

Commonwealth of Virginia
Department of Social Services
REQUEST FOR ASSISTANCE
--- ADAPT ---

GENERAL INFORMATION

This Request for Assistance is the first part of the application process. You must also complete the second part of the application process by (1) having an interview, or (2) completing an Application for Benefits form, or the appropriate Medicaid application

With this Request for Assistance, you can begin the application process for one or more of the following assistance programs. You can also use this Request to request a Medicaid resource assessment for long term care.

- Food Stamps
- Temporary Assistance for Needy Families (TANF)
- Medicaid
- General Relief
- Emergency Assistance
- State and Local Hospitalization
- Auxiliary Grants
- Refugee Resettlement Program

COMPLETE AND ACCURATE INFORMATION

You must give complete, accurate, and truthful information. If you refuse to give needed information, your eligibility for assistance may not be able to be determined. Information regarding your race is not required, but if you decide not to give this information, your worker will complete that section. If you knowingly give false, incorrect or incomplete information, or fail to report changes, you could lose your benefits and be arrested, prosecuted, fined and/or imprisoned. If you knowingly give false, incorrect, or incomplete information in order to help someone else receive benefits, you could be arrested and prosecuted for fraud. You must also provide required verifications.

The Virginia Department of Social Services is an equal opportunity provider.

SPECIAL INFORMATION FOR FOOD STAMP APPLICANTS

You can begin the application process for Food Stamps by completing this Request for Assistance or by completing only the information in the boxes below and providing at least your **name, address, and signature**. You must complete the rest of this application process before your eligibility can be determined.

You must also be interviewed. Under certain hardships, you can be interviewed by telephone. You must turn in this Request for Assistance before you are interviewed. This is important because if you are eligible for the month in which you apply, your food stamp amount will be based on the date you actually turn in your Request.

EXPEDITED SERVICE FOR FOOD STAMPS

Your household may qualify for Expedited Service and receive food stamps within 7 days if you are eligible and your gross monthly income is less than \$150 and liquid resources are \$100 or less; or your monthly shelter bills are higher than your household's gross monthly income plus your liquid resources; or your household is a migrant or seasonal farmworker household with little or no income and resources. **GIVE THE INFORMATION REQUESTED IN THE BOXES BELOW, SO YOUR ELIGIBILITY FOR EXPEDITED SERVICE CAN BE DETERMINED.**

Total money expected this month before deductions	\$ _____
Total cash, money in checking/savings accounts, CDs	\$ _____
Total rent or mortgage for this month	\$ _____
Total utility expenses for this month	\$ _____
Do not count amounts due for previous months. Count only the basic telephone service cost.	
Is anyone in your household a migrant or seasonal farmworker	YES () NO ()

NAME	DATE OF BIRTH
ADDRESS	SOCIAL SECURITY NUMBER
	TELEPHONE
SIGNATURE	DATE

VERIFICATION AND USE OF INFORMATION

The information that you give may be matched against Federal, State, and local records including the Virginia Employment Commission and the Department of Motor Vehicles to determine if it is correct, accurate, and truthful. In addition, your Social Security Number (SSN) will be used to verify your identity, prevent receipt of benefits from more than one social service agency at the same time, and make required program changes.

The INCOME AND ELIGIBILITY VERIFICATION SYSTEM (IEVS) will also be used to verify information. This system uses your SSN to verify wages and salary, unemployment benefits, and unearned income by using records from the Internal Revenue Service and the Social Security Administration. The State Verification Exchange System (SVES) uses your SSN to verify your receipt of social security and Supplement Security Income (SSI) benefits. It is also used to verify quarters of coverage under Social Security, if you are an alien. In addition, the Immigration and Naturalization Service (INS) will be used to verify the status of aliens. Any difference between the information you give and these records will be investigated. Information from these records may affect your eligibility and benefit amount. 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.

VIRGINIA SOCIAL SERVICES – TEMPORARY ASSISTANCE PROGRAMS BOOKLET

This booklet contains information about the programs available at your local social services agency plus other very important information you should know, including your responsibilities. READ THIS BOOKLET CAREFULLY. Refer to the APPEALS Section if you have a complaint about an action taken on your case.

COMPLETING THE REQUEST FOR ASSISTANCE

If you need help completing this Request for Assistance, a friend or relative or your eligibility worker can help you. If you are completing this Request for someone else, answer each question as if you were that person. If you need to change an answer or make a correction, write the correct information nearby and put your initials and date next to the change. If more than 6 people are living in your home and you need more space to list everyone, tell the agency you need extra pages.

FILING A REQUEST FOR ASSISTANCE

You may turn in a partially completed Request for Assistance which contains at least your **name, address, and signature** (or the signature of your authorized representative), but you must complete the rest of the application process before your eligibility can be determined. For some programs, you must also be interviewed, but you may turn in your Request for Assistance before your interview.

You may turn in your Request for Assistance any time during office hours the same day you contact your local social services agency. You have the right to turn in your Request for Assistance, even it looks like you may not be eligible for benefits.

AGENCY USE ONLY EXPEDITED SERVICE DETERMINATION

Income less than \$150 and
Resources \$100 or less YES () NO ()

Income plus resources less than shelter bills YES () NO ()

For migrants or seasonal farmworkers:

Resources \$100 or less, and in next 10 days
\$25 or less is expected from new income:

OR

Resources \$100 or less, and no income
is expected from a terminated source for
the rest of this month or next month. YES () NO ()

EXPEDITE IF YES TO ANY OF THE ABOVE

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AGENCY USE ONLY			
CASE NAME	CASE NUMBER(S)	PROGRAM(S)	REGISTRATION NUMBER
APPLICATION TYPE	LOCALITY	WORKER	CASELOAD NUMBER
DATE OF SERVICE REFERRAL		DATE RECEIVED	

1.

APPLICANT'S NAME	C/O NAME	PHONE NUMBER (HOME/MESSAGES)
		(WORK)
RESIDENCE ADDRESS (INCLUDE CITY, STATE AND ZIP)	MAILING ADDRESS (IF DIFFERENT)	DIRECTIONS TO HOME

2. Check (✓) your household's primary language: () English () Spanish () Cambodian () Vietnamese () Other _____

3. **LIST EVERYONE LIVING IN YOUR HOME**, even if you are not requesting assistance for that person. List yourself on the first line. If you are married, list your spouse on the second line. Then list everyone else. Provide the information requested for each person listed. Check (✓) type of assistance requested for each person. If no assistance is requested, check **NONE** for that person. A Social Security Number and an Alien Registration Number do not have to be provided for any individual for whom assistance is not being requested.

First	MI	NAME		SEX M,F	RACE SEE* BELOW	ETHNICITY SEE** BELOW	DATE OF BIRTH	SOCIAL SECURITY NUMBER	ALIEN REGISTRATION NUMBER	FOOD STAMPS	TANF	MEDICAID	GENERAL RELIEF	EMERGENCY ASSISTANCE	STATE & LOCAL HOSPITALIZATION	AUXILIARY GRANTS	REFUGEE RESETTLEMENT PROGRAM	MEDICAID RESOURCE ASSESSMENT	NONE	THIS PERSON'S RELATIONSHIP TO YOU	AGENCY USE ONLY CLIENT ID
		Last	Suffix (Jr., Sr.)																		
(Your Name)																					
(Your Spouse's Name, if you are married)																					

* RACE: (Not required) Use these codes to indicate RACE: 1 – White, 2 – Black or African American, 3 – American Indian or Alaska Native, 4 – Asian, 5 – Native Hawaiian or Pacific Islander.
 ** ETHNICITY: (Not required) Use these codes to indicate ETHNICITY: 1 – Hispanic or Latino, 2 – Not Hispanic or Latino

4. List anyone from #3 above who is pregnant _____
 or who is disabled: _____
 5. List anyone from #3 above who is requesting Medicaid who had medical treatment during the 3 months before this request: _____

6. YES () NO () Have you or anyone for whom you are applying ever applied for or received or are currently receiving any benefits from a social services agency, including Food Stamps, AFDC, TANF, Medicaid, General Relief, Auxiliary Grants, Foster Care, Adoption Assistance, Refugee Other or Refugee Medicaid Other?

Person Who Applied for or Received Benefits	Under What Case Name	Type of Benefits Received
When	From What County or City of State	

7. YES () NO () Does anyone have any of the following emergencies? If **YES**, check (✓) the type of emergency and explain the cause.
 () Food () Shelter () Medical () Clothing () Other Emergency _____
 Cause: _____

8. YES () NO () Is there anything that you would like to talk about with a service worker? This could include concerns about your children, school problems, day care needs, family planning, family violence, referrals to other community organizations, or other problems or concerns. If **YES**, explain.

Explain:

BY MY SIGNATURE BELOW I DECLARE, UNDER PENALTY OF PERJURY, THAT ALL OF THE FOLLOWING ARE TRUE:

I understand:

- All of the information in the GENERAL INFORMATION Section on pages 1 and 2.
- If I give false, incorrect, or incomplete information, I may be breaking the law and could be prosecuted for perjury, larceny, or welfare fraud.
- If I helped someone else complete this form so as to get benefits he or she is not entitled to receive, I may be breaking the law and could be prosecuted.

I received the Temporary Assistance Programs Booklet YES () NO () **MEDICAID APPLICANTS:** I received the Virginia Medicaid Handbook YES () NO ()

All information I gave on this Request for Assistance is correct and complete to the best of my knowledge and belief. I authorize the release to this agency of all information necessary to determine my eligibility.

I filled in this Request for Assistance myself. YES () NO () If **NO**, it was read back to me when completed. YES () NO ()

APPLICANT <u>OR</u> AUTHORIZED REPRESENTATIVE'S SIGNATURE OR MARK	DATE	WITNESS TO MARK <u>OR</u> INTERPRETER	DATE
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COMPLETE THE BOX BELOW IF THIS REQUEST FOR ASSISTANCE WAS COMPLETED FOR THE APPLICANT BY SOMEONE ELSE:

NAME OF PERSON COMPLETING APPLICATION	DATE	ADDRESS
PHONE NUMBER (HOME) (WORK)	RELATIONSHIP TO APPLICANT	