Simple Application for the Supplemental Nutrition Assistance Program (SNAP) for Elderly and/or Disabled Households

You can use this application for SNAP benefits if:

- Everyone in the household is age 60 or older or disabled and purchases and prepares food together and does not receive any earnings from work; OR
- All household members age 60 or older or disabled with no earnings from work purchase and prepare food separately from other household members.

Options for submitting your application are listed below. Your local DHS office will review and follow-up.

By Mail:
RI Department of Human Services,
P.O. Box 8709, Cranston, RI 02920-8787

Local DHS office:
Find your nearest location at
www.dhs.ri.gov/DHSOffices or call 855-MY-RIDHS (1-855-697-4347)

Questions?
1-855-MY-RIDHS
For LTSS questions: 401-574-8474

We are required to verify the information you provide and take action on your application within thirty (30) days of the filing date unless you are entitled to expedited service (7 days). To determine whether or not you are eligible, you must be interviewed. The application filing date for pre-release applicants is the date of release from the institution.

You will be sent a written request for any verification/documents missing from your application. Your application will be denied if the missing verification is not received within ten (10) days of the written request.

What language do you prefer? Spoken Language: _____ **Written Language:** _____

☐ **It is your right to receive the assistance you need to complete this application. Check here if you need assistance completing this application.**

Let us know if you need any of the following in order to complete this application:

☐ **Interpreter** ☐ **Sign language interpreter** ☐ **TDD/TTY phone number we should call** ☐ **Assistance listening device** ☐ **Other** _____

Si no habla inglés o tiene un impedimento auditivo o una discapacidad, háganos saber cómo podemos ayudarle (con un intérprete, lengua de señas, número de teléfono TDD/TTY al que debemos llamar, dispositivo de ayuda para escuchar, etc.) o traiga su asistencia propia.

Se você não falar Inglês, or tiver uma deficiência auditiva or uma deficiência física, informe-nós como podemos ajudar (um intérprete, língua de sinais, podemos chamar um número de telefone TDD/TTY, um dispositivo de escuta, etc.) or você poder trazer o seu próprio apoio.
If you are refused help, call the Community Relations Liaison Officer at 415-8500 (TDD 462-6239)

FOR MANUAL SUBMISSION, PLEASE COMPLETE USING BLUE OR BLACK INK AND PRINT IN BLACK & WHITE

APPLICATION REGISTRATION

If you are unable to finish the entire application today, you may complete this page and return it to DHS. For food assistance (SNAP), you are only required to fill in your name, address (unless homeless), and signature.

NAME

First Name | Middle Name | Last Name

HOUSEHOLD STREET ADDRESS – the place where you currently live

☐ I am homeless.
If homeless, please include a city/town and mailing address. If you do not have a mailing address, please write in the DHS office.

Address

City/Town | State | Zip Code | Apt/Lot#

MAILING ADDRESS – *if different from above (Street, City, State, ZIP Code)*

Address

City/Town | State | Zip Code | Apt/Lot#

We need a Social Security number (SSN) for people who are requesting assistance and have a SSN or can get one.

If you need help applying for an SSN, a DHS representative can help.

Social Security Number – –

Date of Birth / /

Cell Phone #

Home Phone #

Email

What is your preferred method of contact? ☐ Paper Mail ☐ Email

You may be able to get SNAP benefits within 7 days if your income, cash and money in the bank add up to less than your monthly housing expense; or your monthly income is less than $150 and your money in the bank and liquid resources are less than $100; or you are a migrant or seasonal farmworker.

How much money do you and household members have in the bank? $

What is the total monthly income (before taxes) received by you and members of your household? $

What is your current monthly rent/mortgage payment? $

Do you pay for heating or cooling (e.g. air conditioning)? ☐ Y ☐ N

Is any applicant a migrant or seasonal farm worker? ☐ Y ☐ N

Sign Here

Under penalties of perjury, I state that I have reviewed this application, and to the best of my knowledge and belief, including the information concerning citizenship and non-citizenship status, the answers I give within this application are true. If I am declaring an Authorized Representative, by signing below, I allow this person to sign my application, get official information about this application, and act for me on all future matters with this agency. If you sign this page and submit today, you will still need to complete a full application. Benefits begin from the date the office receives your application.

Applicant Signature | Representative Signature | Date / /

Need more room to write? See pages 13-14 for additional room. ☐ Yes, I have added more notes

HOUSEHOLD MEMBERS

Please list the members of your household below, inlcuding yourself and everyone who lives in your home now, even if they do not want assistance.

SSN and US Citizen/National should not be answered for people who are not requesting assistance.

Ethnicity/race is optional to assure that program benefits are distributed without regard to race, color, and national origin.

Person 1

Relationship to you | Full Legal Name | SSN | DOB (/ /)

Sex ☐ M ☐ F ☐ X | US Citizen/National ☐ Y ☐ N | Naturalized/ Derived Citizen? ☐ Y ☐ N | Married ☐ Y ☐ N

Ethnicity *(optional)*:
- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino

Race *(optional)*:
- ☐ African American/Black
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ White
- ☐ Other

Person 2

Relationship to you | Full Legal Name | SSN | DOB (/ /)

Sex ☐ M ☐ F ☐ X | US Citizen/National ☐ Y ☐ N | Naturalized/ Derived Citizen? ☐ Y ☐ N | Married ☐ Y ☐ N

Ethnicity *(optional)*:
- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino

Race *(optional)*:
- ☐ African American/Black
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ White
- ☐ Other

Need more room to write? See pages 13-14 for additional room. ☐ Yes, I have added more notes

HOUSEHOLD MEMBERS CONTINUED

If you or someone in your household are applying for benefits and are not a U.S. citizen, please complete this section.

Household members choosing not to seek benefits are not required to provide citizenship/immigration information.
Household members who are seeking benefits must supply information about citizenship or immigration status.

If you are a non-citizen applying for benefits, the information you provide in this section will be subject to verification by the United States Citizenship and Immigration Services (USCIS- formerly known as INS) through submission of information from this application to USCIS. Submitted information received from USCIS may affect your household's eligibility and level of benefits.

The amount of benefits will depend on the number of people requesting benefits, but eligible household members who apply will be able to get benefits even though some people in the household are not seeking benefits.

Household members who are not seeking benefits will be required to provide their financial information if it is needed to determine eligibility and benefit amount for persons who are applying.

Non-Citizen 1

Name of Non-U.S. Citizen

Date of U.S. Entry

Country of Origin

Alien Registration #

Name on Immigration Document

Document Expiration Date

USCIS/INS or Permanent residency Date (if applicable)

Alien Visa or SEVIS ID

Non-Citizen Status (Select one)

- ☐ Lawful Permanent Resident
- ☐ Asylee
- ☐ Paroled into the U.S.
- ☐ Conditional entrant
- ☐ Victim of Trafficking
- ☐ Cuban/Haitian Entrant
- ☐ Lawful Temporary Resident
- ☐ Battered Spouse/Child/Parent
- ☐ Temporary Protected Status
- ☐ Work Visa
- ☐ Student Visa
- ☐ Refugee
- ☐ Granted Withholding of Deportation/Removal
- ☐ Other:

Was this person sponsored? ☐ Y ☐ N

If yes, please provide sponsor information below:

Name of Sponsor:

Sponsor Phone #

Is the sponsor an individual or an agency? ☐ Individual ☐ Agency

Is the sponsor a household member? ☐ Y ☐ N

Do you receive financial support from your sponsor? ☐ Y ☐ N

Need more room to write? See pages 13-14 for additional room. ☐ Yes, I have added more notes

HOUSEHOLD MEMBERS CONTINUED

Non-Citizen 2

Name of Non-U.S. Citizen

Date of U.S. Entry

Country of Origin

Alien Registration #

Name on Immigration Document

Document Expiration Date

USCIS/INS or Permanent residency Date (if applicable)

Alien Visa or SEVIS ID

Non-Citizen Status (Select one)

- ☐ Lawful Permanent Resident
- ☐ Asylee
- ☐ Paroled into the U.S.
- ☐ Conditional entrant
- ☐ Victim of Trafficking
- ☐ Cuban/Haitian Entrant
- ☐ Lawful Temporary Resident
- ☐ Battered Spouse/Child/Parent
- ☐ Temporary Protected Status
- ☐ Work Visa
- ☐ Student Visa
- ☐ Refugee
- ☐ Granted Withholding of Deportation/Removal
- ☐ Other:

Was this person sponsored? ☐ Y ☐ N

If yes, please provide sponsor information below:

Name of Sponsor:

Sponsor Phone #

Is the sponsor an individual or an agency? ☐ Individual ☐ Agency

Is the sponsor a household member? ☐ Y ☐ N

Do you receive financial support from your sponsor? ☐ Y ☐ N

Need more room to write? See pages 13-14 for additional room. ☐ Yes, I have added more notes

HOUSEHOLD DETAILS

You will need to select a head of household. A head of household is typically an adult parent of the children in the home or a person who is working and providing financial support for the household. If there is no parent or working individual, you can select any adult to be the head of household. Please select a head of household to the right.

IDENTIFY A HEAD OF HOUSEHOLD

Who is the head of household?

Full legal name

What is your preferred way to interview for SNAP?

☐ Telephone Interview ☐ In-Person Interview

AUTHORIZED REPRESENTATIVE

Authorized Representatives can complete the interview, get information about your case, and you and your Authorized Representative will get mail/notices about your case.

Do you want someone else to act for or represent you in this case? ☐ Y ☐ N

If yes, please fill in the information below:

Name of your Authorized Representative:

First Name Middle Name Last Name

SSN DOB

Address of Representative:

Address

City/Town State Zip Code Apt/Lot#

Phone # of Representative Email of Representative

Need more room to write? See pages 13-14 for additional room. ☐ Yes, I have added more notes

HOUSEHOLD DETAILS CONTINUED

Does anyone in your household buy and make food separately from the rest of the household? ☐ Y ☐ N

If yes, who?

Is anyone living in a group living arrangment (such as a shelter for the homeless, a domestic violence shelter, a hospital, an assisted living facility, a dormitory, or a group home) now, or expects to be for more than 30 days? ☐ Y ☐ N

If yes, who?

Name of Facility

Type of Facility

Is any applicant participating in an alcohol or drug treatment program? ☐ Y ☐ N

If yes, who?

Is anyone a boarder? Is anyone a foster child or foster adult? ☐ Y ☐ N

Is any applicant receiving SNAP from another state? ☐ Y ☐ N

Has any applicant ever applied for or received SNAP/food stamps in RI or another state? ☐ Y ☐ N

If yes, who?

Is anyone in the household living with a mental, emotional or physical disability or illness, or blind?

☐ Y ☐ N If yes, who?

Please describe:

Is any applicant temporarily absent (less than 30 days) from the home (work, military, hospital, etc.)?

☐ Y ☐ N If yes, who?

Is any applicant a non-parent caregiver?

☐ Y ☐ N If yes, who?

Is any applicant incarcerated?

☐ Y ☐ N If yes, who?

Need more room to write? See pages 13-14 for additional room. ☐ Yes, I have added more notes

INCOME

Examples: Employment income; Unemployment Insurance; Supplemental Security Income (SSI); Alimony; Workers' Compensation; Child Support; Social Security Retirement, Survivors, Disability, Insurance Benefit (RSDI/SSDI); Pension/Retirement; Foster care/ adoption subsidy; Loans; Interest/Dividends; Tribal Income/Benefits; Veterans Benefits/ Military Allotments; TDI/TCI/Disability Payment; Other (please describe)

Does any applicant have income?

☐ Y ☐ N If yes, Please check applicable incomes below:

Income 1

Person 1 | $ Amount

☐ Employment Income ☐ Child Support ☐ Loans ☐ Tribal Income/Benefits

☐ Unemployment Insurance ☐ Supplemental Security Income (SSI) ☐ Alimony

☐ Workers' Compensation ☐ Pension/Retirement ☐ TDI/TCI/Disability Payment

☐ Loans ☐ Foster care/Adoption Subsidy ☐ Interest/Dividends

☐ Social Security Retirement, Survivors, Disability, Insurance Benefit (RSDI/SSDI)

☐ Veterans Benefits/Military Allotments ☐ Student Loans/Scholarships ☐ Other

Type of Income

How often do you receive your other income?

☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly

Income 2

Person 1 | $ Amount

☐ Employment Income ☐ Child Support ☐ Loans ☐ Tribal Income/Benefits

☐ Unemployment Insurance ☐ Supplemental Security Income (SSI) ☐ Alimony

☐ Workers' Compensation ☐ Pension/Retirement ☐ TDI/TCI/Disability Payment

☐ Loans ☐ Foster care/Adoption Subsidy ☐ Interest/Dividends

☐ Social Security Retirement, Survivors, Disability, Insurance Benefit (RSDI/SSDI)

☐ Veterans Benefits/Military Allotments ☐ Student Loans/Scholarships ☐ Other

Type of Income

How often do you receive your other income?

☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly

Need more room to write? See pages 13-14 for additional room. ☐ Yes, I have added more notes

EXPENSES

For some households, reporting expenses can affect their eligibility. Additionally, reporting of expenses in this section can affect the amount of benefits you receive. If your household is determined eligible and you do not report an expense, we will assume that you do not want this expense to be counted. If you report your expenses, it may help to increase your SNAP benefits.

All applicant households are encouraged to answer these questions.

HOUSEHOLD EXPENSES

Does anyone pay household expenses? ☐ Y ☐ N

If yes, list below

Who?

Examples: Rent; Land Contract; Homeowner's insurance*; Mortgage; Mobile Home Lot Rent; Property Tax*; Other (please describe in table below)

*Only list insurance/ property tax if not included in mortgage

Type of Expense | $ Amount

How Often Paid: ☐ Weekly ☐ Bi-Weekly ☐ 2x a month ☐ Monthly ☐ Quarterly ☐ Yearly

Who?

Type of Expense | $ Amount

How Often Paid: ☐ Weekly ☐ Bi-Weekly ☐ 2x a month ☐ Monthly ☐ Quarterly ☐ Yearly

Does anyone else help pay (roommate, parent, etc.)? ☐ Y ☐ N

If yes, list below:

Who? | $ Amount

UTILITIES

Does anyone pay utilities (including seasonal costs)? ☐ Y ☐ N

If yes: ☐ Heat ☐ Cooling ☐ Phone ☐ Other:

Has anyone applying for SNAP received a Low Income Home Energy Assistance Payment (LIHEAP) in the last 12 months? ☐ Y ☐ N

Need more room to write? See pages 13-14 for additional room. ☐ Yes, I have added more notes

EXPENSES CONTINUED

MEDICAL

Does any applicant have out-of-pocket medical expenses? ☐ Y ☐ N

If yes, list below:

Who?

Examples: Medical Care, Dental Care, Health Insurance, Medications, Other (over-the-counter medications, medical supplies, etc.)

Type of Expense | $ Amount per month

Who?

Type of Expense | $ Amount per month

Does any applicant travel to and/or from medical care (such as a pharmacy, doctor, therapist, etc.)? ☐ Y ☐ N

If yes, list below:

Who? | Number of car trips per week

Examples: Cost of parking, public transportation, shuttle, taxi cab, etc.

$ Cost | Address of Medical Provider

DEPENDENT CARE

Does any applicant pay for dependent care expenses? ☐ Y ☐ N

If yes, list below:

Person Who Pays

Examples: Childcare (day care, after school programs, etc.) or care for an incapacitated adult

Type of Expense | $ Amount

How Often Paid: ☐ Weekly ☐ Bi-Weekly ☐ 2x a month ☐ Quarterly ☐ Yearly

Person 2 Who Pays

Type of Expense | $ Amount

How Often Paid: ☐ Weekly ☐ Bi-Weekly ☐ 2x a month ☐ Quarterly ☐ Yearly

CHILD SUPPORT

Do you, your spouse or anyone in the household pay court ordered child support for any person not living in this household? ☐ Y ☐ N

If yes:

$ Amount

How Often Paid: ☐ Weekly ☐ Bi-Weekly ☐ 2x a month ☐ Quarterly ☐ Yearly

Need more room to write? See pages 13-14 for additional room. ☐ Yes, I have added more notes

ADDITIONAL INFORMATION

Are you or any member of your household hiding or running from the law to avoid prosecution, being taken into custody, or going to jail, for a felony crime or attempted felony crime, or violating a condition or parole or probation?

☐ Y ☐ N If yes, who? _____ ___/___/___ Warrant/Court Finding Date _____ State

Have you or has any member of your household been convicted as an adult of aggravated sexual abuse, murder, sexual exploitation and other abuse of children, a Federal or State offense involving sexual assault, or an offense under State law determined by the Attorney General to be substantially similar to such an offense, after February 7, 2014? ☐ Y ☐ N

If yes, are you in compliance with your sentence for this conviction? ☐ Y ☐ N

Has any applicant ever been disqualified from food assistance due to welfare fraud or an intentional program violation in any state, including Rhode Island? ☐ Y ☐ N

Name: _____

Have you or any member of your household been convicted of trading SNAP benefits for guns, ammunitions, or explosives after September 22, 1996? ☐ Y ☐ N

Name: _____

Have you or any member of your household been convicted of buying or selling SNAP benefits over $500 after September 22, 1996? ☐ Y ☐ N

Name: _____

Have you or any member of your household had been convicted of trading SNAP benefits for drugs after September 22, 1996? ☐ Y ☐ N

Name: _____

Need more room to write? See pages 13-14 for additional room. ☐ Yes, I have added more notes

ALL APPLICANTS MUST SIGN THIS PAGE

YOUR RIGHTS

After your eligibility is determined, if you think the Rhode Island Department of Human Services (DHS) has made a mistake in determining your eligibility, you can ask for a hearing.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

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

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to: (1) Mail: Food and Nutrition Service, USDA, 1320 Braddock Place, Room 334, Alexandria, VA 22314; or (2) fax: (833) 256-1665 or (202) 690-7442; or (3) email: FNSCIVILRIGHTSCOMPLAINTS@usda.gov.

This institution is an equal opportunity provider. The Rhode Island Department of Human Services (DHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs, or disability.

YOUR RESPONSIBILITIES

By signing this application, you are agreeing to these responsibilities. Please refer to the Handbook to read a complete description of your rights and responsibilities.

- ✓ **I have told the truth; I understand that I can be held criminally responsible for lying on this application.**
- ✓ **I will have to provide documents that show that what I have told the department is true.**
- ✓ **I will have to repay any SNAP benefits I should not have received, even if it is the department's error.**
- ✓ **I need to tell the department about any changes to the information I provided on my application. Your change reporting requirements will be included in your decision notice. If you are unsure of your reporting requirements, contact a DHS worker.**
- ✓ **I agree to cooperate with state or federal reviewers for an audit.**
- ✓ **I will use my benefits legally and will not sell, trade, or give away my benefits online or in person.**
- ✓ **I understand that the information provided on this application will be subject to verification by Federal, State or local officials to determine if the information is factual. If any information is incorrect, benefits may be denied and you may be subject to criminal prosecution for knowingly providing incorrect information.**
- ✓ **I understand that any member of my household who intentionally breaks a SNAP rule will be barred from the SNAP from one year to permanently, fined up to $250,000, imprisoned up to 20 years or both. S/he may also be subject to prosecution under other applicable Federal and State laws. S/he may also be barred from SNAP for an additional 18 months if court ordered.**
- ✓ **I understand that DHS is required to use the Income and Eligibility Verification System (IEVS) at the time of application and at each recertification. Information available through IEVs will be requested, used and may be verified through collateral contacts when discrepancies are found. This information may affect the household's eligibility and level of benefits.**
- ✓ **I understand that for SNAP I am required to report lottery/gambling winnings over the resource limit for an elderly/disabled household (even if I am not elderly or disabled) for myself or anyone in my household and that my household will be disqualified from SNAP if a SNAP recipient in my household wins over this amount.**

☐ **I have reviewed and agree to the Rights and Responsibilities attached to this application**

Sign Here

Under penalties of perjury, I state that I have reviewed this application, and to the best of my knowledge and belief, the answers I give within this application are true, including household, citizenship and non-citizenship information, and I have listed all amounts and sources of income and property I receive/own. If I am declaring an Authorized Representative, by signing below, I allow this person to sign my application, get official information about this application, and act for me on all future matters with this agency. If I am signing as an Authorized Representative for Healthcare coverage, I attest to my agreement to meet confidentiality and act in the best interest of the beneficiary.

Applicant Signature _____ **Date** ___/___/___

Spouse Signature *If applicable* _____ **Date** ___/___/___

Authorized Representative Signature *If applicable* _____ **Date** ___/___/___

FOR STAFF USE ONLY:

When in-person interview completed:

Applicant Signature _____

Date ___/___/___

Need more room to write? See pages 13-14 for additional room. ☐ **Yes, I have added more notes**

NOTES

Page #	

NOTES

Page #	

Your Rights and Responsibilities

You have a RIGHT to non-discriminatory treatment. In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

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

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

mail:

Food and Nutrition Service, USDA
1320 Braddock Place, Room 334
Alexandria, VA 22314; or

fax:

(833) 256-1665 or (202) 690-7442; or

email:

FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.

In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794), Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), and Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Food and Nutrition Act of 2008 (formerly the Food Stamp Act), the Age Discrimination Act of 1975, the U.S. Department of Health and Human Services implementing regulations (45 C.F.R. Parts 80 and 84) and the U.S. Department of Education implementing regulations (34 C.F.R. Parts 104 and 106), and the U.S. Department of Agriculture, Food and Nutrition Services (7 C.F.R. 272.6); the EOHHS and the Department of Human Services (DHS), does not discriminate on the basis of race, color, national origin, disability, religion, political beliefs, age, religion or gender in acceptance for or provision of services, employment or treatment, in its education and other program activities. Under other provisions of

applicable law, EOHHS/DHS does not discriminate on the basis of sexual orientation, gender identity or expression. For further information about these non-discrimination laws, regulations and complaint procedures or for resolution of complaints of discrimination, contact DHS at 1-855-697-4347 (for deaf/hearing impaired 1-800-745-6575 Voice; 1-800-745-5555 TTY, or 711).

The Community Relations Liaison Officer is the coordinator for implementation of Title VI, the Office of Rehabilitation Services (ORS)

Administrator or his/her designee is the coordinator for implementation of the Title IX, Section 504, and ADA. The Director of DHS or his/her designee has the overall responsibility for civil rights compliance for all agency programs. The Secretary of EOHHS is responsible for Medicaid related discrimination issues and any such complaints will be referred accordingly.

You have a RIGHT to confidentiality. Under state law, all agencies administrating programs included as part of this application are bound by state and federal laws and regulations to use information about you and other members of your household only for purposes directly related to the administration of the programs and in compliance of the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information. HIPAA restrictions prevent us from discussing the health information of you or any member of your household with anyone, including unauthorized representative, unless that individual has power of attorney, or you have signed a consent form authorizing the disclosure of this information. This includes disclosure of mental health information, HIV, AIDS, STD test results or treatment and chemical dependency services. I understand that by signing this application, I am giving the EOHHS and the DHS my consent to use or disclose protected health information for the purposes of treatment, payment and health care operations in accordance with applicable agency notices of privacy practices. The EOHHS and DHS do not release information about you or other members of your household without your consent except as provided in Rhode Island General Laws 40-6-12, 40-6-12.1, and 42-7.2-5(13), regulations set forth in the DHS Administrative Code and Medicaid Codes of Administrative Rules. Any person found guilty of violating the provisions of Rhode Island General Laws 40-6-12 shall be deemed guilty of a misdemeanor. Violators are subject to a maximum fine of two hundred dollars ($200), or imprisonment of up to six (6) months, or both.

You have a RIGHT to file a joint application for more than one program or file a separate application for SNAP or Medicaid benefits without applying for other program benefits. All SNAP applications, regardless of whether they are joint applications or separate applications, must be processed for SNAP purposes in accordance with procedural, timeliness, notice, and fair hearing requirements. No household shall have its SNAP or Medicaid application denied solely on the basis that its application to participate in another program has been denied or its benefits under another program have been terminated without a separate determination by the appropriate agency that the household failed to satisfy a SNAP eligibility requirement. Households that file a joint application for SNAP and another program and are denied benefits for the other program shall not be required to resubmit the joint application or to file another application for SNAP but shall have its SNAP eligibility determined based on the joint application in accordance with the SNAP processing time frames from the date the joint application was accepted by the Department.

You have a RIGHT to name an authorized representative. An authorized representative is a person designated by the head of the household or the spouse, or any other responsible member of the

household, to act on behalf of the household in applying for program benefits or using the benefits. The authorized representative for benefits may or may not be the same individual designated as an authorized representative for the application process or for meeting reporting requirements. The authorized representative designation must be made in writing.

RESPONSIBILITIES

You have a RESPONSIBILITY to supply accurate information about your income, resources and living arrangements on this application.

You have a RESPONSIBILITY to inform DHS within ten (10) days of any changes in your income, resources, family composition, or any other changes that affect your household. If you don't give us the information or ask for more time, we may deny, terminate or change your or benefits. If you are unsure about your reporting requirements, contact DHS for assistance.

You have a RESPONSIBILITY to provide Social Security numbers (or proof that you have applied for one) for yourself and your household, or to apply, if you are required to, for them as a condition of eligibility. The collection of information on the application, as well as the Social Security numbers of all members of your household for whom you receive assistance, is authorized under the Food and Nutrition Act of 2008 (formerly the Food Stamp Act), as amended, 7 U.S.C. 2011-2036 and under Federal Law (45 CFR 155.305 and 42 CFR 435.910). This information will be used to determine whether your household is eligible or continues to be eligible to participate in SNAP.

The Department will verify this information through computer matching with the Income and Eligibility Verification System (IEVS), Department of Labor and Training, the Social Security Administration, the Internal Revenue Service, the Food and Nutrition Service, and other governmental and non-governmental entities authorized by law, regulation or contract, and they will be subject to verification by Federal, State, and local officials. The income and eligibility information obtained from these agencies will be used to make sure your household is eligible for and receiving the correct amount of SNAP benefits. The information available through IEVS may be verified through collateral contacts when discrepancies are found, which may affect your household's eligibility and level of benefits. This information will also be used to monitor compliance with program regulations, for program management as well as to prevent fraud. This information may be disclosed to other federal and state agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law. If a claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies as well as private claims collection agencies for claims collection action. Providing the requested information is voluntary. However, failure to provide a SSN will result in the denial of benefits to any individual applying for benefits. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible household members.

You have a RESPONSIBILITY to report and provide proof of your expenses in order to get the maximum amount of SNAP benefits allowed. Failure to report or provide proof of your expenses will be regarded as your statement that you do not want to receive a deduction for the unreported or unproven expense.

You have a RESPONSIBILITY to cooperate fully with state and federal personnel conducting quality control reviews.

Only U.S. citizens and certain legal immigrants may be eligible for SNAP benefits. If there are non-citizens living with you who are not eligible, you may still apply for and receive benefits for other eligible

household members. You are not required to provide immigration information for people not applying for benefits, but you may need to provide other information for those people, such as, income and resources.

SNAP EBT Card Replacement Provisions:

Cardholders who request four (4) or more replacement EBT cards within a twelve (12) month period may be referred to the Fraud Unit for investigation of misuse or abuse of the EBT card. Documented violations may result in one or more of the following actions:

- Disqualification from the program;
- Recovery through recoupment/restitution; and/or
- Referral for criminal prosecution

In all cases, the agency shall act to protect households containing homeless persons, elderly or disabled members, victims of crimes, and other vulnerable persons who may lose EBT cards but are not committing fraud.

SNAP PENALTY WARNINGS

I understand that:

Any member of my household who intentionally breaks a SNAP rule will be barred from the SNAP from one year to permanently, fined up to $250,000, imprisoned up to 20 years or both. S/he may also be subject to prosecution under other applicable Federal and State laws. S/he may also be barred from SNAP for an additional 18 months if court ordered. Any member of my household who intentionally breaks a SNAP rule can be barred from the Supplemental Nutrition Assistance Program:

- For a period of one (1) year for the first violation, with the exceptions in numbers 1. through 5. below;
- For a period of two (2) years after the second violation, with the exceptions in numbers 1. through 5. below; and,
- Permanently for the third occasion of any intentional program violation.

1. Individuals found by a Federal, State, or local court to have used or received SNAP benefits in a transaction involving the sale of firearms, ammunitions or explosives shall be permanently ineligible for the Supplemental Nutrition Assistance Program upon the first occasion of such violation.
2. Individuals found to have made a fraudulent statement or representation with respect to the identity or place of residence of the individual in order to receive multiple SNAP benefits simultaneously shall be ineligible to participate in the Supplemental Nutrition Assistance Program for a period of ten (10) years.
3. Individuals found guilty by a Federal, State or local court of law for using or receiving benefits in a transaction involving the sale of a controlled substance (as defined in section 102 of the

Controlled Substances Act (21 U.S.C. 802)) will not be eligible for benefits for two years for the first offense, and permanently for the second offense.

4. Individuals found guilty by a court of law for buying or selling illegal drugs or certain prescription drugs in exchange for SNAP benefits will be prohibited from participating in the SNAP for 24 months for the first offense and permanently for the second offense.

5. An individual convicted by a Federal, State, or local court of having trafficked benefits for an aggregate amount of $500 or more shall be permanently ineligible to receive SNAP benefits upon the first occasion of such violation.

Trafficking as defined in 7 CFR 271.2 means:

1) Buying, selling, stealing or attempting to buy, sell, steal, or otherwise effect an exchange of SNAP benefits issued and accessed via Electronic Benefit Transfer (EBT) cards, card numbers and personal identification numbers (PINs), or by manual voucher and signature, for cash or consideration other than eligible food, either directly, indirectly, in complicity or collusion with others, or acting alone;

2) The exchange of firearms, ammunition, explosives, or controlled substances for SNAP benefits;

3) Purchasing a product with SNAP benefits that has a container requiring a return deposit with the intent of obtaining cash by discarding the product and returning the container for the deposit amount, intentionally discarding the product, and intentionally returning the container for the deposit amount;

4) Purchasing a product with SNAP benefits with the intent of obtaining cash or consideration other than eligible food by reselling the product, and subsequently intentionally reselling the product purchased with SNAP benefits in exchange for cash or consideration other than eligible food; or

5) Intentionally purchasing products originally purchased with SNAP benefits in exchange for cash or consideration other than eligible food.

DO NOT lie or hide information to get or continue to get SNAP benefits that your household should not get.
DO NOT use SNAP benefits to buy non-food items, such as alcoholic drinks and cigarettes or to pay on credit accounts.
DO NOT trade or sell (or attempt to trade or sell) EBT cards or use someone else's EBT card for your household.

DHS can use or share information on this application for the administration of DHS programs, as well as the administration of other federally funded assistance programs in accordance with state and federal law, contract and regulation.

DHS can release non-identifying information for research purposes. Any release of identifying information shall be done in accordance with state and federal law.

Rhode Island Voter Registration Form

Official use for barcode

This form is for: ☐ New voter ☐ Update my information ☐ Party change

Eligibility

If you check **"No"** in response to any of these questions, do not complete this form.

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

Are you a resident of Rhode Island? ☐ Yes ☐ No

Are you at least 16 years of age? ☐ Yes ☐ No, *You must be 18 years old to vote.*

Personal Information

All fields on this form are required except when indicated as optional.

Phone/email is optional and is public record.

Last Name | Suffix

First Name | Middle Initial

Date of Birth (mm/dd/yyyy) | Phone/Email (optional)

Identification Numbers

If you have never voted in Rhode Island, please enter the appropriate identification number.

Driver's License and State ID card must be issued by the RI Division of Motor Vehicles.

You may also submit a copy of your identification with this application.

☐ Rhode Island Driver's License or State ID card number: _____

☐ I have not been issued a RI Driver's License or State ID card.
Enter the last 4 digits of your Social Security Number (SSN): ____ ____ ____ ____

☐ I have not been issued a RI Driver's License, State ID card, or a Social Security Number.

Rhode Island Home Address

Home Address (Not a PO Box) | Unit Number

RI

City/Town | State | Zip Code

Mailing Address

If different from Rhode Island Home Address.

Mailing Address | Unit Number

City/Town | State | Zip Code

Party Affiliation

☐ Democrat ☐ Republican ☐ Unaffiliated ☐ Other: _____

Affirmation and Signature

Warning: If you sign this form and know it to be false, you can be convicted and fined up to $5,000 or jailed up to 10 years.

I swear or affirm that:

I am a U.S. Citizen; I live at the address set forth above; I will be at least eighteen (18) years old when I vote; I am not incarcerated in a correctional facility upon a felony conviction; I have not been lawfully judged "mentally incompetent" to vote by a court of law. The information I have provided is true to the best of my knowledge under pains and penalty of perjury. If I have provided false information, I may be fined, imprisoned, or (if not a U.S. citizen) deported from or refused entry into the United States.

SIGN HERE:

X

Date Signed (mm/dd/yyyy)

Update my Information

If you have changed your name or were already registered to vote in RI or in another state.

Previous Name

Previous Address (County, City/Town, State, Zip Code)

Get Involved!

☐ I am interested in being a poll worker

Return Address

_____

_____

_____

Postage Required

Post Office will not deliver without proper postage.

Mail to: **BOARD OF CANVASSERS**

_____

_____

_____

Barrington Town Hall
283 County Rd. 02806
247-1900 x4

Bristol Town Hall
10 Court St. 02809
253-7000

Burrillville Town Hall
105 Harrisville Main St.
Harrisville 02830
568-4300

Central Falls City Hall
580 Broad St. 02863
727-7450

Charlestown Town Hall
4540 South County Trl. 02813
364-1200

Coventry Town Hall
1670 Flat River Rd. 02816
822-9150

Cranston City Hall
869 Park Ave. 02910
780-3126

Cumberland Town Hall
45 Broad St. 02864
728-2400

East Greenwich Town Hall
125 Main St.,
P.O. Box 111 02818
886-8603

East Providence City Hall
145 Taunton Ave. 02914
435-7502

Exeter Town Hall
675 Ten Rod Rd. 02822
294-2287

Foster Town Hall
181 Howard Hill Rd. 02825
392-9201

Glocester Town Hall
1145 Putnam Pike
P.O. Box B, Chepachet 02814
568-6206 x0

Hopkinton Town Hall
1 Town House Rd. 02833
377-7777

Jamestown Town Hall
93 Narragansett Ave. 02835
423-9804

Johnston Town Hall
1385 Hartford Ave. 02919
553-8856

Lincoln Town Hall
100 Old River Rd.
P.O. Box 100 02865
333-1140

Little Compton Town Hall
40 Commons
P.O. Box 226 02837
635-4400

Middletown Town Hall
350 East Main Rd. 02842
849-5540

Narragansett Town Hall
25 Fifth Ave. 02882
782-0625

Newport City Hall
43 Broadway 02840
845-5386

New Shoreham Town Hall
16 Old Town Rd.
P.O. Box 220 02807
466-3200

North Kingstown Town Hall
100 Fairway Dr, 02852
294-3331 x128

North Providence Town Hall
2000 Smith St. 02911
232-0900 x234

North Smithfield Municipal Annex
575 Smithfield Rd. 02896
767-2200

Pawtucket City Hall
137 Roosevelt Ave. 02860
722-1637

Portsmouth Town Hall
2200 East Main Rd. 02871
683-3157

Providence City Hall
25 Dorrance St. 02903
Room 102
421-0495

Richmond Town Hall
5 Richmond Townhouse Rd.
Wyoming 02898
539-9000 x9

Scituate Town Hall
195 Danielson Pike
P.O. Box 328
North Scituate 02857
647-7466

Smithfield Town Hall
64 Farnum Pike, 02917
233-1000 x116

South Kingstown Town Hall
180 High St.
Wakefield 02879
789-9331 x1231

Tiverton Town Hall
343 Highland Rd. 02878
625-6703

Warren Town Hall
514 Main St. 02885
245-7340

Warwick City Hall
3275 Post Rd. 02886
738-2010

West Greenwich Town Hall
280 Victory Hwy. 02817
392-3800

West Warwick Town Hall
1170 Main St. West Warwick, RI 02893
822-9201

Westerly Town Hall
45 Broad St. Westerly, RI 02891
348-2503

Woonsocket City Hall
169 Main St.
P.O. Box B 02895
767-9221