

## APPLICATION FOR ASSISTANCE

### Welcome to the Department of Health & Human Services (DHHS), Division of Family Assistance (DFA)

This is your application for the programs and services we offer. Please read all of the information given to you, and answer all of the questions as best as you can. **Do not answer anything that you do not understand.** If you need help in filling out this application, tell us. **We will accept your application even if you only fill in your name, address, signature, and program(s) requested.** DFA assistance is based on your income. Some DFA programs may also look at the cash value of things that you own, your “assets,” when figuring out if you qualify for a program DFA offers. Some assets, such as the home where you live, are not counted. Your Family Services Specialist (FSS) will explain which assets are counted.

#### Food Stamp (FS) Benefits

The Food Stamp Program helps low-income people buy the food they need for good health. You will need to complete an interview with an FSS to see if you are eligible for this program. **Your FS benefits are based on the date of application.**

With identification, you may get emergency FS benefits within 7 calendar days if:

- you have less than \$150 in monthly gross income and no more than \$100 in liquid resources;
- you have shelter costs that are higher than your gross income and liquid resources; **or**
- you are a migrant or seasonal farm worker who is destitute as defined in 7 CFR 273.10(e)(3).

#### Social Security Numbers (SSN)

The Federal Privacy Act of 1974 as amended, requires that we tell you the laws that allow us to ask for the SSN of each person requesting assistance, whether you are required to give them to us, and what we will do with them. SSNs are required for the following programs. After each program is the law or regulation that requires us to ask for these SSNs:

- FANE: 42 USC 405(c)(2), 45 CFR 205.52, & RSA 167:79,iii(h).
- Food Stamps: Food Stamp Act of 1977, as amended, 7 USC 2011-2036, 7 CFR 273.2(b)(4), & 7 CFR 273.6.
- Medical Assistance and other financial assistance: Section 2651 of PL 98-369 & 42 USC 1320b-7.

Each person who wants assistance from the above programs must provide an SSN or apply for a number at the Social Security Administration (SSA). If you are applying only for some members of your

family, such as a parent applying for Medical Assistance just for a child, you only have to give us the child's number or apply for one for your child. Your child's eligibility for medical coverage will not be affected if you don't give us your SSN.

If an SSN is not provided for each person who is applying for the listed programs, your application may be denied or you may get less benefits.

Applicants for Healthy Kids Silver or for NH Child Care Scholarship only, do not have to provide an SSN but if SSNs are provided, it may help shorten the eligibility verification process.

We ask for SSNs so we can verify earned and unearned income and resource information you give us. It will be shared with:

- the SSA;
- various offices within DHHS as allowed by federal law;
- New Hampshire Employment Security;
- the Internal Revenue Service;
- financial institutions; and
- other computer matching programs.

The information will be used:

- to figure out if your household is eligible or continues to be eligible for the assistance you requested;
- to figure out the amount of your benefits or errors in your eligibility or benefits; and
- in an investigation of suspected abuse of program law or rules.

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 Food Stamp claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State

agencies, as well as private claims collection agencies, for claims collection action.

We do not give SSNs or any other information regarding non-applicants to the US Citizenship and Immigration Services (USCIS), formerly known as INS, or any other agency not directly connected with programs and/or services offered by DHHS.

#### Emergency Medicaid for Non-Citizens

Emergency Medicaid may be available to certain non-citizens, regardless of their immigration status, to cover some emergency services, including labor and delivery. **Social Security Numbers are not needed to apply for Emergency Medicaid.**

#### Citizenship & Identity

You must declare and prove the citizenship or non-citizenship status of each household member applying for assistance. Non-citizens applying for assistance, except Emergency Medicaid, must provide USCIS documentation of qualified alien status. USCIS documentation will be verified.

#### Third Party Insurance or Medical Payments

If you are applying for Medical Assistance or Healthy Kids Gold, receipt of such assistance is an assignment to DHHS of your rights to all third party insurance or medical payments without anyone having to sign any other form. All available parties must be billed and all resulting payments must be applied to the cost of medical care before DHHS will pay. Also, if you receive a settlement or an award from a liable third party, you must pay DHHS back for related medical services we paid. RSA 167:14-a.

#### Benefits Received in Error

You are required to pay back any benefits or services received in error, regardless of whether we made a mistake in processing your case or you made a mistake in the information you provided, or failed to provide, to us.

#### Financial or Medical Child Support

If you are applying for TANF cash payments, your receipt of such assistance is an assignment to DHHS of your rights to financial child support. Without signing any other form, you give DHHS the right to collect and keep financial child support payments made on behalf of your children who receive assistance. RSA 161-C:22

DHHS collects and keeps the support to partially offset the amount of cash assistance paid to you. If support payments are equal to or more than the amount we give you, your cash assistance case will be closed and the support payments sent to you.

Receipt of Medical Assistance for children is an assignment of medical child support rights. This means that you must cooperate with DHHS to establish and enforce medical child support for your children. Medical child support usually means health insurance provided by the absent parent, but can also be an ongoing dollar amount paid by the other parent to allow you to buy health insurance for your children.

If you receive money to purchase insurance, this money will be kept by the State while you receive Medicaid and will be used to pay back the state and federal governments. If paternity is not established for any of your children who are getting Medicaid, you must also cooperate with DHHS to legally establish paternity.

The assignment of support rights is a requirement. Your rights and responsibilities and the penalty for refusal without a good reason, will be explained to you when you meet with your District Office worker.

#### Begin Date for Medicaid Eligibility

Your Medicaid eligibility generally begins on the day that you meet all the requirements for the program you applied for, including the resource limit.

### AGENCY USE ONLY

This is your record of application and will be filled out by a Department of Health and Human Services worker and returned to you. DFA has received

a completed application for \_\_\_\_\_ from \_\_\_\_\_ on \_\_\_\_\_

District Office

Signature of Worker

Referred for XFS  Yes  No  
 Initials: \_\_\_\_\_

**A. Please tell us about who you are and where you live.**

Name: \_\_\_\_\_ Primary Language: \_\_\_\_\_  
 Current Place of Residence:  Own home  Nursing Facility  Adult Family Home  Assisted Living  
 Congregate Housing  Homeless  Hospital  Hotel/Motel  Residential Care Facility  Other  
 Street Address: \_\_\_\_\_ Mailing Address: \_\_\_\_\_  
 (if different)  
 City/State/Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell/Message: \_\_\_\_\_  
 E-Mail Address: \_\_\_\_\_  I do not have an E-Mail address  
 Does anyone in your family have Medicare Part A or B?  Y  N  
 Why do you need our help? \_\_\_\_\_

Information Supplier: \_\_\_\_\_  
 (if different from applicant) Name Address Phone #

**B. Please tell us about the people you live with. Start with yourself and list ALL of the people living with you. You do not have to give the Social Security Number or citizenship status of any individual who is not applying for assistance.**

Name	U.S. Citizen?	SSN	DOB	Relation to you	RID (DFA Use Only)
1.	<input type="checkbox"/> Y <input type="checkbox"/> N			SELF	
2.	<input type="checkbox"/> Y <input type="checkbox"/> N				
3.	<input type="checkbox"/> Y <input type="checkbox"/> N				
4.	<input type="checkbox"/> Y <input type="checkbox"/> N				
5.	<input type="checkbox"/> Y <input type="checkbox"/> N				
6.	<input type="checkbox"/> Y <input type="checkbox"/> N				

**C. I want to apply for: (TYPES OF ASSISTANCE REQUESTED)**

ALL PROGRAMS  Cash  Medical Assistance  
 Food Stamps  Child Care  Medicare Savings Programs (MSP) [QMB/QWDI/SLMB/SLMB135]  
 Home and Community-Based Care (HCBC)/Nursing Facility (NF) Services Facility Name: \_\_\_\_\_

**D. The following information is collected to be sure that everyone is served fairly. Your answers are voluntary. The information provided will not affect your eligibility or benefit amount.**

Are you Hispanic or Latino?  Yes  No  
 Are you: White?  Y  N Asian?  Y  N Native Hawaiian or Other Pacific Islander?  Y  N  
 Black or African American?  Y  N American Indian or Alaskan Native?  Y  N

**AGENCY USE ONLY:**

RFA#	CR Case #	Forms Given:	725	177
Cash _____	OPEN _____	CLOSE _____	DENY _____	DATE: _____ DO: _____
Food Stamps _____	OPEN _____	CLOSE _____	DENY _____	DATE: _____ DO: _____
MA _____	OPEN _____	CLOSE _____	DENY _____	DATE: _____ DO: _____
HKG/HKS/MCPW _____	OPEN _____	CLOSE _____	DENY _____	DATE: _____ DO: _____
Child Care _____	OPEN _____	CLOSE _____	DENY _____	DATE: _____ DO: _____
EBT Card Status:	None	Active	Deactivated	Cancelled

**PLEASE COMPLETE THE BACK**

E. Please tell us about all income for everyone in your home.	G. Your Expenses:
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Your Wages: \$ \_\_\_\_\_  Weekly  Bi-Weekly  Monthly  
 Other Wages: \$ \_\_\_\_\_  Weekly  Bi-Weekly  Monthly  
 Other Wages: \$ \_\_\_\_\_  Weekly  Bi-Weekly  Monthly  
 Has anyone recently lost a job?  Yes  No  
 If yes, who? \_\_\_\_\_ When? \_\_\_\_/\_\_\_\_/\_\_\_\_

SSA/SSDI: \$ \_\_\_\_\_ Spousal Support: \$ \_\_\_\_\_  
 SSI: \$ \_\_\_\_\_ Unemployment: \$ \_\_\_\_\_  
 VA: \$ \_\_\_\_\_ Child Support: \$ \_\_\_\_\_  
 Pension: \$ \_\_\_\_\_ Other: \$ \_\_\_\_\_

Rent (monthly): \$ \_\_\_\_\_  
 Mortgage (monthly): \$ \_\_\_\_\_  
 Lot Rent/Condo Fee (monthly): \$ \_\_\_\_\_  
 Taxes (yearly): \$ \_\_\_\_\_  
 Dependent Care: \$ \_\_\_\_\_  
 Medical Expenses: \$ \_\_\_\_\_

F. Please tell us about all assets for everyone in your home.
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Checking/Savings: \$ \_\_\_\_\_ Other Chk/Save: \$ \_\_\_\_\_  
 Stocks/Bonds/CD's: \$ \_\_\_\_\_ IRA: \$ \_\_\_\_\_  
 Your or Your Spouse's Annuity: \$ \_\_\_\_\_ Other Assets: \$ \_\_\_\_\_  
 Trusts: \$ \_\_\_\_\_ Life Insurance: \$ \_\_\_\_\_  
 Vehicle (Yr/Mdl): \_\_\_\_\_ Vehicle (Yr/Mdl): \_\_\_\_\_

**Do you pay for the following utilities separate from your rent or mortgage?**

Heat:  Yes  No  
 Phone:  Yes  No  
 Electric:  Yes  No  
 Other:  Yes  No

H. Potential Eligibility Questionnaire
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1. Are you a migrant or seasonal farm worker?  Yes  No
2. **Have you or anyone in your household received Food Stamp assistance for this month?**  Yes  No
3. Are you currently living in a shelter for battered individuals?  Yes  No
4. **Is anyone in your household blind or disabled?**  Yes  No
5. Have you sold or transferred property in the last 5 years?  Yes  No
6. **Is anyone in your household currently receiving assistance from another State?**  Yes  No  
 If yes, which State? \_\_\_\_\_ What kind of assistance? \_\_\_\_\_
7. Is anyone in your household pregnant or has anyone given birth in the last 3 months?  Yes  No
8. **Do you have any unpaid medical bills from the past 3 months that you would like help paying?**  Yes  No
9. If you are applying for Financial Assistance to Needy Families (FANF), is the father's name blank or "not stated" on the birth certificate for any of your children?  Yes  No
10. **If applying for FANF, how many absent parents?** \_\_\_\_\_
11. Do you or any other household member have health insurance other than Medicaid?  Yes  No  
 If yes, name of Insurer? \_\_\_\_\_ Policy Number: \_\_\_\_\_

I. Signatures
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**I certify, under penalty of perjury, that I have reviewed this information; it is true and complete to the best of my knowledge, including the information concerning citizenship and alien status. I understand a full financial and medical eligibility interview may be conducted before my eligibility can be determined.**

Applicant Signature	Date	
Signature of Person Helping the Applicant	Date	Relationship to Applicant

I withdraw my application for:  Cash  Medical Assistance  Food Stamps  Child Care  HCBC/NF  MSP

Signature	Date
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I certify that I have given the above individual(s) the opportunity to review this application. I also certify that I have provided a copy of this form, if one was requested.

Printed Name & Signature	Title/Agency	Date
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## APPLICATION: YOUR RIGHTS AND RESPONSIBILITIES

### Time Limits

You can only receive Financial Assistance to Needy Families for 60-months in your lifetime. Months you received this assistance while you were a child do not count towards the lifetime limit. Your time limit begins when you receive benefits as an adult. **There is no time limit on State Supplement Programs, Medical Assistance, Food Stamp benefits, or child care assistance.**

### Nondiscrimination Notice

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 also prohibited 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 & TDD). Write HHS, Director, Office of 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). USDA and HHS are equal opportunity providers and employers. Or you may also write Ombudsman, NH DHHS, 129 Pleasant St., Concord, NH 03301-3857 or call (603) 271-6941 or 1-800-852-3345 ext 6941. TDD Access: Relay NH 1-800-735-2964 or 7-1-1.

### Administrative Appeal

You or someone representing you may request an Administrative Appeal if you are not satisfied with any decision regarding eligibility made by DHHS. You may be represented by an attorney or other person at an Administrative Appeal. DHHS will not pay for the cost of any legal services, but there are free and reduced cost legal services available in NH. An Administrative Appeal may be requested either verbally or in writing by contacting a District Office or DHHS, 105 Pleasant Street, Concord, NH 03301-6521. Telephone (603) 271-4292 or 1-800-852-3345 ext 4292; TDD Access: Relay NH 1-800-735-2964 or 7-1-1.

### Quality Control

Your case may be selected for a quality control or other governmental review. Such a review entails an in-depth investigation into your household's financial or medical situation, living arrangements and other circumstances. We may be contacting banks, employers, companies, merchants and other appropriate sources, concerning your household and statements you made to DHHS. **Failure to cooperate in these reviews could result in the loss of your benefits.**

### Reporting Changes

You will be required to periodically complete a review of your circumstances. Your cash assistance and Food Stamp case could be closed, and/or your eligibility for Medical Assistance may be affected, if you do not completely fill out the form and return it by the due date and participate in a personal interview, if required.

If you only get Food Stamp benefits and you have a 4, 5, or 6-month eligibility period, you only need to report those changes in household circumstances that would place your household's income above 130% of the poverty level.

If you receive cash assistance, child care assistance, Medical Assistance, or if your Food Stamp eligibility period is not 4, 5, or 6 months, then you must notify the Department within 10 calendar days after the change happens for changes in:

- source of income;
- hours worked by a household member;
- amount of income of any member in your household;
- assistance group or household composition;
- resources (e.g., cash, stocks, bonds, or money in a bank or savings account);
- receipt of any lump sum payment or settlement;
- residence, or shelter costs; or
- dependent care costs, child support payments or medical deductions, or other changes that may affect the amount of your household's benefits.

### Protection of Medical Assistance for Social Security Beneficiaries

If you are receiving cash assistance under the OAA, ANB, or APTD program, and a Social Security cost-of-living increase or this increase combined with an increase in other income makes you ineligible for financial assistance, you may still be entitled to Medical Assistance under the Pickle Amendment policy.

Once you begin receiving Medical Assistance under the Pickle Amendment, future Social Security cost-of-living increases will not affect your eligibility. However, other changes in your circumstances can still make you ineligible for Medical Assistance.

If you are eligible to receive money payments under one of the above programs, but choose not to receive a payment, you will **NOT** be entitled to this protection of your Medical Assistance under the Pickle Amendment.

## ATTENTION!

Anything you tell or give to us will be verified:

- at the federal, state and local levels; and also
- through computer matching with other verification resources such as, but not limited to, USCIS, IEVS, Vital Records, SSA, financial institutions, & employment databases.

We do this to confirm your eligibility for our programs and determine your benefits. If any information is found to be inaccurate, you may be denied assistance and may be subject to criminal prosecution for knowingly providing false information. Any member of your household who breaks any of these rules on purpose can be prohibited from participating in the cash assistance and Food Stamp programs for periods ranging from one year to permanently. In the Food Stamp Program, you can also be fined up to \$250,000, imprisoned up to 20 years, or both, and will be subject to prosecution under the applicable state and federal laws for violations of the Food Stamp Act.

## Notice to Immigrant Families

If you get help with health care or Food Stamps, it will not affect your immigration status. If you or members of your family used or received Medicaid, Healthy Kids, or Food Stamps, it will not affect your or your family members' ability to become U.S. citizens.

However, if you get cash assistance such as TANF or help with the cost of nursing home care, it might create problems with becoming a U.S. citizen, especially if the benefits are your family's only income. Before you apply, you may want to talk with an agency that helps immigrants with legal questions or contact the US Citizenship and Immigration Services (USCIS).

### DO NOT

- **Do not** give false information or hide information to get or continue to get benefits.
- **Do not** trade or sell Food Stamp benefits to anyone who is not authorized to use them for your household.
- **Do not** use Food Stamp benefits to buy ineligible items, such as alcoholic drinks and tobacco.
- **Do not** use any benefits your household was not entitled to receive.

### Identity & Residence

Anyone convicted of making a fraudulent statement or representation with respect to identity or residence in order to receive benefits in two locations at the same time will be ineligible for financial assistance and Food Stamp benefits for 10 years.

### Trafficking Food Stamp Benefits

Any person who is found guilty in a court of law for buying or selling illegal drugs or certain prescription drugs in exchange for Food Stamp benefits, will be prohibited from participating in the Food Stamp Program for 24 months for the first offense and permanently for the second offense. Any person who is found guilty in a court of law for buying or selling ammunition, firearms or explosives in exchange for Food Stamp benefits, or of any trafficking in Food Stamp benefits of more than \$500, will become permanently ineligible for Food Stamp benefits.

### Medical Assistance Fraud

Section 1128B of the Social Security Act provides federal penalties for fraudulent acts and false reporting in connection with your application for or receipt of Medical Assistance benefits.

A person may be prosecuted in Federal Court for deliberate statements that are known to be false and which affect eligibility for any benefit or payment under the Medical Assistance program.

A person may also be prosecuted for concealing or failing to disclose any event that affects their right to any benefit or payment, or its conversion to a use other than intended. The law also provides a penalty for a kickback, bribe, or rebate in connection with the furnishing of Medical Assistance.

Conviction of an offense could result in loss of Medical Assistance benefits for a period not to exceed 1 year. Penalties are fines up to \$25,000 or imprisonment for not more than 5 years, or both.

### Intentional False Statements

Any person who intentionally makes a false statement or misrepresents his or her circumstances or intentionally fails to disclose the receipt of property, wages, income or resources or any change in circumstances that would affect his or her initial or continued eligibility for assistance may be found guilty of violating state law. The penalties are: a class A felony where the value of the monetary award or goods or services exceeds \$1,000; a class B felony where the value exceeds \$100; and a misdemeanor where the value does not exceed \$100. RSA 167:17-b and 17-c.

Case Number: \_\_\_\_\_ Date: \_\_\_\_\_

**APPLICATION: STATEMENTS OF UNDERSTANDING**

**INITIALS**

**I certify** that I have read "Your Rights and Responsibilities," and I understand them. \_\_\_\_\_

**I understand** that DHHS will keep any information on this application confidential and only persons involved in administering DHHS' programs or as otherwise permitted by Federal regulations or State law will review it. \_\_\_\_\_

**I understand** that I may have to provide documents to prove what I have written on the application or stated to DHHS. \_\_\_\_\_

**I understand** that the information I have provided will be verified by Federal, State, and local officials and that if any information is found to be incorrect or false, or if I have deliberately withheld information related to my receipt of assistance, now or in the future, I may lose my benefits and may be prosecuted for fraud. \_\_\_\_\_

**I understand** that my signature below authorizes DHHS to obtain verification that I meet the eligibility requirements for assistance, and authorizes release of such information to DHHS. My authorization to release information to DHHS remains in effect until the time of my next redetermination of eligibility. \_\_\_\_\_

**I certify** that the Domestic Violence Option has been explained to me, and I understand it. \_\_\_\_\_

**I certify** that I got written information about the treatment of lump sum income if I applied for FANF. \_\_\_\_\_

**I understand** that my receipt of cash assistance under the TANF Program is an assignment to DHHS of each recipient's rights to child and spousal support. \_\_\_\_\_

**I understand** that if my request for cash assistance is approved by DHHS, the amount of assistance I get could cause my Food Stamp benefits to end or be reduced. I also understand that if this happens, I will not get advance notice of this change. \_\_\_\_\_

**I understand** that in NH, if anyone in my household is fleeing to avoid prosecution of a felony crime, or is violating conditions of probation or parole, that person will be ineligible to get cash or Food Stamp benefits until that individual has satisfied his/her legal obligations with respect to the felony crime or probation or parole violations. My signature below is my sworn statement that no one in my household at this time is fleeing felony prosecution or violating conditions of probation or parole. \_\_\_\_\_

**I understand** that the use of my Electronic Benefits Transfer (EBT) card for Food Stamp or cash benefits is controlled by my 4-digit Personal Identification Number (PIN), that I am responsible for the security of my EBT card and PIN, and that EBT benefits will not be replaced if someone else uses my card after I have activated it. \_\_\_\_\_

**I understand** that if I do not use my Food Stamp benefits on my EBT card for 365 days in a row, I will lose those benefits and not get them back. If I do not use my cash benefits for 90 days in a row, I will lose those benefits and not get them back. I understand that I will be disqualified from the Food Stamp Program and may be prosecuted if I use my EBT card for illegal purposes. These illegal activities include selling my card and PIN for cash, drugs, or other items, or exchanging Food Stamp benefits for cash at a retailer. \_\_\_\_\_

**I understand** that for Food Stamp benefits, to get a deduction for child care expenses, rent or mortgage payments, utility or other shelter expenses, child support paid to a non-household member, or medical expenses (only for the elderly or disabled), I **must** tell DHHS about these expenses and then provide proof of them. Failure to report or verify any of the above listed expenses, or of receipt of fuel assistance, could mean that I will get less Food Stamp benefits each month, and will be seen as my statement that my household does not want to get a deduction for the unreported or unverified expense. \_\_\_\_\_

**I understand** that my receipt of medical assistance is an assignment to DHHS of my rights to all third party medical insurance or payments. \_\_\_\_\_

**I understand** that my receipt of medical assistance means DHHS must be able to obtain medical records from medical providers. My signature below authorizes my family's medical providers to release any records to DHHS. \_\_\_\_\_

**I understand** that, if I am in a nursing home, DHHS must be able to exchange eligibility information with the nursing home to best administer the program. My signature below authorizes that exchange and remains in effect until the time of my next redetermination. \_\_\_\_\_

**I understand** that for long-term care services (Nursing Facility or Home and Community-Based Care), I am required to disclose to DHHS any interest that my spouse or I have in any annuity. \_\_\_\_\_

**I understand** that if either my spouse or I are requesting long-term care services, any annuity purchased or modified by my spouse or me on or after February 8, 2006 will be considered a transfer of assets for less than fair market value unless the State is named the beneficiary for at least the amount of Medicaid paid for long-term care services. \_\_\_\_\_

I certify, under penalty of perjury, that I have reviewed this information and the information summarizing my interview, and it is true and complete to the best of my knowledge.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Person Helping the Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Applicant

I certify that I have given the above signed individual(s) the opportunity to review this document, and that I have completely explained and given them a copy of the Rights and Responsibilities Notice. I also certify that I have given them a copy of this page, if it was requested.

\_\_\_\_\_  
Printed Name & Signature

\_\_\_\_\_  
Title/Agency

\_\_\_\_\_  
Date