

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES APPLICATION FOR BENEFITS

The application will be considered if it contains a minimum of the Name, Address, and Signature below. The amount of SNAP benefits will be determined from the date of application. The amount of cash assistance will be determined from the date eligibility requirements are met, including signing the Personal Responsibility Contract (PRC), Self-Sufficiency Plan (SSP), and participating in orientation.

Your Signature	If yes, answer these question Does anyone in your housel Have you or anyone in your hour houng Yes Where	 How much money do the members of your household h What is the total amount of income you expect your household. What is your current monthly rent/mortgage payment? Is anyone in your household a migrant or seasonal farm 	You may receive SNAP bene resources such as cash, chec household's combined month	Name: SNAP EXPEDITED SERVICES	You may appoint someone outsing household's situation well enough still responsible for the information want to appoint someone for this	AUTHORIZED REPRESENTAT	☐ Yes ☐ No Have you ha	Email address	HEALTH COVERAGE ONLY O Yes O No Do you wan	$\vdash \vdash$	Mailing Address	Your Name (first, middle, last)
	ns: Did all of your household nold expect to receive income sehold received or do you ex	How much money do the members of your household have in cash or a bank account What is the total amount of income you expect your household to receive this month? What is your current monthly rent/mortgage payment? Is anyone in your household a migrant or seasonal farm worker? No	fits within 7 calendar days king or savings accounts or savings accounts or savings are sour ly income and liquid resour ly income and liquid resource ly income and l		ide your household to act for gh to give any information ne ion that anyone acting as yo s, write his/her name and add	s your temporary MAID Numb	ad a Presumptive Eligibility P	SS:	GE ONLY Do you want to get information about this application by email?	State		
	If yes, answer these questions: Did all of your household income stop recently? ☐ Yes ☐ No Does anyone in your household expect to receive income from a new source this month? ☐ Yes How Have you or anyone in your household received or do you expect to receive SNAP benefits from any other state this month? ☐ Yes Where ☐ No	How much money do the members of your household have in cash or a bank account? What is the total amount of income you expect your household to receive this month? What is your current monthly rent/mortgage payment? \$ Utilities \$ Is anyone in your household a migrant or seasonal farm worker? Yes No	if: your SNAP household has les: are less than or equal to \$100; or yo ces; or a member of your household	Address:	You may appoint someone outside your household to act for your household to make an application and to be interviewe household's situation well enough to give any information needed to determine your eligibility and will include informatio still responsible for the information that anyone acting as your authorized representative gives, including any information want to appoint someone for this, write his/her name and address here. For health coverage only, complete Appendix C.	If so, what is your temporary MAID Number (can be found on your card): AUTHORIZED REPRESENTATIVE/LEGAL GUARDIAN/PROTECTIVE PAYEE (HEALTH COVERAGE, SNAP, WV WORKS)	Health Care and SNAP: Preferred spoken or written language (it not English): Have you had a Presumptive Eligibility Period at a Hospital Emergency room in the last 12 months?	County:	application by email?	Zip Code	Street Address, if Different	
Date	How I No other state this month?	φ φ φ	You may receive SNAP benefits within 7 calendar days if: your SNAP household has less than \$150 in monthly gross income and liquid resources such as cash, checking or savings accounts are less than or equal to \$100; or your rent/mortgage and utilities are more than your household's combined monthly income and liquid resources; or a member of your household is a migrant or seasonal farm worker.		You may appoint someone outside your household to act for your household to make an application and to be interviewed. This person should know your household's situation well enough to give any information needed to determine your eligibility and will include information from your tax returns. You are still responsible for the information that anyone acting as your authorized representative gives, including any information that may be incorrect. If you want to appoint someone for this, write his/her name and address here. For health coverage only, complete Appendix C.	RAGE, SNAP, WV WORKS)	he last 12 months?	<i>I</i> :		Telephone/Message Number During the Day		Birth Date (month, day, year)

DFA-2 (Revised 1/2014)

TN No: 13-0015-MM2 West Virginia

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BENEFIT QUE	STIONS Ple	ase check	the box t	peside the be	nefit(s) you	want to rec	BENEFIT QUESTIONS Please check the box beside the benefit(s) you want to receive (HEALTH COVERAGE, SNAP, WV WORKS)	ERAGE,	SNAP, WV	NORKS)	
☐ WV WORKS	☐ WV WORKS (Cash Assistance)	nce) /CHIP/Mar	katnlaca)				ow-locome Energy A	ecietano	ileve nadw	ahla)	
SNAP (Supp	☐ SNAP (Supplemental Nutrition Assistance Program)	ion Assista	ince Progra	am)		□ Emerger	☐ Emergency LIEAP (Low-Income Energy Assistance, when available)	ne Energ	y Assistance	, when availa	ble)
☐ EA (Emerge	☐ EA (Emergency Assistance)					SCA (Sc	SCA (School Clothing Allowance, when available)	ce, wher	available)		
Evaluated for a	Evaluated for automatic issuance of LIEAP	nce of LIEA	1								
Have you or ar	Evaluated for automatic issuance of SCA Have you or any member of your househousehouse to a scalar to the scalar t	or househ	old had ar	ny unpaid med	dical expense	s in any of t	Evaluated for automatic issuance of SCA	hs?	Yes 🗆 No		
If yes, do you v	If yes, do you wish to have your Medicaid backdated to cover these expenses? ☐ Yes	ır Medicaio	backdate	d to cover the	se expenses	s? □ Yes	☐ No If yes, indicate starting date	starting	e		
HOUSEHOLD	MEMBER No.	1 Listall For h	individua nealth cov	ls who live in erage only, l	your house ist anyone o	ehold (HE <i>l</i> on your sam	HOUSEHOLD MEMBER No. 1 List all individuals who live in your household (HEALTH COVERAGE, SNAP, WV WORKS For health coverage only, list anyone on your same federal income tax return	NAP, W	/ WORKS)		
LEGAL NAME	LEGAL NAME (Last, First, MI)										
* Social Security Number or date	ate Date of birth	h Sex	Marital	Relationship	Buy/cook food	*Citizenship *Alien Y/N Regisi	*Alien Registration	In school	Last grade	High School Diploma or	Full time student
applied to one		+			Cogonie		200		attellided	C	
**If Hispanic, I	Latino, ethnicity (OPTIONAL - check all that apply.)	y (OPTION	VAL - che	ck all that apply.)							
**Race (OPTIC	**Race (OPTIONAL – check all that apply.)	all that app	oly.)	}	2.	3	T Violation	3		5	
☐ Black or Af	☐ Black or African American	Alask	Alaska Native		□ Japanese		☐ Other Asian	□ Sa	□ Samoan	Si alliono	
		☐ Asian Indian☐ Chinese	Indian		□ Korean		☐ Native Hawaiian	☐ Other	☐ Other Pacific Islander	ander	
'For SNAP, Yoι eαistration num	ມ may leave thi ber for health c	s blank for overage. F	ranyone n Providing y	not in the assivour SSN can	stance requi	est. We ne ven if vou an	*For SNAP. You may leave this blank for anyone not in the assistance request. We need this if you are applying for benefits and have an SSN or alien registration number for health coverage. Providing your SSN can be helpful even if you are not applying since it can speed up the application process.	lying for can spe	benefits and ed up the app	have an SS	N or alien
*Not required. this information	This information will help ensur	n is volunt e program	ary. Your benefits a	benefits will re distributed	not be affect without rega	ed if you do	regarding manufaction health coverage. Froming your convention replacement in you are not applying since it can appear up the application process. "Not required. This information is voluntary. Your benefits will not be affected if you do not answer the race and/or ethnicity questions above. Giving us this information will help ensure program benefits are distributed without regard to race, color, or national origin.	and/or e	thnicity quest	tions above.	Giving us
HEALTH COV	HEALTH COVERAGE ONLY										
 	-	an to file a	federal inc	come tax retur	n NEXT YE/	AR? If yes,	Do you plan to file a federal income tax return NEXT YEAR? If yes, please answer questions a	ons a - c.		If no, skip to question c.	
\vdash	èn	/ill you file	jointly with	Will you file jointly with a spouse? If yes, name of spouse	yes, name o	of spouse:					
□ Yes □ No	b.	/ill you claii	m any dep	endents on yo	our tax return	1? If yes, list	Will you claim any dependents on your tax return? If yes, list name of dependents:				
□ Yes □ No	ç	fill you be o	claimed as	a dependent	on someone	's tax return	Will you be claimed as a dependent on someone's tax return? If yes, list name of tax filer: How are you related to tax filer	tax filer: d to tax f	iler		
-	Н	vidual app	lying for he	Is this individual applying for health coverage?	3?						
□ Yes □ No	-	regnant? If	yes, how	Are you pregnant? If yes, how many babies are expected during this pregnancy?	are expected	during this	pregnancy?				
□ Yes □ No		ive a physi medical fa	cal, menta acility or nu	Do you have a physical, mental, or emotiona or live in a medical facility or nursing home?	I health cond	dition that ca	Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, e' or live in a medical facility or nursing home?	vities (lik	(e bathing, dr	essing, daily	chores, et
□ Yes □ No		e with at le	ast one ch	ild under the	age of 19, ar	nd are you th	Do you live with at least one child under the age of 19, and are you the main person taking care of this child?	care of t	his child?		
☐ Yes ☐ No	_	in foster ca	are in Wes	Were you in foster care in West Virginia at age 18 or older?	ge 18 or olde	317					
□ Yes □ No		an SSI rec	ipient in th	ne past but no	t receiving S	SI now? If y	Were you an SSI recipient in the past but not receiving SSI now? If yes, date SSI ended:				
☐ Yes ☐ No	-	n Americar	Indian or	Are you an American Indian or Alaska Native? If yes, complete Appendix B.	? If yes, co	mplete Appe	endix B.				

LEGAL NAME (Last, First, MI) * Social Security Number or date applied for one **If Hispanic, Latino, ethnicity (OPTIONAL -- check all that apply.) | Mexican | Mexican American | Chicano/a | Puerto Rican **Race (OPTIONAL -- check all that apply.) | White | Damerican Indian or | Filip | Black or African American | Alaska Native | Japan | | Asian Indian | Kor HOUSEHOLD MEMBER No. 2 List all individuals who live in your household (HEALTH COVERAGE, SNAP, WV WORKS) For health coverage only, list anyone on your same federal income tax return Date of birth Sex Marital Status Relationship to you ☐ Filipino ☐ Japanese ☐ Korean Buy/cook food together □ Cuban *Citizenship Y/N □ Other ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian *Alien Registration Number In school Y/N ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Other Last grade attended High School Diploma or GED Full time student Y/N

HEALT	H COVER	HEALTH COVERAGE ONLY
☐ Yes	□ No	☐ Yes ☐ No ☐ Do you plan to file a federal income tax return NEXT YEAR? If yes , please answer questions a – c. If no , skip to question c.
□Yes	□ No	a. Will you file jointly with a spouse? If yes, name of spouse:
□ Yes	O No	b. Will you claim any dependents on your tax return? If yes, list name of dependents:
□ Yes	O No	c. Will you be claimed as a dependent on someone's tax return? If yes, list name of tax filer: How are you related to tax filer
□ Yes	□ No	Is this individual applying for health coverage?
□ Yes	O No	Are you pregnant? If yes, how many babies are expected during this pregnancy?
□Yes	□ No	Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, e or live in a medical facility or nursing home?
□Yes	O No	Do you live with at least one child under the age of 19, and are you the main person taking care of this child?
□ Yes	□ No	Were you in foster care in West Virginia at age 18 or older?
□Yes	□ No	Were you an SSI recipient in the past but not receiving SSI now? If yes, date SSI ended:
□ Yes	□ N _o	Are you an American Indian or Alaska Native? If yes, complete Appendix B.

^{*} For SNAP, You may leave this blank for anyone not in the assistance request. We need this if you are applying for benefits and have an SSN or alien registration number for health coverage. Providing your SSN can be helpful even if you are not applying since it can speed up the application process.

**Not required. This information is voluntary. Your benefits will not be affected if you do not answer the race and/or ethnicity questions above. Giving us this information will help ensure program benefits are distributed without regard to race, color, or national origin.

					_			
☐ Black or African American	**Race (OPTIONAL – check all that apply.) White	"If Hispanic, Latino, ethnicity (OPTIONAL - check all that apply.) □ Mexican □ Mexican American □ Chicano/a □ Puerto Rican □ Cuban □ Other		ate	* Social Security	LEGAL NAME (Last, First, MI)	HOUSEHOLD MEMBER No. 3 List all individuals who live in your household (HEALTH COVERAGE, SNAP, WV WORKS) For health coverage only, list anyone on your same federal income tax return	
	check all th	ethnicity (Cican Americ		Date of birth		irst, MI)	ER No. 3 L	
Alaska N Asian In	Amer	an		Sex			ist all For t	
Alaska Native Asian Indian Chinese	that apply.)☐ American Indian or	VAL - chec Chicano/a		Status			individuals nealth cove	
		k all that ap		to you			s who live in rage only, li	
□ Japanese □ Korean	Filipino	ply.) Rican □ Cu		food together	Buy/cook		your house st anyone o	
		uban □ Ot		Y/N	*Citizenship *Alien		hold (HEA n your sam	
☐ Other Asian☐ Native Hawaiian	□ Vietnamese	her		Registration Number	*Alien		st all individuals who live in your household (HEALTH COVERAGE, SNAP, W For health coverage only, list anyone on your same federal income tax return	
☐ Other Pa	l Gu			school Y/N	ī		NAP, W x return	
□ Samoan □ Other Pacific Islander □ Other	☐ Guamanian or Chamorro			grade attended	Last		/ WORKS)	
lander	Chamorro			Diploma or student GED Y/N	High School Full time			
				student Y/N	Full time			

HEALTH	COVERA	HEALTH COVERAGE ONLY
□ Yes	O No	Do you plan to file a federal income tax return NEXT YEAR? If yes , please answer questions a – c. If no , skip to question c.
□ Yes	□ N ₀	a. Will you file jointly with a spouse? If yes, name of spouse:
□ Yes	ON D	b. Will you claim any dependents on your tax return? If yes, list name of dependents:
□ Yes	□ No	c. Will you be claimed as a dependent on someone's tax return? If yes , list name of tax filer: How are you related to tax filer
□ Yes	□ No	Is this individual applying for health coverage?
□ Yes	□ No	Are you pregnant? If yes, how many babies are expected during this pregnancy?
□ Yes	O No	Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, e or live in a medical facility or nursing home?
☐ Yes	□ No	Do you live with at least one child under the age of 19, and are you the main person taking care of this child?
□ Yes	ON O	Were you in foster care in West Virginia at age 18 or older?
□ Yes	O No	Were you an SSI recipient in the past but not receiving SSI now? If yes, date SSI ended:
□ Yes	□ No	Are you an American Indian or Alaska Native? If yes, complete Appendix B.

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^{*} Fer-SNAP, you may leave this blank for anyone not in the assistance request. We need this if you are applying for benefits and have an SSN or alien registration number for health coverage. Providing your SSN can be helpful even if you are not applying since it can speed up the application process.

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"*If Hispanic, Latino, ethnicity (OPTIONAL – check ☐ Mexican ☐ Mexican American ☐ Chicano/a **Race (OPTIONAL – check all that apply.) ☐ White ☐ Black or African American ☐ Alaska Native * Social Security Number or date HOUSEHOLD MEMBER No. 4 List all individuals who live in your household (HEALTH COVERAGE, SNAP, WV WORKS) For health coverage only, list anyone on your same federal income tax return applied for one LEGAL NAME (Last, First, MI) Date of birth Sex ONAL - check all that apply.) □ Chicano/a □ Puerto Rican Marital Status Relationship to you Buy/cook food together □ Cuban *Citizenship Y/N □ Other *Alien Registration Number school Y/N Last grade attended High School Diploma or GED Full time student Y/N

Alaska Native

Asian Indian

Chinese

□ Filipino □ Japanese □ Korean

☐ Vietnamese☐ Other Asian☐ Native Hawaiian

☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other

COVER!	HEALTH COVERAGE ONLY
ON D	□ No Do you plan to file a federal income tax return NEXT YEAR? If yes , please answer questions a – c. If no , skip to question c.
□ No	a. Will you file jointly with a spouse? If yes, name of spouse:
□ No	b. Will you claim any dependents on your tax return? If yes, list name of dependents:
□ No	c. Will you be claimed as a dependent on someone's tax return? If yes , list name of tax filer:
□ No	Is this individual applying for health coverage?
□ No	Are you pregnant? If yes, how many babies are expected during this pregnancy?
ON O	Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, e or live in a medical facility or nursing home?
□ No	Do you live with at least one child under the age of 19, and are you the main person taking care of this child?
ON O	Were you in foster care in West Virginia at age 18 or older?
□ No	Were you an SSI recipient in the past but not receiving SSI now? If yes, date SSI ended:
O No	Are you an American Indian or Alaska Native? If yes, complete Appendix B.
	COVERY

For additional household members, make copies of this page

^{*} Fer SNAP, you may leave this blank for anyone not in the assistance request. We need this if you are applying for benefits and have an SSN or alien registration number for health coverage. Providing your SSN can be helpful even if you are not applying since it can speed up the application process.

**Not required. This information is voluntary. Your benefits will not be affected if you do not answer the race and/or ethnicity questions above. Giving us this information will help ensure program benefits are distributed without regard to race, color, or national origin.

HOUSE	HOLD INF	OR!	HOUSEHOLD INFORMATION (SNAP)
□Yes	□ No	>	□ Yes □ No 1 Is anyone a boarder?
□Yes	□ Yes □ No	Ν	2 Is anyone a foster child or foster adult?
□Yes	□ No	ω	□ Yes □ No 3 Is anyone on strike?
□Yes	□No	4	□No 4 Is anyone disabled?
		2	
	うつがつ	2	EGISTED TO THE ADATION INCLINE WAY WORKS AND THE

Have you or any member of your household been convicted of trading SNAP benefits for guns, ammunitions, or explosive after September 22, 1986?	თ	□ No	□Yes
Are you or any member of your household hiding or running from the law to avoid prosecution, being taken into custody or going to jail for a felony crime or attempted felony crime, or violation of parole or probation?	5	□ No	□Yes
Have you or any member of your household been convicted of fraudulently receiving duplicate SNAP benefits in any State after September 22, 1996?	4	□ No	□Yes
Have you or any member of your household been convicted of a felony under Federal or State law for possession, use or distribution of a controlled substance (felony drug conviction) after August 22, 1996?	ω	ON D	□Yes
Have you or any member of your household been convicted of buying or selling SNAP benefits over \$500 after September 22, 1996?	N	□No	□Yes
1 Have you or any member of your household been convicted of trading SNAP benefits for drugs after September 22, 1996?		ON 🗆	□Yes
HOUSEHOLD'S DECLARATION INQUIRY (WV WORKS and SNAP)	ECL/	OLD'S D	HOUSEL
Is anyone disabled?	4	□ No	□Yes
Is anyone on strike?	ω	□ No	□Yes
Is anyone a foster child or foster adult?	2	□ No	□Yes
1 Is anyone a boarder?	>	□ No	□Yes
HOUSEHOLD INFORMATION (SNAP)	욅	OLD INF	HOUSEL

If you answered "YES" to any of the above questions, please explain here.

Verification of some information is required. Vehicles are excluded for SNAP. If you have an expense that you do not report and/or provide proof of, you will not receive the deduction for the expense.

Please mark "yes" or "no" for each type of asset listed	no" for	each	type of asset	isted.			
TYPE OF ASSET	YES	O			VALUE		Owner
			Model	Year	∨alue	Amount Owed	
Vehicles			Model	Year	Value	Amount Owed	
Home			Value		Amount Owed	nt .	
Do you own property			Value		Amount		
other than your home?					Owed		
Mobile Home			Model	Year	Value	Amount Owed	

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Other	Personal Collection	Boat	ATV, UTV or 3 Wheeler	Camper/Trailer	Farm/Tractor Equipment	Business Equipment	Mineral Rights	Livestock	Burial Plots	Funeral/Burial Funds	Life Insurance	Account/Home Sale	Escrow	Profit Sharing	IRA/Keogh	Trust Funds	Deposit	Certificates of	Bonds	Bonds/Savings	Stocks	Christmas Club	Cash on Hand	Credit Union	Account	Money Market	Savings Account(s)	Checking Account(s)
		Model	Model	Model	Model	Model					Policy No:																	
		Year	Year	Year	Year	Year					Fac																	
		Value	Value	Value	Value	Value					Face Value:																	
		Amount Owed	Amount Owed	Amount Owed	Amount Owed	Amount Owed					Cash Value:																	

					:	
				ed set aside for burial? If "Yes." which assets?	listed set a	ny of the assets
ngs/orders, etc?	, court proceedin	nt ownership,	vner due to joir whv?	isted not available to the owner d	sted not av	Are any of the assets listed not available to the owner due to joint ownership, court proceedings/orders, etc? YES NO If "Yes," which assets and why?
						Other
						Personal Collection
Amount Owed	Ar	Value	Year	Model		Boat
Amount Owed	Ar	Value	Year	Model		ATV, UTV or 3 Wheeler
Amount Owed	Ar	Value	Year	Model		Camper/Trailer
Amount Owed	Ar	Value	Year	Model		Farm/Tractor Equipment
Amount Owed	Ar	Value	Year	Model		Business Equipment
						Mineral Rights
						Livestock
						Burial Plots
						Funeral/Burial Funds
Cash Value:		Face Value:	_	Policy No:		Life Insurance
						Account/Home Sale
						Profit Sharing
						IRA/Keogh
						Trust Funds
						Deposit
						Certificates of
						Bonds

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acility name: s or life insurance or established a unt Received \$ amount per How often Received PAY PERIOD RECEIVED None of these	Name Type of Name of Business Monthly Income Received List	ENT (HEALTH COVERAGE, SNAP, WV WORKS)	In the past year, did any household member: □ Change jobs □ Stop working □ Start working fewer hours		to public and the second secon		NAME OF EMPLOYER RATE OF HOURS (Include address and phone number) PAY WORKED	Does anyone in your household receive any income from employment? □ Yes □ No If yes, list all gross income before deductions (such as full or part-time employment, self-employment, baby-sitting, odd jobs, days work, roomer/boarder payments, etc.)	EARNED INCOME (HEALTH COVERAGE, SNAP, WV WORKS)	Value of Asset \$	Date of Transfer (month, day, year):	Has anyone transferred or divested (disposed of), sold, or given away property or any other asset, including vehicles or life insurance or established a trust fund within the last five (5) years (60 months)?	Is this person expected to return home within six (6) months of date of admission? ☐ Yes ☐ No	LONG-TERM CARE (MEDICAID) Is this application for anyone who needs pursing home or other specialized medical care? ☐ Yes ☐ No ☐ If yes F	
Amount Received \$ Amount Received \$ Amount PER PAY PERIOD HOW OFTEN RECEIVED RECEIVED List Business Expenses and Amounts	Income Received		☐ Start working fewer ho					list all gross income before stc.)				y other asset, including v	Yes □ No		
ce or established a How OFTEN RECEIVED Received	List Business Expe							edeductions (such as fu		1-		ehicles or life insuran		ves Facility name:	
	nses and Amounts		Ō				HOW OFTEN RECEIVED	ull or part-time		07		ce or established a			

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If anyone in your household receives, applied for or was denied any benefit listed below, place a check in the box next to the benefit	plied for or was de	If anyone in your household receives, applied for or was denied any benefit listed below, plant	ow, place a check	in the box n	ext to the benefit.		
Allanam.	□ Ohild Suppo	A-4		mont Bonefit	1	nation Crante or	10000
☐ Railroad Retirement	☐ Veteran's Pension/Benefit	ension/Benefit	☐ Union Benefits	☐ Union Benefits		☐ Disability/Sick, Maternity Benefits	mity Benefits
☐ Worker's Compensation	Pension or Retirement	Retirement	☐ Black Lung Benefits	g Benefits		☐ Money from friends or relatives	or relatives
□ Military Allotment □ Lump Sum Cash Amounts	☐ Money from Re	 □ Money from Rental Income □ Social Security 	☐ Temporar	 □ Temporary Cash Assistance □ SSI 		☐ Mineral Rights ☐ Student Income	
□ Adoption Assistance	☐ Rent or Utili	☐ Rent or Utility Supplement	(□ Fos:	☐ Foster Care Payments	nts
☐ Interest Dividends from Stocks, Bonds, Savings or Other Investments	avings or Other Inve	estments			[i
If you checked yes to receiving, applying for or being denied any benefits, fill in below	g for or being denie	ed any benefits, fill in belo)W.				
NAME		TYPE OF BENEFIT		APPLIED	CLAIM NUMBER	RECEIVED	AMOUNT
			Yes	No		Yes No	
			Yes	No		Yes No	
			Yes	No		Yes No	
			- d	No		a de	
Complete only if your income changes from month to month	es from month to	month					
Your total income this year: \$		Your total income next year, if you think it will be different: \$	year, if you think	it will be d	fferent: \$		
INCOME DEDUCTIONS (HEALT	(HEALTH COVERAGE)		- foderal incom	the making	o Tallina in about	t thom sould	and the east of
Does any household member pay for certain things that can be deducted on a rederal income tax return? Telling us about them could make the cost of health coverage a little lower. NOTE: You shouldn't include a cost you already considered in your answer to net self-employment.	r certain things the You shouldn't	nat can be deducted on include a cost you alrea	a rederal income ady considered in	your ansy	er to net self-emp	t tnem could i	make the cost of
Name		Туре	Ar	Amount Paid		How	How Often?
	□ Alimony						
	☐ Other deductions	ıctions					
POTENTIAL RESOURCES (HEALTH COVERAGE, SNAP, WV WORKS)	TH COVERAGE	SNAP, WV WORKS)					
□ Yes □ No Do you or anyone	who lives in your	Do you or anyone who lives in your household expect to receive any benefits or income, such as, but not limited to, Social Security	eceive any bene	its or incon	າe, such as, but n	ot limited to, S	ocial Security
Benefits, Wages f	rom Employment,	Benefits, Wages from Employment, Unemployment Benefits, Child Support or Insurance Settlements that you are not now receiving? Type: Type:	its, Child Support or Insuran Fxpected Date of Receipt	t or Insurar of Receipt	nce Settlements th	ents that you are no To: (mm/dd/vvvv)	t now receiving?
If yes, who:		Type:	Expected Date of Receipt:	of Receipt:		To: (mm/dd/yyyy)	
□ Yes □ No Has anyone been	involved in an ac	Has anyone been involved in an accident with a settlement pending?	nt pending?				
	200	Old Oliver Marine	70000				

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Rent	< E	s anyo	HELI	Attend	Hospital	☐ Dentu	No If	MEDIC				MI∃DIGAID □Yes □				Yes	DEDU			Does a	DEDU
ň	EXPENSES	ne in your h	TER AND	Attendant Care	tal	☐ Dentures/Glasses/Hearing Aids	SNAP – Do you or any No If yes, check the ap □ Health/Medicaid Insurance	CAL EXPE				AID No			Name	□ No	CTIONS (ס	any houser les current	DEDUCTIONS
	AMOUNT	s anyone in your household paying for any of the following? Check all those paid and answer the questions	SHELTER AND UTILITY COSTS (SNAP)	40	s	Hearing Aids \$	SNAP – Do you or any household members pay medical expenses for any person age 60 or over, or any person receiving disability benefits? ☐ Yes No. If yes, check the appropriate box and list the monthly amount you pay. ☐ Health/Medicaid Insurance \$ ☐ Medicai/Dental Insurance \$ Others	MEDICAL EXPENSES (SNAP and MEDICAID)	For whom?	Amount of monthly expenses:	If yes, what type of expenses:	Does anyone in your household have impairment related work expenses?			C Incapa	Does any household member pay anyone else to care for a dependent child or disabled/incapacitated adult so a household member can get to work or training/school? If yes, complete the following information:	DEDUCTIONS (MEDICAID, SNAP, WV WORKS)		PERSON WHO PAYS	Does any household member pay legally obligated child support to a NON-HOUSEHOLD member? □ Yes (includes current payments, arrearages, health insurance, alimony, student loan interest or daycare expenses)	(SNAP, WV WORKS)
	How Often?	my of the f	SNAP)				embers p	MEDIC/		expense	expense	ur househ			Child or Disabled/ pacitated Adult's N	id membe ing/schoo	WV WOR			gally oblig ges, healt	KS)
	Who pays?	ollowing? C		☐ Pharmacy Expense	☐ Nursing	☐ Transportation Costs	he monthly amount you Medical/Dental Insurance	ND)		S	S.	nold have in			Child or Disabled/ Incapacitated Adult's Name	er pay anyo ป? If yes , c	RKS)			gated child th insurance	
	pays?	heck all tho		Expense		tion Costs	expenses amount y					npairment	-		ne	ne else to omplete th			TYPE OF PAYMENT	support to e, alimony,	
S	~	se paid ar		69	S	49	for any pour pay.		s this pe			related v			Care	care for ne followi			AYMENT	a NON-I	
Water	EXP	nd answe					person a		rson blin			vork exp			Care Provider	a depend ng inforr				HOUSEN loan inte	
	EXPENSES	the questio					ge 60 or ove Others		ls this person blind? ☐ Yes			enses?			ег	dent child o			MONTHS PAID IN LAST 3 MONTHS	IOLD mem	
	Ą	ns.					er, or an		□ No						Payı	r disable			IS IN	ber? □	
	AMOUNT						y persor								Payment Amount	d/incapa			LEGALL	□ Yes Who? xpenses)	
	How Often?						n receiving dis								nount	citated adult			LEGALLY OBLIGATED AMOUNT	/ho?	
	×						sability benef								How	so a househ			AMOUNT		
	Who Pays?						fits? □ Yes □								How Often	old member can			AMOUNT ACTUALLY PAID	□No	

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Telephone	Oil	Gas	Electric	Mortgage	
Homeowner's Insurance	Property Tax	Wood/Coal	Garbage	Sewer	

Is heat included in your rent? \square Yes \square No
If heat is not included in the rent, what is your source of heat?

Do you pay for air conditioning/heating? \square Yes \square No
Did your household receive LIEAP or does your household expect to receive LIEAP? \square Yes \square No

□ Yes □Yes □ Yes □Yes □ Yes ☐ Yes □ Yes **EMERGENCY ASSISTANCE** No □ No □ No ON O ON_o □ No □ No □ No | 9 | Are you in need of emergency medical care? If yes, what is your medical emergency? □ No 3 4 ω თ ÇI Do you have a notice of utility service termination? If yes, what utility or utilities? Are you in need of shelter, clothing, and/or household supplies/furnishings due to a fire or some other man-made or natural disaster? Are you in need of emergency child care? If yes, what is the reason for the emergency? Are you in need of emergency transportation? If yes, what is your destination and transportation need? Are you without food? Are you in need of telephone service and everyone who lives in your home is 65 years of age or older, or is disabled or temporarily incapacitated for at least the next 30 days? Are you without bulk fuel? If yes, how much is needed for a 30-day supply of fuel? \$ Do you have eviction or foreclosure notice? If yes, how much is needed to avoid eviction/foreclosure? ↔

RENEWAL OF HEALTH COVERAGE

To determine my eligibility for help paying for health coverage in future years, I agree to allow the local office to use my income data, including information from tax returns. The local office will send me a notice, let me make any changes, and I can opt out at any time.

Yes | 5 years (the maximum number of years allowed), or for a shorter number of years: S 4 years
3 years
2 years
1 year
1 year
Don't use information from tax returns to renew my coverage.

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HEALTH COVERAGE	m
Yes □ No Is	Is anyone listed on this application incarcerated, detained or jailed? If yes, who?
HEALTH COVERAGE	
□ Yes □ No 1.	Is anyone enrolled in health coverage now from the following:
	If yes, check the type of coverage and write the person(s) name(s) next to the coverage they have.
	☐ Medicaid: ☐ Employer Insurance:
	☐ CHIP: ☐ Name of Health Insurance:
	□ Medicare: □ Policy Number: □
	□ TRICARE (don't check if you have direct care or Is this COBRA coverage? □ Yes □ No
	Line of Duty):
	□ VA Health Care Programs: □ Other:
	□ Peace Corps:
	Policy Number:
	Is this a limited-benefit plan (like a school accident policy)?
	☐ Yes ☐ No
□Yes □No 2.	Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone's else's
	job, such as a parent or spouse.
	If yes, you'll need to complete and include Appendix A. Is this a state employee benefit plan? ☐ Yes ☐ No

If you want to register to vote, you can complete a voter registration form at www.sos.wv.gov

IMPORTANT INFORMATION ABOUT SNAP

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the basis of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, 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.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

For any other information dealing with Supplemental Nutrition Assistance program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Number at (800) 642-8589.

USDA is an equal opportunity provider and employer.

I understand that DHHR will obtain income and eligibility information from the Systematic Alien Verification and Eligibility (SAVE) System, and U.S.

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applicant/recipient. Citizenship and Immigration Services (USCIS) about each member of my group. This information will be obtained by the use of the SSN of each

IMPORTANT INFORMATION ABOUT SNAP (Continued)

- I understand if I or any member of my household:

 a. Is found guilty in a federal, state, or local court of trading SNAP benefits for firearms, ammunition, explosives, or controlled substances; is a convicted felon, for possession, use or distribution of a controlled substance(s); or is found guilty of trafficking \$500 or more in SNAP benefits, the guilty party will be permanently disqualified from participating in the SNAP Program.

 b. Makes a false statement or misrepresentation of identity and/or residence or receive duplicate benefits at the same time, the responsible party will be disqualified from the SNAP program for 10 years.

 c. Is found guilty of using or receiving benefits in a transaction involving the sale of a controlled substance, you will not be eligible for benefits for two years for the first offense and permanently for the second offense.

I understand if I am found (by court action or an administrative disqualification hearing) to have committed an act of intentional program violation, I will not receive SNAP benefits as follows: First Offense – one year; Second Offense – two years; Third Offense – permanently. In addition, I will have to repay any benefits received for which I was not eligible.

I also understand that any person who obtains benefits from the DHHR by means of a willfully false statement, impersonation, misrepresentation, or any other fraudulent device can be charged with fraud. Upon a conviction, punishment may be a fine up to \$5,000 and/or sentence of 5 years in jail. Federal penalties may include a maximum fine of \$250,000 and a jail sentence of up to 20 years.

Learlify under penalty of perjury, by signing my name below, that I am a United States Citizen or alien in lawful immigration status. This declaration of eligibility for VVV WORKS, Health Coverage, and SNAP.—I certify by signing my name below, under penalty of perjury, that I have correctly listed the citizenship or alien status of the individuals applying for benefits on this application. This declaration of United States Citizenship or alien in lawful immigration status if a condition of eligibility for VVV WORKS, Health Coverage, and SNAP. Any household member for whom citizenship is not declared is not eligible to receive benefits. However, his income and assets will be considered available to the remaining members of the household.

I understand that it is a criminal violation of federal and state law to provide false or misleading information for the purpose of receiving benefits to which I am not entitled. I understand it is my responsibility to provide complete and truthful information.

TN No: 13-0015-MM2 West Virginia		Worker's Signature (Worker Who Interviewed Client)	Applicant's Signature
Appr Appli	P	Date	Date
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			Co-Applicant's Signature (WV WORKS only)
Effective Date: 10/01/2013			Date



APPENDIX A

Health Coverage from Employment

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

1. Em	EMPLOYEE Information 1. Employee name (First, Middle, Last)	4. Employee Social Security number
3. Em	EMPLOYER Information 3. Employer name	4. Employer Identification Number (EIN
5. Em	Employer address	6. Employer phone number
7. City		8. State
10. W	10. Who can we contact about employee health coverage at this job?	age at this job?
11. PP	11. Phone number (if different from above)	12. Email address
3	Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months? Yes (continue) 13a. If you're in a waiting or probationary period, when can you enroll (mm/dd/vvvv)	ed by this employer, or will you becc
	List the name of anyone else who is eligible for coverage from this job Name:	d, when can you enroll (mm/dd/yyyy)
Tell us	Tell us about the health plan offered by this employer	
6 5	Does the employer offer a health plan that meets the minimum value standard*? Yes No Yes No Yes No Yes One Yes One	overage from this job. Name:
.f.6 	family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs. a. How much would the employee have to pay in premiums for this plan? b. How often? □ Weekly □ Every 2 weeks □ Twice a month □ Quarterly □ Yearly	when can you enroll overage from this job. Name: ation). Atthe minimum value standard*? offered only to the grams, provide the premium that the empressation programs, and did not receive in premiums for this plan? Twice a month Quarterly Year



EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

EMPLOYEE Information 1. Employee name (First, Middle, Last)	4. Employee Social Security number	ity number
EMPLOYER Information 3. Employer name	Employer Identification Number (EIN)	n Number (EIN)
5. Employer address (the Marketplace will send notices to this address)	otices to this 6. Employer phone number	ber
7. City	8. State	9. Zip code
10. Who can we contact about employee health coverage at this job?	overage at this job?	
Phone number (if different from above)	12. Email address	y The second sec
13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months? □ Yes (continue) If you're in a waiting or probationary period, when can you enroll in coverage? □ No (Stop and return this form to employee)	period, when can you enroll in	ecome eligible in the next 3 (mm/dd/yyyy) (Continue)
Tell us about the health plan offered by this employer	/er.	
Does the employer offer a health plan that meets the minimum value standard*? □ Yes (go to question 15) □ No (STOP and return form to employee) 15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans). If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs a. How much would the employee have to pay in premiums for this plan? b. How offen? □ Weekly □ Every 2 weeks □ Twice a month □ Quarterly □ Yearly If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't	es (go to question 15) \sum No (STOP and return form to employee) the lowest-cost plan that meets the minimum value standard*? the lowest-cost plan that meets the minimum value standard* offered on ude family plans). If the employer has wellness programs, provide the paid pay if he/she received the maximum discount for any tobacco cessate on the pay offer discounts based on wellness programs. How much would the employee have to pay in premiums for this plan? \$ How often? \sum Weekly \sum Every 2 weeks \sum Twice a month \sum Quarterly r will end soon and you know that the health plans offered will change, go to	only to the employee (don't premium that the employee atton programs, and did not y Pearly 19 Yearly 19 Ye
16. What change will the employer make for the new plan year (if known)? I Employer won't offer health coverage	r the new plan year (if known)?	
☐ Employer will start offering health plan available only to the employe	Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect	premium for the lowest-cost ard.* (Premium should reflect

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

Date of change (mm/dd/yyyy):

How often?

the discount for welliness programs. See question 15.)

How much would the employee have to pay in premiums for this plan? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month

□ Quarterly

☐ Yearly



APPENDIX B

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

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

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

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

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

		AI/AN PERSON 1	AI/AN PERSON 2
. `	Name (First name, Middle name, Last name)	First Middle	First Middle
		Last	Last
[2]	Member of a footerally recognized tribe?	□Yes	□Yes
		If yes, tribe name	If yes, tribe name
اد	Has this person over gotten a	□ No	□ No
ب	service from the Indian Health	□ No	□ No
	Service, a tribal health program or urban Indian Health program, or	If no, is this person eligible to get services from the Indian Health Service.	If no , is this person eligible to get services from the Indian Health
	these programs?	Health programs, or through a referral from one of these programs? ☐ Yes ☐ No	urban Indian Health programs, or through a referral from one of these programs? ☐ Yes ☐ No
4.	Certain money received may not be counted for Medicaid or the	€	59
	Children's Health Insurance	How often:	How Offen?
	(amount and how often) reported		
	on your application that includes money from these sources:		
	 Per capita payments from a tribe that come from natural 		
	resources, usage		
	rights, leases or royalties.		
	resources, farming, ranching,		
	fishing, leases or royalties from land designated		
	as Indian trust land by the		
	Department of Interior		
	former reservations).		
	 Money from selling things that have cultural significance. 		

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APPENDIX C

Assistance with Completing this Application.

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact your local DHHR office. If you're a legally appointed representative for someone on this application, submit proof with the application.

1 Name of sutherized representative (First name Middle name	act name)
i. Traine of authorized representative (First faile, Michael Haire, East faile)	במסג וומוויי)
2. Address	3. Apartment or suite number
4. City 5. State	6. Zip code
7. Phone number ()	
8. Organization name	ID number (if applicable)
By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.	I information about this application, and act
	11. Date (mm/dd/yyyy)
For certified application counselors, navigators, agents, and brokers only. Complete this section if you're a certified application counselor, navigator, agent or broker filling out this application for someone else. 1. Application start date (mm/dd/yyyy)	rokers only. navigator, agent or broker filling out this
2. First name, Middle name, Last name & Suffix	
3. Organization name	ID number (if applicable)

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