Instructions for DHR-FAD-1132
Required Verifications

Use/Purpose

This form is used to provide the applicant/recipient a list of case specific information/ verification needed to establish initial or continuing eligibility according to Sections 1125B and F.

General Instructions

Check those items that represent case specific information and/or verification needed. List the specific individual(s) for whom that information and/or documentation is needed in the space provided for each item checked. Use items 24 through 28, 'Other', to indicate any additional information and/or documentation that the client is responsible for providing. Be as specific and clear as possible.

Distribution

Original: Client
Copy: Case Record

STATE OF ALABAMA
DEPARTMENT OF HUMAN RESOURCES
FAMILY ASSISTANCE PROGRAM
CASE REVIEW CHECKLIST

COUNTY NAME: ______________________ WORKER: ______________________

CASE SSN: ______________________ FOR THE MONTH OF: ______________

PA FILE NO: ______________________ TYPE OF ACTION: [ ] Application
[ ] Pending [ ] Award [ ] Denial
[ ] Review
[ ] Regular [ ] Interim

CLIENT NAME: ______________________

REVIEW ELEMENTS	Correct	Incorrect		COMMENTS:
		Procedure	Payment	
1. AGE				
2. RELATIONSHIP a. Living in the home				
b. Assistance Unit				
3. RESIDENCE a. State (eligibility condition)				
b. County (administration of benefits)				
4. CITIZENSHIP/ALIENAGE				
5. CHILD SUPPORT a. Referral				
b. Non-cooperation action				
6. JOBS a. Referral				
b. Non-compliance action				
7. APPLICANT JOB SEARCH				
8. FURNISHING A SSN				
9. EARNED INCOME				
10. UNEARNED INCOME				
11. NVRA				
12. IEVS				
13. STANDARD OF PROMPTNESS				
14. FORMS COMPLETION				
15. FACETS COMPLETION				
16. TIME LIMIT a. Count				
b. Hardship				
17. DRUG SCREENING				
18. EBT SPENDING RESTRICTIONS				
19. OTHER (specify)				

REVIEWED BY/DATE: ______________________ RETURN BY/DATE: ______________________

CORRECTED BY/DATE: ______________________ CORRECTIONS REVIEWED BY/DATE: ______________

DHR-FAD 1328
Revised Oct. 2015

Instructions for DHR-FAD-1328
Family Assistance Program
Case Review Checklist

Use/Purpose

This form is used to determine correctness and/or to identify errors in application of program policy in selected FA cases, according to Appendix IV, Procedures for Supervisory Case Reviews. It can be found in iDHR on the Family Assistance Division page under important links and on the shared drive; shared/FA/PA/Forms. The form also provides the supervisor a means to assess each worker's strengths and weaknesses in the eligibility process in terms of both application of policy and procedural requirements.

General Instructions

The supervisor is to complete the identifying information in the heading when reviewing the case record. Most items are self-explanatory. Others may need clarification as follows:

- For the month of – The month for which the review sample was pulled.
- Type of action – Indicate what eligibility (award/review/interim review) or denial action took place in the month that is the starting point for the supervisory review. Check pending for applications if not yet disposed.

Use the comments section to document findings/actions of the record review as needed. Sign and date the form and indicate the date the record is to be returned from the worker with corrections.

Review Elements

If an element has been processed according to the following specific instructions, check the 'Correct' column. Check the 'Incorrect' column under 'Procedure' and/or 'Payment' for an element which was not processed correctly. While this designation is generally straightforward, clarification has been added to assist in this distinction in a few elements. Leave columns blank if an item is not applicable. Items with a * apply to all cases, except interim reviews. For interim reviews, only items 14, 15 and 19 are applicable, unless changes are reported which apply to other items.

*1. Age – Correct means that the case record supports eligibility or (ineligibility) for each child in the assistance unit under age 18 or 19, if in school, including required documentation.

*2. Relationship – (a) Living in the Home – Correct means verification is provided to show that all persons for whom assistance is sought or received physically reside in the home with the grantee. An incorrect finding in this regard constitutes a payment error.

(b) Assistance Unit – Correct means all appropriate persons have been identified for inclusion in the assistance unit and any excluded person (s) has been properly documented as to the basis for exclusion, and the case record supports eligibility or ineligibility regarding the relationship of the children to the grantee including required documentation.

*3. Residence – (a) State (eligibility condition) – Correct means all appropriate persons have been verified as residing in the state. An incorrect finding constitutes a payment error.

(b) County (administration of benefits) – Correct means the payee has correctly applied/received in the county where the assistance unit lives. An incorrect finding constitutes a procedural error.

*4. Citizenship/Alienage – Correct means that citizenship/alienage status has been properly documented to support eligibility/ineligibility for each individual in the assistance unit.

5. Child Support – (a) Referral – Correct means that the worker has correctly determined/entered each child's deprivation code and related absent parent information for each child with an absent parent and has correctly processed related forms (601, etc.).

(b) Non-cooperation action – Correct means all applicable procedural requirements are met, including applying penalties for non-cooperation with child support activities.

6. JOBS – (a) Referral – Correct means that the worker has correctly determined/entered the JOBS referral code of each individual in the assistance unit.

(b) Non-compliance action – Correct means all applicable procedural requirements are met, including applying JOBS penalties for non-compliance with JOBS activities.

7. Applicant Job Search – Correct means all policy and procedural requirements related to applying the search rule, evaluation of exemption/good cause and verification provided as well as case action have been properly completed.

*8. Furnishing a SSN – Correct means that all members of the assistance unit have furnished their SSN or have applied for a SSN and documentary evidence of identity for adult members has been provided.

9. Earned Income – Applicable insofar as the case record suggests that a member of the unit receives earned income. Correct means that all sources of earned income have been properly identified, verified and used in the determination of eligibility/payment and/or correctly disregarded. In contrast, an error will occur when the record indicates earned income, but the worker fails to appropriately determine the impact of that income.

10. Unearned Income – Applicable when the case record indicates any member of the unit has unearned income. Correct means that all sources of unearned income are clearly documented (as needed) and their impact on eligibility and benefit amount has been determined correctly.

11. NVRA – Correct means that all procedural requirements related to NVRA for applications, recertification and change of address have been taken including required notation in the narrative.

*12. IEVS – Correct means that all policy and procedural requirements related to application screening and appropriate follow-up have been completed as required on recipients. This includes making certain that FACETS/IEVS are in sync.

13. Standard of Promptness – Applicable to all application actions including adding persons to the assistance unit. Correct means the worker has taken action timely and completed all procedural requirements, including completion of proper forms.

*14. Forms Completion – Correct means that all forms required in determining initial or continuing eligibility have been properly completed.

*15. FACETS Completion – Correct means that all computer documents and/or screens (FACETS, IEVS, Claims System) and all required fields have been properly completed/updated and that all elements were coded correctly.

16. Time Limit – Applicable when the parent is included. (a) Count – Correct means the time limit count for receipt of FA is correct. An incorrect finding when the count is over 60 constitutes a payment error. An incorrect finding when the count is under 60 constitutes a procedural error.

    (b) Hardship – Correct means that all policy and procedural requirements related to a declaration of 'hardship' for the grantee or spouse of the grantee have been properly documented and that the number of months for which assistance was received under hardship is correct.

17. Drug Screening – Correct means all policy and procedural requirements related to applying the drug screening rule, processing of forms, imposition of penalties and client reimbursement have been properly completed.

18. EBT Spending Restrictions – Correct means all policy and procedural requirements related to investigation of reported violations, application of penalties, collection of moneys, documentation of findings etc., have been properly completed.

19. Other – Used as needed to record any element that does not directly relate to any other review element. Elaborate as necessary in the comment section. For interim reviews, use this item and the comments section to confirm that the case was appropriate for an interim review and, if so, to determine the correctness/incorrectness of related processing as described in Section 1115B: the C540 alert, reported changes and FACETS updates.

Distribution

Original: Eligibility worker for information and/or corrections
Copy 1: Public Assistance Field Supervisor
Copy 2: Suspense copy for reviewing supervisor until original is returned
Copy 3: Case Record

DECLARATION OF RELATIONSHIP

STATE OF ____________________ CASE SSN ________________________

COUNTY OF __________________ WORKER ________________________

I ________________________________ do declare and say that to the best
(Declarant's Name)

of my knowledge and belief ____
(name of alleged relative or "I" if same as declarant)

is (am) the ______________________ of ______________________________
(relationship declared) (relative to whom relationship is declared)

based on the following matters of which I have personal knowledge:

____

____

____

____

____

____

____

____

____

This _______________ day of ________________________, 20___.

SIGNED: ________________________
(Declarant's Name)

WITNESS: ________________________

WITNESS: ________________________

Sworn to and subscribed before me
this ________________ day of
_________________________,
20___.

____
(NOTARY PUBLIC)

My commission expires ________________.

DHR-FAD-1376
April, 2004

Instructions for DHR-FAD-1376
Declaration of Relationship

Use/Purpose

The purpose of this form is two-fold: (1) to substantiate the relationship of an alleged (meaning no blood relationship has been legally established) father or his relatives to an applicant/recipient child, according to Section 2405C; and (2) to substantiate the mother's relationship to the child as well as her relatives. Use in (2) is expected to be rare as it is allowable **only** when there is no other acceptable documentation available and all attempts to obtain other documentation have failed. All other attempts must be documented in the case record.

General Instructions

The eligibility worker has principal responsibility for the preparation and proper execution of this statement. Complete this form based on information provided by the applicant/recipient grantee relative or other person(s) with knowledge of the relationship. The form must contain a brief summary of relevant facts and circumstances known to the declarant regarding the declaration/allegation of relationship. The declarant must sign the form. The form should be notarized if possible. When a notary public is not available, there must be two witnesses. The eligibility worker may serve as one witness. Do not require two witnesses and notarization.

When the relationship to be established does not relate to the applicant/recipient child, enter the names of the adults, as appropriate. Example: Alleged great aunt applies for child. Birth certificates of the child and mother document relationship to the grandmother, but the relationship of the grandmother to the great aunt (sisters) cannot be documented. Enter the grandmother's and great aunt's names in the appropriate spaces on the form to document the sibling relationship between them.

Distribution

Original (white): In case record.
Yellow: Child Support
Pink: Client

__________ COUNTY DEPARTMENT OF HUMAN RESOURCES

____

____

OUT-OF-STATE INQUIRY

NAME ________________
CASE # ________________
SOCIAL SECURITY # ________________
DATE OF BIRTH ________________
WORKER ________________ DATE ________
TELEPHONE # ________________

CURRENT ADDRESS ________________ PREVIOUS ADDRESS ________________

NAMES OF OTHER HOUSEHOLD MEMBERS	DATE OF BIRTH	SOCIAL SECURITY NUMBER
1.		
2.		
3.		
4.		

The above-named person(s) has applied for/receives ________________ assistance from this agency. We are requesting your help in determining his/her eligibility. Please complete the information requested below. Thank you for your cooperation.

A. Did the above-named person(s) receive Federal (TANF) financial assistance from your agency? Yes ☐ No ☐ No Record ☐ Currently receiving ☐ If currently receiving, amount of monthly benefit __________; List months of receipt:

____

B. Type(s) of financial assistance ________________ Date closed ________________

C. Was the above-named person(s) certified for food stamps? Yes ☐ No ☐ No record ☐ Currently receiving ☐ If yes, food stamp case number ________________ Last issuance date ________________

If questions A or C are answered yes, please provide: total monthly income ________________; source of income ________________

D. Is there a current Court Order for Child Support? Yes ☐ No ☐ If yes, please supply the following: the name and address of the Court where support is ordered ________________; the case number of the Order ________________; the amount/frequency of ordered support ________________ List obligated parent and name(s) of child(ren).

Parent's name	Children's names
Parent's name	Children's names

F. Other information: ________________

Reply completed by ________________ Title ________________ Date ________

Instructions for DHR-FAP-1389
Out-of-State Inquiry

Use/Purpose

This form is completed by the eligibility worker to make an inquiry of applicant/recipient status from public welfare agencies in other states.

General Instructions

Mail the original and one copy to the appropriate State agency with a stamped self-addressed envelope.

Distribution

Original: Addressee
Copy 1: Addressee
Copy 2: Case Record until Original is returned

STATE OF ALABAMA
DEPARTMENT OF HUMAN RESOURCES
FAMILY ASSISTANCE PROGRAM
CASE REVIEW SUMMARY

COUNTY NAME: ______________________ WORKER/UNIT: ______________________

NAME OF PERSON WHO COMPILED DATA: ______________________ FOR THE MONTH OF: ______________________

NUMBER OF CASES REVIEWED: ______________________

DATE COMPLETED: ______________________ NUMBER OF CASES REQUIRED: ______________________

DATE REQUIRED: ______________________ NUMBER OF CASES WITH PAYMENT ERROR: __________

REVIEW ELEMENTS	CORRECT	INCORRECT Payment
1. AGE		
2. RELATIONSHIP a. Living in the home		
b. Assistance Unit		
3. RESIDENCE a. State (eligibility condition)		
b. County (administration of benefits)		
4. CITIZENSHIP/ALIENAGE		
5. CHILD SUPPORT a. Referral		
b. Non-cooperation action		
6. JOBS a. Referral		
b. Non-compliance action		
7. APPLICANT JOB SEARCH		
8. FURNISHING A SSN		
9. EARNED INCOME		
10. UNEARNED INCOME		
11. NVRA		
12. IEVS		
13. STANDARD OF PROMPTNESS		
14. FORMS COMPLETION		
15. FACETS COMPLETION		
16. TIME LIMIT a. Count		
b. Hardship		
17. DRUG SCREENING		
18. EBT SPENDING RESTRICTIONS		
19. OTHER (specify)		

COMMENTS:

OPTIONAL:

For Information Only: If the number of cases read is less than the number required, please explain:

____

____

____

____

DHR-FAD 1512
Revised Oct. 2015

Instructions for DHR-FAD-1512
Family Assistance Program
Case Review Summary

Use/Purpose

This form is used to prepare a county tally of all cases in the required review for each reporting month, in accordance with Appendix IV, Procedures for Supervisory Case Reviews. This form can be found in iDHR on the Family Assistance Division page under important links and on the shared drive; shared/FA/PA/Forms. A separate tally for each unit in larger counties may be prepared for county use, but only the county report is to be submitted to the field supervisor. Likewise, the supervisor may want to keep a six-month tally for each worker to be used as part of worker performance evaluation. The worker, unit and county summaries should be used in planning local corrective action.

General Instructions

Complete all heading items with the possible exception of the item 'worker/unit'; this has been provided for optional supervisory use.

- Date required – the 15th of the month following the review.
- For the month of – the month from which the review sample was pulled.
- Number of cases reviewed – the total number of cases reviewed for the review month.
- Number of cases required – the number of reviews that should have been completed for the review month based on the number of 07 workers times five.
- Number of cases with payment error – the number of cases recorded with 'payment error'.
- Tally – Complete each block separately by counting individual 1328s which have corresponding checks. The total of any row may be greater than the number of cases reviewed when errors have been indicated. If more than one payment error is designated from item 18, 'other', specify the cause of the additional error(s) in the comments section.

Distribution

The county report is to be distributed as indicated below to be received by the 15th of the month following the review. It is to be sent or e-mailed to the field supervisor whether or not any cases were reviewed. If no

cases or less than the required number are reviewed, an explanation for why the reviews were not done or were incomplete may be provided in the space at the bottom of the form. NOTE: For exceptions related to the effect on a county director's evaluation, explanation should be provided to the Office of the Deputy Commissioner for Field Administration.

Original – Family Assistance Division
Copy 1 – Public Assistance Field Supervisor
Copy 2 – Maintain in the County Office

______________ COUNTY DEPARTMENT OF HUMAN RESOURCES

____

____

Phone #______________________FAX #__________________

EMPLOYMENT/LOSS OF WORK /INCOME VERIFICATION

RE: Employee______________________
SS No. ______________________
Case Name______________________
Case ID #______________________
Case #(s) FA ____________FS__________
Worker______________Date __________

I. AUTHORIZATION FOR RELEASE OF INFORMATION

The above named person receives or has applied for assistance and earnings information is needed to determine eligibility. Your cooperation in providing the requested information is appreciated.

A. { I, ____________________________ give the Department of Human Resources permission to verify my income.

B. { Authorization for release is conveyed by signature on required department forms which provide explanations of the Federally mandated use of social security numbers.

Please complete each section which has been marked on the front and back of this form.

{ II. GENERAL WAGE INFORMATION

Please complete items checked with income information for ______________________________.
Month/Year

A. { Beginning date of employment ______________________________.
B. { Hours expected to work per week ________________.
C. { Wages per hour ________. If not paid hourly, wages per pay period __________________.
D. { Overtime hours expected per week ________. Wages per hour ______________________.
E. { How often paid? { weekly; { bi-weekly; { twice monthly; { monthly; other ____________.
F. { Date 1st check actually received by employee __________. Date pay period ended __________.
G. { Day of the week pay checks usually received by employee ______________.
H. { Is employee covered by a health insurance program? { Yes { No If yes, name of insurance company ____.

{ III. RECORD OF PAY

{ Provide information as indicated which was or will be paid in the month(s) of ________________ in the space below. If additional space is needed use Section V on the back of this form.

{ Information for additional months. Please use Section V on the back of this form.

* Gross pay refers to the total wages earned before any deductions and includes the employee share of Social Security paid by the employer for the employee.

** Report tips/commissions separately if not included in gross pay.

Pay Period From - To	Date Pay Received	Gross Pay*	Hours Worked	Earned Income Credit	Tips/ Commissions**

{ IV. **LOSS OF INCOME**

A. { Date employment ended ______________________________.

B. { Reason for termination ____.

C. { Is the loss of income { Permanent or { Temporary? If temporary, when do you expect the employee to return to work? ______________________________________.

D. { Date employee received final check ___________________. Gross amount $ __________.

E. { Will employee receive any vacation pay, retirement refund or other? { Yes { No
If yes, what type? ________________ Date received ____________ Amount _________.

F. { Is employee eligible for any type of benefits from your company, such as extended insurance coverage, workers' compensation or other? { Yes { No If yes,

1. Please explain: ____
____

2. Name of insurance company ____.

{ V. **ADDITIONAL RECORD OF PAY RECEIVED**

Please complete with income information beginning with _______________ and continuing to _______________.

Pay Period From - To	Date Pay Received	Gross Pay*	Hours Worked	Earned Income Credit	Tips/ Commissions**

{ VI. **EMPLOYER INFORMATION**

____
Signature of Employer/Designee

____
Employer's Title/Designee's Title

____
Name of Business

____
Telephone Number

____
Address

____
FAX Number

____

____
Date Completed

Instructions for DHR-FAD-1532
Verification of Wages

Use/Purpose

This form is to be used to verify employment information when the client cannot provide or asks for assistance in providing the information needed. NOTE: Use of this form by the worker when the client has not been asked to provide the verification means that the worker has assumed responsibility for obtaining verification of employment/wages. Failure of the employer to return the form requires contact with the client to request that the client provide the information.

General Instructions

The form is to be completed in duplicate with the copy maintained in the file until the original is returned from the employer. The worker must complete the address of the employer, client data, program(s) applicable and the worker's name and date and mail the form directly to the employer with a self-addressed, stamped envelope. A faxed return copy is acceptable if Section VI is complete with legible signatures.

Section I. Authorization for Release of Information:

A. Check "A" only if the client has signed the form giving permission for release of the information requested.

B. Check "B" only if the information is being requested as a result of an IEVS match. If the form is being sent solely as a result of an IEVS prompting report for unearned income (IRS) or earnings (Bendex BEER), no information from the screen such as employer name/address, amounts, years/months involved, etc., may be written on the form. Department information to complete the RE: section may be filled in and other pertinent parts of the form checked. **Do not address the form itself to the employer.** (Envelope only.)

Sections II – VI are self explanatory

Distribution

Original: Employer
Copy: Case Record until Original is returned

REPAYMENT AGREEMENT

COUNTY OF
STATE OF ALABAMA
DEPARTMENT OF HUMAN RESOURCES

PROGRAM
CASE NO.
SSN:

☐ **INITIAL** ☐ **SUBSEQUENT AGREEMENT**

I, _____ understand and acknowledge that I have received payments or benefits to which I was not entitled, valued at and in the total amount of $ _____.

Type claim	Seq.	$	from / /	to / /
Type claim	Seq.	$	from / /	to / /
Type claim	Seq.	$	from / /	to / /

I also understand that so long as I comply with all the terms of this repayment agreement, the State of Alabama Department of Human Resources agrees not to initiate a civil action against me in any court to collect the above-stated debt; except that THE STATE OF ALABAMA DEPARTMENT OF HUMAN RESOURCES SHALL RETAIN THE RIGHT TO COLLECT THROUGH THE STATE TAX OFFSET AND/OR THE FEDERAL TREASURY OFFSET PROGRAMS to reduce the above-stated debt.

In consideration of the forbearance of the State of Alabama from initiating civil action against me, I agree and stipulate that I owe the State of Alabama a total balance amount of $ _____.
I promise to pay that amount by cash, check, or money order to the Department of Human Resources, _____ County Office as follows:

(CHECK ONE BOX BELOW)

☐ In equal installments of $ _____ and a final installment of $ _____. Such payments to begin on _____, 20_____, are to be made by the 15th day of each month thereafter until the full amount is paid.

☐ In a lump sum of _____ on _____, 20_____.

Note: This repayment agreement is for non-participants. If you are currently receiving benefits, recoupment (reduction of benefits) is the primary repayment method.

I agree that if I fail to pay any of the installments under the terms of this agreement, I shall be considered to be in default of this agreement and all of the installments comprising the balance of the entire amount due the State of Alabama shall become immediately due and payable without notice or demand.

I agree that this repayment agreement supersedes and replaces any repayment agreement heretofore signed by me for the above claim(s) or issuance period(s).

Done this the _____ day of _____, 20_____

DHR Approval: _____
Title: _____
Date: _____

_____
Signature

Form DHR-OFAO-1562 Revised June, 2014

Instructions for DHR-OFA-1562
Repayment Agreement

Use/Purpose

This form is used to arrange for recovery of overpayments from former clients where recoupment from current assistance is not an option in accordance with Sections 22200A, 22500, 22620.

General Instructions

Fill in the claim information and review the form with the client, explaining repayment options. Have the client sign the form and the worker sign as a witness. Enter information on the Comprehensive Claims System. Use a separate form for each program area. Multiple sequences within the same program area may be put on one form. 'Type Claim' refers to administrative error, non-fraud client error, suspected fraud, or fraud.

Distribution

White copy – Case Record
Yellow copy – Client

STATE OF ALABAMA
DEPARTMENT OF HUMAN RESOURCES
BACKUP APPLICATION INFORMATION

CASE SSN ______________________________ ( ) Application

CASE NAME ______________________________ ( ) Recertification

INTERVIEWER ______________________________ DATE OF INTERVIEW ________

REGISTER CASE MEMBERS WITH IEVS (ZC09)

FURNISH THE FOLLOWING INFORMATION FOR ALL INDIVIDUALS WHO LIVE TOGETHER.

ACTION	LAST NAME	FIRST NAME	MIDDLE	SSN	RACE	SEX	DATE OF BIRTH

ARE THERE ANY OTHER PERSONS THAT LIVE IN THE HOME? Y N

PROGRAM PARTICIPATION (ZC14)

MEMBER'S SSN	MEMBER'S NAME	UNIT SSN	FIN ASST CAT STAT	MEDICAID CAT STAT

CASE GENERAL INFORMATION (ZC10)

WHO IS THE PERSON INTERVIEWED/________________________ HH MEMBER? Y N

IDENTIFICATION VERIFY SOURCE? DATE:
WHAT IS HOUSEHOLD HOUSING TYPE?
WHAT IS HOUSEHOLD LIVING ARRANGEMENT?

HAS ANYONE IN YOUR HOUSEHOLD RECEIVED ANY PUBLIC ASSISTANCE THIS MONTH?
SNAP/FOOD ASSISTANCE Y N FA Y N SSI Y N SUP Y N

RESIDENTIAL ADDRESS (ZC64) (ZC21) REGISTER CASE DATA (ZC08)

IS RESIDENTIAL ADDRESS THE SAME AS MAILING ADDRESS Y N

RESIDENTIAL ADDRESS	MAILING ADDRESS
STREET 1________________	STREET 1________________
STREET 2________________	STREET 2________________
CITY ________________	CITY ________________
STATE __________ ZIP________	STATE __________ ZIP________

EBT ACCOUNT NUMBER SEARCH/ASSIGNMENT (ZC88)

CASE SSN:

OR

LAST NAME: FIRST NAME: MI:
DOB: ELIGIBILITY CATEGORY:

HEAD OF HOUSEHOLD

MEMBER'S SSN ________________________ NAME: ________________________

MEMBER -IDENTIFICATION (ZC16)

IF MEMBER HAS NO SSN
HAS APPLICATION FOR A SSN BEEN MADE? Y N STATUS:
WHAT WAS DATE AS CONFIRMED BY SSA?
VERIFY SOURCE: DATE:

WHAT IS SOURCE OF MEMBER'S IDENTITY? DATE:
DOES MEMBER HAVE A VALID DRIVER'S LICENSE? Y N
WHAT IS STATEMENT OF CITIZENSHIP STATUS?
VERIFY SOURCE: DATE:

IF ALIEN: WHAT IS ALIEN REGISTRATION NUMBER?
WHAT IS MEMBER'S NATIONALITY?
WHAT WAS DATE OF BIRTH?
VERIFY SOURCE: DATE:

MEMBER RELATIONSHIP (ZC17)

CASE MEMBER'S NAME ______________________________

UNIT MEMBER'S NAME ______________________________

MEMBER'S NAME ______________________________

WHAT IS RELATIONSHIP OF (CASE MEMBER) TO (MEMBER)?
WHAT IS RELATIONSHIP OF (UNIT MEMBER) TO (MEMBER)?
DOES MEMBER RECEIVE DEPENDENT CARE? Y N
IF YES, FOR WHAT REASON?
WHO IS PAYING FOR THIS CARE?
WHAT IS MONTHLY AMOUNT PAID FOR THIS CARE?
VERIFY SOURCE: DATE:

MEMBER WATS PARTICIPATION (ZC18)

MEMBER AGE: EXEMPT DUE TO AGE: Y N
IS MEMBER CURRENTLY ATTENDING SCHOOL? Y N
IF NO, WHAT IS THE HIGHEST GADE COMPLETED:
IF YES, WHAT IS CURRENT GRADE LEVEL:
NAME OF SCHOOL :
ATTENDANCE VERIFY SOURCE STATUS:
DATE:
FA REFERRAL STATUS REFERRAL STATUS DATE:

MEMBER EDUCATION INCOME (ZC35)

IF POST-HIGH SCHOOL OR TRADE SCHOOL, DO YOU RECEIVE ANY EDUCATIONAL RELATED INCOME? Y N

TYPE OF INCOME	PERIOD COVERED FROM	TO	AMOUNT OF GRANT	VERIFICATION SOURCE	DATE
WORK STUDY					
PELL SEOG					
NDSL					
GUARANTEED LOAN					
OTHER LOANS/GRANTS					
MONTHLY VA EDUCATIONAL ASSISTANCE					

MEMBER-MARITAL STATUS DEPRIVATION (ZC20)

WHAT IS MEMBER'S MARITAL STATUS?
IF NOT SINGLE, DATE OF STATUS:
VERIFY SOURCE: DATE:
IF WIDOWED, NAME OF DECEASED SPOUSE:
SSN OF DECEASED SPOUSE:
IF MEMBER IS A MINOR CHILD UNDER 18, ENTER THE APPROPRIATE DEPRIVATION CODE FOR EACH PARENT:
MOTHER:
FATHER:

MEMBER-TIME LIMITS/HARDSHIP (ZC94)

CASE HEAD'S SSN: NAME:

UNIT HEAD'S SSN: NAME:

MEMBER'S SSN: NAME:

DOES MEMBER QUALIFY FO HARDSHIP EXEMPTION? Y N
IF YES, FOR WHAT REASON?
VERIF SURCE: DATE:

IS MEMBER AN ADULT OR CHILD FOR TRACKING PURPOSES? A C

MEMBER DISQUALIFICATION INFO (ZC21)

IS MEMBER
DISQUALIFIED DUE TO FRAUD? Y N
IF YES, START DATE: END DATE:
SANCTIONED DUE TO NONCOMPLIANCE WITH WATS? Y N
IF YES, START DATE: END DATE
SANCTIONED DUE TO NONCOMPLIANCE WITH CHILD SUPPORT? Y N
IF YES, START DATE: END DATE

POTENTIAL DISQUALIFICATION FACTORS (ZC22)

IS MEMBER ON STRIKE: Y N
IF YES, DATE: VERIF SOURCE: DATE:

IS MEMBER A FLEEING FELON IN VIOLATION OF PROBATION OR PAROLE? Y N

HAS MEMBER BEEN CONVICTED OF A FELONY FOR POSSESSION, USE, OR DISTRIBUTION OF A CONTROLLED SUBSTANCE? Y N
IF YES, WHEN?

FOR CASE HEAD ONLY

EBT SANCTION INFORMATION (ZC92)

IS MEMBER SANCTIONED DUE TO MISUSE OF EBT CARD? Y N

MEMBER CURRENT EMPLOYMENT (ZC67) (ZC24)

DELETE: Y N REASON: DATE:
DATE JOB STARTED:
WEEKLY SCHEDULED HOURS?
FREQUENCY OF PAY DAY?
MONTHLY WAGE?
IS INCOME EXCLUDED? Y N
INCOME VERIFY SOURCE:

HOURLY WAGE:
EMPLOYMENT STATUS:
WHAT DAY OF WEEK PAID?
JOB CATEGORY?
VERIFICATION SOURCE: DATE:
DATE:

EMPLOYER NAME: ____________________

STREET 1: ____________________

STREET 2: ____________________

CITY: ____________________ STATE: ____________________

ZIP: ____________________ TELEPHONE NUMBER: ____________________

DOES EMPLOYER PAY FOR MEDICAL COVERAGE FO YOU? Y N FOR DEPENDENTS? Y N
IF NOT COVERED BY HEALTH PLAN, WHY NOT?
DOES THE ABOVE NAMED INDIVIDUAL HAVE AN ADDITIONAL EMPLOYER? Y N

MEMBER EMPLOYMENT HISTORY (ZC74) (ZC25)

ARE THERE PAST EMPLOYERS THAT ARE NOT LISTED SINCE LAST ENTRY? Y N

EMPLOYER NAME: ____________________

CITY: ____________________ STATE: ____ ZIP: ________

JOB CATEGORY: HOURLY WAGE:
WEEKLY SCHEDULED HOURS: DATE BEGAN:
DATE JOB ENDED/LEFT: REASON FOR LEAVING:
JOB DUTIES:
OTHER RELATED WORK EXPERIENCE:

EMPLOYER NAME: ____________________

CITY: ____________________ STATE: ____ ZIP: ________

JOB CATEGORY: HOURLY WAGE:
WEEKLY SCHEDULED HOURS: DATE BEGAN:
DATE JOB ENDED/LEFT: REASON FOR LEAVING:
JOB DUTIES:
OTHER RELATED WORK EXPERIENCE:

SUP-MEMBER INFORMATION (ZC26)

TYPE OF CARE:
WHAT IS THE LEVEL OF CARE REQUIRED? A B
ARE YOU PAYING SOMEONE FOR THIS CARE: Y N
IF YES:
WHO IS PROVIDING THIS CARE? RELATIONSHIP:
VERIFY SOURCE: DATE: IN HOME: Y N
MINIMUM INCOME LEVEL:
FEDERAL BENEFIT RATE:

DO YOU WANT THE CHECK TO BE MADE OUT TO SOMEONE OTHER THAN THE PERSON NAMED ABOVE? Y N

MEMBER EARNED INCOME/DEEMED INCOME (ZC68) (ZC28)

DOES MEMBER CURRENTLY HAVE SELF-EMPLOYED OR DEEMED INCOME Y N

TYPE OF INCOME	MONTHLY GROSS AMOUNT	VERIFICATION SOURCE DATE	EXCLUDED FOR FA?
TOTAL WAGES			
ROOMER/BOARDER			
SELF-EMPLOYED (NON-FARM)			
SELF-EMPLOYED (FARM)			
SENIOR PARENT DEEMED INCOME			

	DATE REPORTED	DATE STARTED	HOURLY WAGE	WEEKLY SCH/HRS	JOB CAT	DEL	REA	DATE
SELF-EMP (NON-FARM)								
SELF-EMP (FARM)								

SEND ALERT (Y, N)?

(SUP) MEMBER – EARNED/DEEMED INCOME (ZC29)

DOES SUP MEMBER HAVE SELF-EMPLOYED OR DEEMED INCOME? Y N

TYPE OF INCOME	MONTHLY AMOUNT	MONTHLY EXPENSES	VERIFICATION SOURCE DATE
TOTAL WAGES (GROSS INCOME)			
SELF-EMPLOYED (NON-FARM)			
SELF-EMPLOYED (FARM)			
INKIND EARNED INCOME			
DEEMED INCOME			
EXPENSES OF EMPLOYMENT FOR THE BLIND			

MEMBER – UNEARNED INCOME (ZC70) (ZC30)

DOES MEMBER HAVE ANY UNEARNED INCOME, I.E. INTEREST, PENSIONS, ETC.: Y N

TYPE OF INCOME	CLAIM NUMBER	MONTHLY GROSS AMOUNT	VERIFICATION SOURCE DATE
SOCIAL SECURITY (RSDI)			
SUPPLEMENTAL SECURITY (SSI)			
VETERANS PENSIONS			
VETERANS COMPENSATION			
OTHER PENSIONS			
UNEMPLOYMENT COMPENSATION			
WORKMAN'S COMPENSATION			
DISREGARDED RSDI			
CHILD SUPPORT – CSU MAILED (FA)			
CS ARREARS/EXCESS – CSU MAILED (FA)			
CONTRIBUTIONS/INDIVIDUAL			
CONTRIBUTIONS/CHARITY ORG.			
DIVIDENDS/INTEREST			
ALIMONY			
CHILD SUPPORT – WRKR ENTERED (FA)			
OTHER/CS ARREARS/EXCESS/PROP INC			

END HEAD OF HOUSEHOLD

MEMBER TWO

MEMBER'S SSN: ______________________ NAME: ______________________

MEMBER IDENTIFICATION (ZC16)

IF MEMBER HAS NO SSN
HAS APPLICATION FOR A SSN BEEN MADE? Y N STATUS:
WHAT WAS DATE AS CONFIRMED BY SSA?
VERIFY SOURCE: DATE:

WHAT IS SOURCE OF MEMBER'S IDENTITY? DATE:
DOES MEMBER HAVE A VALID DRIVER'S LICENSE? Y N
WHAT IS STATEMENT OF CITIZENSHIP STATUS?
VERIFY SOURCE: DATE:

IF ALIEN: WHAT IS ALIEN REGISTRATION NUMBER?
WHAT IS MEMBER'S NATIONALITY?
WHAT WAS DATE OF BIRTH?
VERIFY SOURCE: DATE:

MEMBER RELATIONSHIP (ZC17)

CASE MEMBER'S NAME ______________________________

UNIT MEMBER'S NAME ______________________________

MEMBER'S NAME ______________________________

WHAT IS RELATIONSHIP OF (CASE MEMBER) TO (MEMBER)?
WHAT IS RELATIONSHIP OF (UNIT MEMBER) TO (MEMBER)?
DOES MEMBER RECEIVE DEPENDENT CARE? Y N
IF YES, FOR WHAT REASON?
WHO IS PAYING FOR THIS CARE?
WHAT IS MONTHLY AMOUNT PAID FOR THIS CARE?
VERIFY SOURCE: DATE:

MEMBER WATS PARTICIPATION (ZC18)

MEMBER AGE: EXEMPT DUE TO AGE: Y N
IS MEMBER CURRENTLY ATTENDING SCHOOL? Y N
IF NO, WHAT IS THE HIGHEST GADE COMPLETED:
IF YES, WHAT IS CURRENT GRADE LEVEL:
NAME OF SCHOOL :
ATTENDANCE VERIFY SOURCE STATUS:
DATE:
FA REFERRAL STATUS REFERRAL STATUS DATE:

MEMBER EDUCATION INCOME (ZC35)

IF POST-HIGH SCHOOL OR TRADE SCHOOL, DO YOU RECEIVE ANY EDUCATIONAL RELATED INCOME? Y N

TYPE OF INCOME	PERIOD COVERED FROM	TO	AMOUNT OF GRANT	VERIFICATION SOURCE	DATE
WORK STUDY					
PELL SEOG					
NDSL					
GUARANTEED LOAN					
OTHER LOANS/GRANTS					
MONTHLY VA EDUCATIONAL ASSISTANCE					

MEMBER-MARITAL STATUS DEPRIVATION (ZC20)

WHAT IS MEMBER'S MARITAL STATUS?
IF NOT SINGLE, DATE OF STATUS:
VERIFY SOURCE: DATE:
IF WIDOWED, NAME OF DECEASED SPOUSE:
SSN OF DECEASED SPOUSE:
IF MEMBER IS A MINOR CHILD UNDER 18, ENTER THE APPROPRIATE DEPRIVATION CODE FOR EACH PARENT:
MOTHER:
FATHER:

MEMBER-TIME LIMITS/HARDSHIP (ZC94)

CASE HEAD'S SSN: NAME:

UNIT HEAD'S SSN: NAME:

MEMBER'S SSN: NAME:

DOES MEMBER QUALIFY FO HARDSHIP EXEMPTION? Y N
IF YES, FOR WHAT REASON?
VERIF SURCE: DATE:

IS MEMBER AN ADULT OR CHILD FOR TRACKING PURPOSES? A C

MEMBER DISQUALIFICATION INFO (ZC21)

IS MEMBER
DISQUALIFIED DUE TO FRAUD? Y N
IF YES, START DATE: END DATE:
SANCTIONED DUE TO NONCOMPLIANCE WITH WATS? Y N
IF YES, START DATE: END DATE
SANCTIONED DUE TO NONCOMPLIANCE WITH CHILD SUPPORT? Y N
IF YES, START DATE: END DATE

POTENTIAL DISQUALIFICATION FACTORS (ZC22)

IS MEMBER ON STRIKE: Y N
IF YES, DATE: VERIF SOURCE: DATE:

IS MEMBER A FLEEING FELON IN VIOLATION OF PROBATION OR PAROLE? Y N

HAS MEMBER BEEN CONVICTED OF A FELONY FOR POSSESSION, USE, OR DISTRIBUTION OF A CONTROLLED SUBSTANCE? Y N
IF YES, WHEN?

MEMBER CURRENT EMPLOYMENT (ZC67) (ZC24)

DELETE: Y N REASON: DATE:
DATE JOB STARTED: HOURLY WAGE:
WEEKLY SCHEDULED HOURS? EMPLOYMENT STATUS:
FREQUENCY OF PAY DAY? WHAT DAY OF WEEK PAID?
MONTHLY WAGE? JOB CATEGORY?
IS INCOME EXCLUDED? Y N VERIFICATION SOURCE: DATE:
INCOME VERIFY SOURCE: DATE:

EMPLOYER NAME: ____________________

STREET 1: ____________________

STREET 2: ____________________

CITY: ____________________ STATE: ____________________

ZIP: ____________________ TELEPHONE NUMBER: ____________________

DOES EMPLOYER PAY FOR MEDICAL COVERAGE FO YOU? Y N FOR DEPENDENTS? Y N
IF NOT COVERED BY HEALTH PLAN, WHY NOT?
DOES THE ABOVE NAMED INDIVIDUAL HAVE AN ADDITIONAL EMPLOYER? Y N

MEMBER EMPLOYMENT HISTORY (ZC74) (ZC25)

ARE THERE PAST EMPLOYERS THAT ARE NOT LISTED SINCE LAST ENTRY? Y N

EMPLOYER NAME: ____________________

CITY: ____________________ STATE: _____ ZIP: __________

JOB CATEGORY:
WEEKLY SCHEDULED HOURS:
DATE JOB ENDED/LEFT:
JOB DUTIES:
OTHER RELATED WORK EXPERIENCE:

HOURLY WAGE:
DATE BEGAN:
REASON FOR LEAVING:

EMPLOYER NAME: ____________________

CITY: ____________________ STATE: _____ ZIP: __________

JOB CATEGORY:
WEEKLY SCHEDULED HOURS:
DATE JOB ENDED/LEFT:
JOB DUTIES:
OTHER RELATED WORK EXPERIENCE:

HOURLY WAGE:
DATE BEGAN:
REASON FOR LEAVING:

SUP-MEMBER INFORMATION (ZC26)

TYPE OF CARE:
WHAT IS THE LEVEL OF CARE REQUIRED? A B
ARE YOU PAYING SOMEONE FOR THIS CARE: Y N
IF YES:
WHO IS PROVIDING THIS CARE? RELATIONSHIP:
VERIFY SOURCE: DATE: IN HOME: Y N
MINIMUM INCOME LEVEL:
FEDERAL BENEFIT RATE:

DO YOU WANT THE CHECK TO BE MADE OUT TO SOMEONE OTHER THAN THE PERSON NAMED ABOVE? Y N

MEMBER EARNED INCOME/DEEMED INCOME (ZC68) (ZC28)

DOES MEMBER CURRENTLY HAVE SELF-EMPLOYED OR DEEMED INCOME Y N

TYPE OF INCOME	MONTHLY GROSS AMOUNT	VERIFICATION SOURCE DATE	EXCLUDED FOR FA?
TOTAL WAGES			
ROOMER/BOARDER			
SELF-EMPLOYED (NON-FARM)			
SELF-EMPLOYED (FARM)			
SENIOR PARENT DEEMED INCOME			

	DATE REPORTED	DATE STARTED	HOURLY WAGE	WEEKLY SCH/HRS	JOB CAT	DEL	REA	DATE
SELF-EMP (NON-FARM)								
SELF-EMP (FARM)								

SEND ALERT (Y, N)?

(SUP) MEMBER-EARNED DEEMED INCOME (ZC29)

DOES SUP MEMBER HAVE SELF-EMPLOYED OR DEEMED INCOME? Y N

TYPE OF INCOME	MONTHLY AMOUNT	MONTHLY EXPENSES	VERIFICATION SOURCE DATE
TOTAL WAGES (GROSS INCOME)			
SELF-EMPLOYED (NON-FARM)			
SELF-EMPLOYED (FARM)			
INKIND INCOME			
DEEMED INCOME			
EXPENSES OF EMPLOYMENT FOR THE BLIND			

MEMBER-UNEARNED ONCOME (ZC70) (ZC30)

DOES MEMBER HAVE ANY UNEARNED INCOME, i.e.: INTEREST, PENSIONS, ETC: Y N

TYPE OF INCOME	CLAIM NUMBER	MONTHLY GROSS AMOUNT	VERIFICATION SOURCE DATE
SOCIAL SECURITY (RSDI)			
SUPPLEMENTAL SECURITY (SSI)			
VETERANS PENSIONS			
VETERANS COMPENSATION			
OTHER PENSIONS			
UNEMPLOYMENT COMPENSATION			
WORKMAN'S COMPENSATION			
DISREGARED RSDI			
CHILD SUPPORT – CSU MAILED (FA)			
CS ARREARS/EXCESS-CSU MAILED (FA)			
CONTRIBUTIONS/INDIVIDUAL			
CONTRIBUTIONS/CHARITY ORG.			
DIVIDENDS/INTEREST			
ALIMONY			
CHILD SUPPORT-WRK ENTERED (FA)			
OTHER/CS ARREARS/EXCESS/PROP INC.			

END MEMBER TWO

MEMBER THREE

MEMBER'S SSN:____________________ NAME:____________________

MEMBER IDENTIFICATION (ZC16)

IF MEMBER HAS NO SSN
- HAS APPLICATION FOR A SSN BEEN MADE? Y N STATUS:
- WHAT WAS DATE AS CONFIRMED BY SSA?
- VERIFY SOURCE: DATE:

WHAT IS SOURCE OF MEMBER'S IDENTITY?
DOES MEMBER HAVE A VALID DRIVER'S LICENSE? Y N
WHAT IS STATEMENT OF CITIZENSHIO STATUS?
- VERIFY SOURCE: DATE:

IF ALIEN: WHAT IS ALIEN REGISTRATION NUMBER?
- WHAT IS MEMBER'S NATIONALITY
- WHAT WAS DATE OF ENTRY?
- VERIFY SOURCE: DATE:

MEMBER RELATIONSHIP (ZC17)

CASE MEMBER'S NAME: ______________________________

UNIT MEMBER'S NAME: ______________________________

MEMBER'S NAME: ______________________________

WHAT IS RELATIONSHIP OF (CASE MEMBER TO (MEMBER)?
WHAT IS RELATIONSHIP OF (UNIT MEMBER) TO MEMBER?
DOES MEMBER RECEIVE DEPENDENT CARE? Y N
IF YES; FOR WHAT REASON?
WHO IS PAYING FOR THIS CARE?
WHAT IS MONTHLY AMOUNT PAID FOR THIS CARE?
VERIFY SOURCE: DATE:

MEMBER WATS PARTICIPATION (ZC18)

MEMBER AGE: EXEMPT DUE TO AGE: Y N
IS MEMBER CURRNETLY ATTENDING SCHOOL? Y N
IF NO, WHAT IS THE HIGHEST GRADE COMPLETED:
IF YES, WHAT IS CURRENT GRADE LEVEL:
NAME OF SCHOOL: STATUS:
ATTENDANCE VERIFY SOURCE DATE:

FA REFERRAL STATUS REFERRAL STATUS DATE:

MEMBER EDUCATION INCOME (ZC35)

IF POST HIGH SCHOOL OR TRADE SCHOOL; DO YOU RECEIVE ANY EDUCATIONAL RELATED INCOME? Y N

TYPE OF INCOME	PERIOD COVERED FROM	TO	AMOUNT OF GRANT	VERIFICATION SOURCE	DATE
WOKK STUDY					
PELL SEOG					
NDSL					
GUARANTEED LOAN					
OTHER LOANS/GRANTS					
MONTHLY VA EDUCATIONAL ASSISTANCE					

MEMBER-MARITAL STATUS/DEPRIVATION (ZC20)

WHAT IS MEMBER'S MARITAL STATUS"
IS NOT SINGLE, DATE OF STATUS:
VERIFY SOURCE: DATE:
IF WIDOWED, NAME OF DECEASED SPOUSE:
SSN OF DECEASED SPOUSE:
IF MEMBER IS A MINOR CHILD (UNDER 18), ENTER THE APPROPRIATE DEPRIVATION
CODE FOR EACH PARENT:
MOTHER:
FATHER:

MEMBER-TIME LIMITS/HARDSHIP (ZC94)

CASE HEAD'S SSN: NAME:
UNIT HEAD'S SSN: NAME:
MEMBER'S SSN NAME:

DOES MEMBER QUALIFY FOR HARDSHIP EXEMPTION? Y N
IF YES, FOR WHAT REASON"
VERIFY SOURCE DATE:

IS MEMBER AN ADULT OF CHILD FOR TRACKING PURPOSES? A C

MEMBER DISQUALIFICATION INFO (ZC21)

IS MEMBER
DISQUALIFIED DUE TO FRAUD? Y N
IF YES, START DATE: END DATE:
SANCTIONED DUE TO NONCOMPLIANCE WITH WATS? Y N
IF YES, START DATE: END DATE:
SANCTIONED DUE TO NONCOMPLIANCE WITH CHILD SUPPORT?
IF YES, START DATE: END DATE:

POTENTIAL DISQUALIFICATION FACTORS (ZC22)

IS MEMBER ON STRIKE: Y N
IF YES, DATE: VERIFY SOURCE: DATE:

IS MEMBER A FLEEING FELON IN VIOLATION OF PROBATION OR PAROLE Y N

HAS MEMBER BEEN CONVICTED OF A FELONY FOR POSSESSION, USE, OR DISTRIBUTION OF A CONTROLLED SUBSTANCE? Y N
IF YES, WHEN?

HAS MEMBER BEEN CONVICTED WITHIN THE PAST 10 YEARS FOR MISREPRESENTATION OF RESIDENCE OR IDENTITY TO SIMULTANEOUSLY RECEIVE MULTIPLE BENEFITS? Y N
IF YES, WHEN?

MEMBER CURRENT EMPLOYMENT (ZC67) (ZC24)

DELETE: Y N REASON: DATE:
DATE JOB STARTED: HOURLY WAGE:
WEEKLY SCHEDULED HOURS? EMPLOYMENT STATUS:
FREQUENCY OF PAY DAY? WHAT DAY OF WEEK PAID?
MONTHLY WAGE? JOB CATEGORY?
IS INCOME EXCLUDED? Y N VERIFICATION SOURCE: DATE:
INCOME VERIFY SOURCE: DATE:

EMPLOYER NAME: ______________________________

STREET 1: ______________________________

STREET 2: ______________________________

CITY: ______________________ STATE: __________

ZIP: ________________ TELEPHONE: ________________

DOES EMPLOYER PAY FOR MEDICAL COVERAGE FOR YOU? Y N
FOR DEPENDENTS Y N
IF NOT COVERED BY HEALTH PLAN; WHY NOT?
DOES THE ABOVE NAMED INDIVIDUAL HAVE AN ADDITIONAL EMPLOYER? Y N

MEMBER EMPLOYMENT HISTORY (ZC74) (ZC25)

ARE THERE PAST EMPLOYERS THAT ARE NOT LISTED SINCE LAST ENTRY? Y N

EMPLOYER NAME: ______________________________

CITY: ______________________________ STATE: ________ ZIP: __________
JOB CATEGORY: HOURLY WAGE:
WEEKLY SCHEDULED HOURS: DATE BEGAN:
DATE JOB ENDED/LEFT: REASON FOR LEAVING:
JOB DUTIES:
OTHER RELATED WORK EXPERIENCE:
EMPLOYER NAME: ______________________________

CITY: ______________________________ STATE: ________ZIP: __________
JOB CATEGORY: HOURLY WAGE:
WEEKLY SCHEDULED HOURS: DATE BEGAN:
DATE JOB ENDED/LEFT: REASON FOR LEAVING:
JOB DUTIES:
OTHER RELATED WORK EXPERIENCE:

MEMBER EARNED INCOME/DEEMED INCOME (ZC68) (ZC28)

DOES MEMBER CURRENTLY HAVE SELF-EMPLOYED OR DEEMED INCOME? Y N

TYPE OF INCOME	MONTHLY GROSS AMOUNT	VERIFICATION SOURCE	DATE	EXCLUDED FOR FA?
TOTAL WAGES				
ROOMER/BOARDER				
SELF-EMPLOYED (NON-FARM)				
SELF-EMPLOYED (FARM)				
SENIOR DEEMED INCOME				

	DATE REPORTED	DATE STARTED	HOURLY WAGE	WEEKLY SCH/HRS	JOB CAT	DEL	REA	DATE
SELF-EMP (NON-FARM)								
SELF-EMP (FARM)								

SEND ALERT (Y,N)?

MEMBER-UNEARNED INCOME (ZC70) (ZC30)

DOES MEMBER HAVE ANY UNEARNED INCOME, i.e., INTEREST PENSIONS, ETC.: Y N

TYPE OF INCOME	CLAIM NUMBER	MONTHLY GROSS AMOUNT	VERIFICATION SOURCE	DATE
SOCIAL SECURITY (RSDI)				
SUPPLEMENTAL SECURITY (SSI)				
VETERANS PENSIONS				
VETERANS COMPENSATION				
OTHER PENSIONS				
UNEMPLOYMENT COMPENSATION				
WORKMAN'S COMPENSATION				
DISREGARED RSDI				
CHILD SUPPORT – CSU MAILED (FA)				
CS ARREARS/EXCESS-CSU MAILED (FA)				
CONTRIBUTIONS/INDIVIDUAL				
CONTRIBUTIONS/CHARITY ORG.				
DIVIDENDS/INTEREST				
ALIMONY				
CHILD SUPPORT-WRK ENTERED (FA)				
OTHER/CS ARREARS/EXCESS/PROP INC.				

END MEMBER THREE

ABSENT PARENT GROUPING (ZC37)

IS THE (FATHER/MOTHER) THE SAME FOR EACH OF THE FOLLOWING CHILDREN?
IF NOT, GROUP CHILDREN WITH THE SAME PARENT

FATHER GRP DEP MBR	FATHER IV-D REA STAT	CHILD NAME	CHILD SSN	MOTHER GRP DEP NBR	MOTHER IV-D REA STAT	CHILD SUPPORT UNIT NBR

ABSENT PARENT IDENTITY (ZC38)

REQUEST INFORMATION CONCERNING ABSENT FATHER/MOTHER FOR ______

NAME: ______

SSN: ______ RACE: ______ SEX: ______ DOB: ______

MARITAL STATUS: ______ PHONE NUMBER: ______

AP MOTHER NAME: ______

AP FATHER NAME: ______

LAST KNOWN ADDRESS: ______

CITY: ______ STATE: ______ ZIP: ______

ABSENT PARENT EMPLOYMENT (ZC41)

LAST KNOWN EMPLOYER NAME: ______

ADDRESS: ______

CITY: ______ STATE: ______ ZIP: ______

TELEPHONE NUMBER: ______

HEALTH INSURANCE CODE:
HEALTH INSUANCE POLICY NUMBER:

ABSENT PARENT SUPPORT OBLIGATION (ZC54)

CONTRIBUTIONS? Y N

SUPPORT ORDERED? Y N

COURT ORDER NUMBER:
DATE ESTABLISHED:
AMOUNT ORDERED: FREQ:

SUPPORT PAID? Y N

DATE OF LAST PAYMENT:
AMOUNT OF LAST PAYMENT:

CASE REFERENCE INFORMATION (ZC44)

PLEASE PROVIDE THE FOLLOWING INFORMATION ON TWO PEOPLE WHO DO NOT LIVE WITH YOU AND CAN VERIFY YOUR STATEMENTS ABOUT YOUR CIRCUMSTANCES.

NAME: ______________________________

ADDRESS: ______________ CITY:__________ STATE:_____ ZIP________

HOME TELEPHONE NUMBER: ______________ WORK TELEPHONE NUMBER: ______________

RELATIONSHIP: ______________

NAME: ______________________________

ADDRESS: ______________ CITY:__________ STATE:_____ ZIP________

HOME TELEPHONE NUMBER: ______________ WORK TELEPHONE NUMBER: ______________

RELATIONSHIP: ______________

AFFIRMATION AND AGREEMENT

A. I understand that information I give to the Department will be used to determine eligibility for assistance. I understand that the information I give will be used only for reasons allowed by State and Federal rules and includes sharing my income and demographic information for use in determining eligibility for Medicaid benefits for which I have applied. ______ Yes ______ No

B. I agree to give and verify information that is needed to determine if my assistance unit is eligible. I know that I may have to prove that the information is correct. I know that I will not be eligible for benefits if I do not complete the application process or a review of my eligibility. ______ Yes ______ No

C. I understand that applicants must give their social security number or apply for one. I understand that social security numbers are used to check identity; to make sure an individual is receiving in only one case and to make mass changes. Social security numbers are used in computer matching with other programs and agencies such as the Social Security Administration, Internal Revenue Service, Alabama Department of Industrial Relations, etc., program reviews and audits to make sure a family is eligible for assistance. ______ Yes ______ No

D. I understand that, as an applicant, I must report all changes that occur during the application process before my case is awarded. I understand that, after award, I must report all changes within 10 days of the date of the change(s). I understand this includes changes in my/our income, individuals moving in or out of my home, etc. _____Yes_____No

E. I understand that by accepting assistance, I have assigned my rights to child and/or spousal support to the state. I understand that I must cooperate to secure or enforce these rights. If I receive child and/or spousal support, I agree to turn it over to the state within 10 days of the date I receive it. I understand that if I do not cooperate or turn over support payments, my benefits may be reduced or stopped. I understand that any support collected for me or my child(ren) or for a child(ren) in my care may be kept to pay back payments I receive. ______ Yes _____ No

F. I agree that I and members of my family will comply with JOBS Program activities if participation is required. ______ Yes ______ No

G. I understand that I may have to pay back money I receive if I am not eligible for any reason, including agency error. Payments may be deducted from current or future benefits. I understand that civil action may be taken to get back the benefits if I am not eligible. ______ Yes ______ No

H. I understand that if I knowingly give any false information or refuse to give any information about my situation, I may be put on trial for fraud. I understand that if I commit fraud I will be ineligible for FA for 6 months for the first time, 12 months for the second time and forever for the third time or after. ______ Yes ______ No

I. I agree to cooperate with drug screening activities, if required. ______ Yes _____ No

J. I certify to the best of my knowledge and under penalty of lying under oath that:

a. All assistance unit members are U.S. citizens or legal aliens. ______ Yes ______ No
If no, who? ______________________________

b. No one in my assistance unit has ever been found guilty of a felony for the use, sale or of having an illegal substance. ______ Yes ______ No
If no, who? ______________________________

c. No one in my assistance unit has ever been found guilty in court of lying about where we live to get Family Assistance, Food Assistance, Medicaid or SSI benefits from two or more states at the same time. ______ Yes ______ No
If no, who? ______________________________

d. No one in my assistance unit is a convicted felon that is fleeing to avoid trial, arrest or jail. _____ Yes ______ No
If no, who? ____________________________________

e. No one in my assistance unit is breaking a condition of State or Federal probation or parole. _____ Yes _____ No If no, who? ______________________________

f. (Applies to a Parent or Stepparent Grantee Only) I have not been found guilty of a misdemeanor for the use or distribution of a drug in the last 5 years. _____ Yes _____ No If no, Date of Conviction __________. If no, have you used an illegal drug (meaning a drug whose manufacture, sale, use or possession is forbidden by law) or used a prescription medication for a non-medical reason (meaning just because of the feeling or experience it gave you) within the last year? ____Yes _____ No

K. I understand that there are restrictions on where I can use my EBT card and what I can buy. Places where I cannot use my card include liquor, wine and beer stores, gambling establishments, strip clubs, tattoo or body piercing stores or places providing psychic services. I understand I must not buy liquor, wine or beer, tobacco products or lottery tickets. I understand misuse of my EBT card and benefits can result loss of benefits and payback of money misused. ________ Yes ________ No

I certify that my answers to the statements A – K above and to the interview questions are true and complete.

______________________________		______________________________	
Signature of Client	Date	Signature of Spouse	Date
______________________________		______________________________	
Signature of Witness/Interpreter/Other	Date	Signature of PA Worker	Date

WORKER'S DRUG SCREENING CHECK LIST

_____ Not applicable to this grantee.

_____ Applicable and reasonable suspicion does not exist.

_____ Applicable and reasonable suspicion exists. Screening required if otherwise eligible and Form 2216 processed.

Instructions for DHR-WR-1674
Backup Application Information

Use/Purpose

This form is used to conduct an application interview when FACETS is not operational.

General Instructions

The form is identical to the FACETS screens in the application flow. Enter information on the form during the interview as you would on the screens. Be sure to enter all the information on FACETS as soon as it is operational again.

Distribution

Case Record until all information is on FACETS

THIS FORM WILL NOT BE STOCKED. MAKE COPIES AS NEEDED.

_________________________County Department of Human Resources

____

____

Time Limits Hardship
Caring for Individual(s) with Illness/Incapacity

Patient: ____________________

PSD File #: ____________________

Worker: ____________________ Date: ____________

Dear Doctor:

Our FA client claims to be needed on a substantially continuous basis to care for the above-named patient. As part of our determination, we need your recommendation as to whether the patient needs personal care due to being incapable of caring for him/herself because of illness or incapacity.

The patient's consent, or consent of the legally responsible person if a child, is given below for you to furnish us the needed information. This information is confidential. The patient or responsible person will be referred to you if s/he wants any information about this report. However, if there is a fair hearing, the report will be available to the FA applicant/recipient and others involved in the fair hearing process.

The Department of Human Resources can pay a maximum of $15 for completion of this form in its entirety. For payment, please submit your signed bill including your Social Security or Federal ID# in duplicate to the County Department of Human Resources.

Thank you for providing this information at your earliest convenience.

____
Signature of Director

____
Date

Patient's Authorization

I hereby authorize the physician to give the Department of Human Resources any information necessary about my illness/incapacity and my need for personal care.

____
Signature of Patient/Legally Responsible Person

____
Date

Physician's Statement
(Complete all Sections)

1. Nature of illness/incapacity ____________________

2. Severity of illness/incapacity ____________________

3. Prognosis: ____________________

4. Is the patient in need of personal care at this time?

   ________ No. If no, stop and sign.

   ________ Yes. If yes, complete 5, 6, and 7.

5. Personal care required?

   ________ Conducting a prescribed exercise routine.
   ________ Changing bandages or dressings on the advice of the physician.
   ________ Administering prescribed medication.
   ________ Using prostheses or ambulation aids.
   ________ Locomotion.
   ________ Maintaining an acceptable state of cleanliness.
   ________ Maintaining adequate nutritional standards in the purchase and preparation of food.
   ________ Maintaining orientation to time, place and events.
   ________ Reminding of the need for medication or other health related functions.
   ________ Other ____________________

6. When is the care required?

   ________ Regularly, i.e., needs care at different times of the day/night.
   List the time of day/night the care is needed and approximately how long the care should take:

   ____
   ____
   ____

   ________ Continuously, i.e., needs care throughout the day and night, (not to be left alone).
   ________ Infrequently, i.e., needs care but not every day/night. List the number of days per week, time of day/night the care is needed and approximately how long the care should take:

   ____
   ____
   ____

7. I expect this condition to last:

   ________ Permanently
   ________ More than one year
   ________ Less than one year - approximate number of months ________.

I understand that payment can be made for this information only if services are in compliance with the Civil Rights Act of 1964.

____________________ Date

____________________ Signature of Physician or Licensed/Certified Psychologist

____________________ Print Name of Physician or Licensed/Certified Psychologist

____________________ Office Phone Number

Instructions for DHR-FAD-1876
Time Limits Hardship
Caring for Individual(s) with Illness/Incapacity

Use/Purpose

This form is used to obtain medical information about the illness or incapacity of a FA applicant/recipient's spouse, child or other relative within the degrees of relationship specified in Sections 2405A or B to determine the existence of a hardship, according to Section 2960A, based on the need for the applicant/recipient's presence on a substantially continuous basis.

General Instructions

This form must be completed by a physician or licensed or certified psychologist. Complete all items in the upper part of the form and have the applicant/recipient sign in the lower part. Mail the form to the doctor for completion. Payment of up to $15 for information on this form may be made as an administrative expense. If the client is dissatisfied with the agency decision based on this medical information and wishes to have another examination, s/he may do so at his/her own expense.

Distribution

Case Record after completion

________________________________ County Department of Human Resources

____

____

VERIFICATION OF JOB SEARCH

Date ________________________________ Return by______________________________

Part I:

Name:________________________________ Worker: ________________________________

Case ID# ________________________________ Worker's Email: ________________________________

DHR File#________________________________ Worker's Phone:________________________________

Part II: To be filled out by employers to prove the person listed above applied for work.

This is to verify that the above-named individual has applied for employment at this business/establishment.

1.____
Business Name

Accepting Applications: Yes_____ No_____

____
Date of Application

Hiring: Yes_____ No_____

Hired: Yes_____ No_____

____
Address

Business Phone:________________________

____
Signature of appointing authority or designee

2.____
Business Name

Accepting Applications: Yes_____ No_____

____
Date of Application

Hiring: Yes_____ No_____

Hired: Yes_____ No_____

____
Address

Business Phone:________________________

____
Signature of appointing authority or designee

3.____
Business Name

Accepting Applications: Yes_____ No_____

____
Date of Application

Hiring: Yes_____ No_____

Hired: Yes_____ No_____

____
Address

Business Phone:________________________

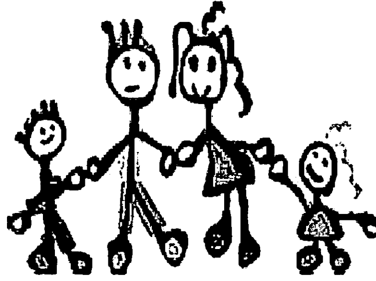
____
Signature of appointing authority or designee

Instructions for DHR-FAD–1922
Verification of Job Search

This form is to be completed for the FA applicant. The worker must complete Part I and the "return by" information. Part II is self-explanatory. Make a copy for the file and give or mail the original to the client. Provide a return postage envelope.

A copy of the completed form should be forwarded to the JOBS Unit upon award of FA benefits.

DEPARTAMENTO DE RECURSOS HUMANOS



PROGRAMA de ASISTENCIA FAMILIAR
(FA, por sus siglas en inglés)
RESUMEN DE LOS REQUISITOS DE ELEGIBILIDAD:

¿ES ELEGIBLE MI FAMILIA?

Las personas que solicitan o reciben beneficios de dinero en efectivo deben cumplir con ciertos requisitos. Deben ayudar a demostrar que son elegibles para los beneficios. Deben participar en actividades que les ayudarán a ser capaces de mantener y cuidar mejor a sus familias. Esto incluye cooperar con la manutención de los niños, con el programa JOBS (TRABAJOS) y con pruebas de detección de drogas. Aquellos que no cooperen pueden ser rechazados o perder los beneficios.

REQUISITOS TÉCNICOS

A. El niño debe vivir en el hogar de uno de los padres o de otro familiar cercano.

B. Una persona adulta solo puede recibir beneficios de FA durante 5 años a lo largo de su vida.

C. El niño debe ser menor de 18 años de edad a menos que asista a la escuela. Si está en la escuela, el niño puede recibir beneficios hasta el mes antes de su cumpleaños 19 o hasta el último mes en la escuela, lo que ocurra primero.

D. El niño debe ser un ciudadano estadounidense o un extranjero legal elegible.

E. El niño debe vivir en Alabama. Una persona que ha sido sancionada por dar una dirección falsa para obtener ayuda de dos Estados de forma simultánea no podrá recibir beneficios durante diez años.

F. El niño no puede estar recibiendo cuidado temporal por parte del Departamento de Recursos Humanos.

G. El niño no debe estar participando en una huelga. Ningún miembro de la familia podrá recibir FA si uno de sus padres o padrastros está participando en una huelga.

H. El pariente debe cooperar con Manutención de Menores a menos que el Departamento decida que ella/él tiene una buena razón para no hacerlo.

   La Manutención de Menores recibida por un menor es asignada al Departamento de Recursos Humanos del Estado cuando se presenta una solicitud de FA para dicho menor.

I. El familiar debe transferir todos los pagos de manutención del niño al Estado.

J. El familiar debe dar un número de Seguro Social por cada miembro de la unidad de asistencia. Si alguno de los miembros no dispone de un número de Seguro Social, el familiar debe solicitar un número. Se debe proporcionar el número cuando se reciba.

K. El familiar debe participar en el programa JOBS. El pariente debe aceptar un trabajo a menos que el Departamento del Condado le diga lo contrario. Se requiere que los padres menores de 18 años, quienes son niños dependientes, participen.

L. El pariente debe solicitar cualquier otro beneficio para el cual puede ser elegible, como los Beneficios de veterano, el Seguro Social, Compensación de Desempleo, etc.

M. Un padre menor de la edad de 18 años y sus hijos deben vivir con un adulto. Este adulto debe ser un pariente o un tutor legal. Si un familiar adulto o tutor no está disponible, los padres menores de 18 años y sus hijos deben vivir en una vivienda supervisada por adultos.

N. El familiar debe informar al asistente las circunstancias familiares. Se le podrá requerir al pariente que pruebe algunas o todas las circunstancias de la familia con documentos.

O. Los padres/madres menores de 18 años con un niño de al menos 12 semanas de edad debe tener un diploma de escuela preparatoria o estar en la escuela o un programa de formación.

P. El menor o el familiar no deben violar la condición de libertad condicional o probatoria. El menor o el pariente no debe ser un criminal convicto que esté huyendo para evitar el arresto, juicio o prisión. El menor o el pariente no debe haber sido condenado por un delito grave por el uso o la venta de una sustancia controlada, o con una sustancia controlada, a menos que ya haya cumplido su sentencia.

Q. Un padre debe firmar y cumplir con las condiciones de su Plan de Responsabilidad de Familia.

R. El solicitante debe participar en las actividades de búsqueda de trabajo durante el proceso de solicitud a menos que esté exento o exista causa fidedigna para no hacerlo.

S. Un beneficiario (o sea uno de los padres o padrastros) debe cooperar con actividades de pruebas de detección de drogas. Esto significa proporcionar información y pagar y tomar la(s) prueba(s) de detección de drogas. Las actividades son determinadas según cada caso.

REQUISITOS FINANCIEROS

T. El menor debe estar necesitado conforme a las reglas de la agencia y no tener padres o padrastros que puedan mantenerlo/a. "Necesitado" significa que la familia no tiene ingresos mensuales netos iguales o mayores que al salario promedio y tiene derecho a por lo menos 10.00 dólares. A continuación se encuentra una tabla con salarios promedio dependiendo del tamaño de la familia. Para determinar la necesidad, se cuentan los ingresos de todas las personas en la unidad de asistencia. Antes de contar los ingresos obtenidos, se resta, del ingreso bruto, el 20 por ciento por los gastos relacionados con el trabajo y con el cuidado de los niños.

ESTÁNDARES DE LA FA

TAMAÑO DE LA FAMILIA	PAGO NORMAL	TAMAÑO DE LA FAMILIA	PAGO NORMAL
1	165	9	395
2	190	10	425
3	215	11	455
4	245	12	485
5	275	13	515
6	305	14	545
7	335	15	575
8	365	16	605

"Familia" significa todas las personas incluidas que conforman el grupo familiar. Por lo general, las personas que se incluyen son los padres y hermanos y hermanas del o los niños que viven en el hogar. Pueden ser incluidos otros niños relacionados con los padres, tales como hijastros, sobrinos, etc. Si se incluye a un niño de un grupo de hermanos y hermanas, todos sus hermanos y hermanas que vivan en el hogar deberán incluirse como elegibles. Se utilizan los ingresos de todas las personas en la unidad para determinar la elegibilidad. Una familia con un ingreso que sea igual o mayor al pago estándar para el grupo familiar, no es elegible para FA.

Ejemplos de ingresos:

Salarios, comisiones, sueldos

Contribuciones

Seguridad Social, Asuntos del Veterano (VA, por sus siglas en inglés), Compensación por Desempleo

Manutención del niño

La asistencia familiar se abonará a los beneficiarios que sean elegibles por al menos $10 por un plazo de hasta cinco años.
No se abonan beneficios por menos de $10.

INFORMACIÓN ADICIONAL

- **DÓNDE SOLICITAR**
  Usted debe solicitar FA en el Departamento de Recursos Humanos en el condado en el que vive.
  La entrevista de solicitud puede comenzar con una explicación general del programa a un grupo de solicitantes. Usted debe participar de una entrevista privada en una oficina o por teléfono con un asistente.

- **REQUISITOS DE PRESENTACIÓN DE INFORMES**
  Solicitante: Debe informar cualquier cambio en la situación familiar antes de que se atienda su petición.

  Beneficiario: Usted debe notificar al Departamento de cualquier cambio en la situación de su familia dentro de los siguientes 10 días del cambio. Usted debe darle al Departamento toda la información necesaria para una revisión completa al menos cada doce meses. El Departamento del Condado podrá solicitar más información necesaria en una entrevista de grupo con otros beneficiarios.

- **SOBREPAGOS**
  Si obtiene un sobrepago cualquiera sea el motivo, tendrá que devolverlo. Si usted recibe un pago en exceso debido a fraude, podría ser sujeto a un proceso de juicio legal o a otra sanción.

- **REVISIÓN DE LA RESOLUCIÓN TOMADA EN SU CASO.**
  - Si usted no está conforme, puede notificárselo al Departamento del Condado o al Departamento Estatal de Recursos Humanos en Montgomery, Alabama. Puede solicitar una conferencia con el Departamento del Condado, un informe del Departamento Estatal o una audiencia formal. El Departamento Estatal y el Departamento del Condado operan de acuerdo con las mismas reglas
  - Puede realizar una petición por escrito para una audiencia dentro de los 60 días de la resolución tomada. El padre, otro familiar, representante designado legalmente u otra persona autorizada, debe realizar la petición.
  - La audiencia puede ser llevada a cabo telefónicamente.
  - Es posible que su abogado o quien lo represente deba presentarse junto a usted en una audiencia o conferencia.
  - Usted puede retirar su petición para una audiencia cuando los problemas se resuelvan de otra manera.

- **RESTRICCIONES y ENTREGA DE BENEFICIOS**
  Los beneficios se expiden a través de una transferencia electrónica de beneficios (EBT, siglas en inglés para transferencia bancaria). Hay restricciones sobre dónde se puede usar la tarjeta y lo que se puede comprar. Los lugares donde no se permite usar la tarjeta son expendios de licores, vinos o cerveza, establecimiento de juego, club de striptease, tatuajes o perforaciones en el cuerpo o lugares que proporcionan servicios psíquicos. Los beneficios no se pueden utilizar para comprar licor, vino o cerveza, productos de tabaco, o billetes de lotería. El mal uso de la tarjeta y los beneficios se traduce en la pérdida de beneficios y reembolso de los fondos mal utilizados.

- **SERVICIOS DE MANUTENCIÓN DE NIÑOS**
  Los servicios de manutención están disponibles para personas que reciban FA. Los servicios de Manutención de Menores continuarán incluso si los pagos de FA son retenidos, a menos que solicite la cancelación de los servicios.

- **GUARDERÍA**
  Usted puede ser elegible para el cuidado infantil luego de que sus beneficios de FA hayan terminado. Usted debe necesitar cuidado de niños porque está trabajando y debe solicitar la atención en un plazo de seis meses a partir de la terminación de sus beneficios de FA y cumplir con otros requisitos.

- **ASISTENCIA ALIMENTARIA**
  Aunque usted no obtenga FA, puede ser elegible para recibir asistencia alimentaria. Para obtener más información, póngase en contacto con su trabajadora social o con la Oficina de Asistencia Alimentaria del Condado.

- **COBERTURA MÉDICA**
  Usted y los miembros de su familia pueden obtener cobertura de salud gratis o a bajo costo, incluso si usted no recibe FA. Si desea solicitar Medicaid, ALL Kids (TODOS los niños), o ayuda para pagar el seguro, solicite en línea en **www.insurealabama.org o llame a la línea gratuita: 1-888-373-5437 ó 1-800-362-1504** si tiene alguna pregunta.

- **ASISTENCIA LEGAL**
  Puede obtener asistencia legal gratuita. Usted puede comunicarse con la oficina local de Servicios Legales u otra agencia comunitaria. La oficina de su condado puede ayudarle a encontrarlas.

- **OTRA AYUDA DISPONIBLE**
  Es posible que desee acceder a la página web de Salud y Servicios Humanos de www.myalabama.gov para obtener información sobre otros programas y servicios disponibles en el Estado.

- **NO DISCRIMINACIÓN:** Las reglas del programa son las mismas para todas las personas. Su raza, color, lugar de nacimiento, sexo, discapacidad, creencias, edad o religión no importan. Díganos si usted tiene un problema físico, mental o de aprendizaje que limite una actividad importante de la vida. Es posible que podamos ayudarle a utilizar plenamente los programas y servicios existentes.

Instructions for DHR-FAD-2077(595)
Summarized Eligibility Requirements Family Assistance
Spanish version

Use/Purpose

This form is to be used according to Section 1120B during the application interview, and, as appropriate, during other contacts with a Spanish-speaking client.

General Instructions

Discuss each item with the applicant, providing detailed explanation or clarification, as needed, and giving opportunity for any questions from the client to be answered.

Distribution

Original: Client

SPECIAL ASSESSMENT, INTERVENTION & LIAISON PROJECT

The Alabama Department of Human Resources and the Alabama Coalition Against Domestic Violence have established the Special Assessment, Intervention & Liaison (SAIL) Project. The SAIL Project will provide domestic violence assessment and services for Family Assistance and JOBS clients.

Name______________________________ **DOB**______________

Address______________________________ **Phone Number**______________

The following questions are to help you and to determine if there are any problems that might prevent you from getting or keeping a job or from getting child support. This information is voluntary. Your answers will not affect your eligibility for Family Assistance. Any information you give will be kept confidential within DHR and related domestic violence programs. If you tell us that any child is abused, we are required by state law to report that information to the Family Services Division, Department of Human Resources for follow-up.
If you answer "yes" to one or more of the following questions, your worker will make a referral to the local Domestic Violence Specialist, unless you indicate you do not want a referral. If you answer "no" to all of the questions, please let us know if your situation changes. We want to help you.

1. Is there someone (friend, relative, child, spouse) who has ever physically, sexually, or emotionally hurt you? For example, has anyone ever:

   - ❖ Pushed, grabbed, shoved, slapped or hit you? _____ Yes _____ No
   - ❖ Kept you away from family and friends, or prevented you from leaving your home or going where you wanted to go? _____ Yes _____ No
   - ❖ Consistently put you down or told you that you are worthless? _____ Yes _____ No
   - ❖ Followed or kept check on you? _____ Yes _____ No
   - ❖ Threatened to hurt you, other family members or your pets? _____ Yes _____ No
   - ❖ Threatened to hurt your children or threatened to take them away, or have them taken away from you? _____ Yes _____ No
   - ❖ Withheld food, clothing, or other needs? _____ Yes _____ No
   - ❖ Caused problems for you by showing up at your place of employment? _____ Yes _____ No

2. If so, who hurt you?______________________________

3. Is this happening now? _____ Yes _____ No

4. Is there anyone you are afraid of? _____ Yes _____ No If so, who?______________________________

5. Are you in danger now and in need of emergency shelter? _____ Yes _____ No

Please give phone number or address where the Assessor may contact you that will not put you in danger.

____

____

DHR USE ONLY

FA Case Number______________________

Payee Gross Income:______________________

Payee Included in FA assistance unit? _____ Yes _____ No

Referred to: Domestic Violence Assessor _____ Yes _____ No

No Referral made due to: _____ 1. All "no" answers

_____ 2. Form not completed

_____ 3. Refused referral

Comments:______________________________

____

Name of JOBS worker:______________________________

____

PA Worker Signature Date

SAIL USE ONLY

Safety Plan Initiated due to client being in imminent danger or threat thereof? _____ Yes _____ No

Comments:______________________________

____

____

Assessor Signature Date

DHR-FAD-2080

Instructions for DHR-FAD-2080
Special Assessment, Intervention & Liaison Project

Use/Purpose

This form is used to provide for self-screening by applicants/recipients for domestic abuse, in accordance with Section 1120C, so that the appropriate referral for services may be made.

General Instructions

Request the grantee to complete this form at application and redetermination interviews.

Distribution

Original and yellow copy: Domestic Violence Assessor (if referral is made)
Pink copy: JOBS Unit (if referral is made)
Goldenrod copy: Case Record

ESTADO DE ALABAMA
DEPARTAMENTO DE RECURSOS HUMANOS
DIVISIÓN DE LA AYUDA DE LA FAMILIA

CAMBIAR LA FORMA DEL INFORME

Condado ____________________

Nombre ____________________ Programa ____________ No. Del Caso. ____________

PARTE I. CAMBIOS

Deseo divulgar el change(s) siguiente que ha ocurrido en mi renta, recursos, costos u ocurrieron los arreglos vivos y la fecha el change(s).

1. ( ) Soy moving/have movido. Fecha ____________ Nueva dirección ____________________
____

2. ( ) Tengo un nuevo miembro en mi casa. Nombre ____________________
Relación a mí ____________________ Fecha movida adentro ____________

3. ( ) Un miembro de mi casa se ha movido hacia fuera.Nombre ____________________
Fecha movida hacia fuera ____________________.

4. ( ) ____________________ ahora recibe SSI. Fecha ____________

5. ( ) Solicito que mis ventajas estén paradas. Fecha ____________________
Razón ____
____

6. ( ) Tengo más / menos recursos. (Cuentas bancarias, característica, etc.) Especificar ____________
____
Fuente ____________________. Fecha ____________

7. ( ) Tengo más / menos renta. Especificar ____________________
Fuente ____________________. Fecha ____________

8. ( ) Me ahora emplean. Fecha comenzada ____________ Salarios ________ por ______
Fecha de la primera cheque ____________ Día de la paga de la semana recibido ________
Número de horas por semana ____________. Patrón ____________________
Dirección Del Patrón ____________________ Tel. No. ____________

(Continuado encendido detrás)

9. ( ) Pago / ningún cuidado más largo del día de cobro. Fecha ____________ Cantidad ________ por ________

Nter del ce del cuidado del día / Casero (Nombre) ______________________________

Dirección ______________________________ Tel. No. ____________

10. ( ) Soy no más largo empleado. Fecha parada ____________ Paga del último de la fecha recibida ________

Razón ______________________________

11. ( ) Otro : Explicar ______________________________

____

____

____

______________________________ ( ) Aspirante ( ) Recipiente ____________
(Firma) (Fecha)

Testigo ____________________ Dirección ____________________ ____________
(Fecha)

PARTE II. PEDIDO LA ACCIÓN ADVERSA INMEDIATA PARA LA VENTAJA REDUCTION/TERMINATION

Como resultado de la información he divulgado, yo entiendo que los artículos terminados abajo demuestran que el efecto que esta información tendrá en mis ventajas.

1. ( ) Mis ventajas serán reducidas a ____________________ eficaz ____________

2. ( ) Mis ventajas serán eficaces terminado ______________________________

Entiendo que firmando este pedido la acción adversa inmediata, estoy dando encima de la comunicación previa de 10 días de tal acción adversa. También entiendo que estoy dando encima de ayuda continuada en el nivel actual.

Deseo la acción inmediata tomada porque ______________________________

____

____

____

He leído o hice esta forma leer a mí.

______________________________ ____________
(Firma) (Fecha)

Testigo ____________________ Dirección ____________________ Fecha ____________

Instructions for DHR-FAD-2097(703)
Change Report Form
Spanish version

Use/Purpose

This form is used to record a Spanish-speaking client's report of a change in accordance with Section 1125G.

General Instructions

Fill in identifying information and complete Part I with the client. If the change will result in a reduction or termination of benefits and the client wishes to waive advance notice and have immediate adverse action taken, complete Part II checking applicable statements and filling in the blanks. Record the client's specific reason(s) for wanting immediate action and have her/him sign the form.

Distribution

Original: Client
Copy: Case Record until replaced by original

THIS FORM WILL NOT BE STOCKED. MAKE COPIES AS NEEDED.

ESTAMPILLA DEL CONDADO

__________________________________ CONDADO

DEPARTAMENTO DE RECURSOS HUMANOS

VERIFICACIÓN OBLIGATORIA

N.º de identificación del caso ______________
Trabajador ______________
N.º de teléfono ______________
Fecha ______________

1. Artículos ______________
que debe ser entregada antes del: (Fecha) ______________
2. Artículos ______________
que debe ser entregada antes del: (Fecha) ______________

Los artículos marcados en este formulario son necesarios para determinar si cumple con los requisitos para recibir ayuda. Debe entregar dichos artículos antes de la(s) fecha(s) indicada(s) anteriormente. Si no los entrega, existe la posibilidad de que rechacen su solicitud de ayuda o cierren su caso. Puede enviar los documentos por correo, pero debe asegurarse de que lleguen a esta oficina antes de la fecha establecida. Si no puede conseguir los documentos, pídale a su trabajador que lo ayude. Su trabajador puede reunirse con usted en los días y horarios establecidos a continuación o también puede llamarlo/a para coordinar una cita.

DÍA	Lunes	Martes	Miércoles	Jueves	Viernes
HORA					

ENVÍENOS POR CORREO O ENTREGUE DIRECTAMENTE LOS SIGUIENTES DATOS Y DOCUMENTOS

GENERAL

1. ☐ Certificado(s) de nacimiento de ______________
2. ☐ Número(s) de seguro social de ______________
3. ☐ Identificación de ______________
4. ☐ Declaración firmada por una persona que sepa que los niños para los cuales presentó la solicitud viven en su hogar
5. ☐ Comprobantes de naturalización de ______________
6. ☐ Documento de inscripción como persona extranjera de ______________
7. ☐ Comprobantes de divorcio de ______________
8. ☐ Acta de matrimonio de ______________
9. ☐ Comprobantes de separación de ______________
10. ☐ Formularios de legitimación/paternidad de ______________
11. ☐ Declaración del prestador de cuidado infantil sobre la cantidad que le paga para que cuide a su(s) hijo(s) mientras usted trabaja
12. ☐ Control de la inscripción escolar de ______________
13. ☐ Comprobante de la solicitud de los Beneficios de Seguro por Desempleo (UCB) de ______________

INGRESOS

14. ☐ Comprobante(s) de sueldo/salario, como recibos del sueldo o declaración del empleador, contable, etc., correspondiente(s) al (a los) mes(es) de ______________
15. ☐ Comprobante(s) de trabajo por cuenta propia correspondiente(s) al (a los) mes(es) de ______________
16. ☐ Declaración de impuestos, registros económicos, recibos, etc. correspondientes al año ______________
17. ☐ Comprobante de Seguro Social, Ingreso de Seguro Suplementario (SSI), Asuntos de Veteranos (VA), Indemnización por Accidentes Laborales o Enfermedad de ______________
18. ☐ Comprobante de Beneficios de Seguro por Desempleo (UCB) de ______________
19. ☐ Comprobante de manutención infantil o pensión alimenticia
20. ☐ Comprobante de la cantidad de dinero que le proporcionaron amigos, familiares, instituciones religiosas, etc., es decir, recibo o declaración del amigo, familiar, institución religiosa, etc.
21. ☐ Comprobante del dinero que recibe por cuidar niños

OTRO (especifique)

22. ☐ ______________
23. ☐ ______________
24. ☐ ______________

Instructions for DHR-FAD-2098(1132)
Required Verifications – Spanish version

Use/Purpose

This form is used to provide the Spanish-speaking applicant/recipient a list of case specific information/verification needed to establish initial or continuing eligibility according to Section 1125B and F.

General Instructions

Check those items that represent case specific information and/or verification needed. List the specific individual(s) for whom that information and/or documentation is needed in the space provided for each item checked. Use items 24 through 28, 'Other', to indicate any additional information and/or documentation that the client is responsible for providing. Be as specific and clear as possible.

Distribution

Original: Client
Copy: Case Record

THIS FORM WILL NOT BE STOCKED. MAKE COPIES AS NEEDED.

CONDADO DE________________________
DEPARTAMENTO DE RECURSOS HUMANOS
NOTIFICACIÓN DE ENTREVISTA

FECHA ____________________________
IDENTIFICACIÓN DE CASO ______________
ARCHIVO PSD N.º _____________________

____
____
____

ES IMPORTANTE QUE HABLEMOS CON USTED. SI NO PUEDE ESTAR DISPONIBLE EN EL MOMENTO MOSTRADO A CONTINUACIÓN, POR FAVOR LLAME AL ______________ O ENVÍE UN CORREO ELECTRÓNICO A ____________ DE INMEDIATO PARA CAMBIAR LA FECHA Y HORA DE LA CITA, O DEJE UN MENSAJE. SI RESPONDE POR LLAMADA TELEFÓNICA O CORREO ELECTRÓNICO, POR FAVOR INCLUYA SU NOMBRE COMPLETO Y LOS ÚLTIMOS CUATRO NÚMEROS DE SU IDENTIFICACIÓN DE CASO. SI NO ESTÁ DISPONIBLE O NO VIENE A LA ENTREVISTA COMO SE SOLICITA A CONTINUACIÓN, SU SOLICITUD PUEDE SER NEGADA O SE PUEDE CERRAR SU CASO. GRACIAS.

____
FIRMA DEL TRABAJADOR/ENCARGADO DE CITAS

PROPÓSITO DE LA ENTREVISTA:
- ☐ **Solicitud inicial**
- ☐ **Revisión**
- ☐ **Otro (especificar)** ______________________________

PROGRAMA DE LA ENTREVISTA

	Fecha		Hora
( ) Por favor asista a			
( ) Oficina del Condado	____________	a las	____________
( ) Otro________________________ _____________________________	____________	a las	____________
( ) Lo contactaré por teléfono el	____________	a las	____________
( ) Llámeme al ________________ el	____________	a las	____________

ARTÍCULOS QUE DEBE TRAER CON USTED CUANDO VENGA A LA OFICINA:
( ) Evidencia de su relación con los siguientes menores: ____________________________
( ) Evidencia de identidad suya y/u otro(s) adulto(s):____________________________
( ) Números de seguridad social de usted y de sus hijos: ____________________________
( ) Información sobre el padre/madre ausente de los siguientes menores:____________________
( ) Evidencia de ingresos de: ____
( ) Evidencia de salarios (recibos de sueldo, declaración del empleador, etc.)________________
( ) Dirección y número telefónico del empleador ______________________________
( ) Declaración por escrito de la persona a la que usted le paga para cuidar su(s) hijo(s) mientras trabaja, indicando la cantidad que paga __________________________________
( ) Otro ____
____

DHR-FAD-2099(686)
Interview Notification – Spanish version

Use/Purpose

This form is used to schedule face to face or telephone appointments with a Spanish-speaking client according to Sections 1120D and 1125B and F.

General Instructions

The "Purpose of Interview" section must be completed to indicate what type of interview is being scheduled. Complete the bottom section of the form to advise the client of the case specific information/verification that s/he should bring to the interview.

Distribution

Original: Client
Copy: Case Record

TESTIMONIO Y ACUERDO

A. Entiendo que la información que yo le proporcione al Departamento se utilizará para determinar la elegibilidad para asistencia. Entiendo que la información que yo proporcione se utilizará solamente por razones permitidas por las normas estatales y federales, e incluye compartir datos demográficos e información sobre mis ingresos para uso en la determinación de elegibilidad para los beneficios de Medicaid que he solicitado. ________Sí ________No.

B. Acepto entregar y verificar la información que sea necesaria para determinar si mi unidad de asistencia es elegible. Entiendo que es posible que tenga que demostrar que la información es correcta. Entiendo que no seremos elegibles para recibir beneficios si no completo el proceso de solicitud o una revisión de mi elegibilidad. ________Sí ________No.

C. Entiendo que los solicitantes deben proporcionar su número de seguro social o solicitar uno. Entiendo que los números de seguro social se utilizan para controlar la identidad de la persona, garantizar que reciba ayuda en un solo caso y hacer cambios globales. Los números de seguro social se utilizan para el cotejo de datos con otros programas y agencias, tales como la Administración del Seguro Social, el Servicio de Impuestos Internos, el Departamento de Relaciones Industriales de Alabama, etc., las revisiones de programas y las auditorías con el fin de garantizar que una familia sea elegible para recibir asistencia. ________Sí ________No.

D. Entiendo que, como solicitante, debo reportar lodos los cambios que surjan durante el proceso de solicitud antes de que mi caso sea aceptado. Entiendo que, posteriormente a la aceptación, debo reportar todos los cambios dentro de los 10 días posteriores a la fecha del cambio o los cambios. Entiendo que estos incluyen modificaciones en mi/nuestro nivel de ingresos, personas que se mudan a mi hogar o que se marchan de él, etc. ________Sí ________No.

E. Entiendo que, al aceptar la asistencia, yo le transfiero al estado mis derechos a la manutención infantil y/o conyugal. Entiendo que debo colaborar a fin de garantizar o hacer cumplir estos derechos. Si recibo manutención infantil y/o conyugal, acepto cederla al estado dentro de los 10 días de haberla recibido. Entiendo que, si no colaboro o cedo los pagos de manutención, mis beneficios pueden ser reducidos o suspendidos. Entiendo que cualquier subvención cobrada para mí, para mi(s) hijo(s) o para uno o más niños que tenga a mi cuidado puede ser retenida para devolver pagos que yo reciba. ________Sí ________No.

F. Acepto que yo y los miembros de mi familia cumpliremos con las actividades que establece el programa JOBS en caso de que nuestra participación sea necesaria. ________Sí ________No.

G. Entiendo que es posible que tenga que devolver el dinero que reciba si no soy elegible por cualquier razón, incluso por un error de la agencia. Los pagos pueden ser deducidos de los beneficios actuales o futuros. Entiendo que si no soy elegible puede iniciarse una acción civil a fin de recuperar los beneficios. ________Sí ________No.

H. Entiendo que si proporciono información falsa en forma deliberada o me niego a entregar datos sobre mi situación, puedo ser sometido a juicio por estafa. Entiendo que en caso de que cometa estafa, no seré elegible para recibir Ayuda Familiar (FA, por sus siglas en inglés) durante 6 meses la primera vez, durante 12 meses la segunda vez y nunca más a partir de la tercera vez. ________Sí ________No.

I. Acepto colaborar con las actividades de detección de drogas, en caso de ser necesario. ________Sí ________No.

J. Certifico a mi leal saber y entender, y bajo la pena de mentir bajo juramento, que:

a. Todos los miembros de la unidad de asistencia son ciudadanos estadounidenses o extranjeros en situación legal. ________Sí ________No.
Si la respuesta es "no", indique quiénes ________________________________

b. Ninguna persona de mi unidad de asistencia ha sido declarada alguna vez culpable del delito de usar, vender o poseer una sustancia ilegal. ________Sí ________No. Si la respuesta es "no", indique quién ________________________________
Si la respuesta es no, indique la fecha de la condena ______________¿Sentencia cumplida?______________Si o ______________No; o ¿cumple satisfactoriamente un período de libertad condicional? Si o ______________No

c. Nadie en mi unidad de asistencia ha sido nunca encontrado culpable judicialmente de mentir sobre el lugar donde vivimos para obtener Ayuda Familiar, Asistencia Alimentaria, Medicaid o beneficios del Ingreso de Seguro Suplementario (SSI, por sus siglas en inglés) de dos o más estados al mismo tiempo. ________Sí ________No. Si la respuesta es "no", indique quién ________________________________

d. Ninguna persona de mi unidad de asistencia es un delincuente convicto que se escapa para evitar ser enjuiciado, arrestado o encarcelado. ________Sí ________No. Si la respuesta es "no", indique quién ________________________________

e. Ninguna persona de mi unidad de asistencia incumple un régimen estatal o federal de libertad condicional o libertad bajo palabra. ________Sí ________No. Si la respuesta es "no", indique quién ________________________________

f. (Se aplica solamente al Padre o la Madre o al beneficiario del Padrastro o la Madrastra) No he tenido condenas por consumo o distribución de drogas en los últimos 5 años. ________Sí ________No. Si la respuesta es no, indique la fecha de la condena ____________*En caso negativo, ¿ha consumido alguna droga ilegal (es decir, una droga cuya fabricación, venta, consumo o posesión esté prohibida por ley) o un medicamento de prescripción por un motivo no médico (es decir, solo por la sensación o la experiencia que le ha brindado) durante el último año? ________Sí ________No.
Fecha de la condena ______________

K. Entiendo que existen limitaciones sobre el lugar donde puedo utilizar mi tarjeta de transferencia electrónica de beneficios (EBT, por sus siglas en inglés) y sobre qué puedo comprar. Los lugares en los que no puedo utilizar mi tarjeta incluyen tiendas en las cuales se venden licor, vino o cerveza, salones de juego, clubes de striptease, tiendas en las cuales se realizan tatuajes o perforaciones corporales (*piercings*) o lugares en los cuales se prestan servicios síquicos. Entiendo que no puedo comprar licor, vino o cerveza, productos con tabaco o billetes de lotería. Entiendo que el uso incorrecto de mi tarjeta EBT y beneficios puede causar que pierda mis beneficios y el reembolso del dinero utilizado para fines no previstos. ________Sí ________No

Certifico que mis respuestas a las declaraciones A a K que anteceden y a las preguntas formuladas en la entrevista son verdaderas y completas.

Firma del cliente	Fecha	Firma del cónyuge	Fecha
Firma del testigo/intérprete/otro	Fecha	Firma del trabajador de asistencia pública (PA)	Fecha

Instructions for DHR-FAD - 2148
Affirmation and Agreement – Spanish Version

Use/Purpose

This form is the Spanish-speaking applicant's/recipient's affirmation of understanding and agreement to his/her rights and responsibilities as a Family Assistance applicant/recipient in accordance with Section 1120B.

General Instructions

This form is to be read to (if interpreter is present) or by the client and completed during the application and child-only, face-to-face review interview. Always obtain the grantee's signature. When the grantee relative is a parent and is married, the spouse of the grantee living in the home must also sign the form. Do not delay the application awaiting the legal spouse's signature. When the grantee relative is someone other than a parent, the legal spouse's signature is not required. If the client is actively assisted by someone during the interview process, obtain their signature as well. This includes an interpreter if present in the office.

Distribution

Original in Case Record
Copy to Client

THIS FORM WILL NOT BE STOCKED. MAKE COPIES AS NEEDED.

Agreement to Comply/Cooperate with the JOBS and/or Child Support Programs

Check Applicable Program(s)
☐ JOBS
☐ Child Support

Case Name:____________________
Case Number:____________________
County:____________________

PART I. Basic Agreement by Program – check all that apply

☐ A. JOBS Program
I understand that I have not met work program requirements in the past and have been penalized by loss of cash assistance. I now agree to comply by coming to appointments, seeking work, attending training or otherwise participating when requested to do so by my JOBS worker.

I understand if I fail to comply again, my family will lose all FA benefits for:
☐ six months
☐ twelve months

☐ B. Child Support Program
I understand that I have not met Child Support Program requirements in the past and have been penalized by loss of cash assistance. I now agree to cooperate by coming to appointments, providing information, going to court or otherwise cooperating when requested to do so by my Child Support worker.

I understand if I fail to cooperate again, my family will lose all FA benefits for:
☐ six months
☐ twelve months

PART II. Affirmation and Agreement

I understand and agree to items in Part I above. I also understand that I am responsible for my family and myself. Helping DHR to help me is in my best interest.

By signing this form, I am making a commitment to myself to value work and responsibility. I am making a commitment to my children for better life prospects through the pursuit of self-sufficiency and economic independence. I am also making a commitment to DHR to do what it takes to realize these goals.

____
Signature of Client Date

____
Signature of Spouse Date

____
Signature of Witness Date
(If client or Spouse signs with an "X" mark)

____
Signature of PA Worker Date

Agreement to Comply/Cooperate with the JOBS and/or Child Support Programs Time Limit Extension

Check Applicable Program(s)
- ☐ JOBS
- ☐ Child Support

Case Name:____________________
Case Number:__________________
County:_______________________

PART I. Basic Agreement by Program – check all that apply

☐ A. JOBS Program
I understand that if I am non-compliant or my spouse is non-compliant with JOBS, I (we) will lose program eligibility permanently which means I (we) will not be able to again receive benefits for any child(ren) in my care nor can I (we) ever be included in any assistance unit. I (we) also understand that any benefit(s) I (we) receive after month 60 is an overpayment which I (we) will have to repay.

☐ B. Child Support Program
I understand that if I am non-cooperative with Child Support, I (we) will lose program eligibility permanently which means I (we) will not be able to again receive benefits for any child(ren) in my care nor can I (we) ever be included in any assistance unit. I (we) also understand that any benefit(s) I (we) receive after month 60 is an overpayment which I (we) will have to repay.

PART II. Affirmation and Agreement

I understand the items in Part I above. I also understand that by signing this form, I am making yet another commitment to program cooperation and compliance. I understand that I will not be given any further opportunity to participate in the FA program if I do not cooperate/comply.

______________________________ ______________________________
Signature of Client Date Signature of Spouse Date

______________________________ ______________________________
Signature of Witness Date Signature of PA Worker Date
(If client or Spouse signs with an "X" mark)

DHR-FAD-2180a
November 2008

INSTRUCTIONS FOR DHR-FAD-2180

Agreement to Comply/Cooperate
With the JOBS and/or Child Support Programs

Use/Purpose

This form is to be used to secure from the applicant, substantial agreement to comply with JOBS and/or cooperate with Child Support following a disqualification for failure to comply/cooperate.

General Instructions

This form is to be completed with the client at reapplication for benefits. The worker must fill in case information and check the appropriate box to identify the applicable program(s) that relates to the disqualification.

Check all applicable sections in Part I. Have the client read Parts I and II and sign and date Part II. Signature of the applicant's spouse, if applicable, is required.

Distribution: Original: File in record
Yellow: JOBS or Child Support Unit as appropriate if case is awarded. (If both, make additional copy.)
Pink: Client

INSTRUCTIONS FOR DHR-FAD-2180a

Agreement to Comply/Cooperate
With the JOBS and/or Child Support Programs
Time Limit Extension

Use/Purpose

This form is to be used to provide information about program cooperation/compliance to applicants/recipients who are otherwise eligible for benefits but for time limits.

General Instructions

This form is to be completed with the applicant/recipient when time limits have expired. The worker must fill in case information and check the appropriate box to identify the applicable program(s).

Check all applicable sections in Part I. Have the client read Parts I and II and sign and date Part II. Signature of the applicant's spouse, if applicable, is required.

Distribution: Original: File in record
Make copy for client

DEPARTAMENTO DE RECURSOS HUMANOS DE ALABAMA
Programa de Ayuda Familiar (FA)
Formulario de solicitud de ayuda

Presentación de la solicitud

Para postularse, solamente necesita completar su nombre, dirección, firma y la fecha a continuación. Llene el formulario tanto como sea posible. Si necesita ayuda, el trabajador le dará una mano para completar el resto de su solicitud. En caso de necesitar los servicios de un intérprete debido a un impedimento del lenguaje o sensorial, déjenos saber para que su trabajador coordine la ayuda sin costo alguno para usted.

Necesita interprete: ☐ Sí ☐ No

Tipo: Lenguaje ____________; Sensorial ____________
(Especificar) (Especificar)

PARA USO EXCLUSIVO DEL ORGANISMO

Fecha de entrega/envío ____________
Fecha de recepción ____________
País ____________
Expediente del caso n.º ____________
Expediente del PSD n.º ____________
Fecha de la cita ____________
Hora de la cita ____________
Trabajador ____________

Apellido, nombre e inicial del segundo nombre	Otros nombres que utilice
Estado civil y fecha correspondiente ❑ Casado Fecha__________ ❑ Separado Fecha__________ ❑ Viudo Fecha__________ ❑ Divorciado Fecha__________ ❑ Soltero	Teléfono particular/para dejar mensajes Correo Electrónico

Domicilio en el que vive		N.º de apartamento
Ciudad y estado	Código postal	País

Domicilio postal (si no coincide con el domicilio en el que vive)

CERTIFICO, BAJO PENA DE PERJURIO, QUE LO QUE DECLARO EN ESTA SOLICITUD ES VERDADERO Y CORRECTO.

Firma o marca	Fecha
Firma del testigo (si colocó una marca)/intérprete/otro	Fecha

Si cumple con los requisitos, recibirá beneficios retroactivos a la fecha en que recibimos su solicitud firmada. Antes de poder acceder a los beneficios, debe presentarse en nuestra oficina para mantener una entrevista con un trabajador. Necesitamos comprobantes de la información que proporcione en su solicitud de Ayuda Familiar. Tomaremos una decisión definitiva con respecto a su solicitud dentro de los 30 días de haberla recibido. Si algo de lo que nos informó cambia después de la entrevista, debe informárselo a su trabajador de inmediato.

Antecedentes de manutención

¿Cómo ha hecho hasta ahora para ocuparse de su manutención y de la manutención de las personas para las que solicita ayuda? ¿Por qué necesita ayuda ahora?

Información sobre el solicitante

EDAD de los NIÑOS QUE VIVEN en el HOGAR: Los niños incluidos a continuación deben vivir con usted y tener menos de 18 años (o 18 años si son estudiantes de tiempo completo en una escuela secundaria o en un -centro de capacitación técnica o vocacional de igual nivel). (La escuela secundaria incluye educación pública, privada, religiosa y enseñanza en el hogar desde 9. ° hasta 12. ° grado).

Solicitante que TIENE VÍNCULO FILIAL: Incluya su nombre en la línea 1 a continuación. A partir de la línea 2, incluye el nombre de los niños para los que desea solicitar ayuda y de sus hermanos y hermanas. Incluya también el nombre de cualquier otro padre de los niños que viva en su hogar y de su cónyuge, si es que vive con usted.

Solicitante que NO TIENE VÍNCULO FILIAL: Incluya su nombre en la línea 1 a continuación. A partir de la línea 2, incluye el nombre de los niños para los que desea solicitar ayuda y de sus hermanos y hermanas. Incluya también el nombre de cualquier padre o padrastro de los niños que viva en su hogar. NOTA: Dado que usted no es el padre, proporcionar su número de seguro social o información sobre su condición de ciudadano o extranjero es opcional.

Apellido, nombre, inicial del segundo nombre Use la primera línea para sus datos	Vínculo con usted	Fecha de nacimiento	Número de seguro social	Sexo	* Raza / Etnia	Condición de ciudadano o extranjero: Ciudadano o natural de Estados Unidos Sí/No	Condición de ciudadano o extranjero: Condición de inmigrante satisfactoria Sí/No
1.	Usted						
2.							
3.							
4.							
5.							
6.							

Otros miembros

OTROS: Incluya a sus padres o padrastro(s) si tiene menos de 18 años y vive en la misma casa.

Registro del Votante

SI NO ESTÁ REGISTRADO PARA VOTAR EN DONDE VIVE AHORA, ¿QUISIERA SOLICITAR REGISTRARSE PARA VOTAR AQUÍ HOY?

- ☐ Sí, quisiera registrarme para votar.
- ☐ Sí, estoy registrado pero quisiera cambiar mi dirección con el fin de votar.
- ☐ No, no deseo solicitar registrarme para votar.

SI NO MARCA NINGÚN CASILLERO, SE CONSIDERARÁ QUE OPTÓ POR NO REGISTRARSE PARA VOTAR EN ESTA OPORTUNIDAD.

Solicitar registrarse para votar o no hacerlo no afectará la cantidad de asistencia que reciba de esta agencia

Si necesita ayuda para completar el formulario de solicitud para registrarse para votar, podemos ayudarlo. Puede buscar asistencia con el formulario de solicitud buscando asistencia al momento de su entrevista o llamando al Departamento local de Recursos Humanos ubicado en su condado. La decisión de buscar o aceptar ayuda corre por cuenta suya. Puede completar el formulario de solicitud en privado.

Si elige solicitar registrarse para votar o si rechaza registrarse para votar, la información en el formulario de solicitud o rechazo permanecerá confidencial y solamente se utilizará para fines de inscripción del votante.

Si considera que alguien ha interferido con su derecho de registrarse para votar o rechazar registrarse para votar, con su derecho de privacidad sobre decidir si registrarse o solicitar registrarse para votar, o su derecho de escoger su propio partido político u otra preferencia política, puede presentar una queja ante la Secretaría de Estado en State Capitol, 600 Dexter Avenue Suite E-208, Montgomery, Al 36130 o llamando al 334-242-7210 o al 1-8CO-274-VOTE (1-800-274-8683).

Códigos de raza y etnia

*Los datos sobre la etnia se usan a nivel federal para fines estadísticos e informativos únicamente.

Esta información no afectará el cumplimiento de los requisitos.

Si no completa esta información, otra persona la completará por usted.

01=Amerindio/Nativo de Alaska
02=Asiático
03=Negro/Afroamericano
04=Nativo de Hawái/Nativo de otra isla del Pacífico
05=Blanco
06=Amerindio/Nativo de Alaska y blanco
07=Asiático y blanco
08=Negro/Afroamericano y blanco
09=Amerindio/Nativo de Alaska y negro
12=Asiático y negro
33=Hispánico/Latino/Cubano/Haitiano
32=Otro (el trabajador determinará el código correspondiente en la entrevista)

Derechos civiles

Las normas del programa son las mismas para todos. Su raza, color, origen nacional, sexo, impedimento físico, creencia o religión no tienen importancia. Para presentar una queja sobre el Programa de Ayuda Familiar, envíe una carta al Department of Health and Human Services (DHHS), Office of Civil Rights, Room 509F, 200 Independence Avenue, S. W., Washington, D. C. 20201 o llame al 1-800-368-1019. El DHHS es un prestador y un empleador que promueve la igualdad de oportunidades.

State of Alabama Agency-Based Voter Registration Form

NVRA-1B-H 2019.06.27

FOR USE BY U.S. CITIZENS ONLY ◆ FILL IN ALL BOXES ON THIS FORM ◆ PLEASE USE INK ◆ PRINT LEGIBLY

To register to vote in the State of Alabama, you must:

- Be a citizen of the United States.
- Live in Alabama.
- Be at least 18 years of age on or before election day.
- Not have been convicted of a disqualifying felony, or if you have been convicted, you must have had your civil rights restored.
- Not have been declared "mentally incompetent" by a court.

FOR USE BY AGENCY OFFICIAL ONLY
Check one (1) box:
☐ Registrars
☐ Motor Voter
☐ State Designated Agency
☐ Agency-Based
☐ Disabilities Services Office

Signature of Agency Representative

Business Phone of Agency Representative

ID requested: You may send with this application a copy of valid photo identification. You will be required to present valid photo identification when you vote at your polling place or by absentee ballot, unless exempted by law. For more information, go to www.AlabamaVoterID.com or call the Elections Division: 800-274-8683.

① Are you a citizen of the United States of America? ☐ Yes ☐ No

② Will you be 18 years of age on or before election day? ☐ Yes ☐ No

ATTENTION! If you answer "No" to either of these questions, do not complete this application.

③ Print Your Name:
First | Middle | Last | Suffix

Alabama Driver's License or Non-Driver ID Number: STATE | NUMBER

④ Print Maiden Name / Former Name (if reporting a change of name)
First | Middle | Last | Suffix

IF YOU HAVE NO ALABAMA DRIVER'S LICENSE OR ALABAMA NON-DRIVER ID NUMBER

Last four digits of Social Security number:

☐ I do not have an Alabama driver's license or Alabama non-driver ID or a social security number.

⑤ Date of Birth (mm/dd/yyyy) | ⑥ Primary Telephone ( ) | ⑦ Email Address

⑧ Addresses

Current

Address where you live: (Do not use post office box)
Home Address (include apartment or other unit number if applicable) | City | State | ZIP

Address where you receive your mail:
Mailing Address, if different from Home Address | City | State | ZIP

Old

Address where you were last registered to vote: (Do not use post office box)
Former Address | City | County | State | ZIP

⑨ Sex (check one)
☐ Female ☐ Male

⑪ Place of Birth
City | County | State | Country

⑩ Race (check one)
☐ White ☐ Black
☐ Asian ☐ American Indian
☐ Hispanic ☐ Other

⑫ Map / Diagram
If your home has no street number or name, please draw a map of where your house is located. Please include roads and landmarks.

⑬ Did you receive assistance?
If you are unable to sign your name, who helped you fill out this application? Give name, address, and phone number (phone number is optional).

REGISTRARS USE ONLY

DATE ☐ APPROVED ☐ DENIED

(mm/dd/yyyy)

County Pct

City Pct

Board member

Board member

Board member

Voter Declaration - Read and Sign Under Penalty of Perjury

- I am a U.S. citizen
- I live in the State of Alabama
- I will be at least 18 years of age on or before election day
- I am not barred from voting by reason of a disqualifying felony conviction (The list of disqualifying felonies is available on the Secretary of State's web site at: sos.alabama.gov/mtfelonies)
- I have not been judged "mentally incompetent" in a court of law

I solemnly swear or affirm to support and defend the constitution of the United States and the State of Alabama and further disavow any belief or affiliation with any group which advocates the overthrow of the governments of the United States or the State of Alabama by unlawful means and that the information contained herein is true, so help me God.

YOUR SIGNATURE | **DATE** (mm/dd/yyyy)

If you falsely sign this statement, you can be convicted and imprisoned for up to five years.

The decision to register to vote is yours. If you decide to register to vote, the office at which you are submitting this application will remain confidential and will be used only for voter registration purposes. If you decline to register to vote, your decision will remain confidential and will be used only for voter registration purposes.

John H. Merrill - Secretary of State

Questions? Call the Elections Division at 1-800-274-8683 or 334-242-7210

Instructions for Form DHR-FAD-2209 (690)
Application for Family Assistance
Spanish Version

Refer to the DHR-FAD-690, Application for Family Assistance Instructions for guidance about the use of this form. Those instructions are found earlier in Appendix II.

Alternate Grantee Relative
Declaration of Qualifications

Part I: To be completed by worker:

Case Name______________________________ County______________________________

Worker______________________________ PSD File No.______________________________

Part II: To be completed by Alternate Grantee Relative:

Instructions: Answer each question and sign/date. Return to the worker identified above.

1. Are you related to the above named individual? Yes____ No____ If yes, state relationship_____________
2. Are you a resident of Alabama? Yes____ No____
3. Are you age 18 or older? Yes____ No____
4. Do you receive Family Assistance (FA) benefits for yourself and/or for children who live with you? Yes____ No____
5. Are you currently disqualified from receiving FA benefits? Yes____ No____
6. Have you been convicted of a felony? Yes____ No____
7. Do you use or have you ever used illegal drugs? Yes____ No____

I certify that answers given by me to questions 1-7 above are true and correct to the best of my knowledge.

______________________________ ______________________________
Signature Date

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Witness if signed by mark

DHR-FAD 2215
July 2014

INSTRUCTIONS FOR DHR-FAD-2215

Alternate Grantee Relative
Declaration of Qualifications

Use/Purpose

This form is used to document the Alternate Grantee Relative's (AGR) statement of qualifications to serve as AGR for an assistance unit in accordance with the Assistance Payments Manual Sections 1400E and 2595.

General Instructions

This form is to be completed by the individual who has been chosen as Alternate Grantee Relative (AGR) to receive benefits for otherwise eligible assistance unit members due to the disqualification of the grantee relative.

Distribution: Original in the case record of AGR.
Copy in the case record of the disqualified grantee relative.

THIS FORM WILL NOT BE STOCKED. MAKE COPIES AS NEEDED.