W-1
(Rev. 11/02) DUPL-CENTER

STATE OF CONNECTICUT – DEPARTMENT OF SOCIAL SERVICES

APPLICATION PART 1: ASSISTANCE REQUEST FORM

For Worker Use Only:	Regional Office	Worker ID	Client #(s)/AU #(s)	Date Received	Application Date
	Program/Coverage Groups Applied for: (Includes Expedited Food Stamps and Expedited SAGA)			Forms Sent:	Due Date

This is part one of the application process. Complete this form and give it to us. Be sure that your answers are clearly printed. You will also be required to complete a longer form, "Application Part 2: Eligibility Determination Document". This form asks for detailed information about your situation. Please refer to the instruction sheet for details on how to complete this form. Your eligibility worker will answer any questions you may have.

WHAT HELP DO YOU NEED?

☑ Money ☑ Food Stamps ☐ Medical Bills or Coverage ☐ Child Care ☐ Cost of Nursing Home Care ☐ Other *(Specify):* _____

WHAT IS YOUR NAME?

First *M.I.* *Last*

WHAT IS YOUR TELEPHONE NUMBER?

(Area Code) *Number*

WHERE DO YOU LIVE?

Number *Street* *Apt. No.* *City* *State* *Zip Code*

WHAT IS YOUR MAILING ADDRESS *(If Different)*

Number *Street* *Apt. No.* *City* *State* *Zip Code*

CHECK ALL THAT APPLY TO YOU OR ANY HOUSEHOLD MEMBER:

☐ Blind ☐ Disabled ☐ Community Based Waiver ☐ Pregnant: Due Date _____

☐ Refugee ☐ Migrant/Seasonal Farm Worker ☐ Everyone Homeless ☐ Medicare Part A

☐ Shelter Cost Greater than Your Income ☐ Rent Includes Meals

What is your household's monthly earned income before taxes?	What is your household's monthly unearned income before taxes?	How much cash, money in the bank or other liquid assets do you or any household member have?
$	$	$

DO YOU HAVE A CONSERVATOR OR AUTHORIZED REPRESENTATIVE?

First Name *M.I.* *Last* *Type* *Telephone No.*

Number *Street* *Apt. No.* *City* *State* *Zip Code*

MEMBERS OF HOUSEHOLD *(List Yourself First)*

Full Name	Sex (M/F)	Date of Birth (Month/Day/Year)	Hispanic/Latino?	Race	Relationship to Applicant	Marital Status	Social Security Number*
		/ /	☐ Yes ☐ No		SELF		
		/ /	☐ Yes ☐ No				
		/ /	☐ Yes ☐ No				
		/ /	☐ Yes ☐ No				
		/ /	☐ Yes ☐ No				
		/ /	☐ Yes ☐ No				

If you or any of your household is known by any other name, write it here. Include maiden name.

*Optional if not applying for this person

BE SURE TO SIGN ON REVERSE SIDE

THIS INFORMATION IS AVAILABLE IN ALTERNATE FORMATS. PHONE (800) 842-1508 OR TDD/TTY (800) 842-4524.

FOR ALL APPLICANTS

I understand and agree to the following:

- I may request a hearing in writing if I disagree with an action taken on my case. I may request a hearing orally if applying for Food Stamps.
- All information given on this form is subject to verification by federal, state and local officials. I agree to cooperate with these officials by providing authorizations, documents and other proof to prove what I have said. I authorize the Department of Social Services to verify any information given on this form.
- All information given on this form, including Social Security numbers, is confidential, except as authorized or required by state or federal law, and will be used only to administer all programs except for certain exceptions for the Food Stamp, TFA and SAGA programs indicated below. Information I give on this form may be shared with law enforcement officials in order to locate and arrest persons fleeing to avoid the law.
- The Social Security numbers of all people requesting assistance will be used to verify identity and eligibility. Social Security numbers also will be cross-matched against federal, state and local government files by computer.
- I will notify the Department of Social Services within 10 days of any change in income, assets or living arrangements.
- I do not need to provide citizenship, immigration status or a Social Security number if I am applying for emergency medical assistance only.
- The Department will not share the information I give, regarding non-applicants, with the Immigration and Naturalization Service (INS). The INS CANNOT use this application to deny admission to the U.S., harm permanent resident status or deport me.
- Getting help with health care or food stamps will not affect my immigration status. If I receive cash benefits, I may have problems getting a green card, especially if the benefits are my family's only income. Refugee's and persons granted asylum may receive cash benefits without hurting eligibility for a green card or citizenship.

FOR JOBS FIRST/TFA

- I understand that my application for and receipt of Jobs First/TFA benefits is a registration for Employment Services for me and all members of my Jobs First/TFA assistance unit. I further understand that I and all other members of the Jobs First/TFA assistance unit who are required to do so must participate in Employment Services unless there is good cause not to.

FOR FOOD STAMPS

- I understand that law enforcement officials can get the name, address, Social Security number and photograph of a person who gets Food Stamps from us. They can do this when they think the person is a fleeing felon or violating parole or probation.
- I swear that I and the other people I am requesting Food Stamps for are either United States citizens or, if any of us are not, that any information I give about their non-citizen status is true.
- I understand that failure to report or verify any of the expenses I would like to claim as deductions from my income will be seen as a statement by my household that we do not want to receive a deduction for the unreported or unverified expense.

FOR SAGA

- I understand that in order to get SAGA cash, you may require any person in my home who is a substance abuser to be in treatment.

READ CAREFULLY AND SIGN

I have read this form or have had it read to me in a language that I understand. I swear that the information given on this form is true and complete to the best of my knowledge. If I have knowingly given incorrect information, I understand that there are penalties for false statement as specified in the Connecticut General Statutes Section 53a-157b and 17b-97 and to penalties for larceny as specified in Section 53a-122 and 53a-123. I also may be subject to penalties for perjury under Federal Law.

Applicant's or Representative's Signature	Date	Witness'/Interpreter's Signature	Date
Signature of Worker Taking Request	Date	☐ G.A. Worker ☐ DSS Worker	

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 religion, or political beliefs.

To file a complaint of discrimination, contact USDA or HHS. Write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). USDA and HHS are equal opportunity providers and employers.