APPLICATION AND AFFIDAVIT FOR PUBLIC ASSISTANCE

OFFICE USE ONLY

IM Worker ______________________ **Date** __________ **Case Number** ______________

IM Supervisor ______________________ **Date** __________ **Related Case Number(s)** __________

TANF Status: ( ) NA ( ) RA ( ) RO ( ) TR **Date Registered** ______________________

SECTION I

APPLICANT: Please use a pen to complete this form carefully and accurately. IF YOU ARE NOT SURE OF ANY ANSWER, LEAVE THE SPACE BLANK. If you have any questions, ask the county welfare worker.

DO NOT WRITE IN THE SHADED BOXES

1. For Which Program(s) Do You Wish to Apply or Reapply?

( ) TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) **( ) AFDC-ONLY MEDICAID** **( ) GENERAL ASSISTANCE**
( ) NJ SNAP PROGRAM **( ) REFUGEE RESETTLEMENT PROGRAM**
( ) EMERGENCY ASSISTANCE **( ) KINSHIP CARE SUBSIDY PROGRAM**

I (we) understand that as a condition of WFNJ eligibility, I (we) shall be required to continuously and actively seek employment in an effort to gain self-sufficiency.
I (we) understand that as a condition of WFNJ eligibility, I (we) shall be required to register for work with New Jersey One Stop Career Center.

2. Are you willing to work? **[ ] YES** **[ ] NO**

3. Applicant's name: ____
(LAST) (FIRST) (MI) (MAIDEN)

4. Resident Address: **The place where you actually live:**

____
(NUMBER AND STREET OR RFD) (CITY) (STATE) (ZIP CODE)

Address where your mail goes if different from your resident address above.

____
(P.O. BOX, STREET ADDRESS, OR RFD) (CITY) (STATE) (ZIP CODE)

Your telephone number: **HOME** ( ) ____________ **WORK** ( ) ____________ **CELL** ( ) ____________

5. New Jersey Residence (NOT APPLICABLE FOR NJ SNAP PURPOSES)

RESIDENCE VERIFICATION

Do you plan to continue living in New Jersey? **[ ] YES** **[ ] NO**
If **"NO",** EXPLAIN:____.

6. You can authorize a person(s) outside your household to apply for NJ SNAP or GA for you, to obtain NJ SNAP benefits or GA benefits, or to use NJ SNAP benefits to purchase food for you. If you are eligible for NJ SNAP benefits, the individual you designate will receive a FAMILIES FIRST EBT card that he or she can use to buy your food. If you wish to designate such a person, complete the following information:

Name of Authorized Representative	Date of Birth	Address	SSN (Optional)	Telephone Number

QUESTIONS 7 and 8 BELOW - FOR NJ SNAP APPLICANTS ONLY

7. You have the right to file an application for NJ SNAP immediately by providing your name, address, signature and date signed. If you are determined eligible, your benefits will be paid from that date. (If you file an application and provide all the necessary information about your circumstances and are found eligible, you can get NJ SNAP within 30 days of the date the NJ SNAP office receives your application.)

8. If you have very little income and resources, you may be eligible for expedited benefits (to be received within 7 days. **YOUR ANSWERS TO THE FOLLOWING QUESTIONS WILL DETERMINE IF YOU QUALIFY FOR THIS SERVICE:**

(a) Is your household's total gross monthly income less than $150.00 and your household's total liquid resources (such as cash or checking/savings accounts) $100.00 or less? **[ ] YES** **[ ] NO**

(b) Is your household's monthly rent or mortgage plus utilities more than your household's total monthly gross income plus total liquid resources? **[ ] YES** **[ ] NO**

(c) Is your household a migrant or seasonal farm-working household with little or no income? **[ ] YES** **[ ] NO**

OFFICE USE ONLY

CATEGORICAL ELIGIBILITY:
Does everyone in the household receive Public Assistance (WFNJ) or SSI? [ ] YES [ ] NO

9. ____
(SIGNATURE OF PERSON INITIATING APPLICATION) (DATE SIGNED)

SECTION II

10. BASIC INFORMATION: (List each person in the household for whom application is being made, including yourself.)
List adult applicants first, beginning with the female adult, then the oldest to the youngest child.
For NJ SNAP purposes, people who live, purchase food and eat with you should be counted as household members.

NOTE: The submission of Social Security numbers (SSNs) for all household members is authorized under the Food Stamp Act of 1977, as amended, 7 U.S.C. 2011-2036; Public Law 104-193 requires the submission of SSNs for all individuals applying for WFNJ. Your SSN will be used to determine whether your household is eligible or continues to be eligible to participate in the NJ SNAP Program and/or WFNJ program. 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 NJ SNAP claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims action. The providing of the requested information, including the SSN of each household member, is voluntary for NJ SNAP purposes. However, failure to provide this information will result in the denial of NJ SNAP benefits and/or WFNJ benefits to your household.

OFFICE USE ONLY FOR TANF/MEDICAID ONLY PURPOSES Date WFNJ-1L Completed ____________	The question below is asked for research purposes in accordance with the Civil Rights Act of 1964. (Failure to answer will not affect eligibility.) For NJ SNAP purposes only! If you do not answer, your eligibility worker will complete it for you. You must complete the RACE and ETHNICITY section. RACE I - American Indian or Alaska Native A - Asian B – Black or African American H – Native Hawaiian or other Pacific Islander W- White 0 – American Indian or Alaska Native and Asian 1 – American Indian or Alaska Native and Black or African American	2 American Indian or Alaska Native and Native Hawaiian or Other Pacific Islander 3 American Indian or Alaska Native and White 4 Asian and Black or African American 5 Asian and Native Hawaiian or Other Pacific Islander 6 Asian and White 7 Black or African American and Native Hawaiian or other Pacific Islander 8 Black or African American and White 9 White and Native Hawaiian or Other Pacific Islander Ethnicity 1 Hispanic or Latino 2 Not Hispanic or Latino

Name	Social Security Number	Birthdate / Birthplace	Relationship To Applicant	Sex (F) or (M)	Race/ Ethnicity	Legal Alien & BCIS Status	Marital Status	Grade and School	
Applicant									PA
Last									NJ SNAP MA
First m.i.									
For Office Use Only									
Other Applicant									PA
Last									NJ SNAP MA
First m.i.									
For Office Use Only									
Other Applicant									PA
Last									NJ SNAP MA
First m.i.									
For Office Use Only									

Name	Social Security Number	Birthdate / Birthplace	Relationship To Applicant	Sex (F) or (M)	Race/ Ethnicity	Legal Alien & BCIS Status	Marital Status	Grade and School	
Other Applicant									PA
Last									NJ SNAP MA
First m.i									
For Office Use Only									
Other Applicant									PA
Last									NJ SNAP MA
First m.i									
For Office Use Only									
Other Applicant									PA
Last									NJ SNAP MA
First m.i.									
For Office Use Only									
Other Applicant									PA
Last									NJ SNAP MA
First m.i.									
For Office Use Only									

11. List Names of Aliens/Non-Citizens in Your Household

NAME	DATE OF ENTRY/ COUNTRY OF ORIGIN	REGISTRATION #	SPONSOR NAME/ RESETTLEMENT AGENCY	SPONSOR/ RESETTLEMENT AGENCY ADDRESS	DATE APPLIED FOR CITIZENSHIP	SPONSOR INCOME

12. List Other Persons in the Home <u>not Listed Above</u> (Include Roomers/Boarders)

NAME	RELATIONSHIP TO APPLICANT

12a. List an Emergency Contact Person (GA Cases Only) ____.

Phone #______________________ Address____.

13. Expectant Mother's Name____Expected Date of Birth______________________
Doctor's Name____________________________ Doctor's Address____

14. What is the main language spoken in your home? ____.

15. Do you or any member of the applicant household receive or have you received TANF in New Jersey or any other state, territory, or General Assistance (GA) in New Jersey since April 1997?			**[ ] Yes [ ] No**
Individual Receiving Assistance	Type of Assistance	When	Assistance Provider

16. Are you or any member of your household a fleeing felon or in violation of a condition of parole or probation imposed by a Federal or State court?	**[ ] Yes [ ] No**
Individual Fleeing or in Violation	Fleeing From

17. Have you or any member of your household been convicted of fraudulently receiving means tested benefits in two or more places at the same time?			**[ ] Yes [ ] No**
Individual Convicted of Fraud	Where Fraud Occurred	When	What Benefits

18. Since August 22, 1996, have you or any member of your applicant household committed and been convicted of possession, use or distribution of a controlled substance, which is an indictable offense**? Applies to GA only**		**[ ] Yes [ ] No**
Individual Committing Offense	Type of Offense	Where Did Offense Occur

19. If you were convicted of an indictable offense for possession or use, have you enrolled in or completed a Department of Health and Senior Services licensed or approved residential drug treatment program?		**[ ] Yes [ ] No**
Individual Receiving Treatment	Treatment Facility	Date of Treatment

19. a. If you have not enrolled in or completed a Department of Health and Senior Services licensed or approved residential drug treatment program, what is the reason?

____

____

____.

20. Has anyone in the household voluntarily quit a job?

In the last 90 days for WFNJ **[ ] YES [ ] NO** If **YES**, Who? ____.

In the last 60 days for NJ SNAP **[ ] YES [ ] NO** If **YES**, Who? ____.

If **YES**, Why? ____.

21. Is anyone in your household on strike? **[ ] YES [ ] NO** If **YES,** Who? ____.

22. What was the last date of employment? ____________________________.

22a. What have you been doing since your last employment? ____

____.

23. For WFNJ purposes only, list all employment for each person applying for assistance in the last 3 years, starting with the most recent.

Name	Name of Employer	Address of Employer	Start Date	End Date

24. Does any member of the applicant household expect any change in circumstances in the near future, such as a change in income; household size; change in residence; shelter costs; or the purchase or sale of an automobile?
[ ] YES [ ] NO If **"YES"**, What changes:____
____.

25. EARNED INCOME: Do you or anyone living with you get money from working, baby-sitting, your own business, odd jobs, selling, or other earned income? **[ ] YES [ ] NO** If **"YES"**, provide the following information for each person:

LAST NAME FIRST NAME						
HOURS PER WEEK						
HOW OFTEN PAID						
EMPLOYER'S NAME AND ADDRESS OR "SELF" IF SELF-EMPLOYED						
PAY (BEFORE ANY PAID DEDUCTIONS) GROSS AMOUNTS AND DATES	DATE	AMOUNT	DATE	AMOUNT	DATE	AMOUNT

26. CHILD/ADULT CARE: Did anyone included in your welfare or NJ SNAP household pay for child care or adult care because of a job, going to school, or looking for work? **[ ] YES [ ] NO** If "**YES**", who was cared for? (List Below)

NAME OF CHILD/ADULT	CARE PROVIDED BY (PERSON)	DAYS PER WEEK	HOURLY RATE	TOTAL DAYS	ACTUAL AMOUNT PAID/ BY WHOM

VERIFICATIONS

27. CHILD SUPPORT: Are you legally obligated to pay or provide child support to a child outside of your household?
[ ] YES [ ] NO If "**YES**", complete the following information: (Include payments for child support arrearages, as long as you are legally obligated to pay them.)

TO WHOM	ADDRESS	AGE OF CHILD	MO. AMOUNT PAID/ PROVIDED	COURT ORDER NUMBER

28. HEALTH INSURANCE: Who is covered by health insurance? **IF NONE, CHECK ( ) HERE.**

LAST NAME, FIRST NAME	INSURANCE COMPANY	POLICY NUMBER	POLICY HOLDER

29. Does an absent spouse have medical or health insurance coverage for you? **[ ] YES [ ] NO** If **"YES",** what insurance?
____.

30. Does any absent parent have medical or health insurance coverage for any of the children for whom you are applying?
[ ] YES [ ] NO If **"YES",** what insurance, and for whom? ____
____.

31. Have you or your household members applied for other Medicaid programs? If **"YES",** which program?
____**.** Date you applied ____________________________.

32. <u>OTHER INCOME:</u> Do you or anyone included in your welfare or NJ SNAP household (including stepparents) receive or applied for any of the following: **YES ___ NO___ IF YES, CHECK ALL THAT APPLY.**

	Unemployment Insurance		Income from Property Rent		Workers' Compensation
	Veterans' Benefits		Income from Roomer(s) and/or Boarders		Union/Pension Benefits
	Social Security/Railroad Retirement		Income from Relative, Friend, Lodges or Unions		Child Support
	Supplemental Security Income (SSI)		Income Tax Refund or Earned Income Credit		Allotment Check from a Serviceman
	Disability Payments		Foster Care Payments		General Assistance
	Subsidized Adoption		Trust Fund		Training Allowance
	Interest/Dividends from Stocks, Bonds, Bank Accounts, etc.		Lump Sum Payments (from Retroactive Benefits, Money from Lawsuits, etc.)		Student Loans, Grants, Scholarships, or Stipends
	Annuity Benefits (Include Life Insurance Dividends)		Lump Sum Earnings, Winnings, or Gifts		Supplemental Work Support
	DCP&P Relative Care Permanency Support		DCP&P Legal Guardianship Subsidy Programs		Other Income, such as, alimony (Specify):

Give the following information for the items checked above:

Last Name, First Name	Source of Income	Dates Received	Total Amount

VERIFICATIONS

33. RESOURCES**: (Does apply to NJ SNAP households not eligible for expanded categorical eligibility**) Do you or anyone living with you have cash, checking, or savings accounts, stocks, bonds, C.D.'s, IRA's/Keogh, mutual funds, trust funds, U.S. Savings Bonds, Christmas/vacation or other club savings accounts, Credit Union membership, money or valuables in a safe deposit box, notes or contracts of value, ownership of mortgages or other resources? **[ ] YES [ ] NO**

Person Who Owns Resource	What is the Resource?	Where is the Resource?	How Much is the Resource Worth?

VERIFICATIONS

34. List all vehicles owned by persons in the applicant household. Include all types of transportation such as cars, vans, tractor trailers, pick-up trucks, trailers, motor homes, motorcycles, boats, etc. **IF NONE, CHECK ( ) HERE.**

Owner's Name	Model/Style	Year/Make	Use	Kelley Bluebook Value

35. Do you or does anyone living with you own any land or real estate other than the house you live in? **[ ] YES [ ] NO**
If **"YES",** explain: ____
____.

36. Did anyone trade, give away, transfer or sell real or personal property (including stocks): For TANF and GA purposes within the past 12 months?					**[ ] YES [ ] NO**
For NJ SNAP purposes within the past 3 months?					**[ ] YES [ ] NO**
What was sold, given away, etc.?	By Whom?	To Whom?	Date of Gift or Sale?	Total Market Value	Amount Received

37. Do you, or anyone included in your applicant household, have any pending claims such as lawsuits, divorce, settlements, inheritance, accident claims, sale of property, other claims, or does anyone owe you or them money? **[ ] YES [ ] NO**
If **"YES"**, explain: ____.
____.

DATE WFNJ-10D COMPLETED ________________________. **(Does not apply to NJ SNAP only clients)**

38. Does anyone in the applicant household have: **(Does not apply to NJ SNAP)**

(a) Part or full ownership of valuable personal property such as jewelry, coin/stamp collections, furs, etc.?
[ ] YES [ ] NO If **"YES",** Explain ____.

(b) A burial plot or arrangement ? **[ ] YES [ ] NO If "YES", VALUE** ____________________________.

NJ SNAP AND GA

SHELTER INFORMATION: To be completed if household is applying for participation in the NJ SNAP Program and/or GA.

39. Does anyone outside of the household pay or assist with payments of any household expenses? **[ ] YES [ ] NO**
If "**YES",** complete below:

TYPE OF SHELTER EXPENSE	PAID TO WHOM	PAID BY	AMOUNT PAID	HOW OFTEN BILLED

40. SHELTER COSTS (List household expenses for the following:)

SHELTER EXPENSE	AMOUNT PAID	HOW OFTEN BILLED	FOR OFFICE USE ONLY MONTHLY COST	
Rent/Mortgage	**$**		**$**	**If using HCSUA**
Property Taxes	**$**		**$**	
Insurance on Home	**$**		**$**	
	SHELTER SUBTOTAL		**$**	
Electricity	**$**		**$**	
Gas	**$**		**$**	
Oil	**$**		**$**	
Water	**$**		**$**	
Sewerage	**$**		**$**	
Garbage/Trash Removal	**$**		**$**	
Cost of Installation of Utilities	**$**		**$**	
Other (Coal, Wood, Kerosene)	**$**		**$**	**HCSUA**
	UTILITIES SUBTOTAL		**$** **or**	
41A. Do you pay for utilities (separate from your rent) to heat or cool your house? **[ ] YES [ ] NO** **41B.** If your household is responsible for payment of utilities in addition to water, sewerage, and garbage removal, your household may qualify to choose to receive either the **standard or heating utility allowance.**			**$**	**or**
			MONTHLY . TOTAL. SHELTER **DATE OPTION SELECTED**	

42. EXCESS MEDICAL COSTS

Is anyone in your household 60 years of age or older, and/or certified for Federal Supplemental Security Income (SSI), Social Security Disability or Veteran's payments? **[ ] YES [ ] NO** If "**YES**", complete the following. If "**NO**", continue on Page 12. Medical expenses may include amounts which have been billed, even if you have not actually paid the medical bill.

Besides regularly occurring medical expenses, list those other medical services which you may have required.	**Amount Paid**	**How Often Billed**	FOR OFFICE USE ONLY **Monthly Total**	**VERIFY RECEIPT OF SSI** ________ **FEDERAL SHARE**
Medical and Dental Services	$		$	
Hospital or Nursing Care	$		$	
Drugs Prescribed by a Doctor	$		$	
Dentures, Hearing Aids and Eye Glasses	$		$	
Transportation Costs to Get Medical Care	$		$	
Services of an Attendant or Nurse	$		$	
Other (Explain)	$		$	
			$	**SSA and SSI Listed on Page 6**
42A. List the names of household members who have these expenses:			**TOTAL**	

42B. Are any of the medical expenses you've listed above paid for, partially paid for or reimbursed by another source outside of your household such as medical insurance, Medicare, PAAD or another individual?
[ ] YES [ ] NO If "**YES**", which expense(s) do they pay? How much do they pay?
____
____
____

FOR OFFICE USE ONLY WORK FIRST NEW JERSEY AND/OR NJ SNAP WORK REGISTRATION						
NAMES (ALL OVER 16)	EXEMPT WFNJ CODE	MANDATORY WFNJ DATE	VOLUNTARY WFNJ DATE	REFERRAL DATE	NJSNAP WORK EXEMPT CODE	DATE OF REG.

43. LEGALLY RESPONSIBLE RELATIVES. (THIS IS APPLICABLE FOR MEDICAID PURPOSES ONLY.)

Provide the name of your spouse if NOT **in the home. Provide the name(s) of any children under 55 years of age for whom assistance is** NOT **being requested. If you are under 18 years of age, list your parents.**

NAME	ADDRESS	RELATIONSHIP	AGE

44. HOME ENERGY ASSISTANCE

Your answer to the following question will be used to determine eligibility for Home Energy Assistance (HEA) and the amount of HEA benefits. Using the list below, indicate which item best describes your heating/living arrangement.

( ) My heat is paid for by others. **(A)** **HEA CODE:** __________________

( ) My heat is provided by a public housing authority or I received a rent subsidy, and my heat is included in my rent. **(C)**

( ) I pay only for a secondary source of heat (such as a wood stove, kerosene heater, electric space heater, etc.). **(E)**

( ) I share the cost of heat with others. **(F)**

( ) My heat is included in my rent, which is not subsidized. **(G)**

( ) I pay a separate charge to my landlord for heat. **(W)**

I pay my fuel supplier directly for the primary source of heat for my house or apartment. My source of heat is:

( ) fuel oil **(J)** ( ) kerosene **(M)** ( ) wood **(R)**

( ) electricity **(K)** ( ) natural gas **(N)**
( ) bottled gas **(L)** ( ) coal **(P)** ( ) I do not wish to receive HEA benefits. **(T)**

IMPORTANT NOTICE

THE INFORMATION PROVIDED ON THIS FORM WILL BE SUBJECT TO VERIFICATION BY FEDERAL, STATE AND/OR COUNTY OFFICIALS. IF ANY IS FOUND INCORRECT, YOU MAY BE DENIED NJ SNAP BENEFITS AND/OR SUBJECT TO CRIMINAL PROSECUTION FOR KNOWINGLY PROVIDING FALSE INFORMATION.

In order to comply with 45 CFR 206.10(a)(iii) and 7 CFR 273.2(b), we are notifying you that income and eligibility information for BCIS, State and local child support agencies, Social Security Wage and Benefit files, and State Wage and Unemployment files will be obtained using your Social Security Number(s) and will be used in the determination of your continuing eligibility. This may involve our contacting your employer, bank, or other party.

THE PENALTIES PROVIDED BELOW APPLY TO THE FOLLOWING:

ANY NJ SNAP RECIPIENT WHO INTENTIONALLY BREAKS ANY OF THE RULES LISTED ON THE APPLICATION; OR

ANY PERSON WHO APPLIES FOR OR RECEIVES NJ SNAP BENEFITS TO WHICH THEY ARE NOT ENTITLED BY HAVING INTENTIONALLY:

MADE A FALSE OR MISLEADING STATEMENT.

CONCEALED OR WITHHELD FACTS.

- **COMMITTED ANY ACT WHICH CONSTITUTES A VIOLATION OF THE FOOD STAMP ACT, NJ SNAP PROGRAM REGULATIONS OR ANY STATE LAW RELATING TO THE USE, PRESENTATION, TRANSFER, ACQUISITION, RECEIPT OR POSSESSION OF NJ SNAP BENEFITS OR ACCESS DEVICES (SUCH AS FAMILIES FIRST EBT CARDS).**

PENALTIES

THE PENALTIES FOR INTENTIONALLY VIOLATING SNAP RULES INCLUDE A DISQUALIFICATION FROM PARTICIPATING IN SNAP FOR THE FOLLOWING TIME PERIODS

- **12 MONTHS for a first offense;**
- **24 MONTHS for a second offense, OR the first court conviction for trading SNAP benefits for a controlled substance;**
- **10 YEARS for lying or misrepresenting information about the identity or residence of an individual to receive multiple SNAP benefits at the same time;**
- **PERMANENTLY for a third offense, OR a second court conviction for trading SNAP benefits for a controlled substance, OR a court conviction for selling/trading SNAP benefits of $500 or more, OR a court conviction for trading SNAP benefits for firearms, ammunition or explosives.**

***AN ADDITIONAL 18 MONTHS SUSPENSION (CONSECUTIVE TO THIS PERIOD) MAY BE IMPOSED BY THE COURT FOR ANY PERSON CONVICTED OF FELONY OR MISDEMEANOR VIOLATION.**

THE VIOLATOR MAY BE FINED UP TO $250,000, IMPRISONED UP TO 20 YEARS, OR BOTH, AND SUBJECT TO PROSECUTION UNDER OTHER APPLICABLE FEDERAL LAWS.

IN ADDITION, THE REMAINING HOUSEHOLD MEMBERS WILL BE REQUIRED TO REPAY ANY NJ SNAP BENEFITS THE HOUSEHOLD RECEIVED TO WHICH IT WAS NOT ENTITLED.

P.L. 103-66 AND 104-193 ESTABLISHED PENALTIES FOR INDIVIDUALS WHO ARE FOUND GUILTY IN A FEDERAL, STATE, OR LOCAL COURT OF:

1) **TRADING NJSNAP BENEFITS FOR FIREARMS, AMMUNITION, EXPLOSIVES, OR CONTROLLED SUBSTANCES; OR**

2) **USING, TRANSFERRING, ACQUIRING, OR POSSESSING NJ SNAP BENEFITS, THROUGH THE USE OF FAMILIES FIRST EBT CARDS, OR PRESENTING NJ SNAP BENEFITS FOR PAYMENT KNOWING SAME TO HAVE BEEN FRAUDULENTLY OBTAINED OR TRANSFERRED, IF THE VALUE IS $500 OR MORE.**

PENALTY WARNING

DON'T give false information, or hide information, in order to apply for or receive or continue to receive NJ SNAP benefits.

DON'T give or sell NJ SNAP benefits or access through the use of Families First EBT cards to anyone who is not authorized to use them for your household.

DON'T use any NJ SNAP benefits to buy ineligible items, such as alcoholic drinks and tobacco, or to pay for food that was purchased on credit.

DON'T use any NJ SNAP benefits your household was not entitled to receive.

DON'T cheat or take part in any dishonest act to get NJ SNAP benefits your household isn't entitled to receive.

DON'T transfer resources to a non-household member in order to apply for and receive NJ SNAP benefits.

I understand the questions on this application. My answers are correct and complete to the best of my knowledge and belief. I understand that I must be interviewed, and that I must cooperate with the NJ SNAP office. I understand the penalty warning. I understand that I may have to provide documents to prove what I've said. I agree to do this. If documents are not available, I agree to give the name of a person or organization the NJ SNAP office may contact to obtain the necessary proof. I understand that if I have not reported any earned income, then I must report any change in unearned income of more than $50.00, or the receipt of earned income within 10 days of the date of my first paycheck. I understand that if I have no earned income, I must report all changes in household composition (including student status), changes in residence and the resulting change in shelter costs, changes in my legal obligation to pay or provide child support, a change in the amount of child support I provide if I have less than a 3-month record of paying it and the change is greater than $50.00, a purchase of a vehicle or an increase in my household's resources (savings and checking account, cash on hand, stocks or lump sum payments, any cash deriving from the sale or trade of a vehicle) if they reach or exceed my maximum resource limit. I understand that if I reported earned income, or I am on a six-month reporting, I am only required to report a change in my monthly total income that exceeds 130 percent of the federal poverty level limit. My worker will provide me with a notice of that limit. I also understand that I may request a fair hearing of the decision made on my application for NJ SNAP benefits. If I need more information concerning NJ SNAP benefits, I can contact the county NJ SNAP office.

I understand that I, or my representative, may request a fair hearing, either orally or in writing, if I disagree with any action taken on my case. My case may be presented at the hearing by any person I choose.

NJ SNAP MANDATORY EMPLOYMENT AND TRAINING PARTICIPANTS

Certain NJ SNAP household members, unless specifically exempted, are required to register for and participate in Employment and Training activities. Mandatory registrants who fail to comply with work requirements will be subject to the following penalties:
1) The 1st violation results in a minimum disqualification of 1 month;
2) The 2nd violation results in a minimum disqualification of 3 months;
3) The 3rd, and subsequent violations, result in a minimum disqualification of 6 months.

U.S. CITIZENSHIP/LEGAL ALIEN STATUS (FOR WFNJ, MEDICAID AND NJ SNAP PROGRAM PURPOSES)

For each person who is not a U.S. citizen, you will need to show the county welfare agency office either documentation from the Bureau of Citizenship and Immigration Service (BCIS) or other documents the State agency determines are proof of your immigration status. Alien status may be subject to verification with the BCIS which will require submission of certain information from this application form to the BCIS. Information received from the BCIS may affect your household's eligibility and level of benefits. You must certify that each household member is a U.S. citizen or is living in the U.S. in lawful immigration status.

BEFORE YOU SIGN, READ THE STATEMENTS BELOW. IF YOU DO NOT UNDERSTAND OR HAVE ANY QUESTIONS, PLEASE ASK.

- I (we) agree that the statements that I (we) made on this form are true and complete to the best of my (our) knowledge. I (we) know that lying about my (our) situation, failing to give the necessary information or causing others to hold back information is against the law and may subject me (us) to prosecution.
- I (we) understand that any information I (we) give is subject to verification by the County Welfare Agency, and/or the Division of Family Development and/or the Division of Medical Assistance and Health Services.
- I (we) hereby authorize the County Welfare Agency, Division of Family Development and/or the Division of Medical Assistance and Health Services to contact any individual or other source who may have knowledge about my (our) circumstances (to include IRS, State and local child support agencies, Social Security Wage and Benefit files, State Wage and Unemployment files, credit reporting services, as well as employers, banks or other parties) for the sole purpose of verifying the statements I (we) have made. I (we) understand that any income and eligibility information obtained will be used to determine my (our) continuing eligibility.
- I (we) understand that, in accordance with Work First New Jersey Act, Public Law 1997 c.13, c.14, c.37 and c.38, application for public assistance will include all future members of the budget unit required to be included, whether by birth, adoption, or by beginning to live with the budget unit after the date of the original application.
- I (we) know that any information I (we) give will be used in connection with my (our) application for public assistance (including Medicaid),NJ SNAP benefits, home energy assistance benefits, Universal Service Fund benefits and other benefits for which I may be eligible.
- I (we) understand that if this application is accepted for the WFNJ category, that I (we) and all members of my (our) household are enrolled in the New Jersey One Stop Career Center and may be required to participate in education, training, vocational assessment and job placement activities.
- I (we) understand that all home energy assistance payments are subject to the availability of federal funds.
- I (we) understand that all home energy assistance payments made are to be used toward the purchase of heating/cooling energy.
- I (we) have received and had explained to me (us), if necessary, information concerning my rights and responsibilities. (See WFNJ Handbook.)
- I (we) agree to let the County Welfare Agency know immediately of any change in living conditions, family situation or money received (except for earned income that is subject to six-month reporting requirements) from any source, when applicable. (See WFNJ Handbook.)
- I (we) understand that I (we) or my (our) representative may request a fair hearing, either orally or in writing, if I (we) am (are) not satisfied with any action taken by the County Welfare Agency. My (our) case may be presented at the hearing by any person I (we) choose.
- I (we) understand that upon signing this application for WFNJ and Medicaid purposes only, I (we) assign to the County Welfare Agency any right to support, including any arrears that have accrued, from any other person for myself or any other family member for whom I (we) am(are) applying for or receiving aid.
- I (we)understand that as a condition of eligibility for medical assistance, it is deemed that I (we) have assigned to the Commissioner any rights to support for the purpose of medical care as determined by a court or administrative order and any rights to payment for medical care from any third party.

*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 Stamp Act and USDA policy, discrimination is prohibited also on the basis of gender identity, religion, reprisal, marital status, familial or parental status, sexual orientation, receipt of public assistance income, genetic information or political beliefs. Discrimination complaint forms may be found online at www.ascr.usda.gov/complain_filing_cust.html, at any USDA office, or call (866) 632-9992. 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). You may also write a letter containing all of the information requested in the form. Completed complaint forms or letters may be submitted in writing to:

HHS, Director
Office for Civil Rights, Room 515-F
200 Independence Avenue, S.W.
Washington, D.C. 20201
Voice (202) 619-0403 / TTY (800) 537-7697

OR

US Department of Agriculture
Director, Office of Adjudication
1400 Independence Ave. SW
Washington, D.C. 20250- 9410
Fax (202) 690-7447
program.intake@usda.gov

OR

Office of the Director
Division of Family Development
New Jersey Department of Human Services
P.O. Box 716
Trenton, New Jersey 08625

COMPLETE BEFORE SIGNING

I (WE) have read the Important Notice on Page 10 of this form referring to the NJ SNAP penalty warnings and Citizenship/Legal Alien Status. (   ) YES   (   ) NO

- I (we) attest that I (we) have read and agree to these statements and fully realize that the Welfare Agency relies upon the truth and accuracy of my (our) statements.
- I (we) certify, under penalty of perjury, by signing my (our) name(s) below, that I (we) and all household members for whom I (we) am (are) applying for NJ SNAP benefits are U.S. citizens or aliens in lawful immigration status.
- I (we) certify under penalty of perjury that my (our) answers regarding application for the NJ SNAP Program and/or the WFNJ program are correct and complete, to the best of my (our) knowledge.
- I (we) have received an orientation to the WFNJ work requirements by the agency representative, if applicable.

SWORN AND SUBSCRIBED BEFORE ME

____
Applicant Signature   Date

______________________________________ This______Day _______2__
Co-Applicant Signature   Date

____
(Agency Representative)

IMPORTANT NOTICE
NJ SNAP INCOME DEDUCTION WAIVER

IF YOU FAIL TO REPORT OR VERIFY ANY OF THE FOLLOWING EXPENSES WHICH EITHER YOU OR ANOTHER HOUSEHOLD MEMBER IS PAYING, WE WILL TAKE THIS TO MEAN THAT YOU DO NOT WANT TO RECEIVE AN INCOME DEDUCTION FOR THOSE UNREPORTED EXPENSES.

- **A DEPENDENT CARE EXPENSE, IF YOU ARE PAYING FOR THE CARE OF A CHILD OR OTHER DEPENDENT SO THAT A HOUSEHOLD MEMBER CAN WORK, SEEK EMPLOYMENT, OR ATTEND TRAINING OR EDUCATION CLASSES IN ORDER TO PREPARE FOR EMPLOYMENT;**

- **AN UNREIMBURSED MEDICAL OR DENTAL EXPENSE, INCLUDING PRESCRIBED MEDICATION, HEALTH OR HOSPITALIZATION INSURANCE, EYE GLASSES, OR ATTENDANT CARE;**

- **A CHILD SUPPORT PAYMENT WHICH A HOUSEHOLD MEMBER IS MAKING UNDER A LEGAL OBLIGATION, INCLUDING PAYMENTS ON ARREARS; OR**

- **A SHELTER EXPENSE, SUCH AS RENT, UTILITIES (INCLUDING INSTALLATION CHARGES), PROPERTY TAXES, HOMEOWNER'S INSURANCE, AND CHARGES FOR REPAIR OF YOUR HOME DUE TO A NATURAL DISASTER.**

EVEN IF YOU DO NOT TELL US (OR VERIFY) THAT YOU ARE INCURRING ONE OF THESE EXPENSES WHEN YOU APPLY FOR NJ SNAP, YOU MAY STILL RECEIVE AN INCOME DEDUCTION LATER IF YOU TELL US (OR VERIFY) THAT YOU ARE PAYING ONE OF THESE EXPENSES. THE DEDUCTION WILL NOT BE RETROACTIVE FOR THOSE MONTHS THAT YOU DID NOT TELL US THAT YOU WERE PAYING THE EXPENSES.

HEAD OF HOUSEHOLD SIGNATURE ________________________

TODAY'S DATE ________________________