APPLICATION FOR CONTINUED ELIGIBILITY FOR FINANCIAL, MEDICAL, CHILD CARE, AND SNAP BENEFITS

We want you to keep getting your benefits on time and in the right amounts, but we need your help. On a regular basis, we must review your eligibility for the benefits you are getting now. You must complete this **Application for Continued Eligibility** if you want to find out if you are eligible to continue to get your benefits. We will accept this Renewal Application even if you only fill in your name, address, and signature. However, we will be able to figure out if you can continue to get your benefits much quicker if you complete this entire Renewal Application.

- This page tells you how to complete this Renewal Application. The back of this page, ✓**CHECKLIST OF REQUIRED PROOF**, tells you what kinds of proof you must give us before we can tell you if you will continue to be eligible. ***Keep this page for your records.***
- The booklet is the actual Renewal Application. Please complete this booklet, **attach copies of as many of the required proofs as you can,** put your proofs and the Renewal Application in the enclosed envelope, and mail it so it reaches us **no later than the 15th of next month**.

If you have any questions, call your District Office right away for help.

HOW TO COMPLETE THIS RENEWAL APPLICATION

- **PLEASE READ EVERYTHING CAREFULLY AND FOLLOW ALL INSTRUCTIONS!**
- Fill out Sections 1 through 6 on the next page for each person who is getting assistance. If you get medical assistance, also complete Section 8.
- The Supplemental Nutrition Assistance Program (SNAP) allows special income deductions. If you get SNAP benefits, you can claim more deductions from your income by filling out Section 7. See the shaded sections for special SNAP information. We will not be able to give you deductions that you do not tell us about and prove.
- When you have finished filling out this Renewal Application, sign and date it in the spaces provided on the bottom of the last page and mail the Renewal Application, **along with copies of as many of the proofs discussed below as you can**, in the enclosed pre-addressed, postage-paid envelope. Return it as soon as possible, but **no later than the 15th of next month**. It is important that we receive your completed Renewal Application by the 15th so that if you are eligible for continued benefits, your benefits will continue without interruption.

PROOFS WE WILL NEED TO DECIDE YOUR ELIGIBILITY

- **YOU MUST GIVE US PROOF OF ALL INCOME RECEIVED BY EVERYONE IN YOUR HOUSEHOLD, even if your household's income has not changed since the last time you gave us this proof.**
- If anything else has changed, such as your address, who lives in your home, or if your expenses have gone up or down, please tell us about these changes.
- This could affect eligibility or, if you get cash or SNAP benefits, the amount you get each month.
- The ✓**CHECKLIST OF REQUIRED PROOF** on the back of this page tells you what kinds of proof we need. **PLEASE GIVE US ONLY *COPIES* OF ORIGINAL DOCUMENTS — NO ORIGINALS WILL BE RETURNED.**

WHAT WILL HAPPEN NEXT

- When we get your completed Renewal Application and all required proofs, we will review the information you tell us, and let you know if you are still eligible for the benefits you are getting now and if there are any changes.
- If we have questions or need any other information, we will contact you and tell you what we need. If we do need other proofs, you will have at least 10 days to provide them.
- If you need help getting the proofs, or you don't understand what we need, contact us right away.
- ***If you want to apply for any new benefits, do not use this form.*** Contact us for more information if you want to apply for new benefits.
- **If on your application you tell us you want to "Go Green,"** you will get all future notifications from us through your NH EASY account. *Going Green* means your notices are paperless – you get your notices electronically. This means you get your notices faster than through "snail mail." Your notices and letters from us will be visible on one screen. Plus, you are helping the environment! After you *Go Green*, we will email you any time you have a notice using the email address you give to us. Go to www.nheasy.nh.gov for more information.

PLEASE TURN THE PAGE – IMPORTANT INFORMATION IS ON THE BACK!

✓CHECKLIST OF REQUIRED PROOF

Use this page to check for all the proofs you need to give us.

NOT GIVING US ALL THE PROOFS WE ASK FOR CAN CAUSE YOUR BENEFITS TO GO DOWN OR EVEN END!

Proof of Household Income

Please give us **ONE proof of income for EACH type of income** that is received by anyone living with you:

Salaried or Hourly Employees

- ✓ Copies of pay stubs for the last 4 weeks.
- ✓ A letter from the employer on company letterhead stating hours worked & gross wages earned for the most recent 4 weeks, or our BFA Form 756, which is available from your worker or online.

Self-employed Individuals

- ✓ Most recent federal income tax forms and all supporting schedules, e.g., Schedules C or E, **or**
- ✓ Other records, such as a recent Profit and Loss Statement, proof of earnings and expenses.

Other Kinds of Income

- ✓ Copy of any letter, bank statement, or check stub that clearly shows the gross amount of any benefits received, such as Social Security, SSI, Unemployment, VA, Worker's Compensation, disability, etc.
- ✓ Child/spousal support or educational income you get.
- ✓ All documents showing income you get from rent, royalties, interest, dividends, roomers/boarders in your home, money from friends/relatives, etc.

Proof of Expenses You Want to Claim

With proof we *may* be able to subtract some other kinds of expenses from your income.

- ✓ Court-Ordered Child or Spousal Support – Give us **one** copy of the court order signed by a court official or a letter from the court or your attorney confirming the amount/frequency, plus proof of payment.
- ✓ Impairment Related Work Expenses - Cancelled checks or receipts for home/workplace modifications, special work or medical equipment, etc. which enable a disabled person to work.
- ✓ Legal Wage Garnishments - Pay stub itemizing the garnished amount, or a statement from your employer on company letterhead verifying the amount/frequency.
- ✓ Other Expenses – Proof of Taxes, child care, transportation, mandatory deductions, cost of special clothes, educational or medical costs.

Proof of NH Residence/Student Status

Give us a copy of any **ONE** of the following that shows your current street address:

- ✓ Lease, rental agreement, or rent receipt; **or**
- ✓ Electric, cable, heating fuel, telephone bill; **or**
- ✓ Property tax bill, car registration, or library card; **and**
- ✓ If a student, proof of attendance and status.

Proof of Resources You Own

Give us **ONE** copy of any of the following that you have:

- ✓ Most recent checking and saving statements.
- ✓ Most recent statements showing the current value of CDs, IRAs, trusts, annuities, Christmas Club accounts, stocks/bonds and any other interest-bearing accounts or instruments.
- ✓ Current face and cash values of life insurance policies other than term insurance.
- ✓ Registrations for all vehicles, boats, snowmobiles, ATVs, motorcycles, etc., owned by members of the household.

Special SNAP Income Deductions

If you give us proof, we can also deduct some additional expenses that you pay out of your own pocket. Give us **ONE** copy of:

Child or Adult Care Expenses

- ✓ Receipts that verify you paid someone to care for your child or to care for a disabled adult in your home so you could go to work or training.

Medical Expenses [only for elderly (age 60 or over) or disabled individuals]

- ✓ Health insurance premium bills or receipts.
- ✓ Bills or receipts for doctors, hospital visits, prescriptions (medical marijuana is not allowed), medical supplies, eyeglasses/contacts, dentures, hearing aids, or any other medical supplies or expenses.

Housing and Utility Expenses

- ✓ Rent, mortgage payments, or property tax receipts.
- ✓ Heat, cooling (A/C), cooking fuel, electricity, water, sewage, phone, internet (including mobile data) or trash collection receipts.
- ✓ Proof that you currently get NH Fuel Assistance (FA) or have received FA of more than $20 in the last 12 months.

PLEASE GIVE US *COPIES* ONLY! ORIGINALS WILL NOT BE RETURNED.

ATTACH ADDITIONAL SHEETS OF PAPER IF THERE IS NOT ENOUGH ROOM ON THE FORM TO WRITE EVERYTHING.

If you have trouble getting any information, call us as soon as possible. We will help you get the proofs you need or will tell you if there are other kinds of proof that we can accept instead.

APPLICATION FOR CONTINUED ELIGIBILITY FOR FINANCIAL, MEDICAL, CHILD CARE, AND SNAP BENEFITS

1. ABOUT YOU AND WHERE YOU LIVE: Please tell us who you are and where you live.

Name (First, Middle Initial, Last)	Mailing Address (If Different from Street Address)		
Street Address (House/Apt. #, Street, City, State, Zip Code)	Home Phone	Work Phone	Cell / MSG
Email address:	DO YOU WANT TO *GO GREEN*? ☐ YES ☐ NO		

WE WILL ACCEPT YOUR APPLICATION EVEN IF YOU ONLY FILL IN YOUR NAME, ADDRESS, AND SIGNATURE. HOWEVER, WE WILL BE ABLE TO FIGURE OUT IF YOU CAN CONTINUE TO GET BENEFITS MUCH QUICKER IF YOU COMPLETE THIS ENTIRE APPLICATION. IF YOU NEED HELP COMPLETING THIS APPLICATION, PLEASE SIGN ON THE BACK OF THIS PAGE IN THE SPACE PROVIDED AND THEN MARK THE BOX LOCATED UNDER THE SIGNATURE AREA WITH A CHECK. THEN RETURN THE APPLICATION TO US AS SOON AS POSSIBLE.

2. ABOUT THE PEOPLE YOU LIVE WITH: Start with yourself and list ALL of the people living with you.

Name (First, MI, Last)	Gender	DOB (mm/dd/yy)	SSN	Relation to You	Student? If Y, put grade
	☐ F ☐ M			SELF	☐ N ☐ Y ____
	☐ F ☐ M				☐ N ☐ Y ____
	☐ F ☐ M				☐ N ☐ Y ____
	☐ F ☐ M				☐ N ☐ Y ____

Did any individual move in since your last review? ☐ Y ☐ N If yes, list his/her name and date s/he moved in:

3. ABOUT YOUR JOB AND INCOME: Tell us how much gross income you and your household members have. Include all money you get from working, SSI/SSA, VA, child support, unemployment, friends, family, etc.

Name of Person Receiving Money	Name of Agency, Employer, or Individual that Provides the Money	Gross Amount Received	How Often?
		$	
		$	
		$	
		$	

4. ABOUT ALL YOUR ASSETS: Please tell us about everything you and the people you live with have.

(Use another sheet if necessary)

How much **total cash money** does your household have? **$**	Savings Accounts: **$**	Other Accounts: **$**	Annuities/Bonds/Trusts: **$**

Do you or anyone living with you own or pay for a house, lot, or land other than where you live? ☐ Yes ☐ No

Did you or anyone living with you sell, trade, or give away any cash or property? ☐ Yes ☐ No

Do you or anyone living with you have life insurance? ☐ Yes ☐ No

Tell us about all the cars, trucks, or other vehicles your household owns:

1. Year/Make/Model:	Amount owed:	2. Year/Make/Model:	Amount owed:
	$		$

5. ABOUT YOUR MEDICAL COVERAGE

Do you or any household member have health insurance other than Medicaid (such as private insurance, dental, vision, or prescription coverage)? ☐ No ☐ Yes If yes, Insurer/Policy #:

6. ABOUT YOUR EXPENSES: We may be able to subtract some expenses from your income when we figure out your eligibility and benefit amounts. Please tell us about your monthly expenses.

Court-ordered child or spousal support (enter the amount of the order):

☐ Child Support: $ ☐ Spousal Support: $ ☐ Wage garnishment (**only** if paid): $

☐ Care for a dependent child or adult in the household who needs care while I am working (**only** if paid): $ ☐ Other legally required expenses (**only** if paid): $

7. SPECIAL SNAP INCOME DEDUCTIONS

Monthly Rent/Mortgage	Heating/Cooling (AC)	Utilities	Telephone	Property Taxes	Home Insurance
$	$	$	$ Internet $	$	$

Do you currently get NH Fuel Assistance (FA) **OR** have you gotten FA of more than $20 in the last 12 months?
☐ Yes ☐ No **If Yes, you may be eligible for more SNAP benefits.**

Does any **elderly (age 60 or over)** or **disabled** member of your household have monthly medical costs, such as doctors' bills or receipts, medicine, medical insurance, transportation, home care, etc., that they pay out of their own pocket?
☐ Yes ☐ No

- If yes, write the name of the person who has the medical expenses: _____
- List the kinds of monthly medical expenses: _____
- Tell us the cost of the person's medical expenses each month: $ _____

TO GET A DEDUCTION FOR ANY OF THE EXPENSES YOU ARE CLAIMING, YOU MUST TELL US ABOUT *AND* PROVIDE PROOF OF THESE EXPENSES. We will not call you or send you any further notice to get this information from you. By not giving us proof or by not answering these questions, you are saying that your household does *not* want to get a deduction for these unreported or unverified expenses. Failure to tell us about or verify any of these expenses means that you may get less SNAP benefits each month.

8. ABOUT YOUR FEDERAL TAX FILING STATUS: Only complete this section if you get Medical Assistance (MA). If you do not get MA, you can skip down to Section 9 below.

First, please tell us **your** federal tax filing information: (You don't need to file taxes to get health coverage.)

	Your Full Name (first, middle initial, and last):			
	Do **you** plan to file a federal income tax return NEXT YEAR?			
	☐ **Yes. If yes,** please answer questions a – e.	☐ **No. If no,** skip to question d.		
a.	Will you file jointly with a spouse? ☐ Yes ☐ No			
	If yes, name of spouse:			
b.	Will you claim any dependents on your tax return? ☐ Yes ☐ No			
	If yes, list name(s) of dependents:			
c.	Do any of these dependents live with someone else? ☐ Yes ☐ No			
	If yes, how many dependents live with someone else?			

Please list their name(s): _____

d. Are you required to file a federal income tax return next year? ☐ Yes ☐ No

e. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How are you related to the tax filer?

Next, please tell us **about your family**: Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. Attach an extra sheet of paper, if needed, to include everyone.

DO Include:
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner if you have children in common or if he or she needs health coverage
- Anyone you include on your tax return, even if they don't live with you

You DON'T have to include:
- Your unmarried partner who doesn't need health coverage if you have no children in common
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

- Anyone else under 21 who you take care of and lives with you

Person 2 Name (first, middle initial, and last):

Does **PERSON 2** plan to file a federal income tax return NEXT YEAR?

☐ **Yes. If yes,** please answer questions a – e. ☐ **No. If no,** skip to question d.

a. Will **PERSON 2** file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse:

b. Will **PERSON 2** claim any dependents on their tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents:

c. Do any of these dependents live with someone else? ☐ Yes ☐ No

If yes, how many dependents live with someone else?

Please list their name(s):

d. Is **PERSON 2** required to file a federal income tax return next year? ☐ Yes ☐ No

e. Will **PERSON 2** be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer:

How is **PERSON 2** related to the tax filer?

Person 3 Name (first, middle initial, and last)

Does PERSON 3 plan to file a federal income tax return NEXT YEAR?

☐ **Yes. If yes,** please answer questions a – e. ☐ **No. If no,** skip to question d.

a. Will **PERSON 3** file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse:

b. Will **PERSON 3** claim any dependents on their tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents:

c. Do any of these dependents live with someone else? ☐ Yes ☐ No

If yes, how many dependents live with someone else?

Please list their name(s):

d. Is **PERSON 3** required to file a federal income tax return next year? ☐ Yes ☐ No

e. Will **PERSON 3** be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer:

How is **PERSON 3** related to the tax filer?

Person 4 Name (first, middle initial, and last)

Does PERSON 4 plan to file a federal income tax return NEXT YEAR?

☐ **Yes. If yes,** please answer questions a – e. ☐ **No. If no,** skip to question d.

a. Will **PERSON 4** file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse:

b. Will **PERSON 4** claim any dependents on their tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents:

c. Do any of these dependents live with someone else? ☐ Yes ☐ No

If yes, how many dependents live with someone else?

Please list their name(s):

d. Is **PERSON 4** required to file a federal income tax return next year? ☐ Yes ☐ No

e. Will **PERSON 4** be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer:

How is **PERSON 4** related to the tax filer?

9. PLEASE READ THE STATEMENTS BELOW, SIGN, & RETURN THIS APPLICATION BEFORE THE 15TH OF NEXT MONTH.

Do you expect any changes to any information on this form in the near future? ☐ No ☐ Yes

If yes, please explain: _____

BY SIGNING MY NAME BELOW, I AGREE TO EACH OF THE FOLLOWING STATEMENTS:

- **I understand** that if I choose to ***Go Green***, this means that I will get future notifications from BFA through my NH EASY account, and will no longer get paper notices. BFA will email me when I have these notices using the email address I gave above. I understand that if I do not want to go paperless, I can go back to getting paper notices though my NH EASY account or by writing to my caseworker.
- **All of the information I have provided on this Application is true to the best of my knowledge**. I understand and agree to give proof of my statements as requested. I also understand and give permission to DHHS to contact other persons or organizations to get additional proofs of my eligibility and understand that the information I have provided will be used in computer matching with other agencies and that information obtained through matching programs may be used to determine and redetermine continued eligibility for and/or amount of my benefits.
- **I understand** that I must report **any** changes in my circumstances within 10 days of when the change occurs, or as instructed by my caseworker. I understand that I must review BFA Form 215, *Reporting Requirements*.
- **I understand** that my receipt of SNAP requires that I comply with SNAP work requirements. **I certify** that I have read and understand BFA Form 213, *SNAP Work Requirements*.
- **I understand** that deprivation of parental support and care is a **condition of eligibility for FANF**. Additionally, if I get FANF because of deprivation due to continued absence of a parent, my signature below also means that **I certify** the continued absence of all responsible parents associated with my FANF case, and I agree to immediately notify DHHS if any responsible parent returns to my home.
- **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 SNAP benefits until that individual has satisfied their legal obligations with respect to the felony crime or probation or parole violations. My signature below is my sworn statement that I will notify DHHS if anyone in my household is fleeing felony prosecution or violating conditions of probation or parole.
- **I understand** that if anyone in my household has been convicted, as an adult, of a crime of aggravated sexual abuse, murder, sexual exploitation and other abuse of children, a Federal or State offense involving sexual assault, or an offense under State law determined by the Attorney General to be substantially similar to such offense, after February 7, 2014, and is out of compliance with terms of the sentence, that person will be ineligible to get cash or SNAP benefits. My signature below is my sworn statement that I will notify DHHS if anyone in my household has been convicted of such crime and is out of compliance with the terms of their sentence.
- **I understand** that if either my spouse or I are requesting long-term care services (Nursing Facility or Home and Community-Based Care), 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 understand** that DHHS may share my SSN and the SSN of my spouse or household member(s) that I have provided with contracted third parties to verify my income and resource eligibility.
- **If I am not satisfied with the decision on my application**, I may request an appeal within 30 days for cash and Medicaid, or within 90 days for SNAP, from the date of the Notice of Decision, by contacting the District Office or DHHS, Administrative Appeals Unit, State Office Park South, 105 Pleasant St., Concord, NH 03301-6521. Telephone 1-800-852-3345, extension 4292. I can choose to have an attorney or other person represent me at an Administrative Appeal. DHHS will *not* pay for the cost of any legal services. I understand that there are free and reduced cost legal services available in NH.

_____ _____
Signature of Recipient **Date**

If someone helped you complete this form, that individual must sign below:

_____ _____ _____
Printed Name & Title **Signature** **Telephone #**

☐ **I Need Help Completing This Form.**

Nondiscrimination Statement

Do Not Send Applications Here.

In accordance with federal civil rights laws and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Programs that receive federal financial assistance from the U.S. Department of Health and Human Services (HHS), such as Temporary Assistance for Needy Families (TANF), and programs HHS directly operates are also prohibited from discrimination under federal civil rights laws and HHS regulations.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or who have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

CIVIL RIGHTS COMPLAINTS INVOLVING USDA PROGRAMS

USDA provides federal financial assistance for many food security and hunger reduction programs such as the Supplemental Nutrition Assistance Program (SNAP), the Food Distribution Program on Indian Reservations (FDPIR) and others. To file a program complaint of discrimination, complete the Program Discrimination Complaint Form, (AD-3027) found online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1. **mail**: Food and Nutrition Service, USDA
   1320 Braddock Place, Room 334, Alexandria, VA 22314; or
2. **fax**: (833) 256-1665 or (202) 690-7442; or
3. **phone**: (833) 620-1071; or
4. **email**: FNSCIVILRIGHTSCOMPLAINTS@usda.gov.

For any other information regarding SNAP issues, persons should either contact the USDA SNAP hotline number at (800) 221-5689, which is also in Spanish, or call the state information/hotline numbers (click the link for a listing of hotline numbers by state); found online at: SNAP hotline.

CIVIL RIGHTS COMPLAINTS INVOLVING HHS PROGRAMS

HHS provides federal financial assistance for many programs to enhance health and well-being, including TANF, Head Start, the Low Income Home Energy Assistance Program (LIHEAP), and others. If you believe that you have been discriminated against because of your race, color, national origin, disability, age, sex (including pregnancy, sexual orientation, and gender identity), or religion in programs or activities that HHS directly operates or to which HHS provides federal financial assistance, you may file a complaint with the Office for Civil Rights (OCR) for yourself or for someone else.

To file a complaint of discrimination for yourself or someone else regarding a program receiving federal financial assistance through HHS, complete the form on line through OCR's Complaint Portal at https://ocrportal.hhs.gov/ocr/. You may also contact OCR via mail at: Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201; fax: (202) 619-3818; or email: OCRmail@hhs.gov. For faster processing, we encourage you to use the OCR online portal to file complaints rather than filing via mail. Persons who need assistance with filing a civil rights complaint can email OCR at OCRMail@hhs.gov or call OCR toll-free at 1-800-368-1019, TDD 1-800-537-7697. For persons who are deaf, hard of hearing, or have speech difficulties, please dial 7-1-1 to access telecommunications relay services. We also provide alternative formats (such as Braille and large print), auxiliary aids and language assistance services free of charge for filing a complaint.

This institution is an equal opportunity provider.

Do Not Send Applications Here.