



DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
 GOVERNMENT OF GUAM
 123 Chalan Kareta
 Mangilao, Guam 96923-6304



APPLICATION FOR PUBLIC BENEFITS - PART 1

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 APPLICAITON

New Application Reapplication Renewal

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

Name of Head of Household			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?		<input type="checkbox"/> YES <input type="checkbox"/> 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. \$ _____

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

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

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

The total amount of your gas, telephone, garbage bill for this month (without arrear). \$ _____

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

SIGNATURE _____ DATE: _____

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 and any required documentation, 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 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 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 and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

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

To file a program complaint of 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 (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 (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 (202) 619-0403 (voice) or (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 by 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 5 years for knowingly providing incorrect information. If you intentionally break any program rules, you may be disqualified for 1 year for the first violation, 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
 Renewal

Medicaid Case
No:

SNAP Case
No:

Cash Assistance Case
No:

MIP Case
No:

Name of Head of Household				
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

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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 HOUSEHOLD MEMBER (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? <input type="checkbox"/> YES <input type="checkbox"/> 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 of parole? <input type="checkbox"/> YES <input type="checkbox"/> NO		

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

Applicant's Signature

Date

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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		MARITAL STATUS CODES			RELATIONSHIP CODES				
Alien	AL	Divorced	DI	Separated	SE	Head of Household	HH	Son	SO
FAS citizen	FS	Married	MA	Widowed	WI	Daughter	DA	Spouse	SP
Permanent Resident	PR	Single	SI	Other	OT	Granddaughter	GD	Other	OT
United States citizen	US					Grandson	GS		

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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 4 (PREVIOUS PAGE).

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

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STUDENT INFORMATION

LIST ALL STUDENTS IN YOUR HOUSEHOLD

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

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LIQUID RESOURCES/NON-FIXED ASSETS CODES

USE THESE CODES TO COMPLETE SECTION 9 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 |

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LIQUID RESOURCES/NON-FIXED ASSETS

LIST THE 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).

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

10 NON-LIQUID RESOURCES/FIXED ASSETS CODES

USE THESE CODES TO COMPLETE SECTION 11 BELOW

Buildings..... B
 Burial Plot..... BP
 House Other Than Home H

Land, No House..... L
 Land With House..... LH
 Off-Island Property..... P

Rental Property..... R
 Vacation and Recreational property... V
 Other..... OT

11 NON-LIQUID RESOURCES/FIXED ASSETS

LIST THE NON-LIQUID RESOURCES OF EACH MEMBER OF YOUR HOUSEHOLD. USE THE CODES LISTED IN SECTION 10 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			
				\$
				\$
				\$
				\$
				\$
				\$

12 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	\$	\$	\$

13 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 MONTHS, COMPLETE THE FOLLOWING INFORMATION.

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

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INCOME CODES

USE THESE CODES TO COMPLETE SECTIONS 15 AND 17

EARNED INCOME CODES	UNEARNED INCOME CODES
Civil Service (Federal) Employment FG	Alimony and Child Support AY
Government of Guam Employment GG	Civil Service (Federal) Retirement FR
Military Earnings MA	Dividends and Interest DI
Private Enterprise Income PE	Foster Care Payments FO
Other OT	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

15

EARNED INCOME

PLEASE BRING TWO FULL MONTHS OF EMPLOYMENT CHECK STUBS, USE THE CODES IN SECTION 14 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			
					\$
					\$
					\$
					\$
					\$
					\$
					\$

16

SELF-EMPLOYMENT INCOME

PLEASE BRING MOST RECENT 1040 TAX FORM AND TWO 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
				\$
				\$
				\$

19

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
		\$	
		\$	
		\$	

20

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
			\$	
			\$	
			\$	

21

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	\$	GARBAGE	\$
WATER	\$	OTHER	\$

22

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 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
		<input type="checkbox"/> YES <input type="checkbox"/> NO		
		<input type="checkbox"/> YES <input type="checkbox"/> NO		
		<input type="checkbox"/> YES <input type="checkbox"/> NO		

23**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 CO.	MONTHLY PREMIUM

24**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				

25**MAP****DRAW A MAP TO YOUR HOUSE**

The Department of Public Health and Social Services 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, religious creed, color, disability, national origin, sex, age, or political beliefs. 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 received it.
3. Receive your SNAP benefits or Medically Indigent Program (MIP) benefits (or be notified that you are not eligible for the program within thirty (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 forty-five (45) calendar days after you turn in your application.
5. Receive SNAP benefits within seven (7) calendar days if you are eligible for Expedite Services.
6. Discuss any action regarding your case with your Case Worker or his/her supervisor if you are dissatisfied.
7. To request 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 ten (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, religious creed, color, disability, national origin, sex, age, political beliefs.

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 that I must let the Department of Public Health & Social Services know when my income exceeds the 130% of the Federal Poverty level by the 10th day of the following month in which the change occurred for the SNAP and Welfare Programs.
- _____ I know that I must let the Department of Public Health Social Services know of any change within ten (10) days after the change happens for the Medicaid Programs.
- _____ I know that my children must go to school. If my children do not go to school, I know that my Cash Assistance and Medicaid will stop.
- _____ I know that I have to get child support for my children. If I do not cooperate to get child support for my children, I know that my Cash Assistance and Medicaid will stop.
- _____ I know that if I am an able-bodied adult aged 18-50, without dependent children and I am not pregnant, I can only receive a maximum of three (3) months of cash benefits under the General Assistance and SNAP.
- _____ I know that 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 children's benefits may be terminated.
- _____ I know that 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 that my Cash Assistance will stop.
- _____ I know that I should not exchange my SNAP benefits for cash.
- _____ I know that I should 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 that I can be taken to court and charged with a crime.

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

APPLICANT'S SIGNATURE

DATE

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 food coupons, ATP cards, Welfare checks, 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	<p>ONE YEAR; or</p> <p>-----</p> <p>TWO YEARS if it involves TRADING COUPONS FOR ILLEGAL SUBSTANCES (DRUGS); or</p> <p>-----</p> <p>PERMANENTLY if it involves TRADING COUPONS FOR GUNS, AMMUNITIONS, OR EXPLOSIVES, or if it involves TRAFFICKING IN COUPONS OF \$500 OR MORE</p>
SECOND OFFENSE	<p>TWO YEARS; or</p> <p>-----</p> <p>PERMANENTLY if it involves TRADING COUPONS FOR ILLEGAL SUBSTANCES (DRUGS);</p>
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 **TEN (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 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 an 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 discontinuance of health coverage is reported to the program.

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

_____ Applicant's Signature

_____ Date

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 that I/We have been informed of my/our rights and responsibilities.
2. I/We understand the questions on this applications and the penalty for hiding or giving false information.
3. My/Our answer 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

CERTIFICATION BY CASE WORKER

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

Eligibility Specialist

Worker Code

Date

REMARKS:



DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
GOVERNMENT OF GUAM

P.O. Box 2816
Hagatña, Guam 96932



CONSENT TO DISCLOSURE OF INFORMATION

I, _____, residing at _____ on _____ hereby authorize Food Stamp and Public Assistance Programs to verify my employment income, disability and retirement benefits, savings and checking accounts; Real and Personal Property; Life and Medical Insurance coverage; children'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 and 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 Food Stamp/Public Assistance Programs.

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

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

Client/Guardian/Parent Signature

Date

Authorized Staff Signature

Date

Witness Signature (if needed)

Date