State of Illinois
Department of Human Services

1 (PERMANENT)

Request for Cash Assistance - Medical Assistance - Food Stamps please print clearly

Last Name: _____ First Name: _____ MI: ___ Maiden Name: _____

Present Address: _____

Apartment Number: _____

City: _____ State: _____ Zip Code: _____ County: _____

Are you homeless? ☐ Yes ☐ No

Mailing Address (if different from above)

Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Previous Address

Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Telephone number(s) where we may get in touch with you

Home: _____ Work: _____ Other: _____

Signature: _____ Date: _____

Instructions to person(s) applying for Cash - Medical, and/or Food Stamp benefits

1. Please print all of your answers on the application form so that we can read and understand your answers.

2. You have the right to immediately file the application as long as this page is completed with your name, address and signature. The filing of this signed form starts the application processing timetable.

3. For your rights and responsibilities see page 7 and page 8 for food stamps and page 9 and page 10 for cash and/or medical.

4. If applying for food stamps, a decision on your eligibility will be made within 30 days. If determined eligible, Food Stamp benefits will be issued from the date the application is filed.

5. You may complete this form at home and mail or bring it to the Department of Human Services (DHS) office, or another member of the household or an adult who knows you may complete and return the form to us. If someone else completes this form for the household, they are to answer the questions for the person(s) they are applying for, not himself or herself.

Request for Cash Assistance - Medical Assistance - Food Stamps please print clearly

Citizenship/Immigration Status

You must complete this section before you complete the rest of the application.

If you or any other person is not applying because you do not wish to provide information about your immigration status, you do not have to give us that information. The failure to provide immigration information will not affect processing the application for the remaining persons. However, any person who is applying for benefits for himself or herself has to provide information on their immigration status.

Are all persons U.S. citizens? ☐ Yes ☐ No

Complete the following information for any non-citizens who are applying for benefits. If you need more room, attach another sheet of paper.

Name	Age	Arrival Date in the United States	Registration Number
1.			
2.			
3.			
4.			
5.			
6.			

If there are any persons who are not applying for food stamps and/or cash benefits because they do not wish to provide proof of their immigration status, please list them below. **We will only ask questions about their income and assets.**

Name (Last) (First) (MI)	Name (Last) (First) (MI)
1.	4.
2.	5.
3.	6.

The following questions are for informational purposes only. Answering the questions will not affect your benefits.

1. Are you Hispanic or Latino? ☐ Yes ☐ No

2. What is your race? (Select one or more) ☐ American Indian/Alaskan Native ☐ Asian
   ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

3. Does the adult member of your household who will usually discuss your case with DHS and/or HFS speak English fluently ☐ Yes ☐ No

4. Does the adult member of your household who will usually receive mail or written information from DHS and/or HFS read English fluently?
   ☐ Yes ☐ No

If you checked either one of the above questions "No", what language do you speak? _____

State of Illinois
Department of Human Services

1 (PERMANENT)

Request for Cash Assistance - Medical Assistance - Food Stamps please print clearly

1. How many people live with you (include yourself)? _____

2. Are you or is anyone who lives with you blind? ☐ Yes ☐ No Disabled? ☐ Yes ☐ No
   If yes, who: _____

3. Do you or does anyone who lives with you receive any kind of assistance from DHS now? ☐ Yes ☐ No
   If yes, who: _____

4. Have you or has anyone who lives with you received any kind of assistance from DHS before? ☐ Yes ☐ No
   If yes, who: _____

5. Have you or has anyone who lives with you recently applied for assistance in this or any other local office? ☐ Yes ☐ No
   If yes, who: _____

6. Are you or is anyone in your household pregnant? ☐ Yes ☐ No

   If yes, who: _____ Expected Date of Delivery: _____

For Food Stamps, complete the rest of this page and page 4 if you are applying for food stamps.
We will interview you within 14 days - right away if you qualify for an expedited food stamp interview.

How many people who live with you buy and prepare food with you? (Include yourself)? _____

Please complete the following: ☐ I am able to come to an office interview. ☐ I must be interviewed by phone because:

☐ hours of work or educational activities conflict with DHS office hours; or

☐ problems related to health, transportation or ongoing severe weather; or

☐ lack of necessary child care

I can be reached by phone Monday - Friday between 8:30 and 5:00 at: _____

Please complete the section below only if you are applying for food stamp benefits, have little or no income, and need food stamp benefits right away. Your answers should include everyone who lives with you.

How much money do you or anyone who lives with you have in cash, checking, and/or savings? _____

What is the monthly **gross income** (income of all sources before any deductions) for you and everyone who lives with you? _____

How much money have you or anyone who lives with you received or expect to receive from any source in the month of application?

$ _____ When? _____ Who: _____ Source: _____

Is this a Food Stamp unit of migrant or seasonal farm workers? ☐ Yes ☐ No If yes, did the income recently stop? ☐ Yes ☐ No

Are you or is anyone who lives with you expecting to receive more than $26 in income from a new source within the next 10 days?

☐ Yes ☐ No

Request for Cash Assistance - Medical Assistance - Food Stamps please print clearly

Complete this page if applying for food stamps.

Shelter Costs

1. How much are you charged each month for your rent or mortgage? _____
   (For mortgage include property taxes and insurance.) Do you share this expense with anyone? ☐ Yes ☐ No

2. Are you receiving, applying, anticipating applying for Low Income Home Energy Assistance Program (LIHEAP), (in Chicago paid through CEDA)?
   ☐ Yes ☐ No

3. If No, are you billed separately from rent or mortgage for: **A.** Heat or air conditioning? ☐ Yes ☐ No

   B. Excess cost for heat or air conditioning? ☐ Yes ☐ No **NOTE:** Air conditioning is a window air or central air conditioning unit.

   C. Does anyone outside of your FS unit pay or help pay for your housing costs? ☐ Yes ☐ No

   D. Does anyone outside of your FS unit pay your utility expenses? ☐ Yes ☐ No

If yes, please list the bills and the amounts paid: _____

Please complete the following information if you answered (NO), to question (2 or 3) and are not billed for heat or air conditioning separately

Expenses	Amount	How Often Due	Amount You Pay	Paid By Others
Electricity				
Water and/or Sewerage				
Garbage				
Cooking Fuel				
Basic Phone Service (including cell phone)				
Septic Tank Installation Maintenance				
Well Installation /Maintenance				
A Fee for Starting Utility Service				
(Specify what utilities you pay)				
A Flat Amount for Utilities				
(Specify what utilities you pay)				

Explain: _____

Request for Cash Assistance - Medical Assistance - Food Stamps please print clearly

You must complete this page for all programs

What is your full name and birthdate and the full name and birth dates of all the people who live with you? Include people who are temporarily absent from the home (do not use nicknames). Also include people who live with you for whom you are not requesting assistance. List in this order: Yourself Your husband or wife Children Other relatives Non-relatives		Enter one of the words below to show the relationship of each person to you. Self / Husband Son / Wife Daughter / Father Grandson / Mother Granddaughter / Sister Stepbrother / Brother Stepdaughter / Aunt Stepson / First Cousin Stepmother / Nephew Stepfather Niece Related Some Other Way Not related. This person's relationship to me is:	A determination of your eligibility under any of the programs administered by the Department will be made unless you do not want to be considered for a particular program(s). Indicate below what type of benefits you do or do not want to apply for by checking "Yes" or "No".	**Enter the social security number of each person requesting benefits.**
1.	Person Making Application First Name: _____ Middle Initial: _____ Last Name: _____ Birthdate: _____	Self	Cash ☐ Yes ☐ No Medical ☐ Yes ☐ No Food stamps ☐ Yes ☐ No	
2.	First Name: _____ Middle Initial: _____ Last Name: _____ Birthdate: _____		Cash ☐ Yes ☐ No Medical ☐ Yes ☐ No Food stamps ☐ Yes ☐ No	
3.	First Name: _____ Middle Initial: _____ Last Name: _____ Birthdate: _____		Cash ☐ Yes ☐ No Medical ☐ Yes ☐ No Food stamps ☐ Yes ☐ No	
4.	First Name: _____ Middle Initial: _____ Last Name: _____ Birthdate: _____		Cash ☐ Yes ☐ No Medical ☐ Yes ☐ No Food stamps ☐ Yes ☐ No	
5.	First Name: _____ Middle Initial: _____ Last Name: _____ Birthdate: _____		Cash ☐ Yes ☐ No Medical ☐ Yes ☐ No Food stamps ☐ Yes ☐ No	
6.	First Name: _____ Middle Initial: _____ Last Name: _____ Birthdate: _____		Cash ☐ Yes ☐ No Medical ☐ Yes ☐ No Food stamps ☐ Yes ☐ No	

Please attach an additional page if there are more persons

State of Illinois
Department of Human Services

1 (PERMANENT)

Request for Cash Assistance - Medical Assistance - Food Stamps **please print clearly**

Complete this page if you are applying for medical benefits

1.	Person #1	Person #2	Person #3
Is this person covered by health or hospital insurance (including Medicare) now or in the last three months? If yes, complete the following.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
a. Date Coverage Began (month/year)	a.	a.	a.
b. Has Insurance Ended? If yes, why? Date Coverage Ended (Month/Year)	☐ Yes ☐ No b.	☐ Yes ☐ No b.	☐ Yes ☐ No b.
c. Name of Insurance Company	c.	c.	c.
d. Name of Policyholder	d.	d.	d.
e. Policyholder's SSN (optional)	e.	e.	e.
f. Employer Name and Phone Number	f.	f.	f.
g. Policy Number and Group Number	g.	g.	g.

2. Is any adult, parent, stepparent, spouse or pregnant woman named on this form currently employed? ☐ Yes ☐ No

   If yes, complete the following and **attach proof** for the last month. Is anyone self-employed? ☐ Yes ☐ No

   Name of Person: _____ Employer: _____

   Employer Address: _____ Employer Phone: _____

   Number of Hours Worked Weekly: _____ Amount Paid (including tips) before taxes $ _____ How Often Paid: _____

   Name of Person: _____ Employer: _____

   Employer Address: _____ Employer Phone: _____

   Number of Hours Worked Weekly: _____ Amount Paid (including tips) before taxes $ _____ How Often Paid: _____

3. Does anyone named on this form GET money from any source other than employment (such as Social Security, child support, spousal support, rental property, unemployment benefits, pensions, retirement, trusts)?
   ☐ Yes ☐ No

   If yes, complete the following and **attach proof** for the last month.

   Name of Person: _____ Source: _____ Monthly Amount $ _____

   Name of Person: _____ Source: _____ Monthly Amount $ _____

   If this income is from rental property, is this person receiving the income also the property manager? ☐ Yes ☐ No

4. Does anyone named on this form PAY child support or spousal support? ☐ Yes ☐ No

   If yes, complete the following and **attach proof** for the last month.

   Name of Person: _____ Source: _____ Monthly Amount $ _____

   Name of Person: _____ Source: _____ Monthly Amount $ _____

5. Does anyone named on this form PAY for day care so they can work? ☐ Yes ☐ No

   If yes, complete the following and **attach proof** for the last month.

   Name of child in Day Care: _____ Name of Care Giver: _____

   Name of child in Day Care: _____ Name of Care Giver: _____

   Person paying Day Care: _____ Monthly Amount $ _____

   Relationship of care giver to child (if any): _____

State of Illinois
Department of Human Services

1 (PERMANENT)

Request for Cash Assistance - Medical Assistance - Food Stamps please print clearly

All Kids/Family Care Insurance Rebate Form

A rebate is a monthly amount we will pay you if you already pay for health insurance for yourself, your spouse or your children. If you choose to get rebates, you will use your current insurance card to get health care.
Only families who have health insurance can get rebate payments. Also, only families with a certain amount of income can get rebates.

- ☐ Have the policyholder complete Part A;
- ☐ Have the policyholder's employer or personal insurance agent complete Part B and return it to you; and
- ☐ Return the completed pages to your local office.

Part A - The main person whose name is on the insurance must sign this part of the form. Often this person is called the policyholder. This person may get the health insurance from a job.

Policyholder's Last Name: _____ Policyholder's First Name: _____

Home Address: _____ Apartment Number: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____ Telephone Number: _____

(We must have the Social Security Number so we can pay the rebate to this person.)

Tell us the names of family members you want a rebate for: _____

I agree to call the All Kids/Family Care Unit right away if this health insurance ends, someone is added or taken off the health insurance, the amount paid for the insurance changes, covered benefits change or someone else becomes the policyholder.
I authorize my employer, plan adminstrator and insurance company to provide the information requested in PART B for the purpose of determining whether I qualify for All Kids/Family Care. I also authorize my employer, plan administrator and insurance company to verify my coverage and any of the information below for any time when I get All Kids/Family Care Rebate.

Signature of Employee/Policyholder: _____

Part B - This part of the form must be completed by the employer providing the health insurance or the insurance agent.

Note to Employer Insurance Agent: The employee/policy holder named above on this form is applying for help to cover the cost of their family's health insurance premiums. Please assist them by completing the information below and returning the form to the employee/policy holder as soon as possible. (As used below, "employee" applies to an employee or private policyholder.) For help in completing this form, call toll-free 1-877-805-5312.

Employer (if employer policy): _____

Employer address: _____

City: _____ State: _____ Zip Code: _____

Person completing this form: _____ Phone: _____ Fax: _____

Insurance Company: _____ Policy Number: _____ Group Number: _____

What benefits are covered? Check all that apply: ☐ Physician Services ☐ Hospital Inpatient Services

Amount of premium paid by employee: $ _____ . (Include amounts paid for dental, vision, and prescription coverage.)

Premiums are paid: ☐ weekly ☐ every 2 weeks ☐ twice a month ☐ monthly ☐ every 2 weeks ☐ quarterly ☐ semi-annually ☐ annually

Persons covered by the employee premium contribution: _____

Does the employer pay 100% of the cost of the employee's coverage: ☐ Yes ☐ No

If No, how much of the amount listed above is for coverage of the employee only (single rate)?

$ _____ (Include amounts paid for dental, vision, and prescription coverage.)

Enrollment Period of Policy: _____

Date of Premium Listed Above Began/Begins: _____

Date of Next Scheduled Change in Premium: _____

Authorized Signature of Employer/Agent: _____ Date: _____

Return the completed rebate form to the employee for submission with the All Kids/Family Care application. Need Help? Visit allkidscovered.com or call toll free 1-866-ALL-KIDS (1-866-255-5437) If you use a Text Telephone, call 1-877-204-1012.

Request for Cash Assistance - Medical Assistance - Food Stamps please print clearly

Read, complete and sign the next two pages if you want food stamp benefits

Federal law requires a social security number (SSN) for every member of your household who is applying for food stamp benefits. We do not require a social security number for any member of your household who is not eligible for the food stamp program or who does not wish to apply. If you or any member of your household wants to apply for food stamp benefits, but does not have a SSN, we can help you to apply for one. The SSN will be used in the administration of the food stamp program to check the identity of household members, prevent duplicate participation, and to facilitate making mass changes. The SSN will also be used in computer matching and program reviews or audits and to make sure the household is eligible for food stamp benefits, other federal assistance programs, and federally assisted state programs, such as school lunch, TANF, and Medicaid. This may result in criminal or civil action or administrative claims against persons fraudulently participating in the food stamp program.

At this application you must report:

* Child care expenses
* Utility expenses

You must report **and** verify:

* Rent or mortgage payment, property taxes and insurance
* Medical expenses
* Child support paid to a non-FS Unit member

Child support payments are subject to verification by computer matching with the records of the Division of Child Support Enforcement.

Failure to report or verify above expenses will be seen as a statement by your FS Unit that you do not want to receive a deduction for the unreported expenses.

Approved Representative

Someone other than the FS unit head can complete the application process or use the food stamp benefits to buy food for the FS unit. If such a person is authorized, write his or her name below. If an approved representative completes and signs this application, written authorization from the FS unit is required.

Name _____ Address: _____ Telephone Number: _____

Penalty Warning

The information on this form is subject to verification by federal, state, and local officials. If any information is found to be inaccurate, you may be denied food stamp benefits, and/or be subject to criminal prosecution for knowingly providing false information.

Individuals found guilty in a court of law of trading food stamp benefits for firearms, ammunition, explosives, or controlled substances will be barred from the food stamp program: 1) 24 months for the first offense and permanently for the second offense involving the sale of a controlled substance for food stamp benefits, and 2) permanently for the first offense involving the sale of firearms, ammunition, or explosives for food stamp benefits.

A person found guilty of trafficking food stamp benefits will be permanently barred from the food stamp program.

A person who is found to have made a fraudulent statement or representation about identity and residence to get multiple benefits at the same time will be barred for 10 years.

Persons who are fleeing felons or probation/parole violators are ineligible for food stamp benefits.

Any member of your FS unit who intentionally breaks any of the following rules can be barred from the food stamp program for 12 months after the first violation, 24 months for the second violation, and permanently for the third violation. The person can also be fined up to $250,000, imprisoned up to 20 years, or both. The person may also be subject to further prosecution under other applicable federal laws.

Do not give false information or hide information to get or continue to get food stamp benefits.

Food stamp benefits may not be traded or sold.

Food stamp benefits may be used for food products only and may not be used to buy ineligible items, such as alcoholic drinks and tobacco.

Do not use someone else's food stamp benefits for your FS unit.

Request for Cash Assistance - Medical Assistance - Food Stamps please print clearly

Client's Rights and Responsibilities - Food Stamps (continued)

I understand the questions on this application and the penalty for hiding or giving false information or breaking any of the rules listed in the penalty warning. By signing, I swear that under penalty of perjury the answers are true and correct to the best of my knowledge.

I understand that documents may have to be provided 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 food stamp office may contact to obtain the necessary proof.

I understand that while my application is pending and once it is approved, I must report any changes in my FS unit's circumstances within 10 days of the date the change occurs, unless otherwise notified. If I have any doubt about whether to report a change, I will ask my Human Services caseworker.

I understand that if approved for food stamp benefits and I receive more benefits than I am entitled to, whether it be an error on my part or an agency error, the amount of overpaid benefits is subject to recoupment/recovery.

Your Signature: _____ Date: _____

You are: Check One

- ☐ Head of FS Unit or a FS Unit member
- ☐ The FS Unit's approved representative

Witness if you signed with an X: _____

A fair hearing may be requested either orally or in writing if there is disagreement with any action taken on this case. The FS unit's case may be presented at the hearing by any person chosen by the FS unit.

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, disability, religion or political belief.

To file a complaint of discrimination, contact the Department of Human Services (DHS), USDA, or HHS. Write DHS at, Department of Human Services, Bureau of Civil Affairs, 401 South Clinton St, 4th Floor, Chicago, Illinois, 60607. Write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W. Washington, D.C. 20250-9410, or call (800) 795-3272 (Voice) or (202) 720-6382 (TTY). 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 (TTY). DHS, USDA and HHS are equal opportunity providers and employers.

Request for Cash Assistance - Medical Assistance - Food Stamps please print clearly

Read and sign the next 2 pages if you want cash or medical benefits

I understand that by signing this application form, I consent to any investigation made by the Department to verify or confirm the information I have given or any other investigation made by them in connection with my request for public assistance. I understand that I must cooperate in these efforts to verify information.

When I file an application for cash or medical assistance, a determination of my eligibility under any of the programs administered by the Department will be made unless I do not want to be considered for a particular program(s). If I do not want to be considered for a particular program, the Department will not consider my eligibility for that program(s).

I agree to inform the agency within 10 days of any change in my household's size, income, property, living arrangements, school attendance, or address.

I understand that if approved for cash benefits, and I receive more benefits than I am entitled to, whether it be an error on my part or an agency error, the amount of overpaid benefits are subject to recoupment/recovery.

I understand that if I am mentally and physically able to apply and I want someone else to apply for cash and/or medical benefits for me, I must attach a written statement that gives the person permission. The statement must include the person's name, address, and phone number. The statement must say that I am still responsible for the information provided by the person .

The Department secures and uses information about all clients through the income and eligibility verification system. This includes such information as receipt of social security benefits, unemployment insurance, unearned income (such as interest and dividends) and wages from employment. Any information obtained will be used in determining eligibility for assistance and the amount of assistance provided for all programs. When discrepancies are found, verification of this information may be obtained through contacts with a third party, such as employers, claims representatives, or financial institutions. This information may affect your eligibility for assistance and the amount of assistance provided.

The information provided on this form will be subject to verification by Federal, State, and Local officials. If any information is found to be inaccurate, I may be denied cash benefits and/or the MediPlan Card.

I understand that anyone who knowingly misuses the health benefits card issued by the State of Illinois may be committing a crime.

I understand that if I am not satisfied with the action taken on my application that I have the right to a fair hearing. I understand that I can ask for a fair hearing by getting in touch with the office where I applied or by writing to: the Bureau of Assistance Hearings, 401 South Clinton Street, Chicago, Illinois 60607, or by calling 1-800-435-0774.

As a condition of eligibility, if I am approved for TANF Cash and/or medical assistance for myself and my children, I understand that I may be required to cooperate with child support enforcement. Cooperation includes establishment of paternity and/or support enforcement and modification of child support orders. I assign and give all my rights, title and interest of child support and medical support to the Illinois Department of Healthcare and Family Services for as long as I receive TANF Cash and/or medical assistance. I understand and agree that any child support payments paid through the clerk of the circuit court and through the State Disbursement Unit (SDU) may be forwarded to the Illinois Department of Healthcare and Family Services as long as I receive TANF Cash.

I understand that if I apply for TANF Cash and/or medical assistance for my children only, I am not required to cooperate with child support enforcement, but I may request services.

If I am approved for TANF Cash and/or medical benefits for myself and my children, I give my right to collect medical support payments and third party payments to the State of Illinois for medical care for members of my family in the assistance unit unless I am declared exempt for a good cause.

All information related to the establishment of paternity and child support enforcement has been provided to the best of my knowledge.

If I am approved for Aid to the Aged, Blind, or Disabled for cash and medical assistance (AABD Cash) I understand that the Department may have the right to place a lien on real property owned by me to the extent of assistance the Department pays out in my behalf.

Request for Cash Assistance - Medical Assistance - Food Stamps please print clearly

If my application is approved, I give the State of Illinois the right to recover under the terms of any private or public health care coverage any amount for which I or a member of my family may be eligible.

I understand that the State of Illinois will release information concerning medical services I have received for any purpose authorized by law.

I understand that if the children I am applying for are approved for Kidcare Share or Kidcare Premium, I am responsible for paying the appropriate premiums and copayment amounts.

I understand that if the children I am applying for are approved for Kidcare Rebate, the State of Illinois is not responsible for additional premiums, deductibles or copayments required by the employer's or private health insurance policy.

I declare under penalty of perjury, that the statements I have made regarding the citizenship or immigration status of each person applying for medical benefits are true and correct.

I understand that the immigration status of each person applying for benefits who is not a citizen of the United States will be verified. This will require the disclosure to Bureau of Citizenship and Immigration Services(BCIS) of certain identifying information which I have provided. The information received from BCIS may affect eligibility for benefits.

☐ If this application is initiated by someone else in behalf of the applicant, they must sign below.

I understand that if I have given false information or intentionally failed to disclose information, I may be subject to prosecution, criminal, civil or both. I certify under the penalty of perjury that the information I have provided on this application from is the truth to the best of my knowledge.

Signature of Approved Representative: _____ Relationship: _____

Home address: _____ Apt. No. _____

Telephone Number: _____

I understand that if I have given false information or intentionally failed to disclose information, I may be subject to prosecution, criminal, civil or both. I certify under the penalty of perjury that the information I have provided on this application form is the truth to the best of knowledge.

☐ Sign your name or make your mark

Applicant: _____ Date: _____

Spouse: _____ Date: _____

☐ If you have made your mark (x) instead of signing your name, one witness must sign here:

Signature of witness: _____ Date: _____

☐ Application based on blindness must attest by two witnesses:

Signature of witness: _____ Date: _____

Signature of witness: _____ Date: _____

For GA applicants only

"The Department of Human Services is requesting your social security number and the number(s) of any other person(s) for whom you are applying in the administration of the general assistance (GA) program. Providing your number or the number(s) of any other person(s) for whom you are applying or receiving assistance is voluntary. If you do not wish to provide the social security number(s) requested, this will not affect your assistance. The Department will only use the social security number(s) you provide in the administration of the GA program as described above."

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, religion or political belief.

To file a complaint of discrimination, contact the Department of Human Services (DHS), USDA, or HHS. Write DHS at, Department of Human Services, Bureau of Civil Affairs, 401 South Clinton St, 4th Floor, Chicago, Illinois, 60607. Write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W. Washington, D.C. 20250-9410, or call (800) 795-3272 (Voice) or (202) 720-6382 (TTY). 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 (TTY). DHS, USDA, and HHS are equal opportunity providers and employers.

Print Form Reset Form