APPLICATION FOR BENEFITS

STATE OF WYOMING
DEPARTMENT OF FAMILY SERVICES

Name of Applicant/Recipient (Print) _____ SSN _______________

EXPEDITED FOOD STAMPS ONLY

You may file an incomplete application immediately. If you are eligible, Food Stamp benefits will begin with your filing date, which is the date the application is received at the Food Stamp office.

EXPEDITED FOOD STAMPS: You may be eligible to receive Food Stamps within seven days if you meet the expedited rules; otherwise, it could take up to 30 days. Complete the information listed below, furnish proof of identity and leave this expedited application page with the Food Stamp office. Completion of the standard application is required for the continuation of benefits. You may submit the completed application to the Food Stamp office either in person, through an authorized representative, by fax or by mail.

1. Your monthly rent/mortgage and utilities are more than your household's gross monthly income and liquid resources/assets.

   ☐ YES ☐ NO

2. Your gross monthly income is less than $150 and your household's resources, such as cash or checking/savings accounts, are $100 or less.

   ☐ YES ☐ NO

3. Are you a migrant or seasonal farm worker? ☐ YES ☐ NO

Name (Print) _____

Signature _____ Date _____

Address _____

AUTHORIZED REPRESENTATIVE: You may name another person who can apply for Food Stamps for you or receive and use your Food Stamps at the grocery store. You will be responsible for any overpayment that results from wrong information given by this person. This person cannot be a member of your household and you must give us an ID on this person. If yes:

Name of person to apply (Print) _____

Address _____

Name of person to receive and use (Print) _____

Address _____

ASSIGNMENT OF SUPPORT/RECOVERY/MEDICAL

For POWER performance payments, foster care and/or EqualityCare (medical assistance):

- I hereby assign any rights to back, current or future support/alimony to the State of Wyoming as a condition of eligibility for POWER. By signing this application, I understand any amount of support/alimony owed or paid for myself or on behalf of children named on this application must be turned into the Department of Family Services.
- I am assigning, on my behalf or on the behalf of any relative or person for whom application is made or assistance is received, to the State of Wyoming, Department of Health: 1) any and all rights to medical support or payment for medical expenses from any other person or entity in order to be eligible for POWER or EqualityCare (medical assistance); 2) any and all right of recovery, subrogation assignment, assignment of claims for benefits, or indemnification arising from an accident or occurrence which resulted in expenditures by the Wyoming Department of Health, against an insurer or other third-party for the cost of hospitalization, pharmaceutical services, physician services, nursing services and other medical services, not to exceed the amount expended by the Wyoming Department of Health in order to be eligible for POWER or EqualityCare (medical assistance). This assignment is effective until the Wyoming Department of Health has been repaid in full for all expenditures made on behalf of the applicant or on behalf of the person for whom the application is made.
- I understand I may request good cause for not cooperating in establishing paternity or pursuing child support if I feel doing so would result in physical or emotional harm to myself or my child(ren). Tell your Benefit Specialist if you wish to request good cause.

THE MEDICAL SUPPORT ASSIGNMENT MEANS:

- If I receive EqualityCare (medical assistance) and also get money for the same medical bills, or the medical bills are paid by another insurance company or third party, I must give the money to the Wyoming Department of Health; and
- The state may collect from any potentially liable third party, insurance company, or from the proceeds of any court settlement or judgment for all medical bills; and
- I am obligated to repay the state for 100% of the medical bills paid from any settlement or judgment prior to my receiving any of the money or other benefits from the settlement or judgment.

I HAVE READ AND FULLY UNDERSTAND THE ASSIGNMENTS I AM MAKING BY APPLYING FOR OR RECEIVING POWER OR EQUALITYCARE (medical assistance) AND THE AUTHORIZATION OF RELEASE OF CONFIDENTIAL INFORMATION (as set forth on the back of this page).

_____ _____
Signature of Applicant/Recipient/Authorized Representative/Caretaker Relative Date

_____ _____
Signature of Minor Parent Date

DECLARATION

All programs except EqualityCare (medical assistance)

Is anyone in your household for whom you are requesting assistance a fugitive felon? ☐ YES ☐ NO

Is anyone in your household for whom you are requesting assistance a parole violator? ☐ YES ☐ NO

Is anyone for whom you are requesting assistance fleeing for personal safety, a victim of domestic violence or at risk of further domestic violence? (Not required for Food Stamps) ☐ YES ☐ NO

Has anyone for whom you are requesting assistance been convicted of trafficking Food Stamp benefits of $500 or more? ☐ YES ☐ NO

Has anyone for whom you are requesting assistance received benefits of any kind from another state? ☐ YES ☐ NO

Is anyone for whom you are requesting Food Stamps a striker or a boarder? ☐ YES ☐ NO

I certify under penalty of perjury all answers are true and correct and agree to provide information if it is needed to verify any statements given on this form. I understand answers I provide here may result in changes in my benefits including a lower amount of benefits and payment or no benefit or payment. I also understand any false answers may result in criminal prosecution.

Signature _____ Date _____

If you do not speak English, or if you are deaf, hard of hearing or deaf/blind, you can have interpretation services provided for you at no charge. Tell the person helping you or you may contact the USDA Target Center at (202) 720-2600 for program information available in Braille, large print, audio tape, etc.

RIGHTS AND RESPONSIBILITIES

ARW = Administrative Rules of Wyoming
CFR = Code of Federal Regulations
PL = Public Laws
WS = Wyoming Statutes

AUTHORITY TO REQUIRE SOCIAL SECURITY NUMBER:

Social Security Numbers (SSNs) are required only for individuals who will actually receive Child Care, Food Stamps, POWER or EqualityCare (medical assistance) benefits. SSNs will be used in the administration of public assistance programs to check the identity of household members to prevent duplicate participation. SSNs will also be used in computer matching, program reviews and/or audits to make sure your household is eligible for these programs. The information on this application may be referred to federal and state agencies, as well as private claims collection agencies, for claims collection action against persons fraudulently participating in or giving false information to be eligible for these programs. Unless requested, DFS does not share SSNs with INS. If you do not have an SSN for yourself or assistance unit member, DFS can help you apply for one. Privacy Act of 1974; Title VI of the Civil Rights Act of 1964.

CIVIL RIGHTS:

In accordance with federal law, U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policies, the Department of Family Services (DFS) is prohibited from discriminating on the basis of race, color, sex, age, disability, religion, national origin or political beliefs. To file a complaint of discrimination, contact DFS and/or USDA Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, D.C., 20250-9410, (202) 720-5964; or HHS Director, Office of Civil Rights, Room 506F, 200 Independence Avenue, S.W., Washington, D.C., 20201, 1-800-368-1019 toll free or 1-800-537-7697 (TTY); or HHS Regional Manager, Office of Civil Rights, 1961 Stout Street, Room 1426, Denver, CO 80294, 1-800-368-1019 toll free or 303-844-3439 (TTY).

COMPUTER MATCHES:

The information you report will be checked by computer using SSNs. We will be comparing what you tell us with information on record with agencies such as the Department of Employment, IRS, Social Security Administration, Vital Statistics, Workers' Compensation, Child Support Enforcement and the Department of Revenue and Taxation. All persons in your home, who are included in benefits, will be included in the computer matches. Outside sources and/or your household members will be asked to verify other information. The information received may affect your eligibility and benefits. POWER: P.L. 104-193, as amended, W.S. 42-2-102, 42-2-103, 42-2-104, 42-2-106, ARW POWER, Chapter 1; Food Stamps: 7 CFR 272.8 and .11, 7 CFR 273.2, 7 CFR 273.16 and 7 CFR 273.18; Medicaid (Equality Care): 42 CFR 433.300; ARW Child Care, Purchase of Service, Chapter 1.

RELEASE OF CONFIDENTIAL INFORMATION:

Subject to certain limited exceptions, the information you provide is kept confidential. 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. For the purpose of administration of the Wyoming Medical Assistance and Services Act, DFS or the Department of Health may disclose information. Limited to a recipient's name, SSN, amount of payment, charge for services, date of services and services rendered related to EqualityCare (medical assistance) payments made under this Act ("assistance payment information"). Any state agency, insurer, group health plan, health maintenance organization or similar entity shall, upon request from the Department of Health, disclose the same limited information. A violation of these confidentiality requirements is a "misdemeanor punishable by imprisonment for not more than six months, a fine of not more than seven hundred fifty dollars ($750), or both." (W.S. 42-4-112-c)

DFS or the Department of Health may give the information you provide, without your consent, in the following circumstances:

1) To federal, state or local authorities responsible for administering or enforcing the regulations of the program for which you apply or receive benefits. These authorities may begin an investigation or bring civil or criminal action on the basis of the information received regarding your case.
2) To a court, judge, or other administrative legal body, but only when the information is required in a civil or criminal proceeding.

ADMINISTRATIVE HEARING:

If you feel our decision to deny, change or reduce your benefits is incorrect, you may request a conference with the local DFS office. If you still do not agree after that conference, you may request an administrative hearing from the State DFS. Except for POWER performance payments and child care, if you request the administrative hearing within 10 days of being notified, the change or reduction will not take place until the administrative hearing has been held and a decision has been made. If you do not request an administrative hearing on Child Care or POWER actions within 30 days, your request will be denied. The local DFS office will help you in arranging for a local conference or in making a request for an administrative hearing with the State. You may be represented by a lawyer, relative, friend, other person or you may represent yourself. If you hire a lawyer, you must pay all the legal charges.

If you want to discuss our decision or ask any questions about how an administrative hearing works, contact us. You may also call the local Legal Services Office to find out if free legal advice is available. 7 CFR 273.12; 42 CFR 435.916; P.L. 104-193, as amended, W.S. 42-2-102, 42-2-103, 42-2-104, 42-2-106, 42-2-109, 42-2-112, 42-2-202, 42-2-106, ARW POWER, Chapter 1; ARW Child Care, Purchase of Service, Chapter 1.

PENALTY WARNING:

- Federal, state or local assistance workers may check everything you tell us on the application. Refusal to cooperate with any authorized federal or state agency may result in denial or loss of benefits.
- You could be subject to criminal prosecution for knowingly giving false information and could lose your benefits for 12 months on the first violation and 24 months on the second violation. You may be barred permanently for the third violation and still be subject to prosecution under state and federal laws.
- Federal Food Stamp statutes provide for a fine of up to $250,000 and/or imprisonment for up to 20 years of any person who attempts to receive or receives Food Stamps to which the person(s) is not entitled.
- Do not use Food Stamps to buy ineligible items such as alcohol and cigarettes. Recipients found guilty of purchasing controlled substances (illegal drugs or certain drugs for which a doctor's prescription is required) shall be disqualified for one year for a first offense and permanently for a second offense.
- Recipients found guilty of purchasing firearms, ammunition or explosives with Food Stamps shall be disqualified permanently for the first offense.
- Any household member who breaks these rules can be barred from the Food Stamp Program.

REPORTING RESPONSIBILITIES:

POWER performance payments, Food Stamps, EqualityCare (Medical Assistance) and Child Care benefits provided through DFS are based on what you tell us about everyone in your household and verification(s) you provide. You must report and verify any change immediately upon finding out about it for POWER or within 10 days for EqualityCare (Medicaid elderly/disabled programs) and Food Stamps unless your eligibility worker has told you otherwise.

What information do you need to tell us about yourself and people living with you?

- Earnings
- Other Income
- Resources/Assets
- Student Status (for POWER only)
- Living Arrangements/Address/Child Care

Do you expect any of this to change or has it already changed? If so, call, write or complete and turn in a Change Report form along with verification of the change. DO NOT let your benefits go down or cause an overpayment just because you did not let us know about the change. **YOU ARE RESPONSIBLE FOR THE ACCURACY OF YOUR BENEFITS. IF YOU DO NOT KNOW IF YOU SHOULD REPORT A CHANGE, REPORT IT!** 7 CFR 273.12, ARW Food Stamps, Chapter 1; 42 CFR 435.916; P.L. 104-193, as amended, W.S. 42-2-102, 42-2-103, 42-2-104, 42-2-106, 42-2-109, 42-2-112, 42-2-202, 42-4-106, ARW POWER, Chapter 1; ARW Child Care, Purchase of Service, Chapter 1.

APPLICATION FOR BENEFITS

STATE OF WYOMING
DEPARTMENT OF FAMILY SERVICES

1. Name (Last, First, Middle Initial)

2. Mailing Address (Street, Box #, City, Zip Code, etc.)

3. Residence, if other than mailing address

4. Telephone/Message Number

5. **Do you intend to reside in Wyoming? ☐ YES ☐ NO

6. What is your preferred language?

7. **Complete the Information Below for All Persons Living With You.** List yourself first.

NAME (Last, First, Middle Initial)	RELATION-SHIP (Spouse, Child, etc.)	*SOCIAL SECURITY NUMBER (SSN)	BIRTH DATE (Mo/Day/Year)	ATTENDING SCHOOL? Y or N	Grade	SEX M or F	*US Citizen? Y or N	**Are you Hispanic or Latino? Y or N	**RACE American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian, Pacific Islander, or White Benefits are provided without regard to race, color or national origin.
	SELF								

8.**For any child under the age of 18, listed in #7, is there a non-custodial parent? ☐ YES ☐ NO

Name of Child(ren) _____ _____

Name of Non-Custodial Parent _____ _____

9. Does anyone, listed in #7, pay for or need child/adult care? ☐ YES ☐ NO

Who pays? _____

Monthly Amount Paid to Provider: _____

Child/Adult Care Provider: _____

_____

_____

Child(ren)'s/Adult's Name: _____

_____

Reason Child/Adult Care is needed: _____

_____

Is the Provider licensed? ☐ YES ☐ NO

10. Is anyone in the household, listed in #7, pregnant? ☐ YES ☐ NO

*If **YES**, please answer the following questions:*

Name of person who is pregnant: _____

How many babies are due? _____

Has the doctor or health professional informed the pregnant woman of her due date? ☐ YES ☐ NO

Due Date _____

If the pregnant woman is under the age of 18, tell us who lives with her.

Check all that apply:

☐ Her parent(s), ☐ On her own, ☐ Father of unborn baby,

☐ Other _____

Do you want to be referred to a Public Health Nurse for prenatal education? ☐ YES ☐ NO

Check the programs you wish to apply for/are receiving. Your income and assets may be considered when applying for these programs.

☐ **Child Care** – Assistance in paying for child care while parent(s) works, attends employment training or school.

☐ **Child Support Enforcement Services** – A referral for assistance in locating non-custodial parent(s), establishing paternity, enforcing court orders and collecting child support.

☐ **Equality Care** – Medical assistance.

☐ **Food Stamps** – Benefits to help buy food items.

☐ **Kid Care CHIP** – Children's Health Insurance Program for eligible uninsured children under the age of 19.

☐ **Personal Opportunities With Employment Responsibilities (POWER)** – Cash assistance for families who cooperate with seeking child support and work. POWER is limited to 60 months.

☐ **POWER–SASFA** – Cash assistance for single parents who are attending college for their first degree or first vocational training program.

☐ **OTHER**_____

Informational Instructions

***** Individuals who apply for benefits, or actually receive benefits, are required to provide the information listed with an asterisk (*).

Information is required for all family unit members whose status affects your eligibility determination and benefit level, i.e., a stepparent, boy/girlfriend or disqualified individual.

****** Items marked with two asterisks (**) need not be completed for Food Stamps.

If you do not have a Social Security Number (SSN), ask your Benefit Specialist about how to get one. An SSN and your Citizenship Status are NOT needed if applying for emergency services.

Immigrant status may be subject to Immigration and Naturalization Services (INS) verification. Information received may affect household eligibility and level of benefits. The Department of Family Services (DFS) will not share immigration information regarding non-applicant family members with INS.

11. * MARITAL STATUS: ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Single

12. Is there any household member who is expecting or has received a one-time payment, i.e., a settlement, inheritance, retroactive payment, etc? ☐ YES ☐ NO

    Who? _____ When? _____

13. Does any household member receive Indian Commodities? ☐ YES ☐ NO

    Who? _____

14. Is anyone, listed in #7, attending post/secondary education or vocational training? ☐ YES ☐ NO

    Who? _____

15. Has anyone, listed in #7, completed post/secondary education, vocational training or a graduate program? ☐ YES ☐ NO

    Who? _____

16. Has any household member quit employment or reduced hours/wages within the past 60 days? ☐ YES ☐ NO

    Who? _____

17. Indicate your living situation:

    Shelter provided free of charge? ☐ YES ☐ NO

    Share expenses? ☐ YES ☐ NO

    Live in subsidized housing? ☐ YES ☐ NO

    Pay rent/mortgage? ☐ YES ☐ NO Monthly Amount $ _____

    Pay property taxes? ☐ YES ☐ NO Monthly Amount $ _____

    Pay property insurance? ☐ YES ☐ NO Monthly Amount $ _____

    Pay utilities? ☐ YES ☐ NO Monthly Amount $ _____

18. Does any household member pay legally obligated child support? ☐ YES ☐ NO

    Who? _____ Monthly Amount $ _____

19. Does any elderly/disabled household member(s) pay medical expenses? ☐ YES ☐ NO

    Who? _____ Monthly Amount $ _____

20. In the past 3 months for Food Stamps or the past 36 months for Medical did anyone, listed in #7, sell, give away items or transfer anything of value, i.e., money, savings, livestock, stocks, bonds, land, home, vehicles, contract for deed, etc.? ☐ YES ☐ NO

    Item: _____ Value: _____

    Date Sold/Transferred: _____ Cash Amount Received: _____

21. ASSETS: Check either YES or NO to indicate whether you or any person, listed in #7, owns or is buying any of the items below. If yes is checked, indicate which person and enter the dollar/sale value.

ITEM Circle type(s)	Y	N	NAME OF PERSON	DOLLAR/SALE VALUE
Home, Land, Rental or Buildings				
Stocks, Bonds, Mineral Rights, Mutual Funds/Shares				
CDs, KEOGH, IRA, Pension Plans				
Trust, Money Market Certificates				
Checking/Savings Account(s) (Include Account Numbers)				
Cash on hand or held by a third party				
Life Insurance Policy, Burial/Funeral Plans				
Contract for Deed, Safety Deposit Box				
Motorcycle, Camper, Trailer				
Boat, Snowmobile, Aircraft, ATV				
Car/SUV/Truck (Make, Model, Year)				
2nd Car/SUV/Truck (Make, Model, Year)				
3rd Car/SUV/Truck (Make, Model, Year)				
Other (Specify)				

22. INCOME: Check either YES or NO to indicate whether you or any person, listed in #7, has income from any of the sources listed below. If yes is checked, indicate which person and enter the monthly income (before taxes or other deductions), including tips, commissions, etc.

SOURCE Circle type(s)	Y	N	NAME OF PERSON WITH INCOME	MONTHLY INCOME (before deductions)
Employed				
Name and Address of Employer				
Self-Employed (i.e. rancher, mechanic, beautician, etc.)				
Social Security Benefits				
SSI/State SSI Supplement				
Veterans/Retirement Benefits				
Rental Income/Contract for Deed				
Educational Income				
Indian Tribal Funds, Per Capita				
Railroad/Civil Service Benefits				
Unemployment/Workers' Compensation				
Child Support/Alimony				
Stocks/Bonds/Interest/Dividends				
Other (Specify)				

23. **Does a child in your household have a diagnosed medical condition? ☐ YES ☐ NO If **YES,** please answer the following questions:

Name of Child: _____ Diagnosed Medical Condition: _____

_____ _____

24. ****HEALTH INSURANCE INFORMATION:**

Are you or your spouse a permanent government employee of the State of Wyoming? ☐ YES ☐ NO
Are you or your spouse an At-Will Employee Contract (AWEC) worker for the State of Wyoming? ☐ YES ☐ NO
Are you applying for health coverage for anyone who currently has health insurance? ☐ YES ☐ NO If **YES,** or if insurance has been cancelled within the last 30 days, please answer the following questions:

Name of Who Is/Was Covered	Name of Insurance Company	Policy Number	Cancellation Date	Cancellation Reason

25. ****RETROACTIVE MEDICAL:** Does anyone in your household have unpaid medical bills that are within 3 months of the date of this application? ☐ YES ☐ NO If **YES,** please answer the following questions:

Name of Person(s) with Income	Month Care Received	Income for Month Care Received (before taxes or other deductions)	Source of Income (i.e. employment, child support, rental income)	Name of Employer

26. ****CHILD SUPPORT INFORMATION:** If you decide not to work with the Child Support Office, **your child(ren) may still be eligible for medical coverage,** but **your** health benefits may be denied.

☐ I would like to work with the Child Support Office to get money that is owed to my child(ren).
☐ I do not wish to work with the Child Support Office.
☐ I would like to claim "Good Cause" for not working with the Child Support Office.

AUTHORIZATION TO FURNISH INFORMATION/RIGHTS/RESPONSIBILITIES

For purposes of determining eligibility, I allow any person having information about me or other household members to give any requested information, including confidential information, to any authorized agent of the State of Wyoming or the federal Government. I also agree to provide information necessary to verify any statement given on this application, to update information promptly and to cooperate fully with all officials of the State of Wyoming in investigations and prosecution of actions Based upon this application or the information it contains. A copy of this authorization is as valid as the original.

I certify I have read this form or it has been read to me and the information given is true and correct. I understand the information given is voluntary and lack of required information could affect eligibility for certain programs. I agree to provide Information if it is needed to verify any statements given on this form. I authorize the Department of Family Services to make inquiry of persons, companies, financial institutions or other agencies to obtain additional information or to verify my Statements. I will report any change in my circumstances to the local Department of Family Services Office immediately for POWER, and within ten (10) days of the day the change becomes known for other programs. I understand the information I provide on this form may result in changes in my benefits, including a lower amount of benefits or no benefits.

Signature of Applicant/Recipient: _____ **Date:** _____ **Signature of Authorized Representative:** _____ **Date:** _____

Signature of Other Adult(s) in the Home: _____ **Date:** _____ **Signature of Worker:** _____ **Date:** _____

FOR YOUR INFORMATION: If your PayWest card is not used for a period of 90 days, it will be inactivated. If this occurs, you must contact your local Department of Family Services office to access remaining Food Stamp benefits on your PayWest card.