Kansas Department for Children and Families

Application for Benefits for Families

This is your application for the programs and services we offer. Answer all of the questions to the best of your ability. If English is not your primary language, an interpreter will be provided at no cost to you. You are subject to severe penalties for any false or misleading information you supply on this application.

Agency Use Only

Date Received: _____

Date Interviewed: _____

_____ Initial _____ Review

Worker: _____

Case Number(s): _____

This form provides us with the information we need to determine eligibility for you and your family. The following are the programs and services you can apply for with this form:

Food Assistance: Food Assistance is electronic benefits you can use to buy food. If you need help buying food fill out all of the sections where you see the shopping cart. You may be eligible to receive food assistance within 7 days.

Cash Assistance: Cash assistance helps families and pregnant women. To apply for cash, fill out all of the sections where you see the dollar sign.

Child Care Assistance: The child care subsidy program provides benefits to help pay child care costs. To apply for child care, fill out all of the sections where you see the adult and child.

Medical Assistance: Medical assistance programs provide medical coverage for families and pregnant women. Medical coverage may help pay medical bills, doctor's visits and medicine. To apply for medical, fill out all of the sections where you see the medical bag.

Follow These Steps to Apply

- Complete this form or go on-line at www.dcf.ks.gov to apply. If you need help or have questions call 1-888-369-4777.
- Read the questions carefully and answer honestly. If you are applying for someone else, please answer the questions for that person.
- Be sure to sign and date this form. Your application is not complete until it is signed.
- If you can't complete the application right now, give your name, address, and signature on Page 1 and return the form. We need all of the information to see if you can get the help you request.
- Return this form as soon as possible. If you are eligible, some benefits start from the date a signed application is received in our office.
- Mail, fax or bring this form to your local DCF office. It may take 30 to 45 days before your application is processed.
- If an interview is required, we will contact you.
- A list of items we may need from you is on the last page of this form. Please tear off and keep for your records.

Other services: DCF also offers the services listed below. If you would like more information or to apply, please check the appropriate box.

☐ **Child Support Services** - To enforce child support orders and to help assure that children have access to financial support and health care.

☐ **Vocational Rehabilitation** - To help persons with disabilities become employed.

Return this form to:

A. Help Us Decide if You Can Get Food/Medical Assistance Faster

If you have little or no money, we may be able to get you food assistance within 7 days. If you are pregnant, we may be able to get you a medical card within 10 days. Complete this section to help us decide if you can get benefits faster.

1. Is anyone in your household pregnant?

   ☐ No ☐ Yes If yes, list name and due date: _____

2. Will your household's gross income for the month be less than $150?

   ☐ No ☐ Yes

3. Does your household have less than $100 in cash, checking, and savings?

   ☐ No ☐ Yes

4. Is anyone in your household a migrant or seasonal farm worker?

   ☐ No ☐ Yes

5. Enter your current rent/mortgage amount ..... $_____

6. Do you pay for heating or cooling costs? ☐ No ☐ Yes

   If no, check the following utilities you **are** responsible to pay and enter the total amount (if none enter zero):..... $_____

   ☐ Water ☐ Sewer ☐ Trash ☐ Telephone

   ☐ Electricity/gas for cooking or lights ☐ Other _____ ☐ None

7. Enter your household's gross income expected this month..... $_____

8. Enter your household's total money in cash, checking and savings..... $_____

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Expedited FS?

☐ No ☐ Yes

Expedited Medical?

☐ No ☐ Yes

Agency Use Only

Rent/Mortgage $_____

SUA/Actual + $_____

TOTAL = $_____

Expected Income $_____

Cash/Check/ Savings + $_____

TOTAL = $_____

Are the household's shelter expenses more than the expected income and resources?

☐ No ☐ Yes

B. Special Services

If you have been a victim of domestic violence or sexual assault in the last 5 years, you may be eligible for special considerations and services. If you want to find out about available services and have a confidential interview, check this box: ☐

C. Tell Us About Yourself and the People in Your Home

For which program(s) are you applying? Check all that apply.

☐ Food Assistance ☐ Child Care Assistance ☐ Cash Assistance ☐ Medical Assistance

Provide the following information and sign this section of the application.

Name: _____ **Signature:** _____

First Name, Middle Initial, Last Name

Street Address: _____ City: _____ County: _____ Zip: _____

Mailing Address: _____ City: _____ County: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____ E-mail: _____

Are You: ☐ Single ☐ Married(Includes Common Law) ☐ Divorced ☐ Separated ☐ Widowed ☐ Member of an Unmarried Couple

C. Tell Us About Yourself and the People in Your Home (continued)

You must tell us about everyone living in your home. List anyone who lives with you even if they do not need assistance. Also list anyone who usually lives with you, but is away right now, but will return soon.

Social Security numbers and citizenship/immigration status must be provided for all persons for whom you are **requesting food and/or cash assistance**. If you request food and/or cash assistance for a household member who does not meet citizenship/immigration status that person cannot get benefits while the remaining household members who DO meet citizenship/immigration status may quality for benefits. If you choose not to request food and/or cash assistance for certain persons in your household, you do not need to answer questions about Social Security numbers or citizenship/immigration status. However, you may be required to provide financial information for these persons as it may be needed to determine eligibility and amount of benefits for persons who you are applying for.

You may choose not to list your race or ethnic heritage and it will not be used against you. We only ask this information for Federal reporting purposes. Answers will in no way affect eligibility or benefits. If applying for food assistance only, identifying the sex of the household members is not required.

Important information about Social Security numbers- A Social Security number is required for each person for whom food and/or cash assistance is requested. If you are not applying for food and/or cash assistance for certain person(s) in your household, you are not required to provide a Social Security number for that person. For each person for whom you are requesting food and/or cash assistance, if you, without good cause, fail to provide or apply for a Social Security number that person will not be able to get benefits.

Use additional information sections on page 11 or 13 if there are more than 6 persons in your household.

First Name, MI, Last Name	Relation to You	Are you applying for this person?	Sex M/F	Birth Date	Social Security number (optional for child care)	Race/Ethnic Group (optional) **Use codes below** Race	Ethnicity	City and State of Birth/ Citizenship Status (List place of birth and check one box.)
	Self	☐ No ☐ Yes	☐ M ☐ F					City and State of Birth _____ ☐ Citizen ☐ Noncitizen
		☐ No ☐ Yes	☐ M ☐ F					City and State of Birth _____ ☐ Citizen ☐ Noncitizen
		☐ No ☐ Yes	☐ M ☐ F					City and State of Birth _____ ☐ Citizen ☐ Noncitizen
		☐ No ☐ Yes	☐ M ☐ F					City and State of Birth _____ ☐ Citizen ☐ Noncitizen
		☐ No ☐ Yes	☐ M ☐ F					City and State of Birth _____ ☐ Citizen ☐ Noncitizen
		☐ No ☐ Yes	☐ M ☐ F					City and State of Birth _____ ☐ Citizen ☐ Noncitizen

Race/Ethnicity Codes: The following codes are for federal reporting purposes and will not affect your benefits.

Race (choose as many as apply): A = American Indian/Alaskan Native B = Black/African American P = Native Hawaiian/Pacific Islander S = Asian W = White

Ethnicity (choose only one): H = Hispanic or Latino N = Not Hispanic/Latino

C. Tell Us About Yourself and the People in Your Home (continued)

1. Is anyone getting, or has anyone received cash, food, medical or child care assistance, or tribal commodities in this or another state? ☐ No ☐ Yes If yes, complete the following:

   What benefits: _____ State: _____ Month/Year: _____

2. Is anyone in your home disabled?

   ☐ No ☐ Yes If yes, please list name and disability: _____

3. Are any household members living outside the home?

   ☐ No ☐ Yes If yes, list name(s): _____

   Why are they living outside the home? _____

   Date expected to return: _____

4. Do any household members get benefits from the Food Distribution Program on Indian Reservations? ☐ No ☐ Yes

   If yes, where? _____

5. Is anyone in your household fleeing from felony prosecution or jail?

   ☐ No ☐ Yes If yes, list name(s): _____

6. Is anyone in your household in violation of probation or parole?

   ☐ No ☐ Yes If yes, list name(s): _____

The following questions are required by federal law for purposes of the <u>food assistance program only</u>. If you answer yes to any of the questions, make sure to list the name(s) of the persons involved.

7. Has anyone in your household been convicted of trading food assistance benefits for drugs after September 22, 1996?

   ☐ No ☐ Yes If yes, list name(s): _____

8. Has anyone in your household been convicted of buying or selling food assistance benefits over $500 after September 22, 1996?

   ☐ No ☐ Yes If yes, list name(s): _____

9. Has anyone in your household been convicted of fraudulently getting duplicate food assistance benefits in any state after September 22, 1996?

   ☐ No ☐ Yes If yes, list name(s): _____

10. Has anyone in your household been convicted of trading food assistance benefits for guns, ammunitions, or explosives after September 22, 1996?

    ☐ No ☐ Yes If yes, list name(s): _____

D. Tell Us How You Want Us to Communicate with You

We provide interpreter and translation services. Complete this section to help us meet your needs. Does anyone in your household have a primary language other than English? ☐ No ☐ Yes

If yes, write in the names of spoken and/or written language below. Also include other communication needs such as braille, relay, signed English, TDD/TTY, Large Print, Voice Synthesizer Program, etc.

Name	Spoken Language	Written Language	Other Needs

E. Do You Want to Choose Someone to Help Get Your Benefits?

You can name another person to help get your benefits. This person can help fill out the application, answer questions for you, and use the Vision card for you. We will be able to share information with this person. This person will be your authorized representative. Do you want to have someone help you? ☐ No ☐ Yes

If yes, tell us about this person:

Their name _____

Their address _____City_____ST_____Zip_____

Their telephone number _____

Do you want the person named above to have access to your benefits? ☐ No ☐ Yes

If yes, which benefits? ☐ food assistance ☐ cash ☐ child care

If no, do you want to choose someone else to access your benefits? This person will be your authorized representative and can have access to your benefits. We will also be able to share information with this person. ☐ No ☐ Yes

If yes, tell us about this person:

Their name _____

Their address _____City_____ST_____Zip_____

Their telephone number _____

If yes, which benefits? ☐ food assistance ☐ cash ☐ child care

F. Who Eats with You

Food assistance households are based on persons who live together and who buy and cook food together. Do you (or will you after approval) buy and cook food separately from other people in your home? If yes, please list their names and relationship to you: _____

G. Tell Us About Students in Your Home

Special rules apply to students. Complete this information to help us decide if these rules apply to your household.

Is anyone in your home a student in high school, college, or vocational-technical school?

☐ No ☐ Yes If yes, complete the following:

Student's Name	Grade	Name of School	PT - Part Time or FT- Full Time

H. Tell Us About the Parents of Each Child in Your Home

We need to know how the people in your household are related. List name of each child, and the names of both parents - even if the parents do not live together. For unborn children, write "unborn". If you need more room, use page 11 or 13.

Child's Name/ Unborn Child	Mother's Name	Father's Name	Was the mother married to the father when the child was born?
1.			☐ No ☐ Yes
2.			☐ No ☐ Yes
3.			☐ No ☐ Yes
4.			☐ No ☐ Yes

I. Tell Us About Parents Not Living in the Home

To get cash or child care assistance, you must cooperate with Child Support Services (CSS). **If this would put you or your child(ren) in danger of abuse, or if you have other good reasons why you cannot cooperate, please tell us.**

Are there any children in your household who have a parent not living in the home? ☐ No ☐ Yes

If yes, list each child's name or number (see Section H on page 4) and fill out the information for the parent not living in the home in the columns below if known. If you need more room, use page 11 or 13.

	Child's Name/Number	Child's Name/Number	Child's Name/Number	Child's Name/Number
Provide the following information for the **parent not living in the home.**				
	List Parent Information Below the Child's Name.			
Parent's Name				
Date of Birth				
Address				
Phone				
SSN				
Employer Name				
Employer Address				
Employer Phone				
Reason Not in Home				
Date of Last Contact				
If divorced, case # and court where filed				
Will you help CSE begin/ enforce support order for each child?	☐ No - tell us why below ☐ Yes	☐ No - tell us why below ☐ Yes	☐ No - tell us why below ☐ Yes	☐ No - tell us why below ☐ Yes
	If you answered no to the last question, tell us why: _____			

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J. Tell Us About Your Resources

We need to know about your resources to decide if you can get benefits. Does anyone in your household have a trust fund?
☐ No ☐ Yes If yes, we may be contacting you for more information.

Please complete the rest of this section if you want food or cash assistance. If you only want medical assistance, go on to Section K, Earned Income, below.

Does anyone in your household own or have their name on any resources? For example: cash, checking/savings/credit union accounts, certificates of deposit (CD's), stocks, bonds, IRA's, property or any other resources?
☐ No ☐ Yes If yes, complete the following information. If needed, use page 11 or 13 to list more information.

Type of Resource	Name(s) on Resources	Where is Resource Held? (Name of Bank, Credit Union or Company)	Amount or Value

K. Tell Us About Your Earned Income

We need to know about all income from jobs, self-employment, contract labor, etc. Is anyone in your household self-employed or working at a job?
☐ No ☐ Yes If yes, complete the information below for all jobs. Self-employment includes earnings from odd jobs, child care, lawn mowing, snow removal, cosmetic sales, etc. If needed, use page 11 or 13 to list more information.

Name	Employers Name, Phone & Address (if self-employed, list type of business)	Salary or Hourly Wage	Tips or Commission	Weekly Hours Worked	How often do you get paid?	Day of the week paid

Has anyone in your household lost or quit a job in the last 60 days? ☐ No ☐ Yes Last pay: $_____Date_____
Name(s) _____ Employer _____
Last Work Day(s): _____ Reason(s): _____

L. Tell Us About Your Other Income

We also need to know about all other income in your household to decide if you can get benefits.

Does anyone in your household, including children, get other income - such as child support, Social Security, SSI, VA, workers compensation, unemployment benefits, other pension/retirement, money from others, or any other income? ☐ No ☐ Yes
If yes, fill out the information below for all types of income. If needed, use page 11 or 13 to list more information.

Type/Source of Income	Name of Person Who Receives This	Amount Received	How Often Received

Has anyone applied for other income or benefits? ☐ No ☐ Yes
If yes, list who and what income or benefits: _____

M. Tell Us if You Have Child Care Needs

To help us decide if you can get child care benefits, tells us why you need help with child care expenses (check all that apply) :

Are all adults in your home who are employed working at least 20 hours a week? ☐ No ☐ Yes

☐ I have a job

☐ I go to school/training

☐ Other - Explain: _____

Do you need help finding quality child care? ☐ No ☐ Yes

Please fill out the information below for each child who needs child care. Use page 11 or 13 if child care is needed for more than 4 children.

Provide the following for each child	Child's Name	Child's Name	Child's Name	Child's Name
	List Child Care Provider Information Below Each Child's Name			
Provider's Name				
Address				
Phone Number				
Parent's Work/ School Schedule **(daily work/school schedule)**	Day: AM/PM - AM/PM	Day: AM/PM - AM/PM	Day: AM/PM - AM/PM	Day: AM/PM - AM/PM
	Mon	Mon	Mon	Mon
	Tue	Tue	Tue	Tue
	Wed	Wed	Wed	Wed
	Thur	Thur	Thur	Thur
	Fri	Fri	Fri	Fri
	Sat	Sat	Sat	Sat
	Sun	Sun	Sun	Sun
Child's School Schedule **(daily school schedule)**	Day: AM/PM - AM/PM	Day: AM/PM - AM/PM	Day: AM/PM - AM/PM	Day: AM/PM - AM/PM
	Mon	Mon	Mon	Mon
	Tue	Tue	Tue	Tue
	Wed	Wed	Wed	Wed
	Thur	Thur	Thur	Thur
	Fri	Fri	Fri	Fri
	Sat	Sat	Sat	Sat
	Sun	Sun	Sun	Sun
Child's Grade and Name of School/ Headstart				

N. Tell Us About Your Medical Bills and Health Insurance

If you are applying for medical assistance, complete this section to help us decide what medical expenses we can help you with.

1. Does anyone you are applying for have unpaid medical bills from the past three months?

   ☐ No ☐ Yes If yes, list total amount: _____

2. Do you want eligibility determined for the past three months?

   ☐ No ☐ Yes

3. Does anyone you are applying for have health insurance of any kind (other than Medicaid and/or HealthWave)?

   ☐ No ☐ Yes If yes, fill out the chart below and provide copies of your insurance card(s) - (both sides.)

Name of Insurance	Policy Holder	Persons Covered	Type of Coverage	End Date	Policy and Group No.

4. If health insurance has ended in the past six months for anyone you are applying for, please explain why:

_____

O. Tell Us About Your Household Expenses

To help us decide the correct amount of food assistance benefits, tell us about your shelter and other expenses.

Type of Expense	Amount	Who Pays?
Do you rent your home? ☐ No ☐ Yes If renting, list landlord's name, address and phone: _____ _____		
Do you own or are you buying your home? ☐ No ☐ Yes What is the amount of your monthly rent or house payment?	$	
If renting, is this subsidized housing, Section 8, HUD, other? ☐ No ☐ Yes If yes, tell us the amount you are obligated to pay each month	$	
Do you pay property taxes not included in house payment? ☐ No ☐ Yes	$	
Do you pay homeowner's insurance not included in house payment? ☐ No ☐ Yes	$	
Do you pay child or dependent care? ☐ No ☐ Yes	$	
Do you pay child support? ☐ No ☐ Yes List amount paid and court order number for each child: _____	$	
If you are 60 or older, or disabled, do you have any medical expenses? ☐ No ☐ Yes Include health insurance and Medicare Premiums. Use page 11 or 13 to list more information.	$	

Do you have any utility expenses? ☐ No ☐ Yes

Do you pay for heating or cooling costs? ☐ No ☐ Yes

If no, check the following utilities you **are** responsible to pay:

☐ Water ☐ Sewer ☐ Trash ☐ Telephone ☐ Electricity/gas for cooking or lights ☐ Other _____ ☐ None

Have you or anyone at your residence received Low Income Energy Assistance (LIEAP)? ☐ No ☐ Yes

If yes when: _____

Does any one help you pay any of the above household expenses? ☐ No ☐ Yes

If yes, what expenses do you get help with? _____How much do they pay? _____

Please Read This Information Before Signing Page 12

Rights, Responsibilities, and Penalties

- I have read and understand my rights and responsibilities listed on the tear off page at the end of this form.
- I understand the questions on this application form.
- I understand the penalties for hiding information (penalties are shown on the tear off page at the end of this form).
- I understand the penalties for giving false information (penalties are shown on the tear off page at the end of this form).

Citizenship Status

- Signing this form means that I agree everyone living in my home who is asking for assistance is a U.S. citizen or is in legal immigration status. I understand this requirement does not apply to persons asking for Emergency Medical Assistance (SOBRA Program).

Changes You Must Report

- I agree to report changes such as changes in my address, income changes, changes in child care, and changes in individuals who live in my home.
- I understand I will be notified about the changes I am required to report.
- I will tell DCF of changes that might affect my eligibility or benefit level.

We Will Verify the Information You Give Us

- I understand you will verify the information I provide on this application form.
- I understand you may contact other agencies such as federal, state, local officials, employers, medical providers, businesses, financial organizations, and child care providers to verify information.
- I understand you will use the information you verify and that it could affect my eligibility or benefit level.

Information About Social Security Numbers

- I understand that I have to provide or apply for a Social Security number for people in my household who are asking for assistance.
- I understand Department for Children and Families (DCF) and the Kansas Department of Health and Environment - Division of Health Care Finance (KDHE - DHCF) use Social Security numbers to operate. The numbers are used for computer matches with the Social Security Administration, banks, the Internal Revenue Service, and other organizations and agencies.

Information About Child Support Services

- I agree to help Child Support Services (CSS) go after support for the children in my home. I will help CSS establish and enforce support orders for the children.
- I agree to give all alimony and/or child support to DCF for each person in my home receiving cash assistance.
- For medical assistance, I understand this rule only applies to me if both adults and children are found eligible for assistance.

Information About Food Assistance Expenses

- I understand I must report and verify my household expenses or I will not get a deduction for them.

Information About Work Program Cooperation

- I agree that everyone applying for and getting cash assistance will cooperate with work requirements unless exempt.
- I agree that everyone getting food assistance will cooperate with work requirements, unless exempt.
- I understand we may not get cash assistance if someone does not cooperate.
- I understand that the person who does not cooperate may also not get food assistance.

Information About Cash and Food Assistance Benefits

- I understand that I may not use cash assistance benefits to purchase alcohol, tobacco or lottery tickets.
- I understand the time limit for receiving Temporary Assistance for Needy Families (TANF) cash assistance benefits is 48 months.
- I understand that to get TANF cash assistance, all children in the home ages 7-18 must be enrolled in school, including home school that is registered with the Kansas Department of Education. Ineligibility for the entire household will exist if a child in the home is not enrolled in school.
- I understand that I may not not use food assistance benefits to buy non food items, such as alcohol or cigarettes, or to pay on credit accounts.

Information About Medical Assistance Coverage

- I understand the Kansas Department of Health and Environment - Division of Health Care Finance (KDHE - DHCF) is responsible for administering the medical assistance program.

Third Party Resources

- I understand that the Kansas Medical Assistance Program (Title XIX and Title XXI) will pay only for services not covered by other insurance or other third parties.
- I am responsible for using and reporting all third party resources for everyone in my home who receives medical assistance. Examples of third party resources are health insurance coverage, a court settlement, medical support payments, a trust, or a conservatorship. These sources may be legally responsible for paying some of the medical expenses of a person.
- I understand that you may not pay for medical services if you believe a third party resource was not used first.
- I agree to help you go after all third party resources. The Medical Subrogation Unit goes after other parties for payment of medical services. I will help this unit pursue all third party resources.

Payments and Support

- If we are approved for medical assistance, we agree to let payments for medical services go directly to our physicians and other medical providers.
- If we are approved for medical assistance, we will turn over to the Kansas Department of Health and Environment - Division of Health Care Finance (KDHE - DHCF) any medical support payments we get.

Estate Recovery Provisions - The following DOES NOT apply to the Medicare Saving Programs.

- If anyone receives medical assistance after the age 54 or while in an institution, I understand there may be a claim against the estate of the recipient or spouse to recover the medical expenditures made on their behalf.
- I understand you will tell all of our financial institution(s) and other investment companies about your pending claim on the estate.

Health Department Referral

I give my permission for my name and the names of those on my case, our address, telephone number, and eligibility status to be given to medical providers and local health departments so that they may give us information about services they provide. ☐ No ☐ Yes

Information About the Lifeline Telephone Program

- For cash (Temporary Assistance for Families) and food assistance, I agree that DCF may provide my name, address, and telephone number to telephone companies participating in the Lifeline data match. The Lifeline Program provides basic telephone service at a reduced rate.
- I understand that my information is confidential and will only be used by the participating telephone carriers to verify my eligibility for Lifeline telephone assistance.
- I understand that the Lifeline program is not mandatory and that I will have to apply for this service by contacting my local telephone company.
- I understand that not all telephone carriers participate in the Lifeline data match with DCF and that I may have to provide proof of my household income to my local telephone company for them to determine my Lifeline eligibility.

Use this space to write additional information.

Permission to Release Information and Signature

My signature on this application authorizes employers, child care providers, health care providers, financial institutions, insurance providers, benefit providers, and other persons or agencies with knowledge of my circumstances to release to the Kansas Department for Children and Families (DCF) and to the Kansas Department of Health and Environment - Division of Health Care Finance (KDHE - DHCF) any information, including confidential and health information, necessary to establish my eligibility for benefits or to administer any program (including Child Support Services) for which I applied.

I authorize DCF and KDHE-DHCF to share medical information for administrative purposes with other agencies and contractors.

I understand all information provided on this application and all information provided to DCF or KHDE-DHCF staff on my behalf is protected by state and federal confidentiality laws.

This release is valid from the date of signature set out below and shall remain valid until revoked in writing by the undersigned. A copy of this authorization is as valid as the original.

I certify under penalty of perjury that my answers are correct and complete to the best of my knowledge. I understand that in addition to other penalties, it is illegal to obtain, attempt to obtain, or help any other person to obtain, by means of a willfully false statement or representation, or by impersonation, collusion, or other fraudulent device, assistance to which they or I am not entitled, and this shall constitute the crime of theft, as defined by K.S.A. 2011 Supp. 21-5801, which could be a felony offense punished by over 11 years imprisonment and fine of up to a $300,000.

Your Signature	**Date**
Your Spouse's Signature or another adult in your home (Not Required)	Date
Signature of First Witness (if "X" is used)	Date
Signature of Second Witness (if "X" is used)	Date
Signature of Court-Appointed Guardian/Conservator (if applicable)	Date
Signature of Medical Representative (if applicable)	Date

Kansas Voter Registration Information

This section will not affect the assistance or services that you can receive from DCF or KHDE-DHCF.

You can easily register to vote using this website: https://www.kdor.org/voterregistration/

Or, DCF can help you with the voter registration. Would you like our help in registering to vote?

☐ No ☐ Yes ☐ Already registered where I live now.

If you do not check any boxes, you will be considered to have decided not to register to vote at this time. This decision will remain confidential and will be used only for voter registration purposes. If you have additional questions or need to report a problem, you may contact your county elections officer, the Secretary of State's office, or call 1-800-262-VOTE(8683). If you do register to vote, information regarding the office where the application was submitted will remain confidential and be used only for voter registration purposes.

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 you own political party or other political preference, you may file a complaint with the Kansas Secretary of State.

Use this space to write additional information.

Kansas Department for Children and Families
Application for Benefits for Families
Rights and Responsibilities - Read and Tear Off for Your Records

Processing times for your application are:

- within 30 days for child care and food assistance;
- within 45 days for cash and medical assistance.

If you are eligible, benefits will start from the date a signed application is received in the DCF office. You may be able to get food assistance within 7 calendar days if you qualify. We will let you know if you qualify for this special processing.

The following information applies to all programs:

Your Responsibilities

You have a responsibility to:

- provide all information needed to determine your eligibility;
- report changes as required - we will tell you what must be reported (examples include pregnancy, birth, someone leaving or moving into your house, a new job, change of income, new address, etc.);
- turn alimony and child support payments over to DCF if you receive cash assistance, and cooperate with Child Support Services (CSS) if you receive cash assistance (TANF) or child care assistance;
- pay your child care provider for services;
- use, and report to DCF, any resources that could help pay for your family's medical expenses (examples include insurance policies, money won through lawsuits, or medical support payments) (medical assistance only);
- cooperate with Quality Assurance staff if your case is reviewed; and
- look for a job and participate in work related services, starting from the date that you apply for cash assistance.

Your Rights

You have a right to:

- have an interpreter provided at no cost if English is not your primary language;
- have information given to DCF kept confidential, unless directly related to the administration of DCF programs;
- withdraw your application at any time;
- request a fair hearing within 30 days for cash, child care and medical assistance, or within 90 days for food assistance if you disagree with the decision. For food assistance, you may request a fair hearing verbally or in writing. Your case may be presented by a household member or by a representative such as legal counsel, a relative, a friend or other spokesperson;
- know that if you apply for food assistance benefits, your application for food assistance may not be denied solely because benefits have been denied for other programs;
- have your benefits determined from the date this application is received by DCF;
- special considerations and confidential services, if looking for a job or pursuing child support puts you in danger of domestic violence or sexual assault; and

In accordance with Federal Law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food and Nutrition Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs.

To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

DCF has a right to:

- **use the information on this application, including the Social Security number (SSN) of each person in your home, to decide whether your household can get benefits. We will verify this information through computer matching programs. This information will also be used to make sure you are getting the correct amount of benefits. For child care assistance only, SSN is voluntary;**
- **verify the alien status of applicant household members by submitting information from the application to USCIS. The information received may affect the household's eligibility and amount of benefits;**
- **deny benefits to your household if you do not provide requested information;**
- **disclose the information on your application to other federal and state agencies for official examination, and to law enforcement officials for the purpose of arresting people who are running from the law.**
- **refer the information on this application to federal and state agencies, as well as private claims agencies, for claims collection if overpayments arise against your household;**
- **conduct a full investigation of your eligibility including contacting employers, child care providers, banks, doctors, or by visiting your home;**
- **deny your application or prosecute you for fraud if you knowingly give us false information so you can receive assistance; and**
- **give information to the KDHE - DHCF to administer medical assistance.**

Penalties

Families may lose benefits for not cooperating with the following agency programs:

I. Work Programs - looking for work, preparing for employment and keeping a job. (Does not apply to child care.)

A. For TANF, the following penalties apply for failure to cooperate with work programs without good cause:

<u>1st Penalty</u>
Your family will not get TANF cash assistance benefits for a minimum of 3 months.

<u>2nd Penalty</u>
Your family will not get TANF cash assistance benefits for a minimum of 6 months.

<u>3rd Penalty</u>
Your family will not get TANF cash assistance benefits for a minimum of 1 year.

<u>4th and subsequent penalties</u>
Your family will lose TANF cash assistance benefits for a period of 10 years.

To be reinstated in the program and resume receiving your benefit, you will be required to cooperate in an assigned work program activity for 2 consecutive weeks for a 1st penalty and for 3 consecutive weeks for a 2nd and 3rd penalty. These penalties will not carry forward if children in your family become adult cash recipients.

B. For Food Assistance, a comparable penalty as described above will be applied only against the person who failed to cooperate. The rest of the food assistance household can get benefits if otherwise eligible. Eligibility will be redetermined at the end of the penalty period.

Penalties (continued)

II. Child Support Services - establishing a child's paternity and collecting child support. (Does not apply to Food Assistance.) For TANF and Child Care, the following penalties apply for failure to cooperate with Child Support Services without good cause:

1st Penalty
Your family will not get TANF cash assistance or child care benefits for a minimum of 3 months.

2nd Penalty
Your family will not get TANF cash assistance or child care benefits for a minimum of 6 months.

3rd Penalty
Your family will not get TANF cash assistance or child care benefits for a minimum of 1 year.

4th and subsequent penalties
Your family will lose TANF cash assistance or child care benefits benefits for a period of 10 years.

To get your cash and/or child care reopened, you must reapply and the penalized individual must cooperate with Child Support Services.

III. Fraud Penalties

A. Food Assistance - Any member of your household who intentionally breaks the following rules will be disqualified as stated below:

- **Do not lie or hide information to get benefits that your household should not get.**
- **Do not use, or have in your possession, Vision Cards that are not yours.**
- **Do not trade or sell Vision Cards.**

If you make false or misleading statements and you are found guilty of misrepresentation, you will not be able to get food assistance benefits:

- **for 10 years if your misrepresentation was about where you live or who you are in order to get duplicate benefits;**
- **for 1 year if your misrepresentation was about something other than identity or residence and it is your first program violation;**
- **for 2 years if your misrepresentation was about something other than identity or residence and its is your second program violation;**
- **ever again if your misrepresentation was about something other than identity or residence and it is your third program violation.**

Your food assistance eligibility will also be suspended for 2 years or permanently lost if you are convicted of buying or selling over $500 worth of benefits or if you use the benefits, or receive them, in a sale of controlled substances, firearms, ammunition or explosives. In all of these cases, the remainder of your food assistance household can get benefits if they are otherwise eligible, and the rest of the household will still be responsible for repaying the amount of any benefits overpayment that was received by the person disqualified.

B. TANF and Child Care - If you or any member of your TANF or Child Care household intentionally break any of the following rules or are otherwise found to have committed fraud (civil, criminal, or administrative), <u>your family is permanently ineligible for TANF and Child Care assistance.</u> A permanent fraud for TANF purposes means you also cannot get Child Care and a permanent fraud for Child Care purposes means you cannot get TANF.

- **Do not lie, make misleading statements, or hide information to get benefits that your household should not get.**
- **Do not use, or have in your possession, Vision Cards that are not yours.**
- **Do not trade or sell Vision Cards.**

Interview

For food and/or cash assistance, we require an interview as part of the application process. An interview is not required for medical or child care, but you may ask for one. You may request a telephone interview. If you miss the interview, you are responsible for scheduling another one.

☐ Your interview has been scheduled at: ->

☐ Your interview date and time is - Date: _____ Time: _____

☐ Please call for an interview appointment: _____

☐ Other: _____

Information Needed to Process Your Application

We may ask you to provide some or all of the following items. Please be ready to provide this information.

- Proof of where you live.
- Proof of age and identity.
- Proof of citizenship for those who want to receive benefits.
- Proof of non-citizen status for those who want to receive benefits
- Child care bills and receipts.
- Proof of child support and/or alimony paid or received.
- Proof of income (pay stubs, earning statements, rental property/sales contracts, government payments, Workers Compensation, pensions, and other).
- If self-employed, federal income tax returns, bookkeeping records, sales, and expenditure records.
- Life insurance, burial plans, and health insurance policies.
- Rent receipt/house payment (including insurance and property taxes).
- Proof of medical expenses for elderly or disabled persons, such as medication, doctor bills and hospital bills.
- Health insurance cards and premium information.
- Bank statements for checking accounts, savings accounts, or stocks/bonds/mutual funds.
- If anyone in the home is pregnant, provide verification of pregnancy with expected due date.
- Other: _____

We can help you get required verification. If you have any questions, or need help completing the application, call us toll free at 1-888-369-4777.