DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES
Division of Public Welfare • Bureau of Economic Security
123 Chalan Kareta, Mangilao, Guam 96913-6304
Phone: 735-7245 / 735-7274 Fax: 735-7092

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APPLICATION FOR PUBLIC BENEFITS - PART I

PLEASE PRINT CLEARLY IN BLACK OR BLUE INK

1. PLEASE COMPLETE THE FOLLOWING INFORMATION
MARK TYPE OF ASSISTANCE NEEDED

☐ Medicaid ☐ Supplemental Nutrition Assistance Program (SNAP) ☐ Cash ☐ Medically Indigent Program

MARK TYPE OF APPLICATION

☐ New Application ☐ Reapplication/Reopening ☐ Renewal

Medicaid Case No:	SNAP Case No:	Cash Assistance Case No:	MIP Case No:

Name of Applicant			Email Address		
Last	First	MI	Social Security Number	Date of Birth (MM/DD/YY)	
Mailing Address	City		State	Zip Code	
Home Address	Village		Home Phone	Work Phone	
Do you need an interpreter? ☐ YES ☐ NO			Cell Phone	Alternate Phone	

2. PLEASE COMPLETE THIS SECTION FOR EMERGENCY ASSISTANCE

Are you or anyone in your household a victim of domestic violence?	☐ YES	☐ NO
Is anyone in your household pregnant?	☐ YES	☐ NO
Does anyone in your household need off-island health care?	☐ YES	☐ NO
Is anyone in your household a boarder? (paying for room and meal)	☐ YES	☐ NO
Is anyone in your household on strike from work?	☐ YES	☐ NO
Have you refused any job within the last 60 days?	☐ YES	☐ NO

How much is the total household's income for this month (before deductions)? $ _____

The total of your household's cash, bank accounts, savings certificates, stocks or bonds. $ _____

The amount of your rental/mortgage for this month (without arrears). $ _____

The amount of your water/sewer bill for this month (without arrears). $ _____

The amount of your power bill for this month (without arrears). $ _____

The total amount of your gas, telephone, trash bill for this month (without arrears). $ _____

How have you been able to pay for your housing, food, power, water, gas, telephone and medical bills before applying for assistance? _____

SIGNATURE: _____ DATE: _____

Please complete back page

APPLICANT'S RIGHTS:

You have the right to immediately file an application. You can complete this first page and give it to us today. The rest of the application can be completed later and submitted at the time of your interview. If you wish to be considered for Expedited Service, complete the Emergency Assistance Section of this form. If you are eligible for Expedited Services, you may receive your SNAP benefits within seven (7) days. If you are eligible, you will receive SNAP benefits retroactively from today's date. Welfare benefits do not begin until the month after your application is approved. You have the option of answering only those questions that are relevant to the programs for which you are applying for.

Note: ***The sooner you submit this first page, the sooner you can be scheduled for your interview. The receptionist will give you a list of what to bring with you to your interview.***

PRIVACY ACT STATEMENT: The collection of information, including the Social Security Number (SSN) of each household member is authorized under the Food Stamp Act of 1977 as amended, 7 U.S.C. 2011-2036. The information will be used to determine whether your household is eligible to participate in the SNAP, Cash and Medical Programs. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management. This information may be disclosed to other Federal and State agencies for official examination and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law. If a SNAP, cash, or a medical claim arises against your household, the information on your application including SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action. Providing the requested information, including SSN of each household member is voluntary. However, failure to provide an SSN will result in the denial of SNAP, Cash and Medical benefits to each individual failing to provide an SSN. Any SSN provided will be used and disclosed in the same manner as the SSN of eligible household member.

USDA Nondiscrimination Statement: This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex, religious creed, political beliefs or reprisal or retaliation for prior civil rights activity.

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, hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at 1(800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a complaint alleging discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call 1(866) 632-9992. Submit your completed form or letter to USDA by:

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

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

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

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at 1(800) 221-5689 which is also in Spanish or call the State Information/Hotline number (click the link for a listing of hotline numbers by State); found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

To file a complaint of discrimination regarding a program receiving Federal Financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call 1(202) 619-0403 (voice) or 1(800) 537-7697 (TTY).

This institution is an equal opportunity provider.

PENALTY WARNING:

The information you provide will be subject to verification by Federal, State and local officials. Information available through Income Eligibility Verification System (IEVS) will be requested, used and may be verified through collateral contacts. The alien status of household members may be subject to verification with Immigration and Naturalization Service (INS). Information obtained through IEVS or from INS may affect your eligibility and level of benefits. Benefits may be denied if any information is incorrect. **You may be criminally prosecuted and fined up to $10,000.00 and imprisoned up to five (5) years for knowingly providing incorrect information. If you intentionally break any program rules, you may be disqualified for one (1) year for the first violation, two (2) years for the second violation and permanently for the third violation. Intentional violations of program rules may disqualify you from both SNAP and cash assistance programs.**

I understand the penalties for providing false or incorrect information and certify under penalty or perjury the truth of the information contained in this application.

SIGNATURE	TODAY'S DATE

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APPLICATION FOR PUBLIC BENEFITS - PART II

PLEASE PRINT CLEARLY IN BLACK OR BLUE INK

1. PLEASE COMPLETE THE FOLLOWING INFORMATION

MARK TYPE OF ASSISTANCE NEEDED

☐ Medicaid ☐ Supplemental Nutrition Assistance Program (SNAP) ☐ Cash ☐ Medically Indigent Program (MIP)

MARK TYPE OF APPLICATION

☐ New Application ☐ Reapplication/Reopening ☐ Renewal

Medicaid Case No:	SNAP Case No:	Cash Assistance Case No:	MIP Case No:

Name of Applicant				
Last	First	MI	Social Security Number	Date of Birth
Mailing Address	City		State	Zip Code
Home Address			Home Phone	Work Phone
Email Address			Cell Phone	Alternate Phone

2 CERTIFICATION THAT NO MEMBERS ARE FLEEING FELONS OR HAVE BEEN CONVICTED OF A DRUG FELONY

IF YOU ANSWER YES TO THESE QUESTIONS, COMPLETE THE INFORMATION TO THE RIGHT.	NAME OF APPLICANT (Last, First, M.I.)	SOCIAL SECURITY NUMBER
Have you or any member of your household been convicted of a felony involving the possession, use or distribution of illegal drugs after August 22, 1996? ☐ YES ☐ NO		
Are you or any member of your household fleeing to avoid prosecution or custody for a crime, or attempting to commit a crime that is a felony in the place you or the household member is fleeing from, or violating a condition of probation or parole? ☐ YES ☐ NO		

I certify under penalty of perjury that I have completed the above information truthfully and the information provided may be compared to court records.

Applicant's Signature _____ Date _____

3 FOR OFFICIAL USE ONLY

ETHNIC CODES

African American	AF	Chamorro - Guam	CG	German	GE	Palauan	PA
American Indian/Alaskan Native	AA	Chamorro - Rota	CR	Hawaiian	HN	Pohnpeian	PO
American Samoan	AS	Chamorro - Saipan	CS	Hispanic	HI	Portuguese	PE
Asian Indian	AI	Chamorro - Tinian	CT	Japanese	JP	Soviet Jew	SJ
Australian	AU	Chinese	CI	Korean	KO	Thai	TH
Cambodian	CB	Chuukese	TR	Kosraean	KS	Vietnamese	VI
Canadian	CN	Cuban	CU	Marshallese	MA	Yapese	YP
Caucasian	CA	Filipino	FO	Mexican	ME	Other	OT

CITIZENSHIP CODES

Alien	AL
FAS citizen	FS
Permanent Resident	PR
United States citizen	US

MARITAL STATUS CODES

Divorced	DI	Separated	SE
Married	MA	Widowed	WI
Single	SI	Other	OT

RELATIONSHIP CODES

Head of Household	HH	Son	SO
Daughter	DA	Spouse	SP
Granddaughter	GD	Other	OT
Grandson	GS		

4 HOUSEHOLD MEMBERS

LIST YOURSELF AND ALL PERSONS WHO LIVE WITH YOU. THE ELIGIBILITY SPECIALIST WILL DETERMINE WHO QUALIFIES FOR ASSISTANCE. DO NOT LIST PERSON INCLUDED IN SECTION 2 OF PAGE 2.

										CURRENTLY PARTICIPATING IN:					
				CITIZENSHIP	ETHNICITY	RELATIONSHIP (to head of household)	PREGNANT (Check Mark)	DISABLED (Check Mark)	HIGHEST GRADE LEVEL COMPLETED	MEDICAID	SNAP	MIP	CASH	CHILD CARE	ELIGIBLE?
1. Your Name (Last, First, M.I.)	SEX	ALIEN NUMBER													Y
SOCIAL SECURITY NUMBER	DATE OF BIRTH (mm/dd/yy)	MARITAL STATUS	DATE OF ENTRY	ABSENT PARENT NAME (Last, First, M.I.)											N
2. Name (Last, First, M.I.)	SEX	ALIEN NUMBER													Y
SOCIAL SECURITY NUMBER	DATE OF BIRTH (mm/dd/yy)	MARITAL STATUS	DATE OF ENTRY	ABSENT PARENT NAME (Last, First, M.I.)											N
3. Name (Last, First, M.I.)	SEX	ALIEN NUMBER													Y
SOCIAL SECURITY NUMBER	DATE OF BIRTH (mm/dd/yy)	MARITAL STATUS	DATE OF ENTRY	ABSENT PARENT NAME (Last, First, M.I.)											N
4. Name (Last, First, M.I.)	SEX	ALIEN NUMBER													Y
SOCIAL SECURITY NUMBER	DATE OF BIRTH (mm/dd/yy)	MARITAL STATUS	DATE OF ENTRY	ABSENT PARENT NAME (Last, First, M.I.)											N
5. Name (Last, First, M.I.)	SEX	ALIEN NUMBER													Y
SOCIAL SECURITY NUMBER	DATE OF BIRTH (mm/dd/yy)	MARITAL STATUS	DATE OF ENTRY	ABSENT PARENT NAME (Last, First, M.I.)											N
6. Name (Last, First, M.I.)	SEX	ALIEN NUMBER													Y
SOCIAL SECURITY NUMBER	DATE OF BIRTH (mm/dd/yy)	MARITAL STATUS	DATE OF ENTRY	ABSENT PARENT NAME (Last, First, M.I.)											N
7. Name (Last, First, M.I.)	SEX	ALIEN NUMBER													Y
SOCIAL SECURITY NUMBER	DATE OF BIRTH (mm/dd/yy)	MARITAL STATUS	DATE OF ENTRY	ABSENT PARENT NAME (Last, First, M.I.)											N
8. Name (Last, First, M.I.)	SEX	ALIEN NUMBER													Y
SOCIAL SECURITY NUMBER	DATE OF BIRTH (mm/dd/yy)	MARITAL STATUS	DATE OF ENTRY	ABSENT PARENT NAME (Last, First, M.I.)											N
9. Name (Last, First, M.I.)	SEX	ALIEN NUMBER													Y
SOCIAL SECURITY NUMBER	DATE OF BIRTH (mm/dd/yy)	MARITAL STATUS	DATE OF ENTRY	ABSENT PARENT NAME (Last, First, M.I.)											N
10. Name (Last, First, M.I.)	SEX	ALIEN NUMBER													Y
SOCIAL SECURITY NUMBER	DATE OF BIRTH (mm/dd/yy)	MARITAL STATUS	DATE OF ENTRY	ABSENT PARENT NAME (Last, First, M.I.)											N

5 STUDENT INFORMATION

LIST ALL STUDENTS IN YOUR HOUSEHOLD.

HOUSEHOLD MEMBER'S NAME (Last, First, M.I.)	NAME OF SCHOOL	TYPE OF SCHOOL/ TRAINING PROGRAM	CLASS HOURS PER WEEK

6 LIQUID RESOURCES/NON-FIXED ASSETS CODES

USE THESE CODES TO COMPLETE SECTION 7 BELOW

Cash Held by Others - - - - - - - - - - - - CO	Life Insurance with Cash Value - - - - - - - LI	Savings Bonds - - - - - - - - - SB
Cash on Hand - - - - - - - - - - - - - - - CH	Money Market Certificates (Shares) - - - - MM	Stocks and Bonds - - - - - - ST
Checking Account - - - - - - - - - - - - CA	Mutual Funds - - - - - - - - - - - - - - - - - MF	Time Certificate - - - - - - - - TC
Health Insurance with Cash Value - - - HI	Pension Plan - - - - - - - - - - - - - - - - - PN	Trust Funds - - - - - - - - - - - TR
Individual Retirement - - - - - - - - - - IR	Savings Account - - - - - - - - - - - - - - - SA	Other - - - - - - - - - - - - - - - OT

7 LIQUID RESOURCES/NON-FIXED ASSETS

LIST THE LIQUID RESOURCES OF EACH MEMBER OF YOUR HOUSEHOLD. USE THE CODES LISTED IN SECTION 6 ABOVE TO INDICATE EACH TYPE OF RESOURCE. INCLUDE ALL JOINTLY OWNED RESOURCES. DESCRIBE ANY RESOURCES LISTED AS "OT" (OTHER).

LIQUID RESOURCE/NON-FIXED ASSET TYPE		HOUSEHOLD MEMBER IT BELONGS TO	WHERE IT IS LOCATED	VALUE
CODE	DESCRIBE OTHER			
				$
				$
				$
				$
				$
				$
				$
				$

8 NON-LIQUID RESOURCES/FIXED ASSETS CODES

USE THESE CODES TO COMPLETE SECTION 9 BELOW

Buildings - - - - - - - - - - - - - - - B	Land, No House - - - - - - - - - - L	Rental Property - - - - - - - - - - - - - - - - - - R
Burial Plot - - - - - - - - - - - - - - BP	Land With House - - - - - - - - - LH	Vacation and Recreational Property - - - - - V
House Other Than Home - - - - - H	Off-Island Property - - - - - - - - P	Other - OT

9 NON-LIQUID RESOURCES/FIXED ASSETS

LIST THE NON-LIQUID RESOURCES OF EACH MEMBER OF YOUR HOUSEHOLD. USE THE CODES LISTED IN SECTION 8 ABOVE TO INDICATE EACH TYPE OF RESOURCE. INCLUDE ALL JOINTLY OWNED RESOURCES, DESCRIBE ANY RESOURCES LISTED AS "OT" (OTHER).

NON- LIQUID RESOURCE/ASSET TYPE		HOUSEHOLD MEMBER IT BELONGS TO	WHERE IT IS LOCATED	VALUE
CODE	DESCRIBE OTHER			
				$
				$
				$
				$
				$
				$

10 MOTOR VEHICLES

LIST ALL VEHICLES USED BY YOUR HOUSEHOLD. INCLUDE ALL JOINTLY OWNED VEHICLES.

ITEM	VEHICLE 1	VEHICLE 2	VEHICLE 3
REGISTERED OWNER OF VEHICLE			
NAME OF PERSON WHO USES VEHICLE			
YEAR, MAKE, MODEL			
LICENSE PLATE NUMBER			
PRINCIPAL BALANCE OWED	$	$	$
APPRAISED VALUE/FAIR MARKET VALUE	$	$	$

11 PROPERTY TRANSFER

IF YOU OR ANYONE IN YOUR HOUSEHOLD HAD GIVEN AWAY, SOLD, OR TRANSFERRED MONEY, VEHICLES, PROPERTY OR OTHER RESOURCES/ASSETS IN THE LAST THREE (3) MONTHS, COMPLETE THE FOLLOWING INFORMATION.

DESCRIPTION OF PROPERTY	DATE OF TRANSFER	VALUE AT TIME OF TRANSFER	AMOUNT RECEIVED	BALANCE
		$	$	$
		$	$	$
		$	$	$

12 INCOME CODES

USE THESE CODES TO COMPLETE SECTIONS 13 AND 14

EARNED INCOME CODES

Civil Service (Federal) Employment	FG
Government of Guam Employment	GG
Military Earnings	MA
Private Enterprise Income	PE
Other	OT

UNEARNED INCOME CODES

Alimony and Child Support	AY
Civil Service (Federal) Retirement	FR
Dividends and Interest	DI
Foster Care Payments	FO
GHURA Subsidy (Utilities)	GH
Government of Guam Retirement	GR
Life Insurance Benefits	LI
Lump Sum Payments	LP
Military Exchange Retirement	MX
Money From Friends, Relatives, Etc.	MO
Payments For Property Sold	PP
Property Rent Payments	PR
Scholarship, Fellowship, Loan	SC
Social Security Benefits	SS
Striker's Benefits	ST
Supplemental Security Income (SSI)	SI
Veteran's Pension	VA
Welfare Payments (Including GA)	PA

13 EARNED INCOME

PLEASE BRING TWO (2) RECENT EMPLOYMENT CHECK STUBS, USE THE CODES IN SECTION 12 ABOVE TO INDICATE THE TYPE OF EARNED INCOME. DESCRIBE ANY INCOME LISTED AS "OT" (OTHER). FOR HOW OFTEN PAID, SPECIFY IF DAILY, WEEKLY, BI-WEEKLY, SEMI-MONTHLY OR MONTHLY.

NAME OF HOUSEHOLD MEMBER RECEIVING INCOME (Last, First, M.I.)	TYPE OF EARNED INCOME		DATE EMPLOYED	HOW OFTEN PAID	GROSS AMOUNT
	CODE	PLACE OF EMPLOYMENT			
					$
					$
					$
					$
					$
					$
					$

14 SELF-EMPLOYMENT INCOME

PLEASE BRING MOST RECENT 1040 TAX FORM AND 12 MOST RECENT GROSS RECEIPT TAX FORMS.

NAME OF HOUSEHOLD MEMBER RECEIVING INCOME (Last, First, M.I.)	TYPE OF SELF-EMPLOYMENT	DATE EMPLOYED	HOW OFTEN PAID	GROSS AMOUNT
				$
				$
				$

15 UNEARNED INCOME

USE THE CODES IN SECTION 12 (PAGE 6) TO INDICATE THE TYPE OF UNEARNED INCOME. DESCRIBE ANY INCOME LISTED AS "OT" (OTHER). FOR HOW OFTEN PAID, SPECIFY IF DAILY, WEEKLY, BI-WEEKLY, SEMI-MONTHLY OR MONTHLY.

NAME OF HOUSEHOLD MEMBER RECEIVING INCOME (Last, First, M.I.)	TYPE OF UNEARNED INCOME		HOW OFTEN PAID	GROSS AMOUNT
	CODE	DESCRIBE OTHER		
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$

16 EMPLOYMENT HISTORY

PLEASE REPORT THE LAST EMPLOYMENT FOR EACH MEMBER OF THE HOUSEHOLD.

EMPLOYEE NAME (Last, First, M.I.)	EMPLOYER NAME AND ADDRESS	DATES EMPLOYED		REASON FOR LEAVING	MONTHLY GROSS INCOME
		FROM MONTH/YEAR	TO MONTH/YEAR		
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$

17 DEPENDENT CARE

IF YOU OR ANYONE IN YOUR HOUSEHOLD PAYS FOR THE CARE OF A CHILD OR DISABLED ADULT SO SOMEONE CAN WORK, LOOK FOR WORK, ATTEND TRAINING, OR GO TO SCHOOL, COMPLETE THE FOLLOWING INFORMATION.

NAME OF PERSON WHO PAYS FOR DEPENDENT CARE	NAME OF PERSON WHO PROVIDES THIS CARE	AMOUNT PAID	HOW OFTEN PAID
		$	
		$	
		$	

18 CHILD SUPPORT

IF YOU OR ANYONE IN YOUR HOUSEHOLD PAYS CHILD SUPPORT AS ORDERED BY THE COURT, COMPLETE THE FOLLOWING INFORMATION.

NAME OF PERSON WHO IS PAYING CHILD SUPPORT	NAME OF PERSON WHO IS PAID CHILD SUPPORT	NAME OF CHILD	AMOUNT PAID	HOW OFTEN PAID
			$	
			$	
			$	

19 SHELTER AND UTILITIES

LIST THE AMOUNT OF YOUR LAST BILL FOR EACH OF THE EXPENSES LISTED BELOW.

ITEM	MONTHLY AMOUNT	ITEM	MONTHLY AMOUNT
RENT/MORTGAGE	$	SEWER	$
HOME INSURANCE (If not included in mortgage)	$	GAS/KEROSENE/FUEL	$
PROPERTY TAX (If not included in mortgage)	$	TELEPHONE	$
POWER	$	TRASH	$
WATER	$	OTHER	$

20 MEDICAL EXPENSE

LIST CURRENT MONTHLY MEDICAL EXPENSES OVER $35.00 FOR ANY PERSON IN YOUR HOUSEHOLD WHO IS AGE 60 OR OVER, OR WHO IS RECEIVING FEDERAL OR LOCAL DISABILITY BENEFITS.

NAME OF PERSON WITH THE MEDICAL BILLS	EXPENSE AMOUNT	WHAT THE EXPENSE WAS FOR
	$	
	$	
	$	

IF YOU OR ANYONE IN YOUR HOUSEHOLD HAS UNPAID MEDICAL BILLS DURING THE LAST THREE (3) MONTHS, PLEASE COMPLETE THE FOLLOWING INFORMATION. YOU MAY BE ELIGIBLE FOR MEDICAL COVERAGE FOR THOSE UNPAID BILLS.

NAME OF PERSON WITH THE MEDICAL BILLS	DATES OF TREATMENT	DUE TO AN ACCIDENT?	NAME OF OTHER PERSON INVOLVED IN ACCIDENT	OTHER PERSON'S INSURANCE COMPANY
		☐ YES ☐ NO		
		☐ YES ☐ NO		
		☐ YES ☐ NO		

21 MEDICAL INSURANCE COVERAGE

IF YOU OR ANYONE IN YOUR HOUSEHOLD HAS MEDICAL INSURANCE COVERAGE, COMPLETE THE FOLLOWING INFORMATION.

NAME OF INSURANCE SUBSCRIBER	NAME OF PERSON COVERED UNDER THE INSURANCE	NAME OF INSURANCE COMPANY	MONTHLY PREMIUM

22 DISQUALIFICATION HISTORY

IF YOU OR ANYONE IN YOUR HOUSEHOLD HAS EVER BEEN DISQUALIFIED FROM THE SNAP AND/OR PUBLIC ASSISTANCE PROGRAM, COMPLETE THE FOLLOWING INFORMATION.

NAME OF PERSON DISQUALIFIED (Last, First, M.I.)	PROGRAM		TYPE OF DISQUALIFICATION	WHERE IT HAPPENED (Country, State)	DATE DISQUALIFIED	DISQUALIFIED FOR HOW LONG
	SNAP	PA				

23 MAP

DRAW A MAP TO YOUR HOUSE

24 YOUR RIGHTS AND RESPONSIBILITIES

The Department of Public Health and Social Services (DPHSS) is responsible for informing all applicants applying for Public Welfare of their Civil Rights under the Federal law as provided by Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, Americans with Disabilities Act of 1990 (ADA) and the Public Welfare Rules and Regulations. Federal and local laws prohibit discrimination against Public Welfare applicants or participants because of race, color, national origin, disability, age, sex, religious creed, political beliefs or reprisal or retaliation for prior civil rights activity. This Department supports the policy of providing equal opportunity to all Public Welfare applicants and participants under all titles of Public Welfare. This means that:

YOU HAVE THE RIGHT TO:

1. Receive an application when you ask for it.
2. Turn in an application the same day you receive it.
3. Receive your SNAP benefits or Medically Indigent Program (MIP) benefits or be notified you are not eligible for the program within 30 calendar days after you turn in your application.
4. Be notified if you are eligible or not eligible for Cash Assistance or Medicaid within 45 calendar days after you turn in your application.
5. Receive SNAP benefits within seven (7) calendar days if you are eligible for Expedited Services.
6. Discuss any action regarding your case with your Eligibility Specialist or his/her supervisor if you are dissatisfied.
7. To request for a Fair Hearing if you disagree with any action taken on your case. You may ask anyone to help you get a fair hearing, and your case may be presented at the hearing by any person of your choice.
8. Be notified 10 calendar days in advance before your assistance is discontinued or reduced.
9. Have your records kept confidential.
10. Be served without regard to race, color, national origin, disability, age, sex, religious creed, political beliefs or reprisal or retaliation for prior civil rights activity.

ACKNOWLEDGEMENT OF RESPONSIBILITIES

READ EACH SENTENCE CAREFULLY. PLACE YOUR INITIALS TO THE LEFT OF EACH STATEMENT TO SHOW THAT YOU UNDERSTAND YOUR RESPONSIBILITIES.

_____ I know I must let the DPHSS know when my income exceeds 130% of the Federal Poverty level by the 10th day of the following month in which the change occured for the SNAP and Public Welfare Programs.

_____ I know I must let the DPHSS know of any change within 10 days after the change happens for the MIP.

_____ I know my child(ren) must go to school. If my child(ren) do not go to school, I know my Cash Assistance will stop.

_____ I know I have to get child support for my child(ren). If I do not cooperate to get child support for my child(ren), I know my Cash Assistance will stop.

_____ I know if I am an able-bodied adult aged 18-50, without dependent children and not pregnant, I can only receive a maximum of three (3) months of cash benefits under the General Assistance and SNAP in a three (3) year period.

_____ I know if I am a teen parent, I must live at home and attend school, sign an Individual Responsibility Plan with the JOBS Program, and comply with this Individual Responsibility Plan. If I don't, my benefits and my child(ren)'s benefits may be terminated.

_____ I know I will have to take part in a work or training program so I can get a job. If I do not take part in the work or training program, I know I my Cash Assistance will not be released.

_____ I know I must not exchange my SNAP benefits for cash.

_____ I know I must not use my SNAP benefits to establish credit for cash or non-food items.

_____ If I gave false information so I can get Cash Assistance, Medicaid, MIP and SNAP, I know I can be taken to court and charged with a crime.

_____ I know I will assign my rights and eligible household member's rights to Medicaid/MIP for the support and payment received from a responsible third party (example, insurance company, court, etc.) as a result of any medical care initially paid by Medicaid/MIP.

I ACKNOWLEDGE I HAVE BEEN INFORMED, READ AND UNDERSTAND MY RIGHTS AND RESPONSIBILITIES FOR THE RESPECTIVE PROGRAM(S) FOR WHICH I AM APPLYING.

_____ APPLICANT'S SIGNATURE

_____ DATE

25 PENALTY WARNING

An Intentional Program Violation (IPV) consist of having intentionally made a false or misleading statement, or misrepresented or concealed facts; or having intentionally committed any act that constitutes a violation of the SNAP/Welfare Program Regulations or any local statute relating to the use, presentation, transfer, acquisition, receipt, or possession of SNAP or other Public Welfare benefits. Anyone found guilty of an Intentional Program Violation will be disqualified as follows:

INTENTIONAL PROGRAM VIOLATION (IPV) DISQUALIFICATION PERIODS

FIRST OFFENSE	**ONE YEAR;** or **TWO YEARS** if it involves TRADING COUPONS FOR ILLEGAL SUBSTANCES (DRUGS); or **PERMANENTLY** if it involves TRADING COUPONS FOR GUNS, AMMUNITIONS, OR EXPLOSIVES, or if it involves TRAFFICKING IN COUPONS OF $500 OR MORE
SECOND OFFENSE	**TWO YEARS;** or **PERMANENTLY** if it involves TRADING COUPONS FOR ILLEGAL SUBSTANCES (DRUGS); or
THIRD OFFENSE	**PERMANENTLY**

ALSO:

- If the Head of Household is disqualified under Cash Assistance due to NON-COMPLIANCE or FRAUD, the entire household may also be disqualified under SNAP for the same duration; and
- If a household member is disqualified under Cash Assistance due to NON-COMPLIANCE or FRAUD, the same household member may be disqualified under SNAP for the same duration; and
- Anyone misrepresenting his/her IDENTITY or RESIDENCE in order to receive multiple benefits will be disqualified for 10 YEARS; and
- Anyone convicted of a DRUG FELONY or FLEEING to avoid prosecution, custody, confinement, or violating probation or a parole is INELIGIBLE.

Any individual receiving assistance under the Medically Indigent Program for which he/she was not eligible on the basis of false declarations shall be liable for repayment and shall be guilty of misdemeanor or felony as specified in the Criminal and Correctional Code. Such individual shall be ineligible for program services for a period of one (1) year or more as ordered by the court.

Any individual who voluntarily discontinues medical insurance shall be disqualified from the Medically Indigent Program for six (6) months starting from the date when the discontinuance of health coverage was discovered/reported.

I HAVE READ THE ABOVE PENALTY WARNING AND UNDERSTAND THE PENALTIES FOR PROGRAM VIOLATIONS.

APPLICANT'S SIGNATURE _____ DATE _____

26 DESIGNATION AND CERTIFICATION OF AUTHORIZED REPRESENTATIVE

IF YOU ARE UNABLE TO FILL OUT THE APPLICATION AND GO TO THE INTERVIEW, YOU CAN NAME AN ADULT OUTSIDE YOUR HOUSEHOLD TO FILL OUT YOUR APPLICATION FORM AND APPLY FOR YOU. FOR SNAP APPLICANT, EVEN IF YOU APPLY FOR SNAP YOURSELF, YOU MAY NAME SOMEONE TO PICK UP YOUR EBT QUEST CARD AND USE YOUR CARD TO BUY FOOD FOR YOU.

TO DESIGNATE SOMEONE TO HELP YOU FILL OUT THIS FORM AND GO TO THE INTERVIEW FOR YOU, AND/OR TO PICK UP YOUR EBT QUEST CARD FOR YOU, COMPLETE THE FOLLOWING INFORMATION. YOU SHOULD FILL OUT AND SIGN THE APPLICATION FORM EVEN IF SOMEONE ELSE GOES TO THE INTERVIEW FOR YOU.

DESIGNATION OF AUTHORIZED REPRESENTATIVE:

I, _____, designate _____ to be my Authorized Representative.
Name of Applicant — Name of Authorized Representative

_____ _____
Signature of Applicant — Date

AUTHORIZED REPRESENTATIVE:

NAME (Last, First, M.I.) _____ HOME ADDRESS _____

PHONE NUMBER _____ _____

SOCIAL SECURITY NUMBER _____ _____

CERTIFICATION BY AUTHORIZED REPRESENTATIVE:

I HELPED THE APPLICANT FILL OUT THIS FORM. I UNDERSTAND ANYONE WHO HELPS ANOTHER PERSON IN DISHONESTLY GETTING HELP IS ALSO SUBJECT TO THE CRIMINAL PENALTIES. I ALSO UNDERSTAND IF I MISREPRESENT THE HOUSEHOLD, I AM SUBJECT TO DISQUALIFICATION AS AUTHORIZED REPRESENTATIVE FOR A PERIOD OF ONE (1) YEAR. I CERTIFY THE INFORMATION ENTERED BY ME ON THIS FORM:

( ) Was furnished by the applicant or recipient; or

( ) Is what I personally know about him/her.

_____ _____
Signature of Authorized Representative, Legal Guardian, Interpreter, or Other Person — Date

27 YOUR CERTIFICATION

BEFORE SIGNING THIS APPLICATION, GO BACK AND CHECK THAT YOU HAVE ANSWERED EACH QUESTION. MAKE SURE YOU UNDERSTAND YOUR RIGHTS AND RESPONSIBILITIES AND YOUR AUTHORIZATION.

1. I/We certify I/we have been informed of my/our rights and responsibilities.
2. I/We understand the questions on this application and the penalty for hiding or giving false information.
3. My/Our answers are correct and complete to the best of my/our knowledge.

Signature (OR MARK) of Applicant	Date	Witness if Signature is "X"	Date

Signature (OR MARK) of Spouse if Joint Declaration	Date

28 CERTIFICATION BY ELIGIBILITY SPECIALIST

I CERTIFY THE APPLICANT/RECIPIENT HAS BEEN INFORMED OF HIS/HER RIGHTS AND RESPONSIBILITIES AND OF THE POSSIBILITY OF CRIMINAL CHARGE FOR MISREPRESENTING OR CONCEALING FACTS WHICH DETERMINE ELIGIBILITY.

Eligibility Specialist (ES)	Date

REMARKS:

DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES
Division of Public Welfare • Bureau of Economic Security
123 Chalan Kareta, Mangilao, Guam 96913-6304
Phone: 735-7245 / 735-7274 Fax: 735-7092

CONSENT TO DISCLOSURE OF INFORMATION

I, _____ , residing at_____ on_____ hereby authorize the SNAP and Public Welfare Programs to verify my employment income, disability and retirement benefits, savings and checking accounts, real and personal property, Life and Medical Insurance coverage, child(ren)'s school attendance records, and any other information relevant to my eligibility for participation and compliance in any of the above programs.

I also authorize any person, partnership, corporation, association, or government agency possessing information of such matters, to release such information to the Department of Public Health Social Services.

I understand this information is confidential and will be used by program staff only for the purpose of verifying my eligibility to participate in the SNAP/Public Welfare Programs.

I further understand my refusal to sign this consent may result in termination or denial of benefits.

This consent will expire three (3) years from the date of signature.

_____ _____
Applicant/Guardian/Parent Signature Date

_____ _____
Authorized Staff's Signature Date

_____ _____
Witness Signature (if needed) Date