

## Grandparents as Caregivers Assistance Application

Agency Use Only:	<input type="checkbox"/> Initial	<input type="checkbox"/> Review
Date received in agency:	_____	
Worker:	_____	Date Registered: _____
Case No(s):	_____	
Interview Date:	_____	

### 1. Applicant Information

The applicant is the grandparent or other relative who has legal custody of the minor child or children.

Applicant Name: \_\_\_\_\_ Daytime phone number: \_\_\_\_\_ Message phone number: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### 2. Family Information

Include everyone living in your home, even if you are not applying for them. **Proof of relationship and legal custody for the minor child or children is required.** Legal custody is defined as a court document parental control.

First Name, MI	Last Name	Relation to you?	Sex	Date of Birth	Social Security Number	U.S. Citizen? (Yes or No)	Race	Spoken Language	Written Language	Is this person Receiving any SRS benefits? (Yes or No)
		Self								

### 3. Earned Income

Are any household members (including children) currently working?  No  Yes. If yes, complete the following: **Proof of income is required.**

Name of Household Member	Employer name and phone number	Salary / Hourly Wage	Hours worked per week	How often Paid	Date of next paycheck

**4. Other Income**

Does any household member, including children, get other income – such as child support, Social Security, SSI, VA, workers compensation, unemployment, other pensions or retirement, money from others, trust funds or any other income?  No  Yes. If yes, complete the following: **Proof of income is required.**

Name of Household Member	Type of Other Income	Amount	How Often Received

**5. Important Information**

I understand the questions on this application and I understand the penalties for hiding or giving false information.

1. I certify under penalty of perjury that my answers are correct and complete to the best of my knowledge.
2. I understand that information needed to determine eligibility may be verified by contacting federal, state or local officials, employers or other business entities.
3. I agree to notify the local SRS office within 10 days of changes in income, address, living arrangements or a change in household members which may affect the amount of assistance or my eligibility to receive assistance.
4. My signature authorizes the use of our social security numbers to administer this program.
5. I understand that I have the right to request a fair hearing if I disagree with a decision. A written request must be made within 30 days of the decision.

**6. Signature**

This application must be signed and dated in order to be considered a complete application.

		My signature on this application signifies that I have read and understood the conditions above. It also authorizes employers, medical providers, financial institutions, insurance providers, and other persons or agencies with knowledge of my circumstances to release to Kansas Department of Social and Rehabilitation Services any information, including confidential information, necessary to establish my eligibility. All information provided on this application is protected by state and federal confidentiality laws. A copy of this authorization is as valid as the original.
Signature of Applicant	Date	
Signature of Spouse or other adult	Date	

**I would like information about the following services: (check all that apply)**

- Food Assistance  
  Medical Assistance  
  Caregiver Resources  
  Child Care Assistance  
  Rehabilitation Services  
  Child Support Services