ETHNICITY (Optional) ☐ Hispanic or Latino ☐ Non Hispanic or Latino

Person 6

CAO Use Only Line #:

Name (Include first, middle initial, last, suffix-Jr./Sr./etc.)

Are you applying for this person? ☐ Yes ☐ No

Social Security number:

Birthdate (MM/DD/YYYY):

Sex ☐ M ☐ F

Driver's license or state ID number if this person has one:

Marital Status ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed

How is this person related to you? ☐ Spouse ☐ Child ☐ Stepchild ☐ Not Related ☐ Other _____

Does this person live with you? ☐ Yes ☐ No

Is this person in school? ☐ Yes ☐ No

If yes, what grade?

Name of school:

Full-time student? ☐ Yes ☐ No

Is this person pregnant? ☐ Yes ☐ No

If yes, due date?

How many babies are expected?

Answer the questions below if you are applying for this person.

You do not need to answer these questions if you are applying only for SNAP.

☐ Yes ☐ No If not eligible for full Medical Assistance coverage, does this person want to be reviewed for coverage for the Family Planning Services program only?

☐ Yes ☐ No If this person is under 21, we will consider only their income in our determination for the Family Planning Services program. If they wish to be reviewed for full Medical Assistance coverage, we will need to evaluate their household income, including their parent(s)' income. Does this person want to be reviewed only for the Family Planning Services program and NOT for full Medical Assistance coverage?

☐ Yes ☐ No Regardless of age, are they afraid that information they may receive where they live about family planning services could cause physical, emotional, or other harm from their spouse, parents, or other person?

If yes, do they have another address (other than where they live) where they'd like to get information about family planning services?

Is this person a U.S. citizen or national? ☐ Yes ☐ No

If this person is not a U.S. citizen or national, answer the following questions:

Does this person have eligible immigration status? ☐ Yes

If yes, fill in the document type and ID number:

Document type:

Document ID number:

Does this person have a sponsor? ☐ Yes ☐ No

Has this person lived in the U.S. since 1996? ☐ Yes ☐ No

RACE (Optional) (Check all that apply) ☐ Black or African American ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native (See Appendix A) ☐ White ☐ Other _____

ETHNICITY (Optional) ☐ Hispanic or Latino ☐ Non Hispanic or Latino

Person 7

CAO Use Only Line #:

Name (Include first, middle initial, last, suffix-Jr./Sr./etc.)

Are you applying for this person? ☐ Yes ☐ No

Social Security number:

Birthdate (MM/DD/YYYY):

Sex ☐ M ☐ F

Driver's license or state ID number if this person has one:

Marital Status ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed

How is this person related to you? ☐ Spouse ☐ Child ☐ Stepchild ☐ Not Related ☐ Other _____

Does this person live with you? ☐ Yes ☐ No

Is this person in school? ☐ Yes ☐ No

If yes, what grade?

Name of school:

Full-time student? ☐ Yes ☐ No

Is this person pregnant? ☐ Yes ☐ No

If yes, due date?

How many babies are expected?

Answer the questions below if you are applying for this person.

You do not need to answer these questions if you are applying only for SNAP.

☐ Yes ☐ No If not eligible for full Medical Assistance coverage, does this person want to be reviewed for coverage for the Family Planning Services program only?

☐ Yes ☐ No If this person is under 21, we will consider only their income in our determination for the Family Planning Services program. If they wish to be reviewed for full Medical Assistance coverage, we will need to evaluate their household income, including their parent(s)' income. Does this person want to be reviewed only for the Family Planning Services program and NOT for full Medical Assistance coverage?

☐ Yes ☐ No Regardless of age, are they afraid that information they may receive where they live about family planning services could cause physical, emotional, or other harm from their spouse, parents, or other person?

If yes, do they have another address (other than where they live) where they'd like to get information about family planning services?

Is this person a U.S. citizen or national? ☐ Yes ☐ No

If this person is not a U.S. citizen or national, answer the following questions:

Does this person have eligible immigration status? ☐ Yes

If yes, fill in the document type and ID number:

Document type:

Document ID number:

Does this person have a sponsor? ☐ Yes ☐ No

Has this person lived in the U.S. since 1996? ☐ Yes ☐ No

RACE (Optional) (Check all that apply) ☐ Black or African American ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native (See Appendix A) ☐ White ☐ Other _____

ETHNICITY (Optional) ☐ Hispanic or Latino ☐ Non Hispanic or Latino

Other questions about people in your home:

Please answer these questions about **you or anyone in your home** who is applying for benefits.

Does anyone get cash assistance, Medical Assistance or SNAP in another state now? ☐ Yes ☐ No	**If yes,** what state and county?		
Have you or anyone in your household been disqualified or agreed to be disqualified for food stamps or SNAP benefits in another state? ☐ Yes ☐ No	**If yes,** tell us who:		
Has anyone ever applied for any benefits using a different name or Social Security number? ☐ Yes ☐ No	**If yes,** please tell us the name and Social Security number:		
Is anyone in the U.S. military, or has anyone been in the U.S. military? ☐ Yes ☐ No	Is anyone a widow, spouse, or child (under age 18) of anyone in the U.S. military, or anyone who has been in the U.S. military? ☐ Yes ☐ No		
Was anyone in foster care at age 18 or older? ☐ Yes ☐ No	**If yes,** who?	State:	
Is anyone disabled, seriously ill, or in need of medical attention? ☐ Yes ☐ No	**If yes,** who?	What is the disability?	
Does anyone have a medical condition that requires health sustaining medication? ☐ Yes ☐ No	**If yes,** who?		
Does anyone live in a medical or long term care facility or have a physical, mental or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.)? ☐ Yes ☐ No			
Does anyone have paid or unpaid medical bills this month or the last three months? ☐ Yes ☐ No	Has anyone been a victim of domestic abuse? ☐ Yes ☐ No		
Is anyone in treatment for drug or alcohol abuse? ☐ Yes ☐ No	**If yes,** who?		

Absent relatives: This section is for cash applicants.

If anyone is applying for a child who has parents not living in your home or if anyone applying has a spouse not living in your home, please answer these questions so that we can try to get support.

You do not need to fill out this section if providing this information or seeking support would put you or family members at risk of domestic violence or make it more difficult to escape domestic violence, or if your child was born as a result of rape or incest, or if you are considering adoption.

If it would be a problem for you to provide this information or seek support because of domestic violence, rape or incest or because you are considering putting a child up for adoption, check this box: ☐

Name of person with an absent relative:	Name of absent relative:	Absent relative is a:
		☐ Parent ☐ Spouse
		☐ Parent ☐ Spouse
		☐ Parent ☐ Spouse
		☐ Parent ☐ Spouse
		☐ Parent ☐ Spouse
		☐ Parent ☐ Spouse

▶ If you are applying for cash assistance, you must name the parents of any minor children and help the Domestic Relations Section (DRS) collect support by providing the information they need unless you have good cause. If you do not help the DRS by providing the information needed and do not have a good reason for not helping, any cash assistance amount for which you are approved will be lowered by at least 25 percent.

If approved for cash assistance, you must give the Department and DRS the right to collect cash for you and others for whom you are applying. The law says that support rights will be assigned to the state if you accept cash assistance.

If support is paid for a child who gets cash assistance, the family may get some of the support in addition to the cash assistance grant.

Tax information: Complete this section if you are applying for health care. You do not need to answer these questions if you are applying only for SNAP.

Complete this information for your spouse/partner and children who live with you and/or anyone else on your same federal income tax return if you file one.

Do any of the persons listed on the application plan to file a federal income tax return NEXT YEAR? ☐ Yes ☐ No
If yes, list tax filer and list the spouse of the tax filer if filing a joint return.

Name of tax filer:	If filing jointly, name of spouse:

Will any of the persons listed on the application claim any dependents on their tax return? ☐ Yes ☐ No
If yes, list tax filer and list dependents.
A dependent can be claimed by only one tax filer. For joint filers, you only need to list dependents for the tax filer who will sign the tax form.

Name of tax filer:	Dependent(s):

Will any of the persons listed on the application be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, list dependent and list tax filer for whom the dependent will be claimed.
You do not need to complete the information in this table if the dependent is already listed above.

Name of dependent:	Name of tax filer:	Relationship to tax filer:

Tax deductions: Complete this section if you are applying for health care. You do not need to answer these questions if you are applying only for SNAP.

If anyone pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health care coverage a little lower.

Note: If self-employed, do not include a cost that you will list as an expense on your Schedule C tax form (for example, car and truck expenses, depreciation, employee wages and fringe benefits, etc.).

Does anyone have expenses from: (✓)(Check **yes**)	**Yes**	**Whose expense is this?**	**How often is the expense paid?** (one time, monthly, quarterly, twice a year, yearly)	**How much?**
Student loan interest deduction				
Self-employed health insurance deduction				
Deductible part of self-employment tax				
Health savings account deduction				
Other (specify)				

Resources (also called "assets"): You do not need to answer these questions if you are applying for SNAP benefits only or if you are applying for health care and you meet one of these exceptions: pregnant; child under age 21; have a dependent child under 21 living with you; you do not have a disability and are under age 65.

Please tell us about resources, such as:

- Cash
- Checking/savings account
- Certificate of deposit
- E-money/Digital Account (PayPal, Cash App)
- IRA/401k/profit sharing
- U.S. Savings Bonds
- Christmas or vacation club
- Stocks and bonds
- Trust fund
- Boat, snowmobile, camper
- Motorcycle, ATV
- Vehicle (car, van, truck)

List each resource separately:

Name of person with the resource:	Kind of resource:	How much?	Where is this resource located/account number?
Name of person with the resource:	Kind of resource:	How much?	Where is this resource located/account number?
Name of person with the resource:	Kind of resource:	How much?	Where is this resource located/account number?
Name of person with the resource:	Kind of resource:	How much?	Where is this resource located/account number?
Name of person with the resource:	Kind of resource:	How much?	Where is this resource located/account number?
Name of person with the resource:	Kind of resource:	How much?	Where is this resource located/account number?

Other questions about resources: You do not need to answer these questions if you are applying for SNAP benefits only or if you are applying for health care and you meet one of these exceptions: pregnant; child under age 21; have a dependent child under 21 living with you; you do not have a disability and are under age 65.

Is anyone in your home expecting money including employment, accident settlement, inheritance, or trust fund? ☐ Yes ☐ No	**If yes,** who?	What kind?	When is it expected?	How much is expected?
Has anyone sold, given away, or transferred a home, land, personal property, or any other resource in the past five years? ☐ Yes ☐ No	**If yes**, who?	What kind?	When?	How much was it worth?

Does anyone own any homes or property that they don't live in? ☐ Yes ☐ No	**If yes,** who?	How many vehicles do the people in your home own?	
Does anyone have a burial agreement with a bank or funeral home? ☐ Yes ☐ No	**If yes,** who?	How many burial plots do the people in your home own?	
Does anyone have a life insurance policy? ☐ Yes ☐ No	**If yes,** who?		

Income:

Please tell us about the income of any child or adult you have listed on this application.
Does anyone in your household have any income? ☐ Yes ☐ No **If yes,** list any income you have already received, or expect to receive, this year.

- ☐ Commissions
- ☐ Dividends
- ☐ Gambling/Lottery
- ☐ Guardian Fees
- ☐ Money Earned from Babysitting
- ☐ Money for Training
- ☐ Money Paid to You for Loans
- ☐ Money Paid to You for Rent
- ☐ Money Paid to You for Room or Board
- ☐ Pensions
- ☐ Self-Employment
- ☐ Sick Benefits
- ☐ Social Security
- ☐ Supplemental Security Income (SSI)
- ☐ Support
- ☐ Unemployment
- ☐ Union Pay
- ☐ Veteran Benefit
- ☐ Wages from Employment
- ☐ Workers' Compensation
- ☐ Other_____

Name of person with income:	Type/Source of income/Name of employer:	Income/Pay: How much?	How often paid?	Date of most recent payment:

Other questions about income:

Has anyone worked in the last 90 days?	**If yes,** who?
Has anyone had work hours reduced in the last 60 days?	**If yes,** who?
Has anyone stopped working at one or more jobs in the past 30 days?	**If yes,** who?
Is anyone on strike?	**If yes,** who?
Has anyone received Social Security in the past?	**If yes,** who?
Has anyone received Supplemental Security Income in the past?	**If yes,** who?

Pre-Tax Deductions

List any pre-tax deductions taken out of the gross income, such as health/dental/vision/life insurance premiums, 401(k) or retirement account contributions, Family Savings Account (FSA) or Health Savings Account (HSA) contributions.

Name	Deduction	Monthly Amount

Has anyone applied for or awaiting a decision for any of these benefits? (Check all that apply.)

- ☐ Social Security
- ☐ Supplemental Security Income (SSI)
- ☐ Unemployment Compensation
- ☐ Veterans Benefits
- ☐ Workers' Compensation
- ☐ Other_____

Who has applied:	Benefit applied for:	Date of benefit application:	Any benefit decisions under appeal:

Does anyone pay for childcare or the care of an adult with a disability so he or she can go to work, school or training? ☐ Yes ☐ No

If yes, how much each month? Monthly amount:	Who receives care?

Does it cost anyone anything to get the income listed above? (Such as transportation costs, court fees, bank or guardian fees, etc.)? ☐ Yes ☐ No

Health insurance: You do not need to answer these questions if you are applying only for SNAP.

Does anyone you are applying for have health insurance coverage? ☐ Yes ☐ No

Has anyone you are applying for had health insurance coverage in the last 90 days? ☐ Yes ☐ No

If you have (or had in the last 90 days) more than one type of health care coverage, please fill in a box for each policy.

NOTE: If you have more than one policy, you will need to make copies of this page and attach them.

Type of health care coverage

☐ Employer Insurance ☐ Medicare ☐ TRICARE*
☐ Peace Corps ☐ Individual plan ☐ Other _____

	List of who is (or was) covered:	
Policy holder name:	First name:	Last name:
Insurance company name:	First name:	Last name:
Policy number:	First name:	Last name:
Group name/number:	First name:	Last name:

What is (or was) covered?

☐ Hospital care ☐ Prescriptions ☐ Eye care
☐ Doctor visits ☐ Dental

Is (or was) this a limited-benefit plan (like a school accident policy)?
☐ Yes ☐ No

When did this insurance start?

When did (or will) this insurance stop?
(Leave blank if you are still covered.)

Did (or will) this health insurance end because the policy holder lost employment (laid off, terminated, quit), or changed jobs? ☐ Yes ☐ No

If yes, who lost coverage?

Did (or will) any children lose health insurance because the employer stopped offering coverage? ☐ Yes ☐ No

*Don't check if you have direct care or Line of Duty

Health insurance from your employer: You do not need to answer these questions if you are applying only for SNAP.

Is anyone you are applying for offered health insurance from a job? ☐ Yes ☐ No
Check yes even if the coverage is from someone else's job, such as a parent or spouse.

If yes, complete this section and as much information as you can in Appendix B: Health Coverage from Job(s).

Is this a state employee benefit plan? ☐ Yes ☐ No

Is this COBRA coverage? ☐ Yes ☐ No

Is this a retiree health plan? ☐ Yes ☐ No

If you are offered health coverage from your job, do (or would) you have to pay for your coverage? ☐ Yes ☐ No

Do (or would) you have to pay for your child(ren)'s coverage? ☐ Yes ☐ No

What is the cost for family coverage through your employer's group health plan?

What is the cost to cover your child(ren) through your employer's health plan?

Expenses: This section is for SNAP applicants.

Please tell us about your expenses so that you can get the most benefits possible. If requested, you must provide proof of your expenses.

▶ At any time, you may report household expenses to us, we may ask you to give us proof of them.

Does anyone in your home pay child support to a person who does not live with you? ☐ Yes ☐ No **If yes,** is it court-ordered? ☐ Yes ☐ No	Does anyone in your home get housing assistance? ☐ Yes ☐ No **If yes,** what kind? _____ **If yes,** do you get a utility allowance? ☐ Yes ☐ No
Are meals included in your rent? ☐ Yes ☐ No	Is there anyone outside of your household who pays any of your expenses? ☐ Yes ☐ No If so, what expenses? _____ How much? _____ How often? _____ To whom? _____
Do you pay for heat? ☐ Yes ☐ No	Do you pay for central air or to run a room air conditioner(s)? ☐ Yes ☐ No

Check any expenses paid each month by you or anyone in your home. Please check even if you only pay part of the bill.

☐ Telephone ☐ Water ☐ Garbage ☐ Utility installation ☐ Electric

☐ Oil, coal, wood, kerosene ☐ Sewer ☐ Gas ☐ Propane ☐ Other _____

If you have any of these expenses, how much do you pay per month?

Rent: $ _____ Condo fees: $ _____

Mortgage $ _____ Property taxes: $ _____ Homeowner's insurance: $ _____

Medical expenses: This section is for SNAP applicants.

You may get more SNAP benefits if someone in your home is 60 years old or older, or disabled, and you can give proof of medical expenses.

Check any medical expense that you or someone in your home pays:	
☐ Dental bills	☐ Any costs to get to medical appointments, medical treatment, or to pick up prescriptions. These can be costs such as taxis and public transportation.
☐ Doctor bills	
☐ Hospital bills	☐ Health aides (people in your home to help with medical treatments).
☐ Health insurance or Medicare premiums	☐ Health related supplies (such as eyeglasses, hearing aids, adult diapers).
☐ Medical equipment	☐ Prescription medicines
☐ Other:	

▶ **Failure to report or verify any of the above listed expenses will be seen as a statement by your household that you do not want to receive a deduction for the unreported expense.**

Criminal history inquiry: You do not need to answer these questions if you are applying only for health care.

Please answer the following questions for yourself and anyone else for whom you are applying:

Does anyone have a summons or warrant to appear as a defendant at a criminal court proceeding?	☐ Yes ☐ No	**If yes,** who?
Does anyone owe fines, costs or restitution for a felony or misdemeanor offense?	☐ Yes ☐ No	**If yes,** who?
Does anyone have a payment plan for fines and costs?	☐ Yes ☐ No	**If yes,** who?
Is anyone on probation or parole?	☐ Yes ☐ No	**If yes,** who?
Is anyone who is on probation or parole not complying?	☐ Yes ☐ No	**If yes,** who?
Has anyone been convicted of welfare fraud?	☐ Yes ☐ No	**If yes,** who?
Is anyone fleeing from law enforcement?	☐ Yes ☐ No	**If yes,** who?
Is anyone required to register as a convicted sexual offender?	☐ Yes ☐ No	**If yes,** who?
Is anyone who is required to register as a convicted sexual offender not complying with their registration requirements?	☐ Yes ☐ No	**If yes,** who?

Voter Registration (Optional): This section is for U.S. Citizens only

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 TO VOTE AT THIS TIME.

To register, you must:
1) Be at least 18 on the day of the next election;
2) Be a citizen of the United States for at least one month PRIOR TO THE NEXT ELECTION;
3) Reside in Pennsylvania and the voting district at least 30 days prior to the next election.

Applying to register or declining to register to vote will not affect the amount of assistance you will be provided by this agency. If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. Please contact the county assistance office if you would like help.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Secretary of the Commonwealth, PA Department of State, Harrisburg, PA 17120. (Toll-free telephone number 1-877-VOTESPA.)

COUNTY ASSISTANCE OFFICE STAFF WILL COMPLETE THIS BOX BASED UPON YOUR RESPONSE ABOVE

☐ Given to Client __/__/__ ☐ Sent to voter registration __/__/__ ☐ Mailed to Client __/__/__
☐ Declined, not interested __/__/__ ☐ Not a U.S. citizen __/__/__ ☐ Declined, already registered __/__/__

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1. ☐ Yes ☐ No Is anyone in the application group receiving SNAP and not living in a certified shelter for battered women and children?
2. ☐ Yes ☐ No Is there any postponed verification from a previous expedited issuance that the household must provide?
3. ☐ Yes ☐ No Are the household liquid resources equal to or less than $100?
4. ☐ Yes ☐ No Is the countable monthly gross income less than $150?
5. ☐ Yes ☐ No Is this a migrant or seasonal farm worker household?
6. ☐ Yes ☐ No Is the household destitute?
7. ☐ Yes ☐ No Are combined monthly gross income and liquid resources less than monthly shelter expenses?

EXPEDITED REVIEW	Initials:	Date:
☐ Eligible ☐ Denied -	**CLIENT NOTIFIED**	
Reason for denial:		
REGISTERED FOR CATEGORIES ▶		

Your Rights and Responsibilities Read about your rights and responsibilities:

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The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

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.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, 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:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

RIGHT TO CONFIDENTIALITY
We will keep your information private. It will only be used to decide which programs you may be eligible for. The county assistance office (CAO), when requested, must provide federal, state and local law enforcement officials with the address, Social Security number (SSN) and photograph (if available) of an individual who is fleeing to avoid prosecution, custody or confinement for a felony or violating probation or parole. Any person knowingly violating any of the rules and regulations of this department shall be guilty of a misdemeanor and, upon conviction shall be sentenced to pay a fine, not exceeding one hundred ($100) dollars, or to undergo imprisonment, not exceeding six months, or both (62 P.S. section 483).

RIGHT TO A WRITTEN NOTICE
We will give you a written notice explaining your benefits. If we deny, change, suspend or stop benefits, we will give you a written explanation of why. You have 30 days (90 days for Supplemental Nutrition Assistance Program (SNAP) benefits) from the mailing date of the notice to ask for a hearing.

RIGHT TO APPEAL
You have the right to ask for a Department of Human Services (DHS) hearing to appeal a decision if you believe it is unfair or incorrect, or if DHS fails to act on your application for benefits. You may file the appeal at the CAO. If you appeal, you may also request an agency conference before the hearing. If your appeal involves expedited SNAP benefits, you have the right to have this conference with a supervisor within two work days. At the hearing you may represent yourself, or someone else, such as a lawyer, friend or relative may represent you.

RIGHT TO CLAIM GOOD CAUSE
If you apply for cash or Medical Assistance benefits, the law requires you to cooperate with establishing paternity and seeking support. You may be excused from these requirements if you prove it may be dangerous for you and/or your children. This is known as good cause. Unless a good cause exemption is established, you will be required to meet employment and training requirements. You will also be required to meet semi-annual reporting requirements unless good cause is granted.

RIGHT TO CERTIFICATE OF CREDITABLE COVERAGE
Federal law limits when health coverage may be denied or limited for a pre-existing condition. If you enroll in a group health plan that excludes treatment for a condition you already had, you can be credited for the time you received Medical Assistance coverage. This may help you obtain coverage. Contact your caseworker to request this certificate.

RESPONSIBILITY TO PROVIDE INFORMATION
You must give true, correct and complete information. You must help in proving the information you give. Benefits may be denied if you fail to provide certain proof. If you cannot provide proof, you should ask the CAO to help you obtain it. If you are contacted by DHS or the Office of State Inspector General, you must fully cooperate with those persons or investigators. If you are age 55 or older and receive Medical Assistance to pay for nursing facility services, home and community-based waiver services and any related hospital and prescription drug service, you may be required to repay the cost of these services from your probate estate. If you are applying for cash assistance, we may require you to sign an agreement to repay benefits that you, your spouse and your children have received.

RESPONSIBILITY TO PROVIDE SOCIAL SECURITY NUMBERS
For cash, Medical Assistance and/or SNAP benefits, you must provide an SSN for each person for whom you are applying. If you do not have an SSN, you must apply for one. Not providing an SSN may result in not being able to receive benefits. For cash benefits, we may ask for an SSN for anyone whose income or resources may affect your eligibility or the amount of benefits. Your SSN will be used for identity, for computer matches which verify income and resources, and to prevent duplication of state and federal benefits. A non-citizen who is applying for emergency Medical Assistance only is not required to provide an SSN. (42 U.S. Code 1320b-7)

RESPONSIBILITY TO USE THE PA ACCESS CARD LAWFULLY
Once you are eligible for benefits, you will be issued a PA ACCESS card. This card may only be used for the person who is eligible and only during the eligibility period. You may only use the card for services that are needed and reasonable.

RESPONSIBILITY TO REPORT CHANGES
If you qualify for benefits, you will be required to report changes in your circumstances to your caseworker or to the Customer Service Center. Types of changes reported would include people leaving or moving into the house, a new address, a new job for someone, if someone loses a job, birth of a child, new sources of income or changes to income, and lottery and gambling winnings. Your caseworker and notices you receive will cover the specifics in detail based on the programs and benefits you are eligible for. Failure to report required changes within the program guidelines could result in a loss of benefits, sanctions, or civil or criminal charges. You may report changes to the CAO in person, by phone, fax, mail or through a MyCOMPASS account. You may also report changes to the Customer Service Center at 1-877-395-8930, or for Philadelphia, 1-215-560-7226 any time.

PRIVACY ACT STATEMENT
(i) The collection of this information, 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. 2011-2036d. The information will be used to determine whether your household is eligible or continues to be eligible to participate in the SNAP Program. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management.

(ii) This 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.

(iii) If a SNAP claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action.

(iv) Providing the requested information, including the SSN of each household member, is voluntary. However, failure to provide an SSN will result in the denial of SNAP benefits to each individual failing to provide an SSN. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible household members.

Prohibitions and Penalties Read about your responsibilities:

IF THIS HAPPENS WITHOUT GOOD CAUSE			THIS MAY HAPPEN (PENALTY)
ALL BENEFITS SNAP CASH MEDICAL ASSISTANCE	Misuse Electronic Benefits Transfer (EBT) Card or PA ACCESS Card.		**Fine, prison, or both.**
	Do not report changes, as required.		**Benefits cut or stopped.**
	On purpose, give information that is false, incorrect or incomplete, or not report changes.		**Fine, disqualification and/or jail time for Welfare Fraud, disqualification for administrative hearing proceedings.** **Not eligible for cash:** • **First time - 6 months.** • **Second time - 12 months.** • **Third time - forever.** **Not eligible for SNAP:** • **First time - 12 months.** • **Second time - 24 months.** • **Third time - forever.**
	Trade, sell or attempt to trade, sell, buy or use another person's ACCESS Card.		**Not eligible:** • **All court convictions - 12 months.**
SNAP	On purpose, misuse SNAP benefits, for example, trade, sell, or buy EBT Card or SNAP benefits; convert benefits; or dump containers purchased with SNAP benefits to receive deposits – or buy things not covered by SNAP, such as alcohol or tobacco – or use SNAP benefits to pay for food already received or food on credit.		**Not eligible:** • **First time - 12 months.** • **Second time - 24 months.** • **Third time - forever.** • **First time court conviction over $500 - forever.**
	Purchase a product with SNAP benefits with the intent of obtaining cash or consideration other than eligible food by reselling the product in exchange for cash or consideration other than eligible food.		
	On purpose, purchase products originally purchased with SNAP benefits in exchange for cash or consideration other than eligible food.		
	Use/receive SNAP benefits to buy drugs or controlled substances.		**Not eligible:** • **First time - 24 months.** • **Second time - forever.**
	Use/receive SNAP benefits in sale of firearms, ammunition, or explosives.		**First time - not eligible forever.**
	Be convicted for buying, selling or trading SNAP benefits for total of $500 or more.		**Not eligible forever.**
	Lie about who you are or where you live to receive more than one SNAP benefit.		**Not eligible for 10 years.**
	Flee to avoid prosecution, custody, or confinement because of a felony/attempted felony – or flee because of breaking probation or parole.		**Not eligible until you do what the law says.**
CASH	Do not comply with your court penalty, including payment of fines, for a felony or misdemeanor.		**Not eligible until you comply with your penalty.**
	Lie about where you live to receive cash in two or more states.		**Not eligible for 10 years.**
	Flee to avoid prosecution, custody, or confinement because of a felony conviction/attempted felony; fail to appear as a defendant at a criminal court proceeding when issued a summons or a bench warrant for a summary offense, felony or misdemeanor; flee because of breaking probation/parole; or have any active warrant against you.		**Not eligible until you do what the law says.**
If you are found guilty of fraud or breaking the above rules:			• **Fine up to $250,000 for SNAP and up to $15,000 for Cash;** • **Jail up to 20 years for SNAP and up to seven years for Cash; and/or** • **Paying back benefits received.** • **Disqualification from benefits for periods stated above by program.**
SNAP WORK RULES	For household members – physically and mentally fit – over age 15 and under 60 – not otherwise exempt or with good cause.		**Not eligible:** • **First time - one month and until you do what is required.** • **Second time - three months and until you do what is required.** • **Three or more times - six months each time and until you do what is required.**
	Refuse to: • Accept a job. • Tell CAO about work status and job availability.	On purpose, take action to: • Quit a job. • Cut work hours to less than 30 per week (unless another job already meets work requirements).	
CASH WORK RULES	Do not meet cash work requirements on purpose, as written on the Agreement of Mutual Responsibility (AMR).		**Not eligible:** • **First violation - You will be ineligible for a minimum of 30 days or until the failure to comply ceases, whichever is longer.** • **Second violation - You will be ineligible for a minimum of 60 days or until the failure to comply ceases, whichever is longer.** • **Third violation - You will be permanently disqualified.** **If the reason for sanction occurs within the first 24 months of receipt of cash assistance, whether consecutive or interrupted, the sanction applies only to the individual.** **If the reason for sanction occurs after 24 months of receipt of cash assistance, whether consecutive or interrupted, the sanction applies to the entire family.**

SIGNATURE REQUIRED

Understanding Your Rights and Responsibilities

When I sign this form:

- I understand that Pennsylvania receives information from the Income Eligibility Verification System (IEVS), financial institutions, consumer reporting, and state and federal agencies to verify the information I give them. Information available through IEVS and other entities will be requested, used and may be verified through collateral contact when conflicting details are found by the state agency, and such information may affect my household's eligibility and level of benefits.
- I understand that by signing this application, I am authorizing any financial institution to disclose, through electronic or any other means, any and all financial information held by that institution, to the Department of Human Services or its designated agent or contractor for the purpose of identifying and verifying resources (also called "assets") when needed to determine and redetermine eligibility for Medical Assistance. I understand that financial information includes deposits, withdrawals, account closures and other relevant information requested or received from the financial institution, including other transactions undertaken by the financial institution with respect to the account or asset. I understand that this authorization is effective until Medical Assistance eligibility is denied or ends, or if I decide to revoke it by written notification to the department, whichever happens first. I understand that if I revoke this authorization, that may make me or my household ineligible for Medical Assistance.
- I understand that if I misrepresent, hide or withhold facts that may affect my eligibility for benefits, I may be required to repay my benefits and I may be prosecuted and disqualified from receiving certain future benefits.
- I understand that I can designate an authorized representative by completing the Authorized Representative section and submitting it with this application.
- I understand and agree that I am responsible for any fraudulent statements made on this application, even if the application is being submitted by someone acting on my behalf.
- I received a copy of my rights and responsibilities, have read them or someone has read them to me, and I understand them.
- I understand that the information entered in this application will be kept confidential and used only to administer benefits. I authorize the release of personal, financial and medical information for the purpose of determining eligibility.
- I understand that the Department of Human Services or its designees may contact me via methods including email and text messaging to help process my application or request feedback on the application process. If I do not want email or text messages, I understand the Department of Human Services will still process my application.
- I understand that any changes I am required to report must be reported within the first 10 days of the month following the month of change.
- I understand that my household may lose SNAP benefits if a household member receives lottery or gambling winnings equal to or greater than the SNAP resource limit for elderly or disabled households.
- I understand that I will receive a written notice explaining the benefits. If benefits are denied, changed, suspended or stopped, the written notice will explain why.
- I understand that I will have 30 days (90 days for SNAP (food stamp) benefits) from the date of the notice to request a hearing if I do not agree with the decision made on this application.
- I understand that my situation is subject to verification from employers, financial sources and other third parties.
- I understand that applicants must provide their Social Security number or apply for one if they do not have one. This number may be used to check the information on this application.
- I understand that I must use the Electronic Benefit Transfer (EBT) or the PA ACCESS Card only during the period I am eligible. I must use the EBT or the PA ACCESS Card only for the person who is eligible and may get only the benefits that are needed and reasonable.
- I understand that I may not use Cash Assistance funds issued through my PA ACCESS card to make EBT transactions in liquor stores, casinos (gambling casinos, gaming establishments), or places for adult entertainment.
- I understand that I do not have to provide a Social Security number for anyone who is not applying for assistance. If I do provide their Social Security number, it may be used to check the information on this application.
- I certify that all information that has been entered is true under penalty of perjury.
- I understand that I have the right to a certificate of creditable coverage to verify my medical coverage. Federal law limits when Medical Assistance coverage may be denied or limited for a pre-existing condition. If I enroll in a group health plan that has a pre-existing condition clause, I can get credit for the time I received Medical Assistance.
- I understand that if I am determined eligible for Medical Assistance, I will be placed in the most comprehensive Medical Assistance benefit package that is available to me. I understand that I may be required to enroll in a health plan. I understand that enrolling in a health plan may be free or low cost to me, because the Department pays a monthly fee to the health plan for me. I understand that the monthly fee is a capitation fee. I understand that if I receive Medical Assistance that I am not eligible for, due to error, fraud, or any other reason, then I may be required to repay the Department all monthly fees paid on my behalf.
- If I receive cash benefits, I will cooperate with the requirements of the child support enforcement program as directed by the department. I give the Department and the Domestic Relations Section the right to pursue and collect cash and/or medical support for me and others for whom I am applying.
- I understand that if I report or provide proof of the household expenses, I will get the maximum amount of SNAP (food stamp) benefits allowed. Failure to report or provide proof of the household expenses will be regarded as my statement that I do not want to receive a deduction for the unreported or unproved expense. (Authority: United States Department of Agriculture, Food and Nutrition Service, Mid-Atlantic Region, Administrative Notice 6-99, issued January 4, 1999).
- I understand that I have the right to receive credit for the household expenses at the time I report and provide proof of them at any time during my SNAP (food stamps) certification period.
- I understand that I have the right to ask the county assistance office (CAO) for assistance in getting proof of expenses and that the CAO can contact other people for confirmation if I am having trouble getting proof of anything.
- I understand that if some or all of the individuals applying do not qualify for Medical Assistance, that they may be eligible for CHIP.
- I understand that if some or all of the individuals applying do not qualify for Medical Assistance, that they may be eligible for federal benefits and/or explore private health care options through Pennsylvania's Health Insurance Marketplace (Pennie). If this is the case, I authorize the Department to give my name and information on this application to Pennie.
- **Renewal of coverage in future years:** To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow Pennsylvania's Health Insurance Marketplace (Pennie) to use my income data, including information from tax returns. Pennie will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next:
(Check one):

- ☐ Five years (the maximum number of years allowed)
- ☐ Four years
- ☐ Three years
- ☐ Two years
- ☐ One year
- ☐ Do not use my information from tax returns to renew my coverage.

Sign here:

X

Your signature or your representative's signature _____ Date _____

IMPORTANT: If your household is eligible for SNAP/LIHEAP, you may receive a Fast Track consent form in the mail that could allow you and your household members to be automatically enrolled in Medical Assistance.

Name of Authorized Representative	Address of Authorized Representative	Phone Number

COUNTY ASSISTANCE OFFICE ONLY

I have explained to the applicant her or his rights and responsibilities.

CAO Signature _____ Date _____

pennsylvania
DEPARTMENT OF HUMAN SERVICES

The Pennsylvania Department of Human Services (DHS) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. DHS does not exclude people or treat them differently because of race, color, national origin, age, disability, creed, religious affiliation, ancestry, gender, gender identity or expression, or sexual orientation.

DHS PROVIDES:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact your local county assistance office.

If you believe that DHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: The Bureau of Equal Opportunity, Room 223, Health and Welfare Building, P.O. Box 2675, Harrisburg, PA 17105-2675, (717) 787-1127, PA Relay Services 711, Fax (717) 772-4366, or Email - RA-PWBEOAO@pa.gov. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Bureau of Equal Opportunity is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Appendix A

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Care Coverage. **You do not need to complete this appendix if you are applying only for SNAP.**

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

AI/AN PERSON 1	Please Print All Information
Name (first name, middle name, last name):	Member of a federally recognized tribe? ☐ Yes ☐ No **If yes**, tribe name: _____ State: _____
Has this person ever gotten a service from the Indian Health Service, a tribal health program or urban Indian health program, or through a referral from one of these programs? ☐ Yes ☐ No	If no, is this person eligible to get services from the Indian Health Service, tribal health programs or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
Certain money received may not be counted for health care. List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties. • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations). • Money from selling things that have cultural significance.	$ _____ How often? _____

AI/AN PERSON 2	Please Print All Information
Name (first name, middle name, last name):	Member of a federally recognized tribe? ☐ Yes ☐ No **If yes**, tribe name: _____ State: _____
Has this person ever gotten a service from the Indian Health Service, a tribal health program or urban Indian health program, or through a referral from one of these programs? ☐ Yes ☐ No	If no, is this person eligible to get services from the Indian Health Service, tribal health programs or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
Certain money received may not be counted for health care. List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties. • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations). • Money from selling things that have cultural significance.	$ _____ How often? _____

Appendix B

Health Coverage from Job(s)

Tell us about the job that offers coverage. You DO NOT need to answer these questions unless someone in the household is eligible for health coverage from a job. **You do not need to complete this appendix if you are applying only for SNAP.**

Write your name and Social Security number in the Employee Information section. You may need to ask your employer to help you complete the Employer Information section. If you are unable to get this information from your employer timely, or you feel like completing this would delay the start of your application, you may submit your application without Appendix B.

Attach a copy of this page for each job that offers coverage.

EMPLOYEE Information

Employee name (first, middle, last):	Social Security number:

EMPLOYER Information

Employer name:		Employer identification number (EIN)
Employer address (include street, number, city, state & ZIP code +4):		Employer phone number: ( )
Who can we contact about employee health coverage at this job? ▶	Phone number (if different from above): ( )	Email address:

Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next three months?

☐ **Yes** (continue) If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____

☐ **No** (STOP and return this form to employee)

Tell us about the **health plan** offered by this **employer.**

Does the employer offer a health plan that covers an employee's spouse or dependent(s)? ☐ Yes. Which people: ☐ Spouse ☐ Dependent(s) ☐ No (go to the next question)

Does the employer offer a health plan that meets the minimum value standard?* ☐ Yes (go to the next question) ☐ No (STOP and return form to employee)

For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

How much would the employee have to pay in premiums for this plan? $_____

How often? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If your plan will end soon and you know that the health plans offered will change, go to the next question. If you don't know, STOP and return form to employee.

What change will the employer make for the new plan year?

☐ Employer will not offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question above.)

How much would the employee have to pay in premiums for this plan? $ _____

How often? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

Date of change: (mm/dd/yyyy) _____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(C)(2)(C)(ii) of the Internal Revenue Code of 1986).

Your Rights and Responsibilities Read about your rights and responsibilities:

RIGHT TO NONDISCRIMINATION

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

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.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, 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:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

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You have the right to ask for a Department of Human Services (DHS) hearing to appeal a decision if you believe it is unfair or incorrect, or if DHS fails to act on your application for benefits. You may file the appeal at the CAO. If you appeal, you may also request an agency conference before the hearing. If your appeal involves expedited SNAP benefits, you have the right to have this conference with a supervisor within two work days. At the hearing you may represent yourself, or someone else, such as a lawyer, friend or relative may represent you.

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If you apply for cash or Medical Assistance benefits, the law requires you to cooperate with establishing paternity and seeking support. You may be excused from these requirements if you prove it may be dangerous for you and/or your children. This is known as good cause. Unless a good cause exemption is established, you will be required to meet employment and training requirements. You will also be required to meet semi-annual reporting requirements unless good cause is granted.

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For cash, Medical Assistance and/or SNAP benefits, you must provide an SSN for each person for whom you are applying. If you do not have an SSN, you must apply for one. Not providing an SSN may result in not being able to receive benefits. For cash benefits, we may ask for an SSN for anyone whose income or resources may affect your eligibility or the amount of benefits. Your SSN will be used for identity, for computer matches which verify income and resources, and to prevent duplication of state and federal benefits. A non-citizen who is applying for emergency Medical Assistance only is not required to provide an SSN. (42 U.S. Code 1320b-7)

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Once you are eligible for benefits, you will be issued a PA ACCESS card. This card may only be used for the person who is eligible and only during the eligibility period. You may only use the card for services that are needed and reasonable.

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(i) The collection of this information, 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. 2011-2036d. The information will be used to determine whether your household is eligible or continues to be eligible to participate in the SNAP Program. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management.

(ii) This 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.

(iii) If a SNAP claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action.

(iv) Providing the requested information, including the SSN of each household member, is voluntary. However, failure to provide an SSN will result in the denial of SNAP benefits to each individual failing to provide an SSN. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible household members.

OMB

Prohibitions and Penalties Read about your responsibilities:

IF THIS HAPPENS WITHOUT GOOD CAUSE			THIS MAY HAPPEN (PENALTY)
ALL BENEFITS SNAP CASH MEDICAL ASSISTANCE	Misuse Electronic Benefits Transfer (EBT) Card or PA ACCESS Card.		**Fine, prison, or both.**
	Do not report changes, as required.		**Benefits cut or stopped.**
	On purpose, give information that is false, incorrect or incomplete, or not report changes.		**Fine, disqualification and/or jail time for Welfare Fraud, disqualification for administrative hearing proceedings.** **Not eligible for cash:** • **First time - 6 months.** • **Second time - 12 months.** • **Third time - forever.** **Not eligible for SNAP:** • **First time - 12 months.** • **Second time - 24 months.** • **Third time - forever.**
	Trade, sell or attempt to trade, sell, buy or use another person's ACCESS Card.		**Not eligible:** • **All court convictions - 12 months.**
SNAP	On purpose, misuse SNAP benefits, for example, trade, sell, or buy EBT Card or SNAP benefits; convert benefits; or dump containers purchased with SNAP benefits to receive deposits – or buy things not covered by SNAP, such as alcohol or tobacco – or use SNAP benefits to pay for food already received or food on credit.		**Not eligible:** • **First time - 12 months.** • **Second time - 24 months.** • **Third time - forever.** • **First time court conviction over $500 - forever.**
	Purchase a product with SNAP benefits with the intent of obtaining cash or consideration other than eligible food by reselling the product in exchange for cash or consideration other than eligible food.		
	On purpose, purchase products originally purchased with SNAP benefits in exchange for cash or consideration other than eligible food.		
	Use/receive SNAP benefits to buy drugs or controlled substances.		**Not eligible:** • **First time - 24 months.** • **Second time - forever.**
	Use/receive SNAP benefits in sale of firearms, ammunition, or explosives.		**First time - not eligible forever.**
	Be convicted for buying, selling or trading SNAP benefits for total of $500 or more.		**Not eligible forever.**
	Lie about who you are or where you live to receive more than one SNAP benefit.		**Not eligible for 10 years.**
	Flee to avoid prosecution, custody, or confinement because of a felony/attempted felony – or flee because of breaking probation or parole.		**Not eligible until you do what the law says.**
CASH	Do not comply with your court penalty, including payment of fines, for a felony or misdemeanor.		**Not eligible until you comply with your penalty.**
	Lie about where you live to receive cash in two or more states.		**Not eligible for 10 years.**
	Flee to avoid prosecution, custody, or confinement because of a felony conviction/attempted felony; fail to appear as a defendant at a criminal court proceeding when issued a summons or a bench warrant for a summary offense, felony or misdemeanor; flee because of breaking probation/parole; or have any active warrant against you.		**Not eligible until you do what the law says.**
If you are found guilty of fraud or breaking the above rules:			• **Fine up to $250,000 for SNAP and up to $15,000 for Cash;** • **Jail up to 20 years for SNAP and up to seven years for Cash; and/or** • **Paying back benefits received.** • **Disqualification from benefits for periods stated above by program.**
SNAP WORK RULES	For household members – physically and mentally fit – over age 15 and under 60 – not otherwise exempt or with good cause.		**Not eligible:** • **First time - one month and until you do what is required.** • **Second time - three months and until you do what is required.** • **Three or more times - six months each time and until you do what is required.**
	Refuse to: • Accept a job. • Tell CAO about work status and job availability.	On purpose, take action to: • Quit a job. • Cut work hours to less than 30 per week (unless another job already meets work requirements).	
CASH WORK RULES	Do not meet cash work requirements on purpose, as written on the Agreement of Mutual Responsibility (AMR).		**Not eligible:** • **First violation - You will be ineligible for a minimum of 30 days or until the failure to comply ceases, whichever is longer.** • **Second violation - You will be ineligible for a minimum of 60 days or until the failure to comply ceases, whichever is longer.** • **Third violation - You will be permanently disqualified.** **If the reason for sanction occurs within the first 24 months of receipt of cash assistance, whether consecutive or interrupted, the sanction applies only to the individual.** **If the reason for sanction occurs after 24 months of receipt of cash assistance, whether consecutive or interrupted, the sanction applies to the entire family.**

CLIENT

Understanding Your Rights and Responsibilities

When I sign this form:

- I understand that Pennsylvania receives information from the Income Eligibility Verification System (IEVS), financial institutions, consumer reporting, and state and federal agencies to verify the information I give them. Information available through IEVS and other entities will be requested, used and may be verified through collateral contact when conflicting details are found by the state agency, and such information may affect my household's eligibility and level of benefits.
- I understand that by signing this application, I am authorizing any financial institution to disclose, through electronic or any other means, any and all financial information held by that institution, to the Department of Human Services or its designated agent or contractor for the purpose of identifying and verifying resources (also called "assets") when needed to determine and redetermine eligibility for Medical Assistance. I understand that financial information includes deposits, withdrawals, account closures and other relevant information requested or received from the financial institution, including other transactions undertaken by the financial institution with respect to the account or asset. I understand that this authorization is effective until Medical Assistance eligibility is denied or ends, or if I decide to revoke it by written notification to the department, whichever happens first. I understand that if I revoke this authorization, that may make me or my household ineligible for Medical Assistance.
- I understand that if I misrepresent, hide or withhold facts that may affect my eligibility for benefits, I may be required to repay my benefits and I may be prosecuted and disqualified from receiving certain future benefits.
- I understand that I can designate an authorized representative by completing the Authorized Representative section and submitting it with this application.
- I understand and agree that I am responsible for any fraudulent statements made on this application, even if the application is being submitted by someone acting on my behalf.
- I received a copy of my rights and responsibilities, have read them or someone has read them to me, and I understand them.
- I understand that the information entered in this application will be kept confidential and used only to administer benefits. I authorize the release of personal, financial and medical information for the purpose of determining eligibility.
- I understand that the Department of Human Services or its designees may contact me via methods including email and text messaging to help process my application or request feedback on the application process. If I do not want email or text messages, I understand the Department of Human Services will still process my application.
- I understand that any changes I am required to report must be reported within the first 10 days of the month following the month of change.
- I understand that my household may lose SNAP benefits if a household member receives lottery or gambling winnings equal to or greater than the SNAP resource limit for elderly or disabled households.
- I understand that I will receive a written notice explaining the benefits. If benefits are denied, changed, suspended or stopped, the written notice will explain why.
- I understand that I will have 30 days (90 days for SNAP (food stamp) benefits) from the date of the notice to request a hearing if I do not agree with the decision made on this application.
- I understand that my situation is subject to verification from employers, financial sources and other third parties.
- I understand that applicants must provide their Social Security number or apply for one if they do not have one. This number may be used to check the information on this application.
- I understand that I must use the Electronic Benefit Transfer (EBT) or the PA ACCESS Card only during the period I am eligible. I must use the EBT or the PA ACCESS Card only for the person who is eligible and may get only the benefits that are needed and reasonable.
- I understand that I may not use Cash Assistance funds issued through my PA ACCESS card to make EBT transactions in liquor stores, casinos (gambling casinos, gaming establishments), or places for adult entertainment.
- I understand that I do not have to provide a Social Security number for anyone who is not applying for assistance. If I do provide their Social Security number, it may be used to check the information on this application.
- I certify that all information that has been entered is true under penalty of perjury.
- I understand that I have the right to a certificate of creditable coverage to verify my medical coverage. Federal law limits when Medical Assistance coverage may be denied or limited for a pre-existing condition. If I enroll in a group health plan that has a pre-existing condition clause, I can get credit for the time I received Medical Assistance.
- I understand that if I am determined eligible for Medical Assistance, I will be placed in the most comprehensive Medical Assistance benefit package that is available to me. I understand that I may be required to enroll in a health plan. I understand that enrolling in a health plan may be free or low cost to me, because the Department pays a monthly fee to the health plan for me. I understand that the monthly fee is a capitation fee. I understand that if I receive Medical Assistance that I am not eligible for, due to error, fraud, or any other reason, then I may be required to repay the Department all monthly fees paid on my behalf.
- If I receive cash benefits, I will cooperate with the requirements of the child support enforcement program as directed by the department. I give the Department and the Domestic Relations Section the right to pursue and collect cash and/or medical support for me and others for whom I am applying.
- I understand that if I report or provide proof of the household expenses, I will get the maximum amount of SNAP (food stamp) benefits allowed. Failure to report or provide proof of the household expenses will be regarded as my statement that I do not want to receive a deduction for the unreported or unproved expense. (Authority: United States Department of Agriculture, Food and Nutrition Service, Mid-Atlantic Region, Administrative Notice 6-99, issued January 4, 1999).
- I understand that I have the right to receive credit for the household expenses at the time I report and provide proof of them at any time during my SNAP (food stamps) certification period.
- I understand that I have the right to ask the county assistance office (CAO) for assistance in getting proof of expenses and that the CAO can contact other people for confirmation if I am having trouble getting proof of anything.
- I understand that if some or all of the individuals applying do not qualify for Medical Assistance, that they may be eligible for CHIP.
- I understand that if some or all of the individuals applying do not qualify for Medical Assistance, that they may be eligible for federal benefits and/or explore private health care options through Pennsylvania's Health Insurance Marketplace (Pennie). If this is the case, I authorize the Department to give my name and information on this application to Pennie.
- **Renewal of coverage in future years:** To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow Pennsylvania's Health Insurance Marketplace (Pennie) to use my income data, including information from tax returns. Pennie will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next:
(Check one):

- ☐ Five years (the maximum number of years allowed)
- ☐ Four years
- ☐ Three years
- ☐ Two years
- ☐ One year
- ☐ Do not use my information from tax returns to renew my coverage.

CHIP

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice contains important information about the privacy of your medical information. If you need this notice in another language or someone to interpret, please contact your local county assistance office. Language assistance will be provided free of charge.

Este aviso contiene información importante acerca de la privacidad de su información médica. Si necesita este aviso en otro idioma o alguien para que interprete, comuníquese con la Oficina de Asistencia de su Condado. La asistencia bilingüe será gratuita.

Данное уведомление содержит важные сведения относительно конфиденциальности вашей медицинской информации. Если вам нужно данное уведомление на другом языке или вам нужны услуги устного переводчика, обращайтесь в Бюро помощи вашего округа (County Assistance Office). Переводческие услуги предоставляются бесплатно.

此通知包括关于您的医疗信息的个人隐私方面的重要资料。如果您需要此通知译成其它语言或需要有人替您翻译，请联系您所在地区的郡县援助办事处。可提供免费语言协助。

Thông báo này gồm những thông tin quan trọng về việc bảo mật các chi tiết y tế cá nhân của quí vị. Nếu cần có thông báo này bằng một ngôn ngữ khác hay người để thông dịch, xin quí vị liên lạc với Văn Phòng Trợ Cấp Địa Phương. Trợ giúp ngôn ngữ sẽ được cung cấp miễn phí.

សំបុត្រនេះមានព័ត៌មានសំខាន់អំពីការរក្សាទុកជាសម្ងាត់នូវព័ត៌មានពេទ្យ របស់ណែកអ្នក។ បើណែកអ្នកត្រូវការសំបុត្រនេះ ជាភាសាផ្សេងទៀត ឬត្រូវការអ្នកណាម្នាក់ដើម្បីបកប្រែ សូមទាក់ទងការិយាល័យជំរឿនប្រៀរបស់ណែកអ្នក។ ជំនួយខាងភាសានឹងផ្តល់ឲ្យដោយឥតគិតថ្លៃ។

يحتوي هذا الإخطار على معلومات هامة حول خصوصية المعلومات الطبية المتعلقة بك. إذا كنت بحاجة إلى هذا الإخطار بلغة أخرى أو إلى شخص ما لترجمته لك، فيرجى الاتصال بمكتب معونة المقاطعة المحلي. وستقدم المساعدة اللغوية مجانًا.

The Department of Human Services (DHS) provides and pays for many types of benefits and social services. We also determine an individual's eligibility to receive benefits and services. To do these things, we have to collect personal and health information about you and/or your family. The information we collect about you and/or your family is private. We call this information "protected health information."

DHS does not use or disclose DHS health information unless it is permitted or required by law. DHS is required by law to maintain the privacy of protected health information, to provide individuals with notice of its legal duties and privacy practices concerning protected health information and to notify affected individuals in the case of a breach of unsecured protected health information. As a "covered entity," DHS must follow applicable laws protecting the privacy of your protected health information which include the Health Insurance Portability and Accountability Act (HIPAA) privacy rules. Under HIPAA, Medicaid agencies, certain health plans and health care providers are examples of covered entities that must comply with HIPAA. Other laws that may apply include rules concerning confidential information about Medical Assistance, other benefits, behavioral health, substance abuse/treatment and HIV/AIDS. When we use or disclose protected health information, we make every reasonable effort to limit its use or disclosure to the minimum necessary to accomplish the intended purpose. This notice explains your right to privacy of your protected health information and how we may use and disclose that information. For more information on DHS privacy practices, or to receive another copy of this notice, please contact us. For information on how to contact us, see the "Questions or Complaints" section on the last page of this notice.

We are required by law to follow the terms of this notice. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all protected health information we maintain. If we make an important change in our privacy policies or procedures, we will post a revised copy of the notice on our website and/or provide you with a new privacy notice by mail or in person. You may request and receive a paper copy of this notice at any time.

What is protected health information?

Protected health information is information about you that relates to a past, present or future physical or mental health condition, treatment or payment for treatment, and that can be used to identify you. This information includes any information, whether verbal or recorded in any form, that is created or received by DHS or persons or organizations that contract with DHS. This includes electronic information and information in any other form or medium that could identify you, for example:

- Your name (or names of your children)
- Address
- Date of birth
- Admission/discharge date
- Diagnostic code
- Telephone number
- DHS case number
- Social Security number
- Medical procedure code

Who sees and shares my health information?

DHS professionals (such as caseworkers and other county assistance office and program staff) and people outside of DHS (such as our contractors, health maintenance organization (HMO) staff, nurses, doctors, therapists, social workers and administrators) may see and use your health information to determine your eligibility for benefits, treatment, payment or for other required or permitted reasons. Sharing your health information may relate to services and benefits you had before, receive now, or may receive later. DHS will not use or share genetic information about you when deciding if you are eligible for Medicaid.

Why is my protected health information used and disclosed by DHS?

There are different reasons why we may use or disclose your protected health information. The law says that we may use or disclose information without your consent or authorization for the reasons described below.

For Treatment: We may use or disclose information so that you can receive medical treatment or services. For example, we may disclose information your doctor, hospital or therapist needs to know to give you quality care and to coordinate your treatment with others helping with your care.

For Payment: We may use or disclose information to pay for your treatment and other services. For example, we may exchange information about you with your doctor, hospital, nursing home, or another government agency to pay the bills for your treatment and services.

For Operating Our Programs: We may use or disclose information in the course of our ordinary business as we manage our various programs. For example, we may use your health information to contact you to provide information about appointments, health-related information and benefits and services. We may also review information we receive from your doctor, hospital, nursing home and other health care providers to review how our programs are working or to review the need for and quality of health care services provided to you and/or your family.

For Public Health Activities: We report public health information to other government agencies concerning such things as contagious diseases, immunization information, and the tracking of some diseases such as cancer.

For Law Enforcement Purposes and As Required by Legal Proceedings: We will disclose information to the police or other law enforcement authorities as required by court order.

For Government Programs: We may disclose information to a provider, government agency or other organization that needs to know if you are enrolled in one of our programs or receiving benefits under other programs such as the Workers' Compensation Program.

For National Security: We may disclose information requested by the federal government when they are investigating something important to protect our country.

For Public Health and Safety: We may disclose information to prevent serious threats to health or safety of a person or the public.

For Research: We may disclose information for permitted research purposes and to develop reports. These reports do not identify specific people.

For Coroners, Funeral Directors and Organ Donation: We may disclose information to a coroner or medical examiner for identification purposes, cause of death determinations, organ donation and related reasons. We may also disclose information to funeral directors to carry out funeral-related duties.

For Reasons Otherwise Required By Law: DHS may use or disclose your protected health information to the extent that the use or disclosure is otherwise required by law. The use or disclosure is made in compliance with the law and is limited to the requirements of the law.

Do other laws also protect certain health information about me?

DHS also follows other federal and state laws that provide additional privacy protections for the use and disclosure of information about you. For example, if we have HIV or substance abuse information, with a few exceptions, we may not release it without special, signed written permission that complies with the law. In some situations, the law also requires us to obtain written permission before we use or release information concerning mental health or intellectual disabilities and certain other information.

Can I ask DHS to use or disclose my health information?

Sometimes, you may need or want to have your protected health information sent or otherwise disclosed to someone or somewhere for reasons other than treatment, payment, operating our programs, or other permitted or required purpose not needing your written authorization. If so, you may be asked to sign an authorization form, allowing us to send or otherwise disclose your protected health care information as you request.

The authorization form tells us what, where and to whom the information will be sent or otherwise disclosed. You may revoke your authorization or limit the amount of information to be disclosed at any time by letting us know in writing, except to the extent that DHS has already taken action in reliance upon the authorization.

If you are younger than 18 years old and, by law, you are able to consent for your own health care, then you will have control of that health information. You may ask to have your health information sent to any person who is helping you with your health care.

Except as described in this Notice, we will not use or disclose your health information without your written authorization. For example, HIPAA generally requires written authorization before a covered entity may use or disclose an individual's psychotherapy notes. In most cases, HIPAA also requires written authorization before a covered entity may use or disclose protected health information for marketing purposes or before it sells it.

What are my rights regarding my health information?

As a DHS client, you have the following rights regarding your protected health information that we use and disclose:

Right to See and Copy Your Health Information: You have the right to see most of your protected health information and to receive a copy of it. If you want copies of information you have a right to see, you may be charged a small fee. However, generally, you may not see or receive a copy of: (1) psychotherapy notes; or (2) information that may not be released to you under federal law.

If we deny your request for protected health information, we will provide you a written explanation for the denial and your rights regarding the denial.

DHS does not receive or keep a file of all of your protected health information. Doctors, hospitals, nursing homes and other health care providers (including an HMO, if you are enrolled in one) may also have your protected health information. You also have a right to your health information through your doctor or other provider who has these records.

Right to Correct or Add Information: If you think some of the protected health information we have is wrong, you may ask us in writing to correct or add new information. You may ask us to send the corrected or new information to others who have received your health information from us. In certain cases, we may deny your request to correct or add information. If we deny your request, we will provide you a written explanation of why we denied your request. We will also explain what you can do if you disagree with our decision.

Right to Receive a List of Disclosures: You have the right to receive a list of where your protected health information has been sent, unless it was sent for purposes relating to treatment, payment, operating our programs, or if the law says we are not required to add the disclosure to the list. For example, the law does not require us to add to the list any disclosures we may have made to you, to family or persons involved in your care, to others you have authorized us to disclose to, or for information disclosed before April 14, 2003.

Right to Request Restrictions on Use and Disclosure: You have the right to ask us to restrict the use and disclosure of your protected health information. We may not be able to agree to your request. In fact, in some situations, we are not permitted to restrict the use or disclosure of the information. If we cannot comply with your request, we will tell you why. Except as otherwise required by law, we must grant your request to restrict disclosure to a health plan if the purpose of disclosure is not for treatment and the medical services to which the request applies have been paid out-of-pocket in full.

Right to Request Confidential Communication: You may ask us to communicate with you in a certain way or at a certain location. For example, you may ask us to contact you only by mail.

Right to Receive Notification of a Breach: You have the right to receive notification if there is a breach of your unsecured protected health information

Whom do I contact about my rights or to ask questions about this notice?

You can contact the DHS HIPAA helpline, toll-free at 800-692-7462 to discuss your rights or to ask questions about this notice. You can also contact your caseworker or health care provider or write to DHS's Privacy Office, 3rd Floor West, Health and Welfare Building, 7th and Forster Streets, Harrisburg, PA 17120.

You can receive important information or updates to this notice by visiting DHS's Web site at **www.dhs.pa.gov**.

How do I file a complaint?

You may contact either office listed below if you want to file a complaint about how DHS has used or disclosed information about you. There is no penalty for filing a complaint. Your benefits will not be affected or changed if you file a complaint. DHS and its employees and contractors cannot and will not retaliate against you for filing a complaint.

PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES PRIVACY OFFICE
3RD FLOOR WEST, HEALTH AND WELFARE BUILDING
7TH AND FORSTER STREETS
HARRISBURG, PA 17120

REGION III
U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE FOR CIVIL RIGHTS
150 S. INDEPENDENCE MALL WEST - SUITE 372
PHILADELPHIA, PA 19106-9111

Effective: April, 2003 – Revised July 28, 2015

pennsylvania
DEPARTMENT OF HUMAN SERVICES

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-800-692-7462 (TDD: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-692-7462 (TDD: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-692-7462 (TDD: 711)。

ВНИМАНИЕ: Если вы говорите на русском языке, то вы можете воспользоваться бесплатными услугами перевода. Звоните 1-800-692-7462 (телетайп: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-692-7462 (TDD: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-692-7462 (TTY: 711)

ملحوظة: إذا كنت تتحدث لغة أخرى، فسوف تتوفر لك خدمات المساعدة اللغوية مجانا. اتصل برقم 1-800-692-7462 (رقم هاتف الصم والبكم: 711)

주: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-692-7462 (TDD: 711)번으로 전화해 주십시오.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-692-7462 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-692-7462 (ATS : 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-692-7462 (TDD: 711).

লক্ষ্য করুন: আপনি যদি বাংলায় কথা বলতে পারেন, তাহলে আপনি বিনা খরচে ভাষা সহায়তা পরিষেবা নিতে পারেন। 1-800-692-7462- নম্বরে কল করুন (TTY: 711)

သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 1-800-692-7462 (TTY: 711) သို့ ခေါ်ဆိုပါ။

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-692-7462 (TDD: 711).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-692-7462 (TDD: 711).

ध्यान दिनुहोस्: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने भाषा सहायता सेवाहरू तपाईंको लागि नि:शुल्क रूपमा उपलब्ध छन्। 1-800-692-7462 (TDD: 711) मा फोन गर्नुहोस्।

pennsylvania
DEPARTMENT OF HUMAN SERVICES