STATE OF MONTANA
Department of Public Health and Human Services

# If you need assistance completing this application, please ask an Office of Public Assistance staff member.

**COMPLETION INSTRUCTIONS**:
The Montana Department of Public Health and Human Services (DPHHS) offer several programs to help you. You may either complete this paper application or apply online at www.apply.mt.gov

**Use this application to apply for:**

- Healthcare Coverage
- Medicare Savings Programs
- Supplemental Nutrition Assistance Program (SNAP) benefits
- Temporary Assistance for Needy Families (TANF) cash assistance
- Refugee Cash Assistance (RCA), Refugee Medical Assistance (RMA) or Refugee Social Services (RSS) – including Refugee Employment & Training (RET).

1. **If you don't have time to complete the full application now, complete the entire first page, including signature, and turn in only the top copy of the first page today.** Complete the entire application to the best of your ability. For **SNAP**, you have the right to immediately file an application as long as it contains the name, address and signature of a responsible household member or that of an authorized representative. However your eligibility will not be determined until the application is completed and all verification has been turned in.
2. If you are eligible for **SNAP benefits or RCA**, benefits may start from the date the front page of the application is received. If you are eligible for **TANF cash assistance**, benefits may start from the date the front page of the application is received, or the date you enroll in the WoRC program, if referred, whichever is later. If you are eligible, some **Healthcare** coverage may begin up to three (3) months prior to the month of application. If you are eligible for **RMA**, benefits start the first of the month in which you applied or the date your refugee/asylee status was granted, whichever is later.
3. You may be entitled to receive **SNAP benefits** within seven days (expedited service). See the back of page 1 for details. **Benefits are provided from the application date.**
4. Applications will be processed in accordance with SNAP procedures, including timeliness, notice and Fair Hearing requirements, regardless of whether the application is for SNAP and other programs. The SNAP application will not be denied solely because the household was denied benefits from other programs.
5. Please use black or blue ink (it is easy to read and copies best). Print your answers.
6. If more space is needed to answer any question, attach an additional sheet with appropriate information about each additional person or authorized representative.
7. The application should be filled out by a household member or an authorized representative who knows the financial situation of all household members. The person completing the application is responsible for the answers given.
8. Any question that refers to “household” is referring to those persons applying for assistance and those financially responsible for them. For Healthcare Coverage, Refugee Medical, TANF and SNAP benefits, you need to enter the Social Security number and citizenship for the household.
9. All questions are marked to indicate the program(s) to which they apply.
   **M for Healthcare Coverage**
   **S for SNAP Benefits**
   **C for TANF or Refugee Cash assistance**
   **If only applying for Refugee Social Services, with or without employment and training services, only the first page of this application is needed. Please request a Refugee Services Assessment form to complete prior to your interview, if possible.**

**Please pay particular attention to these codes in the white section of the application.**

10. If applying for **Healthcare Coverage (M)**, complete questions 35 through 44 (light blue background).
11. If applying for **SNAP Benefits (S)**, complete questions 45 through 55 (green background).
12. If applying for **TANF or Refugee Cash Assistance (C)**, complete questions 60 through 62 (light orange background).

For SNAP, the collection of information on the application, including SSN of each household member, is authorized under the Food and Nutrition Act of 2008. As amended, 7 U.S.C. 2011-2036.

DPHHS-HCS-250
(Rev. 04/2016)

STATE OF MONTANA
Department of Public Health and Human Services

# APPLICATION FOR ASSISTANCE

Date Application Received:________________________
Case Number ____________________________________
Date of Interview: ________________________________

**GRAY SHADED AREAS ARE FOR INSTRUCTIONS AND AGENCY USE ONLY.**

Name: ____________________________________________ County:___________________

Street Address: ______________________________ City:__________ Zip:_____ Home Phone Number: ______________________________

Mailing Address: ______________________________ City:__________ Zip:_____ Message Phone Number: ______________________________

E-Mail Address: ______________________________ Cell Phone Number: ________________

Do you live within the geographic boundaries of an Indian Reservation? ☐ Yes ☐ No

If you do not live at a street address, on a separate piece of paper describe how to get to your home.

**Fill in all required blanks for everyone who lives with you** either permanently or temporarily. **You must list** yourself first, then your spouse and children, including unborn children, then other adults and children. (Individuals under age 22 must list their parents if living in the same home with their parents.) If you are only applying for SNAP benefits, please list yourself, your spouse, children under age 22, and any others who purchase and prepare meals with you.

**M - required for Healthcare Coverage and Refugee Medical Assistance**, **S - required for SNAP**, **C - required for TANF or Refugee Cash Assistance**

| Name (Last, First, Middle) | Relation-ship To You | Requesting Yes/No: Healthcare Coverage | Requesting Yes/No: SNAP | Requesting Yes/No: TANF | Birth date | (M,C) Place of Birth | (M,C) Sex | Social Security Number | (M,C) Marital Status | U.S. Citizen Yes/No |
|---|---|---|---|---|---|---|---|---|---|---|
| 1. | SELF | | | | | | | | | |
| 2. | | | | | | | | | | |
| 3. | | | | | | | | | | |
| 4. | | | | | | | | | | |
| 5. | | | | | | | | | | |
| 6. | | | | | | | | | | |

**(S) *SNAP Expedited Service Questions***

What is the total income before deductions your household has received or expects to receive this month?
If zero, enter zero. $________________

How much do the members of your household have in cash and savings? (Give your best estimate)
If zero, enter zero. $________________

How much is your monthly rent/mortgage?
If zero, enter zero. $________________

How much are your current monthly utilities?
If zero, enter zero. $________________

Is anyone in your household a migrant or seasonal farm worker? ☐ Yes ☐ No

***County Use***

Income less than $150 and cash and savings no more than $100? ☐ Yes ☐ No
(If yes, expedite)

Combined income and resources less than rent/mortgage and utilities? ☐ Yes ☐ No
(If yes, expedite)

Destitute migrant/seasonal farm worker with liquid resources not exceeding $100? ☐ Yes ☐ No
(If yes, expedite)

Screened for expedited services: ☐ Yes ☐ No
Eligible for expedited services: ☐ Yes ☐ No
___________ Worker Initial

**Penalty Warning: I swear or affirm the statements made on this application are true or correct.**

X ________________________________________ ____________
Signature or Mark of Applicant (or legal guardian/authorized representative). Date

________________________________________
Witness to Mark (necessary only if applicant cannot sign full name) Date

**INTERVIEW:**

1. After your application is filed, you will be notified of the time and date of your interview (if needed). **An interview is not required, but is recommended for Healthcare Coverage. Complete as much of the application as you can.** A worker will help you with any unanswered questions at the interview. If you do not have all necessary information, this could delay a decision on your application.
2. For SNAP benefits, TANF Cash Assistance and Refugee programs, if you cannot keep your appointment (if needed), **you must schedule another appointment within 30 days of the application date.** If you do not schedule another appointment, your application will be denied.
3. If you are not able to complete a telephone interview or you are unable to find someone to represent you, you can go to your County Office of Public Assistance and request an in person interview.

**TO GET SNAP BENEFITS WITHIN 7 DAYS (EXPEDITED SERVICE):** You may be entitled to expedited services if your income and resources are not enough to cover your monthly rent/mortgage and utilities, or you have very little income or resources, or your household includes a migrant or seasonal farm worker.

1. Complete the application and provide proof of identity of the person listed as number 1 on the first page. If an authorized representative applies for the household, the identity of the person listed as number 1 on the first page and the authorized representative must be verified.
2. If you do not have time to complete this form now, complete the front page and turn it in now. This will ensure your benefits start from today if you are eligible for SNAP benefits.
3. You must complete all questions not marked with a specific code and all questions marked with the letter S.
4. If you are eligible for expedited service, you will receive SNAP benefits for this month even if you cannot provide all the proof needed at this time.
5. If you feel you are eligible for expedited services but your worker says you are not, you may ask for an administrative review or may request a fair hearing either orally or in writing.
6. If you are not eligible for expedited service, your application will be processed within 30 days following the date the signed application was received.

**RIGHTS AND RESPONSIBILITIES:**

1. You have the right to file an application on the same day you contact us. You may either leave the entire application or completed front page or mail it to your County Office of Public Assistance.
2. You do not have to be interviewed or have a scheduled appointment before filing the application.
3. Your application will be processed within 30 days for SNAP and Cash Assistance benefits, and 45 days for Healthcare Coverage and Refugee Medical Assistance. The processing time frame starts from the date of application but can be extended in unusual circumstances as defined by regulation.
4. Applicants soon to be released from an institution may complete an application for SNAP benefits prior to their release. The application filing date for pre-release applicants is the date of release from the institution if applying for SNAP and SSI at the same time.
5. **Each time you apply for SNAP benefits, do not:**
   - **Trade or sell SNAP benefits;**
   - **Purchase food on credit or purchase food that is being resold.**
   - **Use SNAP benefits to get ineligible items such as alcoholic drinks, tobacco, or pay on credit accounts; or**
   - **Use someone else's SNAP benefits for your household or let someone use your benefits.**
6. For SNAP and RCA benefits all adult household members will be required to repay any benefits for which you aren't eligible, including errors caused by this agency. You will be required to repay any TANF, RMA and/or Medicaid, benefits that you aren't eligible to receive for any reason other than this agency's error.
7. 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, nations 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. If you wish to file a Civil Rights program complaint of discrimination, complete the **USDA Program Discrimination Complaint Form(D-3027),** found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. For any other information dealing with the 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; found online at: http://www.fns.usda.gov/snap/sontact_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 of Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington D.C. 20201 or call (202)6190403(voice) or (800)5377967(TTY). This institution is an equal opportunity provider.

**SNAP WORK REQUIREMENTS:**

1. Individuals who are physically and mentally fit and between the ages of **16 and 60** shall be **ineligible** if they: (1) refuse without good cause to provide sufficient information to allow a determination of their employment status or job availability; (2) voluntarily and without good cause quit a job; or (3) voluntarily and without good cause reduce their work effort (and after the reduction, are working less than 30 hours a week).
2. Individuals who reside in a county with a SNAP Employment and Training Program may attend this program.
3. Cash Assistance work requirements do not apply to SNAP.

**TIME LIMITED BENEFITS:**

1. The household may not be eligible for TANF cash assistance benefits if a member of the household has received 60 months of TANF cash assistance benefits in any state. TANF time limits do not apply to Healthcare Coverage, SNAP benefits or Refugee programs.
2. An individual who is an able bodied adult without dependents may not be eligible for SNAP benefits if they have received 3 months of SNAP benefits in a 36-month period, unless they meet an exemption, or meet the work requirement.
3. Refugee Cash Assistance and Refugee Medical Assistance are only available to eligible refugees/asylees for 8 months from date of entry or from the date their asylum status was granted. However, Refugee Social Services, such as employment and training assistance, could extend up to five years from date of entry/ date asylee status was granted, depending on federal funding. This application form is not required to apply for Refugee Social Services. For more information about the Refugee Social Service Program, please ask your Office of Public Assistance Case Manager

**PENALTIES: SNAP AND TANF CASH ASSISTANCE PROGRAMS**:

1. **It is unlawful for you to knowingly make false statements, misrepresent facts, or conceal information to obtain benefits.**
2. **Individuals who knowingly and intentionally break a rule can be prosecuted and fined. Under SNAP, the fine may be up to $250,000 or you may be imprisoned up to 20 years, or both. Individuals are also subject to prosecution under other applicable federal laws. Individuals may also be barred for an additional 18 months if court ordered.**
3. **Any household member who knowingly and intentionally breaks a SNAP or TANF cash assistance rule can be barred from the program for one year for the first violation; for two years for the second violation; and permanently disqualified after the third violation.**
4. **Any SNAP recipient who has been found guilty in a federal, state or local court of trading SNAP benefits for controlled substances (illegal drugs or certain drugs for which a doctor's prescription is required) will be disqualified from participation for two years for the first offense and permanently for the second offense.**
5. **Any SNAP recipient who has been found guilty in a federal, state or local court of trading SNAP benefits for firearms, ammunition, or explosives will be permanently disqualified from participation upon the first occasion of such violation.**
6. **An individual shall be permanently disqualified from SNAP if he/she has been found guilty in a federal, state or local court of trafficking SNAP benefits of $500 or more.**
7. **An individual shall be ineligible to participate in SNAP for ten years if he/she is found to have made a fraudulent statement or representation with respect to identity and/or residence in order to receive multiple benefits simultaneously.**
8. **For TANF cash assistance, an individual shall be ineligible to participate in the TANF cash assistance program for 10 years if he/she is found to have made a fraudulent statement or representation with respect to where they live or benefits received in another state in order to receive multiple benefits simultaneously.**


3

**(M-S-C)1.** **Are you a Montana resident?** ☐ **Yes** ☐ **No**

**(M-C) 2. If you moved to Montana in the last 12 months, what county and state did you come from and when did you move?**

______________________________________________

**Please check one reason why you moved to Montana:**

☐ **Work** ☐ **Like Montana** ☐ **Relatives**
☐ **Cash Assistance (TANF) time limits used up in another state** ☐ **Other**

**(M-S-C) 3. You can choose an AUTHORIZED REPRESENTATIVE to help you with your Healthcare Coverage, RMA, SNAP or Cash Assistance.**

**Do you want your authorized representative to help you with your cash assistance or Medicaid card?** ☐ **Yes** ☐ **No**
**Do you want your authorized representative to help you apply for your SNAP assistance?** ☐ **Yes** ☐ **No**
**Do you want your authorized representative to have access to your Montana Access SNAP account and use your benefits to buy food for you?** ☐ **Yes** ☐ **No**
**Do you want your authorized representative to receive copies of your letters or notices?** ☐ **Yes** ☐ **No**
**Do you have a Power of Attorney or legal guardian?** ☐ **Yes** ☐ **No**

**List the authorized representative's, Power of Attorney, or Legal Guardian's name, address, and telephone number below.** ***(You can name multiple authorized representatives for your SNAP case, but for Medicaid, HMK Plus and RMA, only one per individual. If additional representatives are named, please complete the following information on an additional piece of paper. Be sure to provide the legal documents.)***

______________________________________________

**Last Name** **First Name** **Middle Initial** **Phone**

______________________________________________

**Mailing Address** **City** **Zip**

**(M-S-C) 4. Is any household member temporarily out of the home?** ☐ **Yes** ☐ **No**
**If yes, list name, date left, date to return, where person went (such as in the hospital, away at school, looking for work, etc.)**

______________________________________________

**(M-C) 5. Is anyone in your home pregnant?** ☐ **Yes** ☐ **No**

| Who is Pregnant? | How Many Babies? (Twins, triplets, etc?) | Estimated Due Date | Father of Unborn |
|---|---|---|---|
| | | | |
| | | | |

**(Medical proof may be required)**

**(S-C) 6. Do you share your home with others not listed on the front page?** ☐ **Yes** ☐ **No**
**If so, please list names**

______________________________________________

**(M-S-C) 7. Has anyone listed on page 1 ever used another name (such as a maiden name, former married name, etc.) or Social Security Number?** ☐ **Yes** ☐ **No**
**If yes, please provide details:**

______________________________________________


4

**(M-C) 8. Do you share custody of a child with another adult not included in your household?** ☐ **Yes** ☐ **No**
**If yes, please complete the following:**

| Name of child | Who shares custody with you? | What percentage of the time does this child live with you? |
|---|---|---|
| | | |
| | | |

**(M-S-C) 9. Is any household member currently a student (beyond high school level)?** ☐ **Yes** ☐ **No**
**If Yes and applying for Medicaid, HMK *Plus,* Refugee Medical Assistance, TANF or Refugee Cash, please complete the following box by entering data for each household member age 16 or older.**

| Household Member Name | Attending school (list name of school) | No Degree/ GED/ Diploma | High School Diploma/ GED | Associate's Degree | Bachelor's Degree | Other Credentials |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |

**VOLUNTARY:** Please complete questions 10 and 11 for all household members. These questions regarding ethnic and racial background will not be used to determine your benefit level or eligibility. If you do not answer, your worker will complete this section. Questions about ethnic and racial background are authorized by Title VI of the Civil Rights Act of 1964. The reason for the information is to assure that program benefits are distributed without regard to race, color, or national origin. This answer will not be used to make a decision about your assistance, but will help determine your out-of-pocket expense for healthcare coverage.

**(M-S-C) 10. Please mark one ethnic category for each household member.**

| Household Member Name | Hispanic/Latino | Non-Hispanic/Latino |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**IF MORE SPACE IS NEEDED, ATTACH A SEPARATE SHEET**

**(M-S-C) 11. Please mark one or more racial heritage categories for each household member.**

| Household Member Name | American Indian or Alaskan Native | Asian | Native Hawaiian or Pacific Islander | Black or African American | White |
|---|---|---|---|---|---|
| | | | | | |
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**IF MORE SPACE IS NEEDED, ATTACH A SEPARATE SHEET**

**(M-C) 12. If anyone in the household is an enrolled tribal member, enter the individual's name, the name of the tribe, and the tribal enrollment number.**

| Enrolled Member's Name | Name of Tribe | Tribal Enrollment Number |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**IF MORE SPACE IS NEEDED, ATTACH A SEPARATE SHEET**

**(M-S-C) 13. Is anyone in your household a roomer or boarder (pays for room and/or meals)?** ☐ **Yes** ☐ **No**
If yes, please list who. ______________________________

**(M-S-C) 14. Is anyone unable to work or disabled because of physical or mental health problems?**

(If a payment is not being received, additional information or proof may be required.) ☐ Yes ☐ No

**If yes, complete the following:**

| Name | Medical condition | Source of disability payment |
|---|---|---|
| | | |
| | | |

**(M-S-C) 15. Is any household member unable to work outside the home because he or she is caring for a disabled household member?** ☐ Yes ☐ No

**If yes, please complete the following:**

| Disabled member's name | Name of person providing care | Name of physician | Expected length of disability |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**(M-C) 16. Is anyone applying for assistance an alien (not a U.S. Citizen)?** ☐ Yes ☐ No

**If yes, please complete the following:**

| Alien's Name | Alien Number | Alien Status | Date of Entry into US or date asylum status was granted | Sponsor's Name/Address (If applicable) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**(M-C) 17. Have you ever been declared a Refugee or applied for asylum in the U.S?** ☐ Yes ☐ No
**If yes, what year ____________ and what services do you currently need?**

- ☐ Medical
- ☐ Case Management
- ☐ Immigration/Legal Assistance
- ☐ Cash
- ☐ Employment & Training

****** If you are applying for only Family or Child related Healthcare coverage, please skip to question 22 ******

**(M-S-C) 18. Put a check mark in the box in front of the property/account owned by household members (including children). Include property/accounts jointly owned with others in or outside the household. (If not applicable, please check none).**

- ☐ Bank Account(s)
- ☐ Cash
- ☐ Individual Indian Money Accounts
- ☐ Retirement Accounts
- ☐ Certificates of Deposit
- ☐ Stocks / Bonds
- ☐ Trust Funds
- ☐ Child Support MAC Account
- ☐ Other (Specify)
- ☐ None

**For all items checked, fill in the boxes below.**

| Names of Financial Institutions | Type of Property/Account | Owner(s)/Joint Owner(s) | Amount |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**(M-S-C) 19. Put a check mark in the box in front of the property owned or being purchased by any household member. Include property co-owned with others in or outside the household. (Copies of the contracts will be required for all such arrangements.)** (If not applicable, please check none)

- ☐ The Home You Live In (Include mobile homes)
- ☐ Camper/Trailer (other than the home you live in)
- ☐ Life Insurance (List all policies) (Optional if applying for SNAP only)
- ☐ Farm/Business Equipment
- ☐ Livestock
- ☐ Tools/Equipment for Work
- ☐ Other Houses, Land or Buildings
- ☐ Income Producing Property
- ☐ Contracts for Deed
- ☐ Burial Trust/Contracts/Policies
- ☐ Life Estates
- ☐ Mineral Rights (oil, gas, coal, etc.)
- ☐ Annuity
- ☐ Other (specify) ________________________
- ☐ None

**For all items checked, fill in the boxes below.**

| Owner(s)/Joint Owners | Type of Property/Account | Value | Amount Owed | Location/Account Number | For Sale Yes/No | Equity |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
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**(M-C) 20. Put a check mark in the box in front of all vehicles owned or being purchased by any household member. Include vehicles owned with others in or outside the household.** (If not applicable, please check none).

- ☐ Car
- ☐ Truck
- ☐ Motorcycle/ATV
- ☐ Trailer
- ☐ Other __________________________
- ☐ Snowmobile
- ☐ Boat and/or Boat Motor
- ☐ Motor Home or Recreational Vehicle
- ☐ Airplane
- ☐ None

**Fill in the boxes below for all vehicles, including vehicles that are not running or are not licensed.**

| Year | Make | Model | Owner(s)/Joint Owner(s) | Licensed or Unlicensed | Amount Owed | County Use |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
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**(M-S-C) 21. List any vehicles, money, property or other assets sold, traded or given away by any household member within the last 3 months for SNAP applications or within the last 5 years for Medical.**

***This is evaluated on a case by case basis. If additional information is needed you will be notified.***

| Item | Date sold, traded or given away | Name of person who sold, traded or gave away item | Name of person item was sold, traded or given to | Relationship to person who sold, traded or gave away item |
|---|---|---|---|---|
| | | | | |
| | | | | |
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**(M-S-C) 22. Put a check mark in the box in front of all unearned income (not from employment) received by any household members. (If not applicable, please check none)**

- ☐ Social Security
- ☐ Supplemental Security Income
- ☐ Unemployment Insurance
- ☐ Workers' Compensation
- ☐ Alimony
- ☐ Child Support Current
- ☐ Child Support Arrears(Back Pay)
- ☐ Gifts/Contributions
- ☐ Assistance Payments from a Tribe or Other State
- ☐ General Assistance (includes County or BIA)
- ☐ Interest/Dividends/Annuity payments
- ☐ Trust Payments:
  Do you pay taxes on trust payments? ☐ Yes ☐ No
- ☐ Veterans Benefits
- ☐ Military Allotment
- ☐ Retirement Benefits/Pensions
- ☐ Lease Income
- ☐ Royalties
- ☐ Foster Care Payments/Adoption Payments
- ☐ Insurance Settlement
- ☐ Loans
- ☐ Temporary Disability Insurance
- ☐ Other *(Specify)*
- ☐ None

| Name | Type of Income | How Often Paid | Amount |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**(M-S-C) 23. Has anyone in your household applied for or received Unemployment Insurance (UI) or Workers' Compensation (WC) within the last 12 months?** ☐ **Yes** ☐ **No**

**If yes, complete the following:**

| UI ☐ WC ☐ | UI ☐ WC ☐ |
|---|---|
| Name: ______ | Name: ______ |
| Start Date: ______ End Date: ______ | Start Date: ______ End Date: ______ |
| Reason Terminated/Denied: ______ | Reason Terminated/Denied: ______ |
| Received During Past 12 Months: ☐ Yes ☐ No | Received During Past 12 Months: ☐ Yes ☐ No |

**(M-S-C) 24. Mark the box and list the amount of student financial aid applied for or received within the last 12 months by any household member.**

- ☐ Student Loan $______
- ☐ PELL Grant $______
- ☐ Bureau of Indian Affairs $______
- ☐ Veterans Assistance $______
- ☐ Scholarships $______
- ☐ Other (include family, work study, church, employer, etc.) $______

**(M-S-C) 25. Does anyone expect to receive any money (such as settlement from a legal action, child support, retirement, pensions, disability or accident insurance)?** ☐ **Yes** ☐ **No**

**If yes complete the following:**

| Who will receive money | Source | Expected date | Expected amount |
|---|---|---|---|
| | | | |
| | | | |

**County Use Only**: ______ Date of Accident:

Name of Person Injured: ______ Lawyer's Name: ______

Person or insurance company who is or may be responsible for paying any of these medical costs:

______

**(M-S-C) 26. Is anyone in the household currently working or have they worked in the past 4 months?** ☐ **Yes** ☐ **No**

List all household members who **have worked, will work, or are currently working any kind of job *this month*, or will receive wages *this month* due to work done in a previous month**. Include: Present Employment (full-time and part-time), Spot Jobs, Tips, Commissions, Work Study. **PLEASE PROVIDE WAGE VERIFICATION FOR THIS MONTH AND LAST MONTH**

| | **Complete a column for each job held by any household member** | | |
|---|---|---|---|
| **Person Employed** | | | |
| **This Month's Total Wages Before Taxes** | | | |
| **Business Name** | | | |
| **Business Address** | | | |
| **Business Phone** | | | |
| **Date Job Starts** | | | |
| **Average Hours Per Week** | | | |
| **Pay Per Hour** | | | |
| **Average Tips Per Week** | | | |
| **How Often Paid** | | | |
| **Dates Pay Received** | | | |
| **Ending Pay Period Date** | | | |
| **(M) Is Health Insurance available from your job?** | ☐ **Yes** ☐ **No** | ☐ **Yes** ☐ **No** | ☐ **Yes** ☐ **No** |

**(M-C) 27. Do you or any household member expect a change in earnings or number of hours worked (e.g., vacation, seasonal employment)?** ☐ **Yes** ☐ **No**

If yes, please explain. ______________________________

**(S-C) 28. Has anyone in your household stopped working or reduced work hours in the last 30 days?** ☐ **Yes** ☐ **No**

If yes, fill in the boxes below, and include any wages paid ***this month*** in question 24.

| **Name** | | **Name of Employer** | **Date Left Job or Reduced Hours** |
|---|---|---|---|
| | | | |
| **Date & Amount of Final Check** | **Reason for Leaving** | **Is it a Temporary Layoff?** | **Date Expected to Return to Work** |
| | | | |

*Use separate sheet for additional persons.*

**(S-C) 29. Is anyone in your household on strike?** ☐ **Yes** ☐ **No**

If yes, please list who, when the strike began, employer's name and amount of strike income.

______________________________

**(M-C) 30. Is any member of your household a veteran, a spouse or child of a veteran (living or deceased)?** ☐ **Yes** ☐ **No**

**If yes, complete the following:**

| **Name of Veteran** | **Discharge Date** | **Relationship to You** |
|---|---|---|
| | | |

**Is any member of your immediate family (living with you or are not part of the household) an active duty member of the U.S. Armed Forces? (Including reservists on active duty.)** ☐ **Yes** ☐ **No**

**If yes, complete the following:**

| **Name of Active Duty Individual** | **Relationship to You** |
|---|---|
| | |

**(M-S-C)31. Is anyone in the household self-employed or have they been self-employed within the past year?** ☐ **Yes** ☐ **No**

**If yes, complete the following:**

| Name and Type of Business | Name of Owner | Tax status of Business | Gross Income | For Sale? Yes/No |
|---|---|---|---|---|
| | | ☐ Sole Proprietor<br>☐ Partnership<br>☐ Limited Liability Corporation<br>☐ Corporation<br>☐ S Corporation | | |
| | | ☐ Sole Proprietor<br>☐ Partnership<br>☐ Limited Liability Corporation<br>☐ Corporation<br>☐ S Corporation | | |

****Please Provide Self-Employment Records****

**County Use Only:**

**(M-S-C)32. Is anyone in your household working in exchange for any living expense or housing cost(s)?** ☐ **Yes** ☐ **No**

If yes, please explain. ____________________________________________

____________________________________________

**(M-S-C)33.** List expenses for which you are billed, and responsible to pay. If you do not report and verify expenses, the expense deduction will not be allowed. Not all expenses are allowed for all programs. If anyone outside the household pays any expense for the household, please write their name in the last column.

| Item | Current Total Monthly Cost | Household's Share | Who Assists in Paying the Expense? |
|---|---|---|---|
| Rent | $ | | |
| Lot Rent | $ | | |
| Mortgage | $ | | |
| Property Taxes (if separate from mortgage) | $ | | |
| Home Insurance (if separate from mortgage) | $ | | |
| Electricity | $ | | |
| Natural Gas/Propane | $ | | |
| Oil | $ | | |
| Wood/Coal/Other Heat Source | $ | | |
| Water/Sewer | $ | | |
| Garbage/Trash | $ | | |
| Basic Phone Rate (do not include long distance calls) | $ | | |
| Utility Installation Fee (not deposit) | $ | | |
| Dependent Care (adult or child) | $ | | |
| Child Support (paid) Current (Is it Legally obligated?) (If not paid monthly, how often is it paid?) | $ | | |
| Child Support (paid) Arrears/Back pay | $ | | |
| Alimony/Spousal Support (not for SNAP) | $ | | |
| Medical Insurance Premiums | $ | | |
| Medical Payments/Bills (elderly or disabled only) | $ | | |
| Medicare Premiums | $ | | |
| Other Expenses (specify) | $ | | |

**(M-C-S)** Please check: I live with others and do not pay rent. ☐Yes ☐No

**(M-S)** Please list your primary heating and cooling source ____________________________

Are your utilities included in your rent? ☐Yes ☐No

**(M-S-C)34. If you indicated a dependent care expense above, please complete the following:**

| Child(ren) Name | Person or Program Paying for care | Name of Provider | Monthly Amount Paid | Reason for Care (Check all that apply) | Type of Provider | Is provider a Relative of the Household? | Is provider Licensed ? |
|---|---|---|---|---|---|---|---|
| | | | | ☐ Looking for Work<br>☐ Training/School<br>☐ Employment | ☐ In Home Daycare<br>☐ Family Daycare<br>☐ Group Daycare<br>☐ Daycare Center | Yes ☐<br>No ☐ | Yes ☐<br>No ☐ |
| | | | | ☐ Looking for Work<br>☐ Training/School<br>☐ Employment | ☐ In Home Daycare<br>☐ Family Daycare<br>☐ Group Daycare<br>☐ Daycare Center | Yes ☐<br>No ☐ | Yes ☐<br>No ☐ |
| | | | | ☐ Looking for Work<br>☐ Training/School<br>☐ Employment | ☐ In Home Daycare<br>☐ Family Daycare<br>☐ Group Daycare<br>☐ Daycare Center | Yes ☐<br>No ☐ | Yes ☐<br>No ☐ |

**IF MORE SPACE IS NEEDED, ATTACH A SEPARATE SHEET**

**COMPLETE THE BLUE SECTION (QUESTIONS 36 THROUGH 42) ONLY IF YOU ARE APPLYING FOR HEALTHCARE COVERAGE, OR REFUGEE MEDICAL ASSISTANCE.**

**ATTENTION:** ***ALL MEDICAL APPLICANTS:***

All Medicaid recipients under 21 years of age are eligible for the Early Periodic Screening Diagnostic Treatment (EPSDT) Program. This program promotes preventive health care and offers a comprehensive well-child examination. The examination includes:

- measurement of height and weight
- blood pressure test
- lab tests
- hearing test
- growth and developmental assessment
- immunizations
- dental exam
- vision test

The EPSDT Program also offers follow-up diagnosis and treatment for any problems found.

**ATTENTION:** ***ALL LONG TERM CARE AND HOME AND COMMUNITY BASED SERVICE(WAIVER) APPLICANTS:***
You MUST contact the Mountain Pacific Quality Foundation Screening Team immediately at 1-800-219-7035 or 406-443-0320(In Helena Area). The screening team will set the effective date for Medicaid payment (provided all other eligibility criteria are met). Medicaid payment may not be available for care provided before the screening date.

**(M) 35. Does anyone in the household have medical benefits through either Medicare (Part A, B, C or D) or railroad retirement?** ☐ **Yes** ☐ **No**

**If yes, please list their name(s) and provide verification.**
**Who:**_______________________________ **Medicare Number**_____________________________________
**Who:**_______________________________ **Medicare Number**_____________________________________

**(M) 36. Is a group health insurance plan available to anyone in your household?** ☐ **Yes** ☐ **No**
**Is coverage available through an absent parent?** ☐ **Yes** ☐ **No**
**Is anyone in your household enrolled a group or private insurance?** ☐ **Yes** ☐ **No**

**(M) 37. Is anyone in the household covered by health and/or dental insurance?** ☐ **Yes** ☐ **No**

**If yes, Complete the following information. If you have separate insurance cards for medical, dental or eye care, the** following information must be completed for each coverage. For additional policies, please attach a sheet containing this information.

**Policy Holder:** _______________________________ **SSN:** _________________________________
**Insurance Company(Name and Address):**_________________________________________________
_______________________________________________________________________________
**Policy Number:** _____________________ **Group Number:** ________________________________
**Covered Persons:**____________________________________________________________________

(M) 38. Does anyone in the household have medical bills for services received during the last three months OR is anyone making payments on unpaid medical bills for services received at any time? ☐ Yes ☐ No

If yes, do you want Medicaid coverage for the services received in the last three months? ☐ Yes ☐ No

If yes, list months: ______________________________________________
(Verification of income, resources and medical expenses for each month listed will be required)

(M) 39. Do you intend to file a tax return next year? ☐ Yes ☐ No
Will you file jointly with a spouse? ☐ Yes ☐ No Name of spouse:____________________
Will you claim any dependents? ☐ Yes ☐ No Who: ____________________________
______________________________________________

Will you be claimed as a dependent on someone else's taxes? ☐ Yes ☐ No
If yes, who and what is your relation to that person: ______________________________

Is there a second tax filer in the household? ☐ Yes ☐ No
Who? ________________________ Will they file with a spouse? ☐ Yes ☐ No
Name of Spouse:_____________________ Any Dependents?_______________________________
(If more space is needed attach separate paper)

(M) 40. Were your or anyone in the household in Foster Care and receiving Medicaid at age 18 or older? ☐ Yes ☐ No
Who:______________________________________________

(M) 41. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

(M) 42. Do you want your Medicaid cost share/cash option slips mailed to someone other than yourself? ☐ Yes ☐ No
If yes: Name and address: ______________________________________________
______________________________________________

(M) 43. Do you have any of the following taxable (by the IRS) Income? Check all that apply (if not applicable please select none).

☐ Taxable Interest
☐ Dividends (ordinary or Qualified)
☐ Other (Example: Jury Duty)
☐ Tax Exempt Interest
☐ IRA Distributions
☐ None

| Who? | What Type? | How Often? | How much? |
|---|---|---|---|
| | | | |
| | | | |

(M) 44. Do you have any of the following tax expenses?

☐ Moving Expenses
☐ IRA Deduction
☐ Tuition and Fees
☐ None
☐ Self-Employed health insurance deduction
☐ Student Loan Interest Deduction
☐ Other

| Who? | What Type? | How Often? | How much? |
|---|---|---|---|
| | | | |
| | | | |

(M) 45. Did anyone in your home once receive Supplemental Security Income(SSI) which later stopped? ☐ Yes ☐ No

If yes, does this person now receive Social Security Administration(SSA)benefits? ☐ Yes ☐ No

**COMPLETE THE GREEN SECTION (QUESTIONS 43 and 52) ONLY IF YOU ARE APPLYING FOR SNAP BENEFITS.**


12

(S) **46. Are you approved for or receiving LIEAP?** (Low Income Energy Assistance Program) ☐ **Yes** ☐ **No**

(S) **47. Do you pay heating or cooling costs separate from rent?** ☐ **Yes** ☐ **No**

(S) **48. Does anyone in your household purchase and prepare food separately from other household members?** ☐ **Yes** ☐ **No**

(S) **49. Is anyone in your household certified to receive Tribal food commodities?** ☐ **Yes** ☐ **No**

If yes, who and where? ____________________________________________

(S) **50. Has anyone in your household received SNAP benefits in the last 30 days?** ☐ **Yes** ☐ **No**

If yes, where and when? ____________________________________________

(S) **51. Have you ever had an EBT card issued from Montana?** ☐ **Yes** ☐ **No**
**Do you still have your EBT card?** ☐ **Yes** ☐ **No**

(S) **52. Have you or any member of your household ever been disqualified from SNAP for providing incorrect information or failing to provide information to a caseworker that affected SNAP eligibility and benefits?** ☐ **Yes** ☐ **No**

If yes, list the person's name, date it happened, date disqualified, and the length of the disqualification period.

____________________________________________

____________________________________________

(S) **53. Have you or any member of your household been found guilty of trading SNAP benefits for drugs after September 22, 1996?** ☐ **Yes** ☐ **No**

(S) **54. Have you or any member of your household ever been convicted of trafficking SNAP benefits of $500 or more after September 22, 1996?** ☐ **Yes** ☐ **No**

(S) **55. Have you or any member of your household been found guilty of trading SNAP benefits for drugs, guns, ammunition or explosives after September 22, 1996?** ☐ **Yes** ☐ **No**

(S) **56. Have you or any member of your household been convicted of fraudulently receiving duplicate SNAP benefits in any State after September 22, 1996?** ☐ **Yes** ☐ **No**

**(S-C) 57. Are you, or any member of your household, fleeing to avoid prosecution, or custody/confinement after conviction for a crime which is a felony?** ☐ **Yes** ☐ **No**

**(S-C) 58. Are you, or any member of your household, currently in violation of probation or parole?** ☐ **Yes** ☐ **No**

**(S-C) 59. Are you, or any member of your household, a convicted felon (after August 22, 1996) for possession, use, or distribution of a controlled substance (illegal drugs or certain drugs for which a doctor's prescription is required)?** ☐ **Yes** ☐ **No**

**If yes, please explain. (Has the sentence been discharged? Are you in compliance with the conditions of supervision or actively participating in treatment, if required, or for a crime committed while under the influence of a controlled substance?)**

____________________________________________

____________________________________________

____________________________________________



13

**(S-C) 60. Have you, or any member of your household, ever been found to have fraudulently misrepresented identity or residence in order to obtain multiple benefits at the same time after September 22, 1996?** ☐ **Yes** ☐ **No**

**If yes, who?____________________________ Where? ____________________**

**COMPLETE THE ORANGE SECTION (QUESTIONS 57 THROUGH 60) IF YOU ARE APPLYING FOR TANF OR REFUGEE CASH ASSISTANCE.**

**(C) 61.** Has any household member received family cash assistance in any other state or tribal program between October 1, 1996 and today's date? ☐ Yes ☐ No

If yes, list the household member(s), state, name of tribal program (if applicable), and estimated time period of assistance.

| Household Member Name | State | Tribal Program | Time Period |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**(C) 62.** Does any agency help you in paying your shelter costs? ☐ Yes ☐ No

If yes, please put a check mark in front of the type of assistance received:

☐ Public Housing--Housing units or buildings owned or under the control of the Public Housing Authority.
☐ Rent Subsidy--Any other form of housing in which money is paid from a government-funded housing program.

Amount you pay: $________________________________________

**(C) 63.** Enter the appropriate education level and status for each household member as follows:

| EDUCATION LEVEL | EDUCATION STATUS |
|---|---|
| Enter the highest grade **COMPLETED** for each household member of any age **or** enter one of the following codes for household members who have not yet started or never attended school:<br>**PS** Pre-school<br>**HS** Head start<br>**KI** Kindergarten<br>**NS** Never attended school | Enter the appropriate education status for all household members sixteen (16) years of age or older from the following code table:<br>**H** GED/High School Diploma<br>**A** Associate Degree<br>**B** Bachelor Degree<br>**M** Master Degree<br>**O** Other Degree<br>**N** No Degree/GED/Diploma |

| NAME | EDUCATIONAL LEVEL | EDUCATION STATUS |
|---|---|---|
| | | |
| | | |
| | | |

**(M-C) 64. Do you expect any changes within the next three months regarding the information you gave us today?** ☐ Yes ☐ No

If yes, please explain. ________________________________________
__________________________________________________


14

**(M-S-C)65. If you are not registered to vote where you live now, would you like to register to vote here today?**

If you leave both the “Yes” and “No” boxes blank in question 62, you will be considered to have decided NOT to apply to register to vote at this time. 42 U.S.C § 1073gg-5(a)(6)(B)(iii)

Applying to register or declining to register to vote will NOT affect the amount of assistance this agency will provide you.

☐ Yes, I would like to register to vote here today.

☐ No, I would NOT like to register to vote here today.

☐ No, I am already registered to vote and therefore do NOT want to register to vote here today.

If you believe that someone has interfered with your right to register to vote 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 State, PO Box 202801, Helena, MT 59620-2801; toll free telephone number: 1-888-884-8683.

**(M-S-C)66. Would you like us to help you in filling out the Voter Registration Application form?**

We will help if you want our help. The decision is yours as to whether or not you wish to seek or accept our help in filling out the Voter Registration Application form. You may fill out the Voter Registration Application form in private.

☐ Yes, I would like help in filling out the Voter Registration form.

☐ No, I would NOT like help in filling out the Voter Registration Application form.

Submitting a completed voter registration application to the DPHHS office is **free.** If you choose to complete the voter registration application later, you will be responsible for postage.

| Additional Comments |
| --- |
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15

**READ CAREFULLY BEFORE SIGNING.**
**IF YOU DO NOT UNDERSTAND SOMETHING, ASK YOUR WORKER ABOUT IT.**

I UNDERSTAND THAT:

- □ I must report any changes in my situation to the county Office of Public Assistance. For Healthcare Coverage, Refugee Medical, TANF or Refugee Cash Assistance, changes must be reported within 10 days of knowledge of the change. Late reporting may cause incorrect benefits.
- □ I must provide information and proof as requested to help determine that I am eligible for assistance. DPHHS may help me obtain the proof or contact other persons or agencies to assist me. If I need help with gathering proof, I must tell the Office of Public Assistance that I do need help.
- □ **The information I (we) give here is subject to verification by federal, state, and local officials to determine if the information is factual.** If any information is incorrect, my application may be denied and I may be subject to the criminal penalties for knowingly providing incorrect information. If a SNAP claim arises against your household the information on this application, including all SSN's, may be referred to Federal or State agencies, as well as private claims collection agencies, for claims collection action.
- □ The collection of information on the application including my (our) Social Security number(s) will be used by state and federal agencies to check identity of household members, to prevent duplicate participation, and to exchange information by computer with other agencies (Social Security Administration, Internal Revenue Service, employers, and banks). The information obtained from these sources may affect my eligibility or benefit level and may be verified through collateral contacts when discrepancies are found by the State agency. The Social Security number(s) may also be disclosed to other Federal and State agencies for official examination, and to law enforcement officials for the purpose of apprehending fleeing felons/probation or parole violators. It will also be used for claims collection purposes and used to monitor compliance with program regulations and program management. For SNAP the collection of this information on the application, including SSN of each household member, is authorized under the Food and Nutrition Act of 2008. As Amended, 7 U.S.C 2011-2036.
- □ My (our) alien status information may be verified with United States Citizenship and Immigration Services (USCIS). This information may affect eligibility or level of benefits.
- □ By asking for and receiving TANF or Refugee Cash Assistance, adults may be required to participate in an employment or training activity. may be pro-rated from the date all adults negotiate and sign an agreement to participate in employment or training activities.
- □ Federal and state laws and regulations limit the use and disclosure of confidential or protected health information about applicants and recipients of assistance programs.
- □ If approved for Healthcare Coverage, my (our) rights to any health insurance or other third party payment are automatically assigned by law to the State of Montana.
- □ If approved for TANF cash assistance, my (our) rights to medical and child support are automatically assigned to the State of Montana.
- □ If approved for Healthcare Coverage under certain family-related programs, my (our) rights to medical support are automatically assigned to the State of Montana.
- □ Under Montana law, medical assistance paid on behalf of individuals age 55 or older or anyone who lived in a nursing home (regardless of age) may be subject to recovery from the individual's estate. Additionally, a lien may be placed on any real property owned by any individual who receives medical assistance for nursing home services.
- □ I may request a fair hearing if I disagree with any action taken on my case. For SNAP, the request may be orally or in writing. For other assistance programs, the request must be submitted to the agency in writing. Your case may be presented by a household member or a representative, such as a legal counsel, a relative, a friend or other spokesperson.
- □ By asking for and receiving TANF or Refugee Cash Assistance and/or Medicaid I (we) will be required to apply for and/or accept other benefits, programs, income or assets to which I (we) may be entitled. These include, but are not limited to: Social Security Disability, Child Support, annuity payments, Medicare, Unemployment Insurance, settlements, inheritance, winnings etc.
- □ DPHHS is authorized to match TANF and SNAP recipients' information through the National Directory of New Hires (NDNH). The results may affect your eligibility for TANF and/or SNAP Benefits.
- □ For SNAP the signature of the primary information person, other adult household member or an authorized representative on this application constitutes registering for work of all non-exempt household members.
- □ Information provided by applicants and/or recipients of financial assistance may be subject to verification via a computer matching program with the Social Security Administration. This is authorized per the Privacy Act of 1974; 5 U.S.C. 552a as amended.
- □ Cooperation with a random Program Compliance review is mandatory to remain eligible for continued benefits.

**Required for all programs:**
**I understand the questions on this application and the penalty for withholding or giving false information or breaking any of the rules listed in the penalty warning. I understand and agree to provide documents to prove what I have said. I understand and agree that the Agency may contact other persons or organizations to obtain necessary verification of any statements on this application.**
**By signing below, I certify under penalty of perjury, that all my answers are correct and complete to the best of my knowledge, including information about the citizenship or alien status of each household member. I understand the information provided on this application can be used to establish identity for children under age 16. I have been informed my household is authorized to receive TANF Information and Referral services. I have been given the TANF Information and Referral Service brochure that has information about these services.**

| Your Signature | Today's Date | Witness Signature (If applicant signed with an X) |
|---|---|---|
| | | |

**(M, C)** Signature(s) of ALL other individuals age 18 or older who live with you (if applying for TANF/Refugee Cash Assistance or Medicaid/HMK *Plus*):

| Name | Relationship to Applicant | Date |
|---|---|---|
| | | |
| | | |

 16

| **COUNTY USE ONLY:** | Date of Application: ______________________ |
|---|---|
| Your interview is scheduled for: Date: ______________________ | Time: ____________ |

## VERIFICATION

The following is a list of possible verifications to bring to the interview or submit with your application which may speed up the application process. Social Security Number, Citizenship/alien status and identity must all be verified for all individuals requesting Health Care Coverage. For SNAP benefits, only the head of household needs to verify identity.

**Social Security Numbers:**

- You must be able to provide a Social Security number or proof that you have applied for a number for all individuals requesting assistance for any program (SNAP-**S**, Healthcare Coverage-**M**, or TANF/Refugee Cash Assistance-**C**)

**Citizenship/Alien Status:** (Required only for those requesting Healthcare Coverage or TANF/Refugee Cash Assistance.) SNAP only requires verification of citizenship/alien status if questionable)**:**

- U.S. Passport
- Official Birth Certificate
- Certificate of Naturalization
- USCIS forms
- Alien Registration Card
- Certificate of Citizenship
- Baptismal Certificate (allowed for Medicaid only if within three months of birth)

**Identity:** Medicaid: Required for all household members who are applying for Medicaid, HMK *Plus* or Refugee Medical benefits, and may be needed for spouses, minor children or siblings of those applying and parents of minor children who are applying. SNAP: only the head of household is required to verify their identity**:**

- Driver's license
- State ID card
- Military dependent ID card
- Tribal documents
- Federal or local government ID card
- Military card or draft record
- School ID with picture
- Nursery or day care records

Certain other documents may be accepted as proof of identity based on federal guidance.

**Income and Resources:**

- Pay stubs, pay envelopes, earnings statements from employers
- Award letters for Social Security, Supplemental Security Income, Unemployment Insurance benefits, Workers' Compensation, Veterans Administration benefits, pensions, etc.
- Child support and/or alimony stubs or payment records
- Bank statements for checking accounts and savings accounts
- Financial statements for certificates of deposit or stocks and bonds
- Federal income tax returns, bookkeeping records, expense records
- Rental income or sales contract records/ledgers
- Life insurance and/or burial policies (Not required for SNAP)
- Trust documents
- Statements of loans, gifts or contributions that you have received
- Automobile/equipment statements of loans or balance due (Not required for SNAP)
- Vehicle registrations or titles (Not required for SNAP)
- Printout or other documentation of IIM account activity

**Expenses:** (Providing verification of expenses is optional; however, failure to do so will result in the expense not being allowed which may result in a determination of ineligibility or in fewer benefits)**:**

- Dependent care bills and receipts
- Medical expense bills or statements (medication, doctor bills, hospital bills, insurance premiums). Include copies of Medicare and health insurance explanation of benefits/payment statements.
- Child support paid to a non-household member.

**Other:**

- Doctor's statements of pregnancy and due date (Required for TANF Cash Assistance)
- Copy of certified divorce decree/legal separation (Not required for SNAP)
- Medicare card or information showing eligibility for Medicare Part A, B, C or D (Not required for SNAP, TANF or Refugee Cash Assistance).
- Health insurance policies (Not required for SNAP)
- Commodity release (SNAP Only)
- School Enrollment


17

## An Information and Referral Guide for Families

| Program Name | For more information: |
|---|---|
| Aging Services | 800-551-3191 |
| Big Sky Rx<br>(Medicare Prescription Assistance) | 866-369-1233 |
| Child Abuse Hotline | 866-820-5437 |
| Childcare Resource and Referral | www.bestbeginnings.mt.gov |
| Healthy Montana Kids | 877-543-7669 |
| Community Health Centers | http://www.mtpca.org |
| Domestic Violence Hotline | 800-799-7233 |
| Employment | http://montanajobs.mt.gov |
| Energy Assistance, Weatherization (LIEAP) | 800-332-2272 |
| | http://deq.mt.gov/Energy/warmhomes |
| Food Bank Listings | http://www.mfbn.org |
| Governors Advocacy | 800-332-2272 |
| Montana Housing Division | http://housing.mt.gov |
| Social Security Administration (SSA) | http://www.ssa.gov |
| Unemployment | http://uid.dli.mt.gov |
| Vocational Rehabilitation | http://www.dphhs.mt.gov/detd/vocrehab |
| Women, Infants and Children Supplemental Nutrition (WIC) | 800-433-4298 |

The County Office of Public Assistance provides information and/or referral services to applicants/recipients of public assistance programs. This brochure provides information on some of the programs and services available to help you and your family. Please let your Eligibility Case Manager know if you are interested in more information on these or other programs. Asking for information does not require you to be referred or to participate. Not all programs or services are available everywhere in the state. All programs have different eligibility rules.

DPHHS HCS-185 (Rev. 1/17)

Information and Referral Services

# Temporary Assistance for Needy Families

HCSD

Montana Public Assistance Helpline

1-888-706-1535

P.O. Box 202925
Helena, MT 59620
www.apply.mt.gov

## Pathways Offices and Service Counties

| Office | Counties | Office | Counties |
| --- | --- | --- | --- |
| Career Futures, Inc.<br>55 West Granite<br>Butte, MT 59701<br>406-723-9101 | Silver Bow, South Jefferson, Beaverhead, Deer Lodge, Granite, Powell | DLI Job Service<br>20 West Dog Soldier Street<br>Lame Deer, MT 59043<br>406-447-6611 | Rosebud, Treasure, Powder River |
| Career Transitions<br>189 Arden Drive<br>Belgrade, MT 59714<br>406-388-6701 | Gallatin, Madison | DLI Job Service<br>1201 West Holly #3<br>Sidney, MT 59270<br>406-433-3505 | Richland, Dawson, Wibaux |
| Career Transitions<br>1800 West Koch, #9<br>Bozeman, MT 59718<br>406-522-0791 | Gallatin, Madison | HRDC District IV<br>2229 5th Avenue<br>Havre, MT 59501<br>406-265-6743 | Hill, Liberty, Blaine |
| Community Action Partnership<br>214 Main Street<br>Kalispell, MT 59904<br>406-752-6565 | Flathead | District 6 HRDC<br>300 1st Avenue North #203<br>Lewistown, MT 59457<br>406-535-7488 | Fergus, Golden Valley, Judith Basin, Musselshell, Petroleum, Wheatland |
| Community Action Partnership<br>933 Farm to Market #B<br>Libby, MT 59923<br>406-293-2712 | Lincoln | HRDC District VII<br>7 North 31 Street<br>Billings, MT 59103<br>406-247-4732 | Yellowstone, Carbon, Stillwater, Sweet Grass |
| Community Works<br>311 South Main, Suite A<br>Conrad, MT 59425<br>406-271-2777 | Pondera, Teton, Toole, Glacier | HRDC District VII<br>501 North Center Avenue<br>Hardin, MT 59034<br>406-665-3500 | Bighorn |
| Career Training Institute<br>347 North Last Chance Gulch<br>Helena, MT 59601<br>406-443-0800 | Lewis and Clark, Broadwater, North Jefferson | HRDC District XI<br>303 North Third Street<br>Hamilton, MT 59840<br>406-363-6101 | Ravalli |
| DLI Job Service<br>1018 7th Street South<br>Great Falls, MT 59405<br>406-791-5866 | Cascade, Chouteau | Learning Partners<br>112 West Lewis<br>Livingston, MT 59047<br>406-823-6356 | Park, Meagher |
| DLI Job Service<br>2677 Palmer #222<br>Missoula, MT 59808<br>406-329-1275 | Missoula | Working Innovations<br>414 D 1st Street East<br>Polson, MT 59860<br>406-883-6717 | Lake |
| DLI Job Service<br>201 Main Street<br>Wolf Point, MT 59201<br>406-653-1720 | Roosevelt, Sheridan, Daniels, Custer, Garfield, McCone, Prairie, Fallon, Carter | Working Innovations<br>2504 Tradewinds Way #2<br>Thompson Falls, MT 59873<br>406-241-5434 | Sanders, Mineral |
| DLI Job Service<br>74 4th Street North<br>Glasgow, MT 59230<br>406-228-3938 | Valley, Phillips | | |

## Other Resources

| Resource | Information |
| --- | --- |
| Submit Verification & Paperwork | Mail to: **PO Box 202925 Helena MT 59620-2925**<br>Fax to: **1-877-418-4533**<br>Online: **Apply.MT.gov**<br>Make sure your case number is on each page to avoid documents getting lost. |
| SNAP / TANF EBT Card | To get a new EBT card, check your account balance, or report a lost or stolen EBT card, call **1-866-850-1556** or go to **dphhs.mt.gov/mtaccess**. |
| Medicaid Health Care Coverage | Call Medicaid at **1-800-362-8312** to find a provider or get information on coverage or why a bill was not paid. |
| Medicaid Travel | For travel assistance, call **1-800-292-7114** as soon as you schedule your Medicaid-covered appointment. When calling provide:<br>*Patient's name, address, phone number, and Medicaid ID number.<br>*Name, address, and phone of appointment location.<br>*Type of appointment or service being provided.<br>*To reschedule or cancel an appointment, call **1-800-292-7114**. |
| HMK Blue Cross Blue Shield | For questions related to coverage claims and other inquires, call **1-855-258-3489**. |
| apply.mt.gov | Apply for benefits, report changes, submit renewals, upload verification, check benefit status and amounts, read notices, and print your benefit history online. This requires an internet connection and one-time account setup. Log on to **Apply.MT.gov** to register or learn more. |
| SNAP-Ed | SNAP-Ed provides nutrition education, obesity prevention, and stretching your budget classes free to persons eligible for SNAP. For more information, go to **www.buyeatlivebetter.org** or contact MSU Extension SNAP-Ed at **406-994-6022**. |
| SNAP E&T | SNAP Employment and Training assists SNAP recipients in gaining employment. SNAP E&T is located in Missoula, Yellowstone, and Lewis & Clark Counties. For more information, contact the Montana Public Assistance Helpline at **1-888-706-1535** to determine eligibility and referral. |

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