MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF FAMILY SERVICES

APPLICANT'S ELIGIBILITY STATEMENT

The following information is necessary to determine your eligibility for assistance. It is important to answer each applicable question accurately and completely. You may be required to provide verification of your statements. COMPLETE THIS FORM IN INK.

A. SOCIAL SECURITY NUMBERS

Provide Social Security Numbers (SSN) of all persons applying for or receiving public assistance. It is a condition of eligibility except for Blind Pension. The SSN is used to determine eligibility and level of benefits, verify information, prevent duplicate participation, and facilitate mass changes in Federal benefits (Public Law 97-98 and Section 1137 of the Social Security Act). Included in the agencies contacted for income and eligibility information are the Social Security Administration, the Internal Revenue Service, Division of Workforce Development, Missouri Department of Corrections, Child Support Enforcement, and any local law enforcement. Some of the information may be obtained by computer match.

I/We will apply for Social Security Numbers or verify present numbers for all persons for whom I am/we are applying/receiving assistance as a condition of eligibility. ☐ Yes ☐ No

B. HOUSEHOLD MEMBERS

1. List all of the persons who live in your home. Include children attending school away from home. (List your name first). The question on race is optional. Your Eligibility Specialist will make the entry for you if you leave it blank. Your answer in no way affects your eligibility.

NAME (FIRST, MIDDLE, LAST) (MAIDEN)	HISPANIC Y/N	*RACE/ SEX	RELATIONSHIP (SON-SISTER-FRIEND)	BIRTHDATE	PLACE OF BIRTH	SOCIAL SECURITY NUMBER	SCHOOL CHILD ATTENDS	APPLYING FOR (✓)
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								

* 1 - WHITE 2 - BLACK/AFRICAN AMERICAN 4 - AMERICAN INDIAN/ALASKA NATIVE 5 - ASIAN 6 - NATIVE HAWAIIAN /PACIFIC ISLANDER

2. Are all of the persons applying for assistance U.S. citizens? ☐ Yes ☐ No If no, list the following information for each non-citizen applying.

NAME	IMMIGRATION STATUS	REGISTRATION NUMBER	DATE OF ENTRY

C. RESIDENCY

1. I/We are residents of Missouri. ☐ Yes ☐ No
2. I/We intend to remain in Missouri. ☐ Yes ☐ No

IF YOU ARE APPLYING FOR MEDICAL BENEFITS ONLY, SKIP TO SECTION E.

D. HOUSEHOLD'S DECLARATION INQUIRY

Answer yes or no to each of the questions in this section. For each question answered yes, explain in the space provided.

1. Are you or any member of your household fleeing to avoid prosecution, custody, or jail for a crime (or attempted crime) that is a felony? ☐ Yes ☐ No
2. Are you or any member of your household receiving benefits under another identity or as a member of another household or in another state? If yes, who? _____ ☐ Yes ☐ No
3. Have you or any member of your household been convicted in a Federal or State court of a felony committed after 8/22/96 related to illegal possession, use, or distribution of a controlled substance? If yes, who? _____ ☐ Yes ☐ No
4. Have you or any member of your household ever been found by a State agency or convicted in a Federal or State court of having made a fraudulent statement or misrepresentation with respect to identity or place of residence for the purpose of receiving cash benefits under Temporary Assistance for Needy Families in two (2) or more places at the same time? If yes, who? _____ ☐ Yes ☐ No

E. EARNED INCOME

1. Does anyone in your household have earned income? ☐ Yes ☐ No If yes, list below the amount of earned income, **BEFORE DEDUCTIONS,** for each person. Sources of earned income can be full/part-time wages, self-employment, odd jobs, baby-sitting, tips, boarders/lodgers, agriculture payments, or any other type of earned income.

NAME	EMPLOYER (INCLUDE ADDRESS AND PHONE NUMBER)	RATE OF PAY	NUMBER OF HOURS WORKED	AMOUNT PER PAY PERIOD	HOW OFTEN RECEIVED

2. Do you anticipate any change in the information listed above? ☐ Yes ☐ No If yes, explain: _____

_____

3. Has anyone in your household started working? ☐ Yes ☐ No If yes, who? _____

4. Does anyone in your household work overtime? ☐ Yes ☐ No If yes, who? _____

5. Has anyone in the household quit a job, been terminated from a job, or reduced the number of hours of work? ☐ Yes ☐ No If yes,

who? _____ Reason: _____

Date last worked _____ Date last check received _____ Amount of last check $ _____

F. UNEARNED INCOME

1. Does anyone in your household have income other than from employment? ☐ Yes ☐ No If yes, check the appropriate box(es) and list the amount you receive from each source you have checked.

☐ Social Security $_____ ☐ Interest/Dividends $_____ ☐ Unemployment Compensation $_____

Claim # _____ ☐ Child Support $_____ ☐ Retirement/Disability Pension $_____

☐ VA $_____ ☐ Scholarships $_____ ☐ SSI $_____

☐ Training Program $_____ ☐ Family/Friends $_____ ☐ Trust Funds/Annuities $_____

☐ Other _____ If other, explain _____

2. Do you expect any changes in unearned income? ☐ Yes ☐ No If yes, explain _____

G. OTHER PAYMENTS

1. Does anyone in your household have a lawsuit or claim pending for cash or medical benefits against an employer, insurance company, or other? ☐ Yes ☐ No If yes, who? _____ Date filed: _____ Explain: _____

_____

2. Has anyone in your household received a lump sum payment in the last 12 months? ☐ Yes ☐ No If yes, who? _____

H. DEPENDENT CARE EXPENSE

CHILD PROTECTION CLAUSE

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 prohibits the reduction or termination of Temporary Assistance benefits to single custodial caretakers of children under the age of six (6) if the caretaker demonstrates that he or she is unable to obtain needed childcare. If you are a single caretaker, with a child under the age of six (6), and are unable to obtain needed childcare for one or more of the following reasons, your Temporary Assistance benefits cannot be sanctioned for failure to participate in work requirements:

- Unavailability of appropriate childcare within a reasonable distance from your home or work site;
- Unavailability or unsuitability of informal childcare by a relative or under other arrangements;
- Unavailability of appropriate and affordable formal childcare arrangements.

This clause may be applied in single custodial households for children over the age of six (6) under certain circumstances. Discuss any of these issues with your Eligibility Specialist.

1. Does anyone in your household pay someone to care for a ☐ Child or ☐ Disabled person while a household member ☐ works ☐ attends school ☐ participates in an employment training program? ☐ Yes ☐ No If yes, complete the following:

Name of person cared for _____ Amount you pay $ _____ How often paid? _____

Name of person cared for _____ Amount you pay $ _____ How often paid? _____

Name of person cared for _____ Amount you pay $ _____ How often paid? _____

Mileage or cost from home to provider and back _____ Number of trips per week _____

Name of care provider _____ Phone Number _____

2. Do you receive state paid childcare? ☐ Yes ☐ No Are you interested in state paid childcare? ☐ Yes ☐ No

I. PAST EMPLOYMENT Give employment information for yourself, your spouse and all children age 16 and over for the last 36 months.

NAME OF PERSON EMPLOYED	EMPLOYER NAME AND ADDRESS	TYPE OF WORK	FROM	TO

J. RESOURCES This section applies to all persons, including children, who live in your household. Include the spouse, parent, or stepparent (if living in the home) of any person in your household.

1. I/We have the following cash and securities:	YES	NO	IN WHOSE NAME	LOCATION	BALANCE/VALUE
A. Checking accounts/joint checking accounts Account Numbers:					
B. Savings Accounts, Joint Savings Accounts, Christmas Club, Certificates of Deposit, Trust Funds, etc. Account Numbers:					
C. Patient accounts at a nursing home or other institution					
D. Cash on hand					
E. Stocks, bonds, or other investments. If yes, how many?					
F. Annuities, Trust Funds					
G. Notes or mortgages owed to you (Does anyone owe you money?)					

2. I/We have the following personal property:	YES	NO	LOCATION	VALUE	DEBT
A. Household furniture (not in use)					
B. Housetrailer (mobile home)					
C. Business equipment, farm machinery, grain, livestock					
D. Burial lot(s)					
E. Other (list)					

F. Are you or any member of your household buying, or do you own a car, boat, trailer, snowmobile, recreational vehicle, airplane, motorcycle, farm equipment (out of use more than 12 months), or other type of vehicle? ☐ Yes ☐ No If yes, list below:

MAKE	MODEL	YEAR	OWNER	IS IT LICENSED?	VALUE	DEBT	HOW IS VEHICLE OR EQUIPMENT USED?

3. Real Estate: We are buying or own real estate. ☐ Yes ☐ No If yes, complete the following:

LIST KIND AND LOCATION	WHO HOLDS THE MORTGAGE?	WHOSE NAME IS ON THE DEED?	CURRENT VALUE	AMOUNT OWED	HOW IS IT USED? (HOME-RENTAL?)

4. Is your net worth above $250,000? ☐ Yes ☐ No (Net worth is the value of everything you own minus the debt.)

K. TRANSFER OF PROPERTY OR RESOURCES FOR MEDICAL ASSISTANCE ONLY (ELDERLY/BLIND/DISABLED)

1. Has anyone in your home sold or given away any money, vehicles, property or other resources in the last 5 years? ☐ Yes ☐ No
If yes, complete the following.

WHAT?		WHEN?
TO WHOM?	AMOUNT RECEIVED	WHY?

2. Have you or your spouse created, or been a party of, a trust within the past five (5) years? ☐ Yes ☐ No If yes, explain _____

L. LIFE INSURANCE OR BURIAL PLAN

I/We have life insurance, or burial plans. ☐ Yes ☐ No If yes, list policies below.

LIST PERSON INSURED	NAME OF COMPANY	KIND OF INSURANCE	FACE VALUE	POLICY OWNER

M. HEALTH INSURANCE

1. I/We have medical, hospital insurance or Medicare. ☐ Yes ☐ No If yes, list policies below.

PERSONS INSURED	NAME OF COMPANY AND POLICY NUMBER	TYPE OF COVERAGE
		☐ Doctor ☐ Hospital If limited coverage explain:
		☐ Doctor ☐ Hospital If limited coverage explain:
		☐ Doctor ☐ Hospital If limited coverage explain:

2. Has anyone in your household lost health insurance within the past six (6) months? ☐ Yes ☐ No If yes, provide name(s), date, and reason coverage ended. _____

3. Is health insurance available through your employer or other group membership? ☐ Yes ☐ No

If yes, name of employer or group _____

The insurance is available for ☐ Self ☐ Spouse ☐ Child(ren) How much is the premium for the children? $ _____ per _____

N. PRIOR-QUARTER MC+/MEDICAL BENEFITS

If you are applying for medical coverage, have you received any medical services in any of the past three (3) months? ☐ Yes ☐ No

O. REFERENCE INFORMATION

This information is not required for your application, unless there is no other method of verification. We only contact your references if there is not sufficient documentary evidence to support your statements. You may choose to leave this blank and we will request your reference persons if needed. Please provide the names of two persons who live outside of your household and are not related to you who can verify your statements.

NAME	NAME
ADDRESS	ADDRESS
TELEPHONE HOME WORK	TELEPHONE HOME WORK
This person is able to verify my statements because	This person is able to verify my statements because
_____ _____	_____ _____

P1. EBT CARD

I need a new EBT Card to access my EBT account

☐ Yes ☐ No If yes, why?

☐ Threw card away ☐ Lost ☐ Stolen ☐ Name changed

☐ Damaged ☐ Card undelivered ☐ Payee/Head of Household changed ☐ Other (explain)

P2. DIRECT DEPOSIT

You can have your cash assistance paid by direct deposit if you have a bank or credit union account, or if you do not have an account, but will open an account now.

☐ I want direct deposit ☐ I do not want direct deposit

Q. MEDICAL ASSISTANCE, SUPPLEMENTAL NURSING CARE, SUPPLEMENTAL AID TO THE BLIND OR BLIND PENSION.

1. The reason I/we are applying: (Check all that apply.)

☐ Age 65 or over ☐ Blind ☐ Disabled ☐ Unable to work due to illness

2. Are you living in or supported by a public, medical, or private facility? ☐ Yes ☐ No If yes, facility name _____

_____

3. If you are a resident of a nursing facility and wish to give part of your income to your spouse or dependent relative, list the name(s). _____

_____

4. If disabled, list all sources you wish contacted to provide a full and accurate statement of your medical history and condition.

DOCTORS, HOSPITALS, CLINICS, OTHER

NAME	ADDRESS

5. **SUPPLEMENTAL AID TO THE BLIND OR BLIND PENSION**

A. Do you have a sighted spouse or parent? ☐ Yes ☐ No

B. Do you solicit alms? ☐ Yes ☐ No

C. Have you applied or do you agree to apply for Supplemental Security Income (SSI) as a condition of eligibility? ☐ Yes ☐ No

6. **IF YOU ARE APPLYING FOR BLIND PENSION, PLEASE COMPLETE THE FOLLOWING QUESTIONS ALSO:**

A. Have you had eye surgery within the last five (5) years? ☐ Yes ☐ No

B. If you are under age 75, are you willing to have medical treatment or an operation to correct blindness? ☐ Yes ☐ No

C. If recommended, are you willing to accept vocational training or work at an occupation for which you are suited? ☐ Yes ☐ No

R. APPLICANTS FOR TEMPORARY ASSISTANCE, COMPLETE ITEMS 1-10.
APPLICANTS FOR MC+ FOR PREGNANT WOMEN, COMPLETE ITEMS 9-10.
APPLICANTS FOR MAF & MC+, COMPLETE ITEMS 4-5 & 7-10.

Temporary Assistance payments may only be received for a total of 60 months in your lifetime beginning July 1, 1997. Any month that you have received benefits since that time is included in your lifetime limit.

If applying for Temporary Assistance, you may be asked to seek employment while your application is pending. Our hope is that you find employment and do not deplete your lifetime limit of receiving assistance. A self-sufficiency case manager will assist you in your job search.

If approved for Temporary Assistance, you will receive a call-in letter to meet with the Division of Workforce Development (DWD) in the Career Assistance Program (CAP). All Temporary Assistance participants are subject to participating in a work activity within the first 24 months that Temporary Assistance is received.

If approved for Temporary Assistance, your grant cannot be reduced by sanction for failure to participate in a work activity for the following reasons:

A. You are a single custodial caretaker caring for a child who has not reached six (6) years of age and,

B. You are unable to obtain needed childcare for one or more of the following reasons:

- Unavailability of appropriate childcare within a reasonable distance from your home or work site;
- Unavailability or unsuitability of informal childcare by a relative or under other arrangements;
- Unavailability of appropriate and affordable formal childcare arrangements.

This may apply if you are a single caretaker who has children over age six (6) under certain circumstances. Your Eligibility Specialist will explain to you what this means.

1. Have you received cash benefits in another state since August 1996? ☐ Yes ☐ No If yes, complete the following:

NAME OF STATE	TYPE OF ASSISTANCE	MONTH(S) AND YEAR(S) ASSISTANCE RECEIVED

2. Has any individual, for whom you are applying, lived on an Indian Reservation? ☐ Yes ☐ No
If yes, who? _____ When?_____

3. If you are a teen parent, are you residing in an adult supervised setting? ☐ Yes ☐ No If yes, complete the following:

NAME OF ADULT	RELATIONSHIP

4. CHILD IN HOME

A. The child(ren) for whom I am applying or receiving live in my home. ☐ Yes ☐ No

B. Is any child visiting away from your household? ☐ Yes ☐ No If yes, who? _____ How long?_____

C. Is any child attending school away from your household? ☐ Yes ☐ No If yes, who? _____ How long?_____

5. ABSENT PARENT INFORMATION:

List the name(s) of the child(ren) for whom you are applying or receiving, and the name(s) of the other parent(s). From the list below, give the reason for the absence.

CHILD'S NAME	CHILD'S MOTHER	CHILD'S FATHER	REASON CODE	REASON FOR ABSENCE
				a. Death
				b. Desertion or Separation
				c. Divorce
				d. Imprisoned or Jailed
				e. Institutionalized
				f. Never married to the parent
				g. Vocational Rehabilitation treatment or training

6. IF APPLYING AS A TWO-PARENT FAMILY, COMPLETE THE FOLLOWING:

Reason for application:

☐ Financial Need

A. Does the parent agree to apply for and accept Unemployment Compensation? ☐ Yes ☐ No

B. Does the parent agree to cooperate with Career Assistance Program (CAP)? ☐ Yes ☐ No

☐ Disability

7. ASSIGNMENT/REFERRAL

A. If I am approved for Temporary Assistance cash, I agree to send any future child support, maintenance, and alimony, to Child Support Enforcement. ☐ Yes ☐ No

B. I understand the automatic assignment of medical support is effective with the application and acceptance of MC+ healthcare benefits. ☐ Yes ☐ No

C. I/We will cooperate/continue to cooperate with the Family Support Division and Child Support Enforcement in establishing paternity and in securing support, including medical support, by identifying (naming) the absent parent(s), by providing information to help locate the absent parent(s), and by helping, as necessary, to obtain support payments from the absent parent(s).

☐ Yes ☐ No If no, explain: _____

8. STEPPARENT

A. Do your children have a stepparent living in your household? ☐ Yes ☐ No If yes, be sure to list the stepparent's income in Section E and/or F.

B. Give information on support the stepparent gives to dependents outside the household.

	CLAIMED ON TAX RETURN		AMOUNT PAID		
DEPENDENT'S NAME	YES	NO	ALIMONY	CHILD SUPPORT	OTHER

9. PREGNANCY: Is anyone in your household pregnant? ☐ Yes ☐ No If yes, who? _____ Due Date _____

10. SERVICES

A. I would like information about counseling, educational, or medical services related to health, birth control, and family planning. ☐ Yes ☐ No

B. I understand that by applying for Temporary Assistance, my name and the names of my eligible children may be provided to other federally assisted programs, such as Head Start, for additional services. ☐ Yes ☐ No

C. If you are pregnant and would like a health risk appraisal and case management services, contact your local health department or call TEL-LINK (1-800-835-5465).

D. If you are pregnant or a nursing mother, or have infants or children under the age of five (5), you may be eligible for the WIC (Women, Infant & Children) program. It can provide you with free infant formula, eggs, milk, cheese, and help you to plan healthy meals for you and your family. If you are interested in this program, talk to your Eligibility Specialist.

S. CHILD SUPPORT EXPENSE Does any household member pay court ordered child support to a **NON-HOUSEHOLD** member? (Includes current payments, arrearages, health insurance) ☐ Yes ☐ No If yes, who? _____

Complete the following below:

DEPENDENT'S NAME, ADDRESS AND PHONE NUMBER	AMOUNT PAID	PERSON OR AGENCY PAID	HOW OFTEN PAID?

T. STUDENTS A. Are any of the household members attending a school for higher education at least half-time (i.e., college, vocational/technical school), listed on page 3? ☐ Yes ☐ No If yes, complete the following.

NAME OF STUDENT(S)	SCHOOL

B. Is/are the student(s) receiving educational grants, scholarships, or loans? ☐ Yes ☐ No Amount $ _____

C. Amount of tuition $ _____ Books $ _____ Fees $ _____ Transportation $ _____

D. Is/are the student(s) employed? ☐ Yes ☐ No If yes, complete section E and/or F.

U. COMMENTS/ADDITIONAL INFORMATION

VOLUNTARY VOTER REGISTRATION SERVICES – The National Voter Registration Act of 1993 has designated public assistance offices as offering voter registration services to applicants and recipients of public assistance. Whether you register is strictly voluntary. Your decision has no effect on your eligibility for assistance.

NON-DISCRIMINATION AND FAIR HEARING RIGHTS – In accordance with Federal law, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political beliefs, or disability.

To file a complaint of discrimination for any Family Support Division (FSD) assistance programs, contact your local FSD office or the Office of Civil Rights, P.O. Box 1527, Jefferson City, MO 65102-1527 or call 1-800-776-8014.

You can request a fair hearing if you are denied benefits and wish to appeal the decision. You can also request a hearing, either orally or in writing, regarding any agency action which affects your participation in any program(s).

PLEASE READ EACH STATEMENT CAREFULLY.
WHEN YOU SIGN PAGE 9, IT MEANS YOU UNDERSTAND THE STATEMENTS ON THIS PAGE

I/WE AUTHORIZE THE FAMILY SUPPORT DIVISION TO INVESTIGATE THESE CIRCUMSTANCES AND STATEMENTS.

- It is against the law to obtain or attempt to obtain public assistance benefits to which I am/we are not entitled or to obtain or attempt to obtain public assistance benefits in an amount greater than those to which I am/we are entitled.
- Criminal or civil prosecution may result if I/we make any false statements or conceal any facts if found guilty of the crime of perjury. I was/we were given an opportunity to ask questions about fraud laws.
- I/We claim public assistance benefits under the laws and regulations of the State of Missouri and the United States. I/we understand that application for and acceptance of medical assistance allows the Department of Social Services, Division of Medical Services to collect payment for medical care from a third party.
- If I am/we are an applicant for or recipient of Temporary Assistance from the Family Support Division, I/we have assigned rights to child support and the rights to receive support payments which are past due, currently due, or which will become due in the future to which I am/we are entitled in my/our own behalf or in behalf of the child or children for whom I am/we are applying for or receiving assistance payments to the State of Missouri. This assignment shall take effect upon a determination of eligibility for Temporary Assistance and shall remain in full force and effect as long as I am/we are a recipient of Temporary Assistance. Upon the termination of my/our receipt of assistance payments, this assignment shall remain in effect as to the unpaid support obligations owing at the time of the discontinuance of assistance payments.
- I/We must provide the Family Support Division with complete information regarding any health or accident insurance benefit available to any member of the assistance household. I/we must report, within 30 days, any accident or accidental injury for which I/we seek professional medical services.
- I/We authorize all providers of MC+ or Medicaid benefits who render services or merchandise to me/us under MC+ or Medicaid to release all records regarding such services or merchandise to the Department of Social Services and its representatives. I/we also understand that by applying for (and being determined eligible for) MC+ healthcare benefits for a child who is deprived of parental support, I/we have assigned all rights to medical support to the State of Missouri. I/we must cooperate in obtaining medical support. Cooperation may involve identifying the absent parent, helping locate the absent parent, helping to establish paternity, and other action as needed to obtain this medical support.
- Any immigrant members of my/our household who are applying for or receiving assistance may have to provide valid documentation of their immigration status to the Family Support Division office. The

documentation may be verified with the Bureau of U.S. Citizenship and Immigration Service (USCIS); therefore, the Family Support Division will provide USCIS with identifying information. The response of USCIS may affect my/our eligibility and benefit level.

- The State of Missouri may file a claim against my/our estate to recover any assistance received.
- I/We understand that I/we must report changes described on Form IM-3 "Changes You Must Report". I/we understand I/we will owe the amount of assistance/benefits I/we receive as a result of not reporting changes.
- I/We must cooperate with the Department of Social Services, Family Support Division staff, and Quality Assurance if my/our case is selected for review.
- I/We understand by applying for Medical Assistance, I/we may be required to apply for Supplemental Security Income (SSI) as a condition of eligibility.

NOTIFICATION AND ACKNOWLEDGEMENT OF FRAUD PROVISIONS

Missouri state law (Sections 205.967 and 570.030 RSMo) provide that it is the crime of stealing if a person obtains, attempts to obtain or aids and abets another in obtaining any public assistance benefits by means of willful false statements or representation, or willful concealment or failure to report any fact or event required to be reported by any law, regulation or rule of this state or the United States, or by impersonation, collusion or other fraudulent device.

Pursuant to Section 205.967, RSMo, public assistance benefits means anything of value, including money, food, food stamp benefits, commodities, clothing, utilities, utility payments, shelter, drugs and medicine, materials, goods and services including institutional care, dental care, medical care, childcare, psychiatric and psychological services, rehabilitation instruction, training, or counseling, or benefits, programs and services provided or administered by the Missouri Department of Social Services or any of its Divisions.

Pursuant to Section 570.030, RSMo the stealing of public assistance benefits is a Class C felony if the value of the benefits is $750.00 or more. Punishment includes imprisonment for up to seven (7) years and a fine not to exceed $5,000.00. If the value of the benefits is less than $750.00, the crime is a Class A misdemeanor.

13 CSR 40-2.355 and 42 USC 608 (a)(8). Any individual convicted by a Federal/State court of misrepresenting residency in order to receive Temporary Assistance simultaneously in two (2) or more states is ineligible for Temporary Assistance for ten (10) years from the date of conviction.

7 USC 2015(k), 42 USC 608 (a)(9) and 13 CSR 40-2.360. Any individual who is a fleeing felon, or a probation/parole violator is ineligible to participate in the Temporary Assistance Program(s).

P.L. 104-194, Section 115. Individuals convicted in a Federal or State court of a felony committed after 8/22/96 related to illegal possession, use, or distribution of a controlled substance are permanently barred from the Temporary Assistance Program.

SIGNATURE: This is to certify that I/we understand the questions on this form and the penalties for giving false statements or withholding information about any individual, for whom I am/we are applying or receiving assistance. Under the penalty of perjury, I/we certify that I/we have given true, accurate and complete statements to the best of my/our knowledge.

SIGNATURE/AFFIDAVIT	DATE
SPOUSE/SECOND PARENT/AFFIDAVIT	DATE

IF SIGNATURE IS MADE BY A MARK (X), IT SHOULD BE WITNESSED BY TWO PERSONS

WITNESS NAME	DATE
WITNESS NAME	DATE

If someone else has helped you enter information on this form, have him/her read and complete the following: **I certify that I completed this eligibility statement at the request of the applicant and that the information on this form is correctly recorded as stated by the applicant.**

SIGNATURE	DATE
ELIGIBILITY SPECIALIST SIGNATURE	DATE