SES 101F
Issued 01/06
/

Affidavit in Support of Establishing Paternity
Father

A Separate Affidavit is Required for Each Child Needing Paternity Established

Section 1

I, _____ , on oath, under penalty of perjury depose and allege
Name (First, Middle, Last)
upon information and belief that:

1. I am possibly the father of the child named below:

Child's Full Legal Name (First, Middle, Last)	**Child's Date of Birth** (Month, Day, Year)	**Place of Birth** (City, Parish, State)

2. The child was possibly conceived as a result of sexual intercourse between _____ and me during the time stated below:
Mother (First Middle, Last)

Relationship dates (Month, Day, Year)
From: _____ To: _____

3. _____ is the father of this child.
Father's Name

The following facts support my allegations of paternity:

a. We lived together ☐ Yes ☐ No ☐ Don't know
If yes, complete the dates and address

Dates From: _____ / _____ / _____ To: _____ / _____ / _____
Address: _____
City: _____ State _____

b. The mother told me that I am the father of this child. ☐ Yes ☐ No ☐ Don't know

c. I am named as the father on the birth certificate. ☐ Yes ☐ No ☐ Don't know
☐ Copies attached

d. I signed an acknowledgment of paternity before an acknowledgment became a legal finding of paternity. ☐ Yes ☐ No ☐ Don't know

e. I admitted being the father of the child ☐ Yes ☐ No ☐ Don't know

f. I sent cards/letters regarding the pregnancy and/or about the child. ☐ Yes ☐ No ☐ Don't know
☐ Copies attached

g. I was present at the birth of the child. ☐ Yes ☐ No ☐ Don't know

h. I visited the child at the hospital following the birth. ☐ Yes ☐ No ☐ Don't know

i. I offered to pay abortion expenses. ☐ Yes ☐ No ☐ Don't know

j. I offered to pay medical expenses. ☐ Yes ☐ No ☐ Don't know

k. I paid for birth related expenses. ☐ Yes ☐ No ☐ Don't know

l. I claimed the child on tax returns. ☐ Yes ☐ No ☐ Don't know

m. I have provided food, clothing, gifts or financial support for the child. ☐ Yes ☐ No ☐ Don't know

n. I lived with the child. ☐ Yes ☐ No ☐ Don't know
If yes, explain in Section 2

o. I visited the child. ☐ Yes ☐ No ☐ Don't know
If yes, explain in Section 2

p. The child resembles me. ☐ Yes ☐ No ☐ Don't know
☐ Photo(s) attached
If yes, explain in Section 2

q. There are other witnesses to my relationship with the mother. ☐ Yes ☐ No ☐ Don't know
If Yes, list names and addresses and briefly describe relevant facts known about each.

Name F: _____ M: _____ L: _____ Suf: _____
Address: _____
City: _____ ST: _____ Zip: _____ Phone: ( )
Comments: _____

Name F: _____ M: _____ L: _____ Suf: _____
Address: _____
City: _____ ST: _____ Zip: _____ Phone: ( )
Comments: _____

Section 2 **ADDITIONAL COMMENTS**

I swear that I have read this questionnaire or that it has been read to me, and certify that my answer to each question is true and correct. I understand that if I have given false information or answer to any material question herein, I may be subject to criminal prosecution for knowingly giving false information or answer. I further understand the information I have provided may affect the priority assigned to my case and any change in priority will only result from additional information received by the Child Support/District Attorney's Office. I agree to submit myself to genetic testing as may be necessary to establish paternity.

Father - Print First, Middle, Last Name	Signature Date
Legal Guardian (If Father is a minor)	Signature Date

Sworn to and signed before me this _____ day of _____ , _____

at _____ , Louisiana.

Typed or Printed Name and Title/Notary ID. No.	Signature

LOUISIANA OFFICE OF COMMUNITY SERVICES
CHILD'S PHYSICAL EXAMINATION

Date of Physical Exam:

Type of Physical (Check One): ☐ Annual Check-up ☐ Other, specify:

I. **PHYSICAL EXAMINATION** of _____ D.O.B. _____
(Child's Name)

RACE _____ SEX _____ HEIGHT _____ WEIGHT _____

HEAD CIRCUMFERENCE _____ GROWTH CHART PERCENTILE _____
(For a child age six or under, evaluate head circumference and growth chart percentiles and document above.)

TEMP._____ RESP. _____ PULSE _____ POSTURE _____

SKIN _____ NOSE _____ CHEST _____ HERNIA _____

SCALP_____ TEETH _____ LUNGS _____ GENITALIA _____

EYES _____ THROAT_____ HEART _____ HANDS _____

EARS_____ GLANDS _____ ABDOMEN _____ FEET _____

REFLEXES _____ MOTOR DEVELOPMENT _____

DOES PATIENT HAVE ANY INFECTIOUS, CONTAGIOUS OR COMMUNICABLE DISEASE? IF SO, DIAGNOSIS AND REQUIRED TREATMENT _____

_____

CHRONIC AILMENTS _____

PREVIOUS SERIOUS ILLNESS _____

KNOWN ALLERGIES_____

MEDICATIONS _____

WHAT, IF ANY, IMMUNIZATIONS WERE GIVEN _____

INFANT ONLY: PRESENT FORMULA_____

FOODS TO BE ADDED_____

II. **IMPRESSIONS**:

DIAGNOSIS(If applicable): _____

GENERAL HEALTH_____

III. **REMARKS AND RECOMMENDATIONS** _____

_____

If there are any concerns or referrals, please call OCS Worker named below at _____.

Please mail directly:

_____

_____

_____

Signature of Examining Professional: _____
Circle the following which applies: Physician, Physician's Assistant, Nurse Practitioner, KID-MED Screener

Date of Signature: _____

Name: _____

City, State: _____

OCS Form 98-F
Reissued: 11/97

OFFICE OF COMMUNITY SERVICES

AFFIDAVIT OF WAIVER OF PRE-SURRENDER COUNSELING BY SURRENDERING FATHER OF MAJORITY AGE IN ACCORDANCE WITH LOUISIANA CHILDREN=S CODE ARTICLE 1120

STATE OF LOUISIANA
PARISH OF _____

BEFORE ME, the undersigned Notary Public, came and appeared

_____, **who is a licensed practitioner or counselor**
(Licensed Practitioner/Counselor's Name)
meeting the Art. 1120 definition thereof who, after being duly sworn, did depose and state the following:

I hereby confirm that_____ **of**
(Name of Surrendering Father)

_____ **born** _____
(Address) **(Date of Birth)**
chose to waive the counseling sessions otherwise mandated by Louisiana Children=s Code Article 1120 and that he appeared to understand the nature and consequences of his intended act.

SWORN TO AND SUBSCRIBED BEFORE ME, the undersigned Notary Public

on the _____ **day of** _____ **20___, at**

_____, _____, _____.
(City) **(Parish/County)** **(State)**

_____ _____
LICENSED PRACTITIONER/COUNSELOR'S NAME **LICENSE NO.**

NOTARY

OCS Form 444-A
Reissued: 11/04
Replacing: 05/00

SES 101
Rev. 08/09
12/08 Version Usable
Rec. Ret = Active + 4CY

State of Louisiana
Support Enforcement Services

APPLICATION OR DOCUMENTATION FOR CHILD SUPPORT SERVICES

LOCAL OFFICE BLOCK

LASES NO. _____
Date:
Appl Requested _____
Appl/Flyer 1 Provided _____
Appl/Rec/Fee Paid _____
Full Service - $25
Parent Locate Only
SSN - $10 / No SSN - 14
Adding a Child ☐

Department of Social Services
Office of Family Support

What services are you applying for? ☐ Child and Medical Support ☐ Medical Support ☐ Locate

SECTION A. APPLICANT INFORMATION

_____
Name-First, Middle, Last, Suffix

_____ _____
Maiden Name Other Names Used

_____ _____ _____ _____
Date of Birth Social Security Number Race Sex

_____ _____ ( ) _____
Street Address Mailing Address Home Phone Number

_____ _____ ( ) _____
City, State, & Zip City, State, & Zip Cell Phone Number

_____ _____ ( ) _____
Parish/County of Residence Email address Work Phone Number

Do you or any of the children listed receive: ☐ **MEDICAID,** ☐ **FITAP,** ☐ **KINSHIP CARE?**

Your relationship to child(ren): ☐ Mother ☐ Father ☐ Other (specify) _____

Does the child(ren) live with you? ☐ Yes ☐ No If no, where is the child(ren) living and with whom:

Name of Custodial Party: _____ Street Address: _____

City/State/Zip: _____ Home Phone Number ( ) _____

Cell Phone Number: ( ) _____ Email Address: _____

Race: _____ Sex: _____ DOB: _____ SSN: _____

Note: Medicaid recipients receive child and medical support services unless the recipient indicates that child support services are not wanted.

IS THERE FAMILY VIOLENCE WITH ANYONE APPEARING ON THE APPLICATION? ☐ **YES** ☐ **NO**

NONDICLOSURE OF INFORMATION: When the Department has reasonable evidence of family violence, either domestic violence or child abuse, the case record will include an indicator of family violence for any person who is a party to the case. The indicator will prohibit release of information except to a court or agent of a court that has authority to issue an order for support or to make or enforce custody or visitation determination.

SECTION B. MOTHER OF CHILD(REN) INFORMATION:

Name-First, Middle, Last, Suffix _____ Maiden Name _____ Other Names Used _____

Date of Birth _____ Place of Birth (City, State) _____ Social Security Number _____

Street Address _____ City, State, Zip _____ ( ) Home Phone Number _____

Mailing Address _____ City, State, Zip _____ ( ) Cell Phone Number _____

Email address: _____ ( ) Work Phone Number _____

Is the address listed above a current address? ☐ Yes ☐ No ☐ Unknown

SECTION C. FATHER OF CHILD(REN) INFORMATION:

Name-First, Middle, Last, Suffix _____ Other Names Used _____

Date of Birth _____ Place of Birth (City, State) _____ Social Security Number _____

Street Address _____ City, State, Zip _____ ( ) Home Phone Number _____

Mailing Address _____ City, State, Zip _____ ( ) Cell Phone Number _____

Email address: _____ ( ) Work Phone Number _____

Is the address listed above a current address? ☐ Yes ☐ No ☐ Unknown

SECTION D.- CHILD 1 INFORMATION

Name-First, Middle, Last, Suffix _____ Date of Birth _____ Social Security Number _____

Current State of Residence _____ State of Residence Last Six Months _____

Were the father and mother of this child legally married to each other? ☐ Yes ☐ No ☐ Unknown

Date of marriage _____ (MM) _____ (DD) _____ (YY) City: _____ State: _____

Date of divorce _____ (MM) _____ (DD) _____ (YY) City: _____ State: _____ Parish/County _____

Is the father's name on the Birth Certificate? ☐ Yes ☐ No If yes, provide a copy.
If no, has the biological father signed an Acknowledgment of Paternity? ☐ Yes ☐ No If yes, provide a copy.

Is there a court order establishing paternity? ☐ Yes ☐ No If yes, provide a copy.
If yes, what state and parish/county established the order? State _____ Parish/County _____

Is there a court order for child and/or medical support for the child? ☐ Yes ☐ No If yes, provide a copy.
If yes, what state and parish/county established the order? State _____ Parish/County _____
If yes, is past due support owed? ☐ Yes ☐ No

SECTION D.- CHILD 2 INFORMATION

Name-First, Middle, Last, Suffix _____ Date of Birth _____ Social Security Number _____

Current State of Residence _____ State of Residence Last Six Months _____

Were the father and mother of this child legally married to each other? ☐ Yes ☐ No ☐ Unknown

Date of marriage ____ (MM) ____ (DD) ____ (YY) City: _____ State: _____

Date of divorce ____ (MM) ____ (DD) ____ (YY) City: _____ State: _____ Parish/County _____

Is the father's name on the Birth Certificate? ☐ Yes ☐ No If yes, provide a copy.
If no, has the biological father signed an Acknowledgment of Paternity? ☐ Yes ☐ No If yes, provide a copy.

Is there a court order establishing paternity? ☐ Yes ☐ No If yes, provide a copy.
If yes, what state and parish/county established the order? State _____ Parish/County _____

Is there a court order for child and/or medical support for the child? ☐ Yes ☐ No If yes, provide a copy.
If yes, what state and parish/county established the order? State _____ Parish/County _____
If yes, is past due support owed? ☐ Yes ☐ No

SECTION D.- CHILD 3 INFORMATION

Name-First, Middle, Last, Suffix _____ Date of Birth _____ Social Security Number _____

Current State of Residence _____ State of Residence Last Six Months _____

Were the father and mother of this child legally married to each other? ☐ Yes ☐ No ☐ Unknown

Date of marriage ____ (MM) ____ (DD) ____ (YY) City: _____ State: _____

Date of divorce ____ (MM) ____ (DD) ____ (YY) City: _____ State: _____ Parish/County _____

Is the father's name on the Birth Certificate? ☐ Yes ☐ No If yes, provide a copy.
If no, has the biological father signed an Acknowledgment of Paternity? ☐ Yes ☐ No If yes, provide a copy.

Is there a court order establishing paternity? ☐ Yes ☐ No If yes, provide a copy.
If yes, what state and parish/county established the order? State _____ Parish/County _____

Is there a court order for child and/or medical support for the child? ☐ Yes ☐ No If yes, provide a copy.
If yes, what state and parish/county established the order? State _____ Parish/County _____
If yes, is past due support owed? ☐ Yes ☐ No

SECTION D.- CHILD 4 INFORMATION

Name-First, Middle, Last, Suffix _____ Date of Birth _____ Social Security Number _____

Current State of Residence _____ State of Residence Last Six Months _____

Were the father and mother of this child legally married to each other? ☐ Yes ☐ No ☐ Unknown

Date of marriage ____ (MM) ____ (DD) ____ (YY) City: _____ State: _____

Date of divorce ____ (MM) ____ (DD) ____ (YY) City: _____ State: _____ Parish/County _____

Is the father's name on the Birth Certificate? ☐ Yes ☐ No If yes, provide a copy.
If no, has the biological father signed an Acknowledgment of Paternity? ☐ Yes ☐ No If yes, provide a copy.

Is there a court order establishing paternity? ☐ Yes ☐ No If yes, provide a copy.
If yes, what state and parish/county established the order? State _____ Parish/County _____

Is there a court order for child and/or medical support for the child? ☐ Yes ☐ No If yes, provide a copy.
If yes, what state and parish/county established the order? State _____ Parish/County _____
If yes, is past due support owed? ☐ Yes ☐ No

YOUR RIGHTS AND RESPONSIBILITIES

I understand the following conditions:

1. Support Enforcement Services has the authority to take whatever action is necessary to establish paternity and to establish, modify and/or enforce an obligation for child and medical support. I have been advised that the court may order that I provide medical support for my child(ren). Support Enforcement Services does not guarantee that efforts on my behalf will be successful.

2. If I do not cooperate with Support Enforcement Services, my case may be closed after advance notice is provided. The information I provide may affect the relative priority assigned to my case and any change in priority will only result from additional information received by Support Enforcement Services. I must notify Support Enforcement Services if my street/mailing address should change; failure to do so could be considered as failure to cooperate and reason to close my case.

3. A nonrefundable fee of $25.00 is charged for full service, unless I receive FITAP, KCSP, or Medicaid benefits. No action will be taken on my case until this fee is paid. A nonrefundable fee of $10.00 is charged for parent locate only cases. An additional fee of $4.00 is charged if I do not provide the noncustodial parent's social security number.

4. A $25.00 annual fee will be imposed in each case where an individual has never received FITAP assistance and for whom the State has collected at least $500.00 of support. CP's Initials: _____

5. I understand that it is mandatory that all recipients of child support payments receive payments via Direct Deposit or the Direct Payment Card. I acknowledge that I have been advised that fees will be associated with the Chase Direct Payment Card and I have been provided a Direct Deposit Authorization Form.

6. I must notify Support Enforcement Services of any direct support payments received from the noncustodial parent. I must also report if the child(ren) receiving services are no longer residing with me.

7. The state staff attorney, District Attorney, and/or private contract attorney providing services pursuant to this application:
   a. Does not represent me in any actions that may occur.
   b. Represents only the State and the State's interest.
   c. Cannot give me any legal advice. I must contact my own attorney or the local legal services for legal advice.

8. Any information provided, orally, in writing, or in other form, is not protected by the attorney-client privilege and could be used by the State in a civil or criminal action against me. Whenever the interests of the Louisiana Department of Social Services conflict or are adverse to me, I should retain independent counsel to advise me of my rights. Any monies paid by me herein are not attorney fees.

9. Either party to a child support order may request a review of the child support order every three years to determine if the amount of support is consistent with the Louisiana child support award guidelines.

10. In accordance with Section 466(a)(13) of the Social Security Act [42 U.S.C. 666(a)(13)], disclosure of social security numbers is required. The information may be used for purposes of establishing paternity, modifying, and enforcing support obligations. Social security numbers may also be released for reasons directly connected to programs within the Department of Social Services.

11. Support Enforcement Services has authority to deposit and distribute all monies collected pursuant to this authorization in accordance with LA R.S. 46:236.1.1 through 236.1.10.

12. Support Enforcement Services does not calculate interest on delinquent child support payments. However, if an individual obtains a judgment for interest owed and requests enforcement on the delinquency, the judgment may be enforced.

13. **Support Enforcement Services may withhold up to 10% from future child support payments from all of my child support cases to correct an overpayment. ☐ Yes ☐ No CP's Initials: _____**

14. By applying for child support services, I understand that medical support services will be provided and that the court may order me to obtain medical insurance and/or provide medical support for my child(ren).

15. Either party to a child support order may request a review of actions taken, or when there is evidence that an action should have been taken on a case. The purpose of the administrative review is to determine if the action or proposed action is appropriate and in compliance with all applicable federal and state laws and regulations. A request for an administrative review should be forwarded to the office that is handling the case.

16. If I believe that I have been discriminated against because of race, color, or national origin, it is my right to file a complaint either through my local Office of Family Support or directly to the State Office of Family Support, or to the federal government. If I wish to file such a complaint, I may secure the complaint form from my local Support Enforcement Services office.

17. I have read the above, or it has been read to me, and I certify that my answer to each question is true and correct. I understand that if I have given false information or answer to any material question herein, I may be subject to criminal and civil prosecution for knowingly giving such false information or answer.

WITNESSESS:

_____
Signature of Applicant

_____ _____
Typed or Printed Name of Witness Signature

_____ _____
Typed or Printed Name of Witness Signature

_____ _____
Typed or Printed Name, Title, and Notary Identification Number Signature

DIS 1
Rev. 11/09
07/09 Issue Obsolete

Louisiana Department of Social Services
Office of Family Support

UNITED STATES DEPARTMENT OF AGRICULTURE
FOOD AND CONSUMER SERVICES

APPLICATION FOR DISASTER SUPPLEMENTAL NUTRITION ASSISTANCE

(PURSUANT TO 7 CFR 280)

We will consider all applicants without regard to color, race, sex, handicap, religion, national origin or political belief.

DO NOT WRITE IN SHADED AREAS.

For Office Use Only

Disaster #: _____

Application Date: _____

Parish of Residence #: _____
(Parish of residence when disaster occurred)

Number in Household: _____

EBT Card #: _____

INSTRUCTIONS: Complete this application honestly and to the best of your knowledge. If your household knows but refuses to give any requested information, it will not be eligible to receive supplemental nutrition assistance. When you are interviewed, you must show proof of identity. You may be required to show proof that your household lived in the disaster area at the time of the disaster. You may have to verify any questionable expenses. You can authorize someone outside your household to apply for, get, or use Disaster Supplemental Nutrition Assistance benefits on your behalf.

Head of Household:	**Verified**	Authorized Representative:
Home Address at time of disaster:		Address and Telephone Number where you live now (if different):
City: State: Zip Code:		City: State: Zip Code:
Phone Number:		Mailing Address (if different):
Parish at time of disaster:		City: State: Zip Code:

Part A - Household Situation

		YES	NO
1.	Was your household living in the disaster area at the time of the disaster? **If yes**, please answer the following questions:	☐	☐
a.	Does your household plan to buy food before the end of the disaster benefit period?	☐	☐
b.	Did you lose food as a result of the disaster?	☐	☐
c.	Did the disaster damage or destroy your home or self-employment property? **If yes**, briefly explain:	☐	☐
d.	Did the disaster delay, reduce, or stop your household's income?	☐	☐
e.	Does your household have any cash or money in checking or savings accounts which you cannot get to because the bank is closed due to the disaster and the ATM is not working?	☐	☐
f.	Does your household have any additional expenses as a result of the disaster? **If yes**, briefly explain:	☐	☐

2. Are you a current Supplemental Nutrition Assistance participant?
If so, in what State? County/Parish:

List the members of your household, **including yourself**, who were affected by the disaster who are living and eating with you. List each household member's social security number (SSN), if available, date of birth, sex, and race. List the source and amount of take-home pay and any other income your household members have received or expect to receive during the disaster benefit period.

- **DO NOT INCLUDE PEOPLE WHO WERE NOT PART OF YOUR HOUSEHOLD WHEN THE DISASTER HAPPENED.**
- **IF YOU ARE TEMPORARILY STAYING WITH ANOTHER HOUSEHOLD BECAUSE OF THE DISASTER, DO NOT LIST MEMBERS OF THAT HOUSEHOLD.**

PART B - HOUSEHOLD MEMBERS (Attach paper for more space)					Part C - Income	
First Name / Last Name	**Social Security No.**	**Birth Date**	**Sex**	**Race**	**Employer/Source/Type**	**Amount**

PART D – RESOURCES

List all money your household will be able to get to during the disaster benefit period.

	AMOUNT
Cash on hand	
Checking accounts	
Saving accounts	
Certificates of deposit	
Money market accounts	

PART E – EXPENSES

List disaster-caused expenses that your household paid or expects to pay during this disaster benefit period. DO NOT INCLUDE EXPENSES THAT WERE PAID OR WILL BE PAID BY SOMEONE OUTSIDE YOUR HOUSEHOLD DURING THIS DISASTER BENEFIT PERIOD.

	AMOUNT
Food destroyed in disaster	
Dependent care due to disaster	
Funeral/medical expenses due to disaster	
Moving and storage costs due to disaster	
Temporary shelter expenses	
Cost to protect property during disaster	
Cost to repair or replace items for home or self-employment property	
Other disaster-related expenses	

Please explain any amounts listed above.

PART F - PENALTY WARNING

If your household gets Supplemental Nutrition Assistance benefits, it must follow the rules listed below. We may choose your household for a Federal or State review sometime after you receive your Supplemental Nutrition Assistance benefits to make sure you were eligible for disaster aid.

DO NOT give false information or hide information to get or to continue to get Supplemental Nutrition Assistance benefits.

DO NOT give or sell Supplemental Nutrition Assistance benefits or authorization documents to anyone not authorized to use them.

DO NOT alter any Supplemental Nutrition Assistance authorization document to get Supplemental Nutrition Assistance benefits you are not entitled to.

DO NOT use Supplemental Nutrition Assistance benefits to buy unauthorized items such as alcohol or tobacco.

DO NOT use another household's Supplemental Nutrition Assistance benefits or authorization document for your household.

PART G - CERTIFICATION AND SIGNATURE

I understand the questions on this application and the penalties for hiding or giving false information. My household is in need of immediate food assistance as a result of the disaster. I certify, under penalty of perjury, that the information I have given is correct and complete to the best of my knowledge. I also authorize the release of any information necessary to determine the correctness of my certification. I understand that if I disagree with any action taken on my case, I have the right to request a fair hearing orally or in writing.

REQUIRED SIGNATURES: APPLICANT, AUTHORIZED REPRESENTATIVE, OR WITNESS (if signed with an X)

Applicant	Date	Authorized Representative (See note)	Date
Witness (if anyone signed with an X)	Date	DSS Employee or a DSNAP worker? ☐ Yes ☐ No	
Worker	Date	Parish Manager or Designee (If Required)	Date

Note: If the applicant chooses to have an authorized representative apply for him, both the applicant **AND** the authorized representative must sign this form **OR** the applicant must sign a statement giving the authorized representative permission to apply on his behalf.

Note: Disaster Supplemental Nutrition Assistance benefits expire 365 days after they are issued. Any benefits that are unused after 365 days will be lost and cannot be reinstated.

OFS 4APP
Rev. 12/10
02/10 Issue Obsolete
II

Louisiana Department of Children and Family Services

OFFICE USE ONLY

Date Received _____

Assigned to _____

Application for Assistance

Is an **EBT** card needed? ☐ Yes ☐ No

Check only those programs for which you are applying:

- ☐ Child Care Assistance Program (CCAP)
- ☐ Family Independence Temporary Assistance Program (FITAP)
- ☐ Kinship Care Subsidy Program (KCSP)
- ☐ Supplemental Nutrition Assistance Program (SNAP) (formerly the Food Stamp Program)

You can begin to apply and establish your application date by filling in your name, address and signature below and give this form to us today. It will help us to process your application faster if you also give us a telephone number where you can be reached during the day and **provide a copy of a photo ID or other proof of identity.**

Can you read and understand English? (¿Puede leer usted y poder comprender ingles?) ☐ Yes (Sí) ☐ No

If No, what language can you read and understand? (¿Si no, qué idioma le puede lee y comprende?) _____

_____

(Last Name) (First Name) (Middle Name) Social Security Number

_____

Street or Rural Route Apt. or Lot# City and State Zip Code Phone#

Mailing Address if different from above: _____

_____

Your Signature

What if you need SNAP benefits right away?

We may be able to get SNAP benefits to you within 4 days of the date you apply if you qualify. You may qualify if:

- The total amount of money you have received or expect to receive this month is less than $150 and you have $100 or less in liquid resources such as cash, savings or checking accounts; or
- Your household's rent/mortgage and utilities are more than your total income and resources; or
- Your household includes migrant or seasonal farm workers.

If any of the above describes your household, answer the following questions:

1. What is the total amount of money that your household will receive this month? Include money from all sources such as earned income, contributions, Social Security, SSI, VA, etc. $ _____
2. How much money does your household have in liquid resources? Include cash on hand, checking accounts, savings accounts, etc. $ _____
3. How much is your household's monthly rent or mortgage? $ _____
4. Do you pay for utilities, such as electricity, gas, water, etc.? ☐ Yes ☐ No
5. Do you pay utility costs for heating or air conditioning? ☐ Yes ☐ No
6. Do you pay telephone expenses? ☐ Yes ☐ No
7. Is anyone in your household a migrant or seasonal farm worker? ☐ Yes ☐ No

Office Use Only

1.	Income		$ _____	Is #1 less than $150? ☐ Yes ☐ No
		+		AND
2.	Resources		$ _____	Is #2 less than $101? ☐ Yes ☐ No
		=		
	Total		$ _____ (A)	If yes to both, Expedite. If no, consider shelter costs.
3.	Rent/Mortgage		$ _____	Is B greater than A? ☐ Yes ☐ No
		+		If yes, Expedite. If no, consider migrant or seasonal farm worker status.
	Utility Standard*		$ _____	Is anyone in the household a migrant or seasonal farm worker? ☐ Yes ☐ No
		=		AND
	Total		$ _____ (B)	Is #2 less than $101? ☐ Yes ☐ No
				If yes to both, Expedite. If no, the case is not expedited.

*If, on the reverse side, the answer to:
#4 is Yes **and** #5 is No, use BUA.
#5 is Yes, use SUA
#6 is Yes **and** #4 **and** #5 are No, use TEL.

Expedited: ☐ Yes ☐ No If yes, enter "Expedited Date" on CP CA screen of LAMI.

Due Date*: _____

*The case must be certified and the client must have their EBT card in sufficient time to be able to use their SNAP benefits by the 4th calendar day after the date of application. If the 4th calendar day falls on a weekend or holiday, the due date becomes the previous workday.

Expedited status determined by: _____ _____
Signature of Agency Representative Date

A. Tell Us About You

You can choose not to give Ethnicity and Racial information. It will not affect your eligibility. This information helps us follow Title VI of the Civil Rights Act of 1964

Do you need a new Louisiana Purchase Card? ☐ Yes ☐ No

First Name | Middle Initial | Last Name | Maiden or Other Name

Mailing Address | Apt/Lot No. | City | State | Zip Code

Home Address (If different from mailing) | Apt/Lot No. | City | State | Zip Code

( ) Home Telephone Number | ( ) Cell Telephone Number | ( ) Work or Other Telephone Number

Social Security Number | Parish of Residence

Date of Birth | E-mail Address

Sex: ☐ Male ☐ Female

Ethnicity: Hispanic/Latino? ☐ Yes ☐ No

Marital Status:
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Never Married
- ☐ Widowed

Racial Heritage (check all that apply):
- ☐ Asian
- ☐ White
- ☐ Native Hawaiian/ Pacific Islander
- ☐ American Indian/ Alaskan Native
- ☐ Black or African American

Highest grade level completed in school? _____

Student? ☐ Yes ☐ No

U.S. Citizen? ☐ Yes ☐ No

If no, do you have immigration papers? ☐ Yes ☐ No

Date of entry in U.S.: _____

B. Tell Us If You Have An Authorized Representative

An Authorized Representative is someone you allow us to talk with about your SNAP/Child Care Assistance Program benefits. You can name someone, but it is not required.

Would you like to have an Authorized Representative? ☐ Yes ☐ No

If yes, tell us about your Authorized Representative.

Name of Authorized Representative | ( ) Telephone Number

Address | City | State | Zip Code

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Rights and Responsibilities discussed with applicant? ☐ Yes ☐ No

Reporting requirements explained to applicant? ☐ Yes ☐ No

Is an EBT card needed? ☐ Yes ☐ No

Is there an authorized representative? ☐ Yes ☐ No

Identity verified by: ☐ Driver's License ☐ Identification card ☐ Other

Residency verified by:

Marital status verified by:

Reason for application:

FITAP/KCSP explained? ☐ Yes ☐ No Client selected: ☐ FITAP ☐ KCSP

C. Tell Us About The Other People In Your Household – Do Not Include Yourself

List everyone else who lives in your household, even if you are not applying for them. *You can choose not to give Ethnicity & Racial information. It will not affect your eligibility. This information helps us follow Title VI of the Civil Rights Act of 1964.*

Don't miss out on No Cost Health Insurance for your children! If you check the box below, we will share what you put on this form with the Louisiana Department of Health and Hospitals (DHH). DHH will sign up children who qualify and send you a letter with more information about the Medicaid Program.

☐ **Yes, please share my information with DHH so I do not need to complete another application.**

I understand that if my children get Medicaid, and their medical bills are paid by a private health insurance or lawsuit settlement, Medicaid can get its money back from this source.

Household Members (Enter Name)	Relation to you (NR=Not Related)	Birth Date	Social Security Number	Sex (M/F)	US Citizen? (Yes/No)	ED Level *	Marital Status	Race/ Ethnic Code **
Last First MI	Complete these sections only for those who need benefits							

**Race: (You may select more than one race)	**Ethnicity:
AN = Alaskan Native **WH** = White **BL** = Black or African American	**Y** = Hispanic or Latino
AI = American Indian **AS** = Asian **PI** = Native Hawaiian or other Pacific Islander	**N** = Not Hispanic or Latino

***ED Level:** List highest grade completed or GED/college

If you need more space for additional household members, you can write the information on plain paper or ask for an "Additional Household Members Form."
If anyone for whom you are applying is not a U. S. citizen, your worker will complete an Alien Addendum and Checklist with you during your interview.

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Household composition: _____ person household

Are all members linked on LAMI? ☐ Yes ☐ No

Enumeration verified by:

Age and relationship verified by:

Document CR 5

Citizenship: Are all household members U.S. citizens? ☐ Yes ☐ No

If no, complete Alien Addendum and Alien Checklist.

D. Tell Us About Your Household

Please answer the following questions for yourself and everyone else in your home.

1. Do you usually buy food and prepare your meals with everyone who lives with you? ☐ Yes ☐ No
   If no, who buys and prepares their food separately?
2. Do you or anyone in your household rent a room? ☐ Yes ☐ No
3. Do you or anyone in your household pay someone for meals? ☐ Yes ☐ No
4. Are you or anyone in your household a fleeing felon? ☐ Yes ☐ No
5. Are you or anyone in your household in violation of their probation or parole? ☐ Yes ☐ No
6. Have you or anyone in your household been convicted of a drug-related felony? ☐ Yes ☐ No
7. Have you or anyone in your household been disqualified or had their benefits reduced or stopped for breaking the rules of SNAP, FITAP, KCSP, or SSI? ☐ Yes ☐ No
8. Do you or anyone in your household need to get away from an abusive situation? ☐ Yes ☐ No
9. Does anyone in your home make you afraid by threatening, yelling, or physically hurting you or a member of your family? ☐ Yes ☐ No
10. Do you or anyone in your household have a disability? ☐ Yes ☐ No
11. Are you or anyone in your household pregnant? ☐ Yes ☐ No
    If yes, who? Due date:
12. Are immunizations current on all children? ☐ Yes ☐ No
    If no, who? Why?
13. Does anyone in your household attend high school, college, vocational or technical school? ☐ Yes ☐ No
    If yes, complete the following for each student:

a. _____ (Name of Student) _____ (Name of School and Program of study)
   How many hours does the student attend school each week? _____
   Is this considered full or part-time? ☐ Full-time ☐ Part-time

b. _____ (Name of Student) _____ (Name of School and Program of study)
   How many hours does the student attend school each week? _____
   Is this considered full or part-time? ☐ Full-time ☐ Part-time

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6. If yes, complete supplement.

7. If yes, complete supplement.

8-9. Referral needed for domestic violence?
☐ Yes ☐ No

If yes and FITAP/KCSP: Issue Flyer DV.

10. If yes, complete supplement. If FITAP, complete OFS 90 or OFS 90L.

12. Verification: ☐ OFS IM ☐ CR 9 ☐ LINKS

13. If yes, is anyone attending an institution of higher education?
☐ Yes ☐ No
If yes, complete supplement.

☐ Eligible student
☐ Ineligible student

☐ Eligible student
☐ Ineligible student

E. Tell Us About Your Household's Work

Tell us about any money received by you or anyone in your household for work including full-time, part-time, temporary, or seasonal jobs, self-employment, training, military reserve pay, or work study. This includes money received from wages, salaries, tips, or commissions.

1. Do you or anyone in your household work? ☐ Yes ☐ No

*Complete the following information for **each person** who works for an employer. If anyone works for more than one employer, complete a separate block for each employer. Use plain paper if you need more space.*

2. Person Who Works For An Employer

Name _____ Start Date _____

Employer's Name _____ Phone # _____

Address _____

How often paid? ☐ Weekly ☐ Every two weeks ☐ Twice monthly ☐ Monthly ☐ Other _____

Paid by Direct Deposit? ☐ Yes ☐ No

If yes, at what bank or credit union? _____

If no, where do you cash your paycheck? _____

# of hours worked per week _____ Hourly wage _____

# of days worked per week _____

Do you ever work overtime? ☐ Yes ☐ No

If yes, how often? _____ How many hours? _____

Are tips earned? ☐ Yes ☐ No

If yes, how much? _____ How often? _____

Is this Work Study? ☐ Yes ☐ No

Is this job temporary? ☐ Yes ☐ No

If yes, date expected to end? _____

3. Person Who Works For An Employer

Name _____ Start Date _____

Employer's Name _____ Phone # _____

Address _____

How often paid? ☐ Weekly ☐ Every two weeks ☐ Twice monthly ☐ Monthly ☐ Other _____

Paid by Direct Deposit? ☐ Yes ☐ No

If yes, at what bank or credit union? _____

If no, where do you cash your paycheck? _____

# of hours worked per week _____ Hourly wage _____

# of days worked per week _____

Do you ever work overtime? ☐ Yes ☐ No

If yes, how often? _____ How many hours? _____

Are tips earned? ☐ Yes ☐ No

If yes, how much? _____ How often? _____

Is this Work Study? ☐ Yes ☐ No

Is this job temporary? ☐ Yes ☐ No

If yes, date expected to end? _____

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Use OFS 3

Verified by:

Are reimbursements received?
☐ Yes ☐ No

Is commission earned?
☐ Yes ☐ No
If yes, how much?
How often?

Is this piecework?
☐ Yes ☐ No
Rate per piece?

Use OFS 3

Verified by:

Are reimbursements received?
☐ Yes ☐ No

Is commission earned?
☐ Yes ☐ No
If yes, how much?
How often?

Is this piecework?
☐ Yes ☐ No
Rate per piece?

4. Has anyone in your household (including you) stopped working in the last 90 days? ☐ Yes ☐ No

5. Is anyone in your household (including you) looking for work? ☐ Yes ☐ No

6. Is anyone on strike? ☐ Yes ☐ No

7. Is anyone in your household a migrant or seasonal farmworker? ☐ Yes ☐ No

*Complete the following information for **each person** who is self-employed. This includes fishermen, child care providers, hair dressers, and people who do odd jobs such as cutting grass, picking up cans, etc. Use plain paper if you need more space.*

8. Persons Who Are Self-Employed

Name		Name
Type of Business		Type of Business
Monthly Business Income		Monthly Business Income
Monthly Business Expenses		Monthly Business Expenses
# Hours Worked Per Week		# Hours Worked Per Week

F. Tell Us About Other Income

1. Do you or anyone in your household receive money from a source other than work? ☐ Yes ☐ No **If yes**, check each type of income.

- ☐ Annuity Income
- ☐ Child Support Income
- ☐ Contributions From Family/Friends
- ☐ Disability Insurance Benefits
- ☐ Energy Check
- ☐ Gifts
- ☐ Interest Income
- ☐ Loans
- ☐ Military Allotment
- ☐ Oil Lease/Royalties
- ☐ Railroad Benefits
- ☐ Rental Income
- ☐ Retirement Pension
- ☐ Roomer/Boarder
- ☐ Social Security
- ☐ Scholarships/Grants/School Loans
- ☐ SSI
- ☐ Spousal Support/Alimony
- ☐ Tribal Money
- ☐ Training Allowance (WIA)
- ☐ Trust Income
- ☐ Unemployment Benefits
- ☐ Veterans Benefits
- ☐ Workers Compensation
- ☐ Other

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4. If yes, complete supplement.

5. If yes, complete supplement.

8. Verified by:

- ☐ Prior year's income tax return
- ☐ Accountant or bookkeeper records
- ☐ Personal business records

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Name	**Age**	**WR Code**	**Reason For Exemption**	**WR Code**	**Reason For Exemption**

2. *For each box checked in #1 of this section on page 5, complete the following information. Include any money you expect to receive in the next 30 days.*

Name	Type Of Income	Amount	How Often (Weekly, Monthly, etc)	Do You Expect This Income To End
				☐ Yes ☐ No **If yes,** when?
				☐ Yes ☐ No **If yes,** when?
				☐ Yes ☐ No **If yes,** when?
				☐ Yes ☐ No **If yes,** when?

3. Do you or anyone in your household have an application pending for any benefits that you are not receiving yet? ☐ Yes ☐ No

4. Have you or anyone in your household received cash assistance or SNAP benefits from another state? ☐ Yes ☐ No
   a. **If yes**, who? _____
   b. When? _____
   c. What state(s)? _____

5. Is someone court-ordered to pay child support to you or anyone in your household? ☐ Yes ☐ No

6. Do you or anyone in your household receive any money from a child's parent who is not court-ordered to pay? ☐ Yes ☐ No

G. Tell Us About Your Expenses

In order to receive the most benefits possible, you need to tell us about and provide proof of your household expenses. Failure to report or verify any of the expenses listed below will be seen as a statement by your household that you do not want to receive a deduction for the unreported expense.

HOUSING EXPENSES

1. Check each type of housing expense that you or anyone in your household has.

- ☐ Rent
- ☐ Mortgage(s), (if buying)
- ☐ Lot Rent
- ☐ Homeowner's Insurance
- ☐ Flood Insurance
- ☐ Property Tax
- ☐ Condominium Fees
- ☐ Electricity
- ☐ Gas
- ☐ Sewer
- ☐ Water
- ☐ Garbage
- ☐ Telephone
- ☐ Other

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Verified by:

3. If yes, what type?

5. If yes, complete supplement.

6. If yes, complete supplement.

Living Arrangement

- ☐ Public housing
- ☐ HUD or Section 8 subsidy
- ☐ Other subsidy
- ☐ No rent subsidy

Are insurance and property taxes included in the mortgage payment?
☐ Yes ☐ No

Are any of these bills past due?
☐ Yes ☐ No

2. *For each box checked in #1 of this section on page 6, complete the following information.*

Type Of Housing Expense	Name and Phone Number of Person or Company Paid	Amount Paid	How Often Paid (Weekly, Monthly, Etc.)

3. Do you pay utility costs for heating and/or air conditioning? ☐ Yes ☐ No
4. Does anyone help you pay your housing expenses? ☐ Yes ☐ No
5. Do you receive energy assistance? ☐ Yes ☐ No
   If yes, is the assistance through the Low-Income Home Energy Assistance Program (LIHEAP)? ☐ Yes ☐ No
6. Do you pay housing expenses for a home you are no longer living in but plan to return to? ☐ Yes ☐ No

CHILD SUPPORT EXPENSES

1. Does anyone in your household pay court-ordered child support? ☐ Yes ☐ No
   If yes, complete the following information.

Who Pays	Paid to Whom	Amount Paid	How Often Paid (Weekly, Monthly, Etc.)

MEDICAL EXPENSES

*We can allow a medical deduction in your SNAP case for each household member who has a disability or is over the age of 59. A deduction may be given for medical expenses that are **more than $35.00 per month.***

1. Is there anyone in your household who has a disability or is over the age of 59? ☐ Yes ☐ No
   If yes, answer the questions in this section.
   If no, skip to the Dependent Care Expenses section on the next page.
2. Does this person have to pay medical expenses? ☐ Yes ☐ No
   a. **If yes**, do you want to verify these expenses so that you can receive a medical deduction? ☐ Yes ☐ No
   b. Check each medical expense that this person has.

- ☐ Dental Bills
- ☐ Hospital Bills
- ☐ Health Insurance Or Medicare Premiums
- ☐ Medical Appliances
- ☐ Prescribed Medicine
- ☐ Prescription Drug Plan Premium
- ☐ Nursing Home
- ☐ Other

3. *For each box checked above, complete the following information.*

Names	Type of Expense	Amount Paid	How Often Paid (Weekly, Monthly, Etc.)

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Indicate how each expense was verified.

Eligible for: ☐ SUA ☐ BUA ☐ TEL ☐ None

4. If yes, complete supplement.

Court-ordered child support expenses:

Medical expenses:
Use form SNAP 1MW

Medical Transportation Expense is money spent for trips to the doctor, hospital, drug store, etc. This includes miles driven in your own vehicle.

4. Does any elderly or disabled person listed on previous page have medical transportation costs? ☐ Yes ☐ No

   a. Does this person use their own vehicle or a household member's vehicle? ☐ Yes ☐ No

   b. **If yes**, complete the following information.

Name Of Person	List All Places Visited For Medical Purposes (Ex. Doctors, Drug Store, Hospital, Etc.)	# Of Miles Traveled Round Trip	Number Of Visits Per Month

   c. Does this person pay someone other than a household member for medical transportation? ☐ Yes ☐ No

   d. **If yes**, complete the following information.

Name Of Person	Who Is Paid	Where Does This Person Go	How Much Does This Person Pay Per Trip	How Many Trips Does This Person Pay For Each Month

If you need more space, you can write the information on plain paper.

5. Will this person or anyone in your household be reimbursed for any of the medical expenses listed above? ☐ Yes ☐ No

6. Does anyone help pay the medical expenses? ☐ Yes ☐ No

DEPENDENT CARE EXPENSES

1. Do you or anyone in your household pay someone to care for a child, or an adult who is elderly or disabled, so that you or a household member can work, attend training or school, or look for work? ☐ Yes ☐ No

2. **If yes**, complete the following information.

Paid For Whom	Name And Telephone Number Of Person Paid	Amount Paid	How Often Paid (Weekly, Monthly, Etc.)

3. Does anyone help you pay your dependent care expenses? ☐ Yes ☐ No

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5. If yes, complete supplement.

6. If yes, complete supplement.

Certified for CCAP?
☐ Yes ☐ No

What is co-payment amount?

When management is questionable, use form OFS 4MW.

3. If yes, complete supplement.

H. Tell Us About Your Household's Resources

Resources include cash, money in the bank, Certificates of Deposit, stocks, and bonds. Resources do not include personal property such as jewelry, furniture, electrical equipment, or clothing.

1. Does your name or the name of anyone in your household appear on a bank/credit union account with someone else? ☐ Yes ☐ No
   a. **If yes**, whose names are on the account? _____
   b. Why is this name on the account? _____
   c. Does someone else make deposits into this account? ☐ Yes ☐ No
   d. **If yes**, who and how much per month? _____

2. Check each resource listed below that you or anyone in your household has.

- ☐ Bank/Credit Union Account (Checking)
- ☐ Bank/Credit Union Account (Saving)
- ☐ Joint Account
- ☐ Bonds
- ☐ Cash On Hand
- ☐ Certificate Of Deposit (CD)
- ☐ Money Market Account
- ☐ Mutual Funds
- ☐ Safe Deposit Box
- ☐ Savings Bond
- ☐ Stocks

3. *For each box checked above, complete the following information.*

In Whose Name Is The Resource Listed	Type Of Resource	How Much Is It Worth	Where Is The Resource (Include Name Of Bank Or Company, Where Money Is Held, Address Of Property, Etc.)

4. Have you or anyone in your household sold, traded, given away, or transferred a resource in the last three months? ☐ Yes ☐ No

5. Have you or anyone in your household received or do you or anyone in your household expect to receive a lump sum of money? ☐ Yes ☐ No

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How was this verified?

☐ Client statement
☐ Bank statement
☐ Other

Are liquid resources $1500 or less? ☐ Yes ☐ No

4. If yes, complete supplement.

5. If yes, complete supplement.
☐ Countable lump sum
☐ Non-countable lump sum

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IF YOU ARE APPLYING FOR SNAP BENEFITS ONLY, SKIP TO PAGE 13.

COMPLETE THIS PAGE ONLY IF YOU ARE APPLYING FOR CHILD CARE ASSISTANCE

I. Child Care Assistance Program

1. Are you applying for the Child Care Assistance Program? ☐ Yes ☐ No

   If yes, complete this page. **If no**, skip to page 11.

2. List all children who need care and the times each day that the care is needed. If school-aged children need care before and after school, list both times (for example: 7:00 a.m. to 8:00 a.m. and 3:30 p.m. to 6:00 p.m.).

Name Of Child	Age	Type Of Care	Provider's Name Address/Phone Number	Provider's Relationship To Child	Cost Of Care	Time Care Needed Each Day
		☐Child's Home ☐Provider's Home ☐Class A Center ☐Other				
		☐Child's Home ☐Provider's Home ☐Class A Center ☐Other				
		☐Child's Home ☐Provider's Home ☐Class A Center ☐Other				
		☐Child's Home ☐Provider's Home ☐Class A Center ☐Other				
		☐Child's Home ☐Provider's Home ☐Class A Center ☐Other				

3. List all children who attend or will attend Head Start, Pre-Kindergarten, Kindergarten, or school this school year. _____

4. Do any of the children listed above need specialized care because of a physical, mental, or emotional condition? ☐ Yes ☐ No

   a. **If yes**, who? _____

   b. For what condition? _____

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Did the provider change? ☐ Yes ☐ No

How were special needs verified?

COMPLETE THIS PAGE ONLY IF YOU ARE APPLYING FOR FITAP OR KCSP

J. FITAP or KCSP

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1. Are you applying for FITAP or KCSP? ☐ Yes ☐ No

   If yes, complete this page. **If no**, skip to page 13.

HEALTH INSURANCE

2. Is anyone in your household covered by medical insurance other than Medicaid? ☐ Yes ☐ No

   a. **If yes**, name of insurance: _____

   b. Type of coverage (Hospital, Dental, Etc.): _____

3. Can you or anyone in your household get health insurance through an employer? ☐ Yes ☐ No

2. If yes, complete form 117-1

COLLATERALS

4. Please complete the following information for two people who are not related to you who can verify your household situation.

Name	Address	Daytime Phone Number

CUSTODY

5. If you are not the parent of the child(ren) for whom you are applying, do you have custody? ☐ Yes ☐ No

   a. **If yes**, complete the following information.

Children For Whom You Have Custody	Type Of Custody	Effective Date Of Custody

5. Custody verified by:

A non-custodial parent is a parent who does not live in the home with his/her child. Tell us about the non-custodial parent(s) of each child living in your home. This includes both mother and father if you are not the parent of the child(ren). If a child's biological father and legal father are not the same person, give the requested information for both fathers. Use plain paper if you need more space.

6. **Non-Custodial Parent Information**

Name | Social Security Number | Date of Birth

Street Address

City | State | Phone Number

Employer

Name(s) of Children

Parental Relationship (relationship of children's parents) : ☐ Married ☐ Widowed ☐ Never Married ☐ Divorced

7. **Non-Custodial Parent Information**

Name	Social Security Number	Date of Birth
Street Address		
City	State	Phone Number
Employer		
Name(s) of Children		
Parental Relationship (relationship of children's parents) :	☐ Married ☐ Never Married	☐ Widowed ☐ Divorced

8. **Non-Custodial Parent Information**

Name	Social Security Number	Date of Birth
Street Address		
	State	Phone Number
Employer		
Name(s) of Children		
Parental Relationship (relationship of children's parents) :	☐ Married ☐ Never Married	☐ Widowed ☐ Divorced

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Living in the home with qualified relative? ☐ Yes ☐ No

Verified by:

- ☐ Landlord statement
- ☐ School records
- ☐ Collateral
- ☐ Other

NCP: Complete form 4NCP and 4NCP Supplement, if applicable:

Voter Registration

Any citizen in the State of Louisiana who has met the voter registration requirements and applies for public assistance must be provided the opportunity to register to vote.

If you are not registered to vote where you live now, would you like to apply to register to vote? ☐ Yes ☐ No

If you do not check either box, we will assume that you do not want to register to vote at this time.

Please note that the information you give to the agency will remain confidential and will be used only for voter registration purposes. Applying to register or refusing to register to vote will not affect the amount of assistance or services that you may receive from the Department of Children and Family Services.

If you would like help filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. Contact your worker if you need help. You may file a complaint if you believe that someone has interfered with your:

- right to register to vote,
- right to decline to register to vote,
- right to privacy in deciding whether to register to vote,
- privacy in applying to register to vote, or
- right to choose your own political party or other political preference.

You may file a complaint with: Louisiana Secretary of State, P.O. Box 94125, Baton Rouge, LA 70804-9125. 1-800-825-3805

Read Carefully And Sign Below

I certify under penalty of perjury that the information I have given on this application is true, complete, and correct to the best of my knowledge, including the information I have given regarding the U.S. citizenship or immigration status of all household members. I understand that I and any adult household member will be subject to disqualification and prosecution and will be required to repay ineligible benefits if we knowingly give false, incorrect, or incomplete information in order to obtain or try to obtain financial, food, or child care assistance. By signing this application, I give permission for the release of information to the Department of Children and Family Services by any persons or agencies who have knowledge of my circumstances.

Remember, you must turn in proof of the information you reported on this application form and verification of your identity.

Your Signature (or mark) _____ Date Signed _____

Signature (or mark) of your wife or husband _____ Date Signed _____

Signature of Minor Unmarried Parent _____ Date Signed _____

If you, or your wife or husband, sign with an "X" mark, ask two people to witness the mark; if applicant is blind, ask three people to witness.

Witness _____ Witness _____ Witness _____

Signature of Person Who Helped You Complete this Form and His or Her Relationship to You

Signature _____ Relationship _____

Signature of Agency Representative _____ Date _____

I want to withdraw my _____ application because _____

_____

Signature of Applicant _____ Date _____

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Rev. 01/10
11/99 Issue Obsolete
IV

Louisiana Department of Social Services
Office of Family Support

Referral for Social Security Number Application

OFS Office Name and Address:

Case Name: _____
Case No : _____
Worker's Name: _____
Worker's Phone No.: _____
Date Completed: _____

Social Security Number applications must be made for the following people:

Examples: 190-2803 and Interim numbers for FITAP 190-2826 and Interim numbers for SNAP

Name _____ ID No. 190 _____
Name _____ ID No. 190 _____
Name _____ ID No. 190 _____
Name _____ ID No. 190 _____

Instructions on How to Apply for Social Security Numbers:

You must apply for a Social Security Number for the person(s) listed above no later than _____. Adults age 18 or older that are listed should apply for their number in person. You must obtain verification that you have applied by taking this form with you to your local Social Security Office. You must bring proof of age and proof of identity for each person listed. If you were born outside the U.S. you must also bring proof of U.S. citizenship or alien status.

Proof of Age. AN OFFICIAL BIRTH CERTIFICATE IS ALWAYS THE PREFERRED DOCUMENT. Hospital birth certificates and baptismal certificates are acceptable. If those documents are not available, Social Security may accept other documents that show the date of birth.

Proof of Citizenship/Alien Status. If you were born outside the U.S., you must have proof of citizenship or lawful alien status.

Proof of identity. A second document is required for all persons to establish identity. Examples of proof of identity would be a driver's license, insurance policy, or draft card. For children of school age, a school report card or school record may be acceptable. For younger children, medical records may be acceptable.

YOU MUST TAKE THIS FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE WHEN YOU APPLY FOR THE NUMBER(S).

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION

Name(s) of Person(s) Needing Number	Completed Application?	
_____	☐ Yes	☐ No
_____	☐ Yes	☐ No
_____	☐ Yes	☐ No

Comments: _____

_____ _____ _____
Signature of Social Security Official | Date | Phone Number

Date: _____

SSN: _____

Caseload #: _____

Parish: _____

LOUISIANA DEPARTMENT OF CHILDREN AND FAMILY SERVICES
SIMPLIFIED REPORT

Important: You must complete, sign, and return this form and all required verification by _____ or your case may be closed.

If you need help, call your worker. This information will be used to determine eligibility and benefits. For more information about programs and services or for specific information about your case, call 1-888-LAHELPU (1-888-524-3578).

1. Is the address shown above correct? ☐ YES ☐ NO
2. Have you moved? ☐ YES ☐ NO
3. If you have moved or the address shown above is not correct, complete the information below:

_____

Street or Rural Route Apt. or Lot# City and State Zip Code Phone #

4. Mailing address if different from above: _____

5.	**If you have moved,** you must report changes in your shelter costs. **If you have not moved** but your shelter costs have changed, you may report those changes below. YOU MUST SUBMIT VERIFICATION OF ALL CHANGES YOU REPORT.				
A.	Mortgage/Rent Payment: $ _____	E.	**Do you pay the following expense:**	**Yes**	**No**
B.	Property Taxes (if <u>not</u> included in mortgage payment) $ _____		Utility costs for Heating or Air Conditioning		
C.	Homeowner's Insurance (if <u>not</u> included in mortgage payment) $ _____		Utilities other than Heating or Air Conditioning		
D.	Installation Fee $ _____		Telephone		

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6. List the names and birth dates of everyone living in your home **other than yourself**. Complete the information within the **dark** lines only for newborn babies and people who have moved into your home since your last report. Use extra paper if necessary.

Name	Date of Birth	Does this person buy food & prepare meals separately?	Social Security Number	Relationship to you	U.S. Citizen	
					Yes	No
		☐ Yes ☐ No				
		☐ Yes ☐ No				
		☐ Yes ☐ No				
		☐ Yes ☐ No				
		☐ Yes ☐ No				

7. If a household member died or left your home since your last report, complete this section. Use extra paper if necessary.

Name	Date Left	Why did this person Leave?

8. **a. Phone number where you can be reached during the day.** ( ) _____

   b. E-mail address, if available: _____

9. **REPORT ALL INFORMATION FROM WORK HERE**

Does anyone in your household work? ☐ Yes ☐ No Provide information below about each person who works. Use extra paper if necessary.

Person's Name: _____ Person's Name: _____

Employer's Name: _____ Employer's Name: _____

Employer's Phone Number: _____ Employer's Phone Number: _____

Did the job begin in the last 6 months? ☐ Yes ☐ No Did the job begin in the last 6 months? ☐ Yes ☐ No

If yes, when did the job start? _____ If yes, when did the job start? _____

You must send proof of each employed person's wages for the last four pay periods from each place of employment. If you do not have the last four check stubs, have the employer complete one of the wage verification forms enclosed.

10. Complete the following if anyone stopped working in the last 6 months.

Person's Name: _____ Last day of work: _____

Former Employer's Name: _____ Former Employer's Phone Number: _____

Reason for Leaving Job: _____

If anyone has stopped working since your last report, you must verify the last date worked. Attach the termination notice, pink slip or a statement from the employer.

11. **REPORT ALL OTHER INCOME HERE**
List all checks/money currently received by any household member. Example: Social Security, SSI, VA, unemployment benefits, worker's compensation, child support, military allotment, contributions, royalties, pensions, etc. Use an extra sheet of paper if necessary.

Name of person receiving this income	Source of this income (List agency or person who gives the money)	Amount of income	How often is income received? (monthly, weekly, etc.)	Did this income start in the last 6 months?
		$		☐ Yes ☐ No
		$		☐ Yes ☐ No
		$		☐ Yes ☐ No
		$		☐ Yes ☐ No

If any income listed above is new or has changed since your last application or report, provide proof of the amount, such as an award letter or other documentation which shows the current income amount.

12. If income of any household member stopped in the last 6 months, complete the following and **provide proof of when the income stopped.**

Name of person whose income stopped	Source of income that stopped	Date Stopped

13. **RESOURCES**
If the total amount of money that the members of your household have in cash, savings accounts, checking accounts, stocks, and bonds **increased to more than $2000**, enter the total amount here.
$ _____

14. **CHILD SUPPORT PAID**
Has anyone had a change in their legal obligation to pay child support? ☐ Yes ☐ No
If yes, provide proof of the change.

15. **OTHER**
Are there other changes that you would like to report to us? If so, you must **provide verification of these changes.**

_____

_____

If your costs for dependent care or medical expenses have changed and you provide proof of these changes, your benefits will be adjusted accordingly. **Your benefits cannot be increased without verification of the changes.**

SOCIAL SECURITY NUMBERS

Social Security numbers (SSNs) are used to collect information from sources other than the Department of Children and Family Services to check identity of household members, to prevent households from getting more benefits than they are entitled to, and to identify groups of cases that must be adjusted. SSNs are used in program reviews, audits, and computer matching with other agencies such as Louisiana Workforce Commission, Social Security Administration, and Internal Revenue Service. Under the Privacy Act of 1974 (P.L. 93-579) SSNs may be released for various reasons directly connected to the administration of the Child Support Enforcement Program.

PENALTY WARNING

It is against program rules for household members to trade or sell Supplemental Nutrition Assistance Program (SNAP) benefits, to use SNAP benefits to buy ineligible items, such as alcoholic drinks and tobacco, or to use someone else's SNAP benefits. Any member of the household who deliberately breaks any rules of SNAP can be barred from the program for one year for the first violation, two years for the second violation, and permanently for the third violation and be fined up to $20,000 or imprisoned up to five years, or both. Any member of the household who deliberately breaks FITAP rules can be barred from the program for one year for the first violation, two years for the second violation, and permanently for the third violation and can be fined up to $20,000 or imprisoned up to five years, or both.

Any member found by the courts to have purchased illegal drugs with SNAP benefits, or received SNAP benefits as payment for illegal drugs, will be barred from the program for two years for the first finding and permanently for the second finding. Any member found by the court to have purchased firearms, ammunition or explosives with SNAP benefits will be barred from the program permanently for the first finding. Any member convicted of trafficking in SNAP benefits of $500 or more will be permanently disqualified. Any member found to have made fraudulent statements or representations with respect to residency or identity in order to receive multiple benefits simultaneously will be disqualified for ten years.

Any individual fleeing to avoid prosecution or custody or confinement after conviction for a felony and any individual violating a condition of probation or parole will be disqualified. Any individual convicted of a felony under federal or state law involving the possession, use, or distribution of a controlled substance will be disqualified for one year if the offense was committed after August 22, 1996.

SNAP benefits will not be increased when a household's income is reduced because of a penalty imposed under a federal, state, or local means-tested public assistance program for failure to perform a required action.

READ AND SIGN BELOW

I understand that the information I have provided will be used to determine my household's SNAP eligibility and benefit amount. My benefits may be increased, decreased, or terminated based on this information. I understand that I will be subject to prosecution for fraud if I knowingly give false, incorrect, or incomplete information in order to obtain or try to obtain, or help someone else obtain or try to obtain, food assistance. In addition to the penalties listed above, my household will also be subject to prosecution and/or disqualification under other applicable federal or state laws. I further understand that I will be required to repay any benefits received improperly for any person in my household.

_____	_____	_____
Signature	Today's Date	Home Telephone Number

If signed with a mark, ask two people to witness the mark and sign below.

Witness: _____ Witness: _____

WAGE VERIFICATION
TO BE COMPLETED BY EMPLOYER IF CHECK STUBS ARE NOT AVAILABLE

Name of Employee _____ SSN _____

Name of Employer _____ Date Employment Started _____

Check how often employee is paid (i.e. Pay Period):

☐ Weekly ☐ Every two weeks ☐ Twice monthly ☐ Once monthly

Is employee paid by Direct Deposit? ☐ Yes ☐ No If yes, at what bank or credit union? _____

_____

If employment is new:

Number of hours expected to work **Per WEEK** _____ **Per PAY PERIOD** _____ Hourly rate of pay _____

Number of hours of overtime expected to work **Per WEEK** _____ **Per PAY PERIOD** _____

Hourly rate of overtime pay _____

If Tips are expected to be received, amount of Tips expected **Per WEEK** _____ **Per PAY PERIOD** _____

Complete chart below to show wages for the last 4 pay periods.

Pay Period Ending	Date Wages Received	Hours Worked	Hourly Pay Rate	Gross Pay	Tips Received

Are you aware of any other income this person may be receiving? ☐ Yes ☐ No

If yes, source and amount. _____

If employment terminated, give date and reason no longer employed. _____

_____ _____ _____

Date Signed | Employer's Signature | Employer's Phone Number

_____

Employer's Printed Name or Stamp

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