



MISSOURI DEPARTMENT OF SOCIAL SERVICES
 DIVISION OF FAMILY SERVICES
APPLICANT'S ELIGIBILITY STATEMENT ADDENDUM

The following information is necessary to determine your eligibility for assistance. It is important to answer each applicable question accurately and completely. You may be required to provide verification of your statements. **THIS FORM MUST BE COMPLETED IN INK.**

A. SOCIAL SECURITY NUMBERS

Provide Social Security Numbers (SSN) of all persons applying for or receiving public assistance. It is a condition of eligibility except for General Relief and Blind Pension. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible household members. The SSN is used to determine eligibility and level of benefits, verify information, prevent duplicate participation, and facilitate mass changes in Federal benefits (Public Law 97-98 and Section 1137 of the Social Security Act). Included in the agencies contacted for income and eligibility information are the Social Security Administration, the Internal Revenue Service, Division of Workforce Development, Missouri Department of Corrections, Division of Child Support Enforcement and any local law enforcement. Some of the information may be obtained by computer match.

B. RESIDENCY

1. I/We are residents of Missouri. Yes No
 2. I/We intend to remain in Missouri. Yes No

IF YOU ARE APPLYING FOR MEDICAL BENEFITS ONLY, SKIP TO SECTION E.

C. HOUSEHOLD'S DECLARATION INQUIRY

Answer yes or no to each of the questions in this section. For each question answered yes, explain in the space provided.

1. Are you or any member of your household fleeing to avoid prosecution, custody or jail for a crime (or attempted crime) that is a felony?
 If yes, who? _____ Yes No
2. Are you or any member of your household receiving benefits under another identity or as a member of another household or in another state? If yes, who? _____ Yes No
3. Have you or any member of your household been convicted in a Federal or State court of a felony committed after 8-22-96 related to illegal possession, use or distribution of a controlled substance? If yes, who? _____ Yes No
4. Have you or any member of your household ever been found by a State agency or convicted in a Federal or State court of having made a fraudulent statement or misrepresentation with respect to identity or place of residence for the purpose of receiving cash benefits under Temporary Assistance for Needy Families in two (2) or more places at the same time?
 If yes, who? _____ Yes No

D. EARNED INCOME

1. Has anyone in your household started working? Yes No If yes, has this person received a paycheck? Yes No
 2. Does anyone in your household work overtime? Yes No If yes, who? _____ How often? _____
 3. Do you expect any changes in earned income? Yes No If yes, explain _____
 If yes, who? _____ Reason _____ Date of change _____
 If your job has ended recently, list the amount of income and the date received. \$ _____ Date received _____
 4. Has anyone in the household quit a job, been terminated from a job, or reduced the number of hours of work in the last 3 months?
 Yes No If yes, who? _____ Reason _____
 Date last worked _____ Date last check received _____ Amount earned this month _____

E. OTHER PAYMENTS

1. Does anyone in your home have a lawsuit or claim pending for cash or medical benefits against an employer, insurance company, or other?
 Yes No If yes, who? _____ Date filed _____ Explain _____
 2. Has anyone in your household received a lump sum payment in the last 12 months? Yes No If yes, who? _____
 Amount \$ _____ Date received _____ Source _____

F. DEPENDENT CARE EXPENSE

CHILD PROTECTION CLAUSE

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 prohibits the reduction or termination of Temporary Assistance benefits to single custodial caretakers of children under the age of six if the caretaker demonstrates that he or she is unable to obtain needed child care. If you are a single caretaker, with a child under age six (6), and are unable to obtain needed child care for one or more of the following reasons, your Temporary Assistance benefits cannot be sanctioned for failure to participate in work requirements:

- Unavailability of appropriate child care within a reasonable distance from your home or work site;
- Unavailability or unsuitability of informal child care by a relative or under other arrangements;
- Unavailability of appropriate and affordable formal child care arrangements.

This clause may be applied in single custodial households for children over the age of six under certain circumstances. Discuss any of these issues with your caseworker.

M. DIRECT DEPOSIT

You can have your cash assistance paid by direct deposit if you have a bank or credit union account, or if you do not have an account but will open an account now.

I want direct deposit I do not want direct deposit

N. GENERAL RELIEF, MEDICAL ASSISTANCE, SUPPLEMENTAL NURSING CARE, TEMPORARY ASSISTANCE DISABLED PARENT, SUPPLEMENTAL AID TO THE BLIND OR BLIND PENSION

- The reason I/we are applying: (Check all that apply)
 - Age 65 or over Blind Disabled Unable to work due to illness
 - I am needed in the home to care for a relative who lives with me I am under the age of 18 and emancipated
- Have you applied or do you agree to apply for Supplemental Security Income (SSI) as a condition of eligibility? Yes No
- Are you living in or supported by a public, medical, or private facility? Yes No If yes, facility name: _____
- If you are a resident of a nursing facility and wish to give part of your income to your spouse or dependent relative, list the name(s): _____
- If disabled, list all sources you wish contacted to provide a full and accurate statement of your medical history and condition.

DOCTORS, HOSPITALS, CLINICS, OTHER

NAME	ADDRESS

6. SUPPLEMENTAL AID TO THE BLIND OR BLIND PENSION

- Do you have a sighted spouse or parent? Yes No
- Do you solicit alms? Yes No

7. IF YOU ARE APPLYING FOR BLIND PENSION, PLEASE COMPLETE THE FOLLOWING QUESTIONS ALSO:

- Have you had eye surgery within the last 5 years? Yes No
- If you are under age 75, are you willing to have medical treatment or an operation to correct blindness? Yes No
- If recommended, are you willing to accept vocational training or work at an occupation for which you are suited? Yes No

O. APPLICANTS FOR TEMPORARY ASSISTANCE, COMPLETE ITEMS 1-10. APPLICANTS FOR MC+ FOR PREGNANT WOMEN, COMPLETE ITEMS 9-11. APPLICANTS FOR MAF & MC+, COMPLETE ITEMS 4-5 & 7-11.

Temporary Assistance payments may only be received for a total of 60 months in your lifetime beginning July 1, 1997. Any month that you have received benefits since that time is included in your lifetime limit.

If applying for Temporary Assistance, you may be asked to seek employment while your application is pending. Our hope is that you find employment and do not deplete your lifetime limit of receiving assistance. A self-sufficiency case manager will assist you in your job search.

If approved for Temporary Assistance, you will be asked to develop a Self-Sufficiency Pact with the assistance of a self-sufficiency case manager. This is your plan for employment and financial independence. All Temporary Assistance participants are subject to participating in a work activity within the first 24 months that Temporary Assistance is received.

If approved for Temporary Assistance, your grant cannot be reduced by sanction for failure to participate in a work activity for the following reasons:

- You are a single custodial caretaker caring for a child who has not reached 6 years of age and,
- You are unable to obtain needed child care for one or more of the following reasons:
 - Unavailability of appropriate child care within a reasonable distance from your home or work site;
 - Unavailability or unsuitability of informal child care by a relative or under other arrangements;
 - Unavailability of appropriate and affordable formal child care arrangements.

This may apply if you are a single caretaker who has children over age 6 under certain circumstances. Your caseworker will explain to you what this means.

1. Have you received cash benefits in another state since August 1996? Yes No If yes, complete the following:

NAME OF STATE	TYPE OF ASSISTANCE	MONTH(S) AND YEAR(S) ASSISTANCE RECEIVED

2. Has any individual, for whom you are applying, lived on an Indian Reservation? Yes No If yes, who? _____ When? _____

3. If you are a teen parent, are you residing in an adult supervised setting? Yes No If yes, complete the following:

NAME OF ADULT	RELATIONSHIP

4. CHILD IN HOME

- The child(ren) for whom I am applying or receiving live in my home. Yes No
- Is any child visiting away from your home? Yes No If yes, who? _____ How long? _____
- Is any child attending school away from home? Yes No If yes, who? _____ How long? _____

5. ABSENT PARENT INFORMATION:
List the name(s) of the child(ren) for whom you are applying or receiving, and the name(s) of the other parent(s). From the list below, give the reason for the absence.

CHILD'S NAME	CHILD'S MOTHER	CHILD'S FATHER	REASON CODE	REASON FOR ABSENCE
				a. Death
				b. Desertion or Separation
				c. Divorce
				d. Imprisoned or Jailed
				e. Institutionalized
				f. Never Married to the Parent
				g. Vocational Rehabilitation Treatment or Training

6. IF APPLYING AS A TWO-PARENT FAMILY, COMPLETE THE FOLLOWING:
Reason for application:
 Financial Need
A. Does the parent agree to apply for and accept Unemployment Compensation? Yes No
B. Does the parent agree to cooperate with Case Management? Yes No
 Disability

7. ASSIGNMENT/REFERRAL
A. If I am approved for Temporary Assistance cash, I agree to send any future child support, maintenance, and alimony, to the Division of Child Support Enforcement. Yes No
B. I understand the automatic assignment of medical support is effective with the application and acceptance of MC+ healthcare benefits. Yes No
C. I/We will cooperate/continue to cooperate with the Division of Family Services and the Division of Child Support Enforcement in establishing paternity and in securing support, including medical support, by identifying (naming) the absent parent(s), by providing information to help locate the absent parent(s), and by helping, as necessary, to obtain support payments from the absent parent(s).
 Yes No If no, explain: _____

8. STEPPARENT
A. Do your children have a stepparent living in your home? Yes No If yes, be sure to list the stepparent's income in Section E and/or F.
B. Give information on support the stepparent gives to dependents outside the home:

DEPENDENT'S NAME	CLAIMED ON TAX RETURN		ALIMONY	AMOUNT PAID	
	YES	NO		CHILD SUPPORT	OTHER

9. PREGNANCY: Is anyone in your household pregnant? Yes No
If yes, who? _____ Due Date _____

10. SERVICES
A. I would like information about counseling, educational, or medical services related to health, birth control, and family planning.
 Yes No
B. I understand that by applying for Temporary Assistance, my name and the names of my eligible children may be provided to other federally assisted programs, such as Head Start, for additional services. Yes No
C. If you are pregnant and would like a health risk appraisal and case management services, contact your local health department or call TEL-LINK (1-800-835-5465).
D. If you are pregnant or a nursing mother, or have infants or children under the age of five, you may be eligible for the WIC (Women, Infant & Children) program. It can provide you with free infant formula, eggs, milk, cheese and help you to plan healthy meals for you and your family. If you are interested in this program, talk to your caseworker.

11. Is your net worth (Net worth is the value of everything you own minus any debt):
 less than \$50,000 \$50,000-\$100,000 \$100,000-\$150,000 \$150,000-\$200,000 \$200,000-\$250,000 above \$250,000

P. COMMENTS/ADDITIONAL INFORMATION

VOLUNTARY VOTER REGISTRATION SERVICES

The National Voter Registration Act of 1993 has designated public assistance offices as offering voter registration services to applicants and recipients of public assistance. Whether you register is strictly voluntary. Your decision has no effect on your eligibility for assistance.

NON-DISCRIMINATION AND FAIR HEARING RIGHTS: In accordance with Federal law this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political beliefs, or disability.

To file a complaint of discrimination for any Division of Family Services (DFS) assistance programs, contact your local DFS office or the Office of Civil Rights, P.O. Box 1527, Jefferson City, MO 65102-1527 or call 1-800-776-8014.

You can have a fair hearing if you are denied benefits and wish to appeal the decision. You can also request a hearing, either orally or in writing, regarding any agency action which affects your participation in any program(s).

PLEASE READ EACH STATEMENT CAREFULLY.

WHEN YOU SIGN PAGE 6, IT MEANS YOU UNDERSTAND THE STATEMENTS ON THIS PAGE

I/WE AUTHORIZE THE DIVISION OF FAMILY SERVICES TO INVESTIGATE THESE CIRCUMSTANCES AND STATEMENTS.

- It is against the law to obtain or attempt to obtain public assistance benefits to which I am not entitled or to obtain or attempt to obtain public assistance benefits in an amount greater than those to which I am entitled.
- Criminal or civil prosecution may result if I make any false statements or conceal any facts if found guilty of the crime of perjury. I was given an opportunity to ask questions about fraud laws.
- I claim public assistance benefits under the laws and regulations of the State of Missouri and the United States. I understand that application for and acceptance of medical assistance allows the Department of Social Services, Division of Medical Services to collect payment for medical care from a third party.
- If I am an applicant for or recipient of Temporary Assistance from the Division of Family Services, I have assigned rights to child support and the rights to receive support payments which are past due, currently due, or which will become due in the future to which I am entitled in my own behalf or in behalf of the child or children for whom I am applying for or receiving assistance payments to the State of Missouri. This assignment shall take effect upon a determination of eligibility for Temporary Assistance and shall remain in full force and effect as long as I am a recipient of Temporary Assistance. Upon the termination of my receipt of assistance payments, this assignment shall remain in effect as to the unpaid support obligations owing at the time of the discontinuance of assistance payments.
- I must provide the Division of Family Services with complete information regarding any health or accident insurance benefit available to any member of the assistance household. I must report, within 30 days, any accident or accidental injury for which I seek professional medical services.
- I authorize all providers of MC+ or Medicaid benefits who render services or merchandise to me/us under MC+ or Medicaid to release all records regarding such services or merchandise to the Department of Social Services and its representatives. I also understand that by applying for (and being determined eligible for) MC+ healthcare benefits for a child who is deprived of parental support, I have assigned all rights to medical support to the State of Missouri. I must cooperate in obtaining medical support. Cooperation may involve identifying the absent parent, helping locate the absent parent, helping to establish paternity, and other action as needed to obtain this medical support.
- Any immigrant members of my household who are applying for or receiving assistance may have to provide valid documentation of their immigration status to the Division of Family Services office. The documentation may be verified with the Immigration and Naturalization Service (INS); therefore, the Division of Family Services will provide INS with identifying information. The response of INS may affect my eligibility and benefit level.

- The State of Missouri may file a claim against my/our estate to recover any assistance received.
- I understand that I must report changes described on Form IM-3 "Changes You Must Report". I understand I will owe the amount of assistance/benefits I receive as a result of not reporting changes.
- I/We must cooperate with the Department of Social Services, the Division of Family Services staff, and/or Quality Assurance if my case is selected for review.
- I/We understand by applying for General Relief, I/we may be required to apply for Supplemental Security Income (SSI) as a condition of eligibility.

NOTIFICATION AND ACKNOWLEDGEMENT OF FRAUD PROVISIONS

Missouri state law (Sections 205.967 and 570.030 RSMo) provide that it is the crime of stealing if a person obtains, attempts to obtain or aids and abets another in obtaining any public assistance benefits by means of willful false statements or representation, or willful concealment or failure to report any fact or event required to be reported by any law, regulation or rule of this state or the United States, or by impersonation, collusion or other fraudulent device.

Pursuant to Section 205.967, RSMo, public assistance benefits means anything of value, including money, food, food stamp benefits, commodities, clothing, utilities, utility payments, shelter, drugs and medicine, materials, goods and services including institutional care, dental care, medical care, child care, psychiatric and psychological services, rehabilitation instruction, training or counseling or benefits, programs and services provided or administered by the Missouri Department of Social Services or any of its Divisions.

Pursuant to Section 570.030, RSMo the stealing of public assistance benefits is a Class C felony if the value of the benefits is \$750.00 or more. Punishment includes imprisonment for up to seven years and a fine not to exceed \$5,000.00. If the value of the benefits is less than \$750.00, the crime is a Class A misdemeanor.

13 CSR 40-2.355 and 42 USC 608 (a)(8). Any individual convicted by a Federal/State court of misrepresenting residency in order to receive Temporary Assistance simultaneously in two or more states is ineligible for Temporary Assistance for ten (10) years from the date of conviction.

7 USC 2015(k), 42 USC 608 (a)(9) and 13 CSR 40-2.360. Any individual who is a fleeing felon, or a probation/parole violator is ineligible to participate in the Temporary Assistance Program(s).

P.L. 104-194, Section 115. Individuals convicted in a Federal or State court of a felony committed after 8/22/96 related to illegal possession, use, or distribution of a controlled substance are permanently barred from the Temporary Assistance Program.

SIGNATURE: This is to certify that I understand the questions on this form and the penalties for giving false statements or withholding information about any individual, for whom I am applying or receiving assistance. Under the penalty of perjury, I certify that I have given true, accurate and complete statements to the best of my knowledge.

SIGNATURE	DATE
-----------	------

SPOUSE/SECOND PARENT	DATE
----------------------	------

IF SIGNATURE IS MADE BY A MARK (X), IT SHOULD BE WITNESSED BY TWO PERSONS

NAME	DATE
------	------

NAME	DATE
------	------

If someone else has helped you enter information on this form, have him/her complete the following: I certify that I completed this eligibility statement at the request of the applicant and that the information on this form is correctly recorded as stated by the applicant.

SIGNATURE	DATE
-----------	------

CASEWORKER SIGNATURE	DATE
----------------------	------