

**APPLICATION AND AFFIDAVIT FOR  
PUBLIC ASSISTANCE**

OFFICE USE ONLY			
IM Worker _____	Date _____	Case Number _____	Su _____
IM Supervisor _____	Date _____	Related Case Number(s) _____	
TANF Status: ( ) NA ( ) RA ( ) RO ( ) TR		Date Registered _____	
<b>CATEGORICAL ELIGIBILITY:</b>			
Does everyone in the household receive Public Assistance (WFNJ) or SSI? [ ] YES [ ] NO			

**SECTION I**

APPLICANT: Please use a pen to complete this form carefully and accurately. IF YOU ARE NOT SURE OF ANY ANSWER, LEAVE THE SPACE BLANK. If you have any questions, ask the county welfare worker.

**DO NOT WRITE IN THE SHADED BOXES**

1. For Which Program(s) Do You Wish to Apply or Reapply?

- ( ) TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)                      ( ) NJ SUPPLEMENTAL NURTITION ASSISTANCE PROGRAM (SNAP)
- ( ) GENERAL ASSISTANCE (GA)      ( ) EMERGENCY ASSISTANCE (EA)      ( ) KINSHIP CARE SUBSIDY PROGRAM

I (we) understand that as a condition of WFNJ eligibility, I (we) shall be required to continuously and actively seek employment in an effort to gain self-sufficiency.

I (we) understand that as a condition of WFNJ eligibility, I (we) shall be required to register for work with New Jersey One Stop Career Center.

2. Are you willing to work? [ ] YES [ ] NO

3. Applicant's name: \_\_\_\_\_  
(LAST)                                      (FIRST)                                      (MI)                                      (MAIDEN)

4. Resident Address: **The place where you actually live:**

\_\_\_\_\_  
(NUMBER AND STREET OR RFD)                                      (CITY)                                      (STATE)                                      (ZIP CODE)

Address where your mail goes if different from your resident address above.

\_\_\_\_\_  
(P.O. BOX, STREET ADDRESS, OR RFD)                                      (CITY)                                      (STATE)                                      (ZIP CODE)

Your telephone number: HOME ( ) \_\_\_\_\_ WORK ( ) \_\_\_\_\_ CELL ( ) \_\_\_\_\_

5. Are you currently residing in an institution or facility? [ ] YES [ ] NO If "YES" answer questions 6-9, If "NO" skip to question 10.

6. What is the name of the institution or facility? \_\_\_\_\_

7. Is this a correctional facility? [ ] YES [ ] NO

7a. If "YES" what is your State Bureau of Identification (SBI) number? \_\_\_\_\_

8. What is your release date? \_\_\_\_\_

9. Do you have a place to stay when you are released? [ ] YES [ ] NO

**If yes, please complete**

\_\_\_\_\_  
(P.O. BOX, STREET ADDRESS, OR RFD)                                      (CITY)                                      (STATE)                                      (ZIP CODE)

10. New Jersey Residence (NOT APPLICABLE FOR NJ SNAP PURPOSES)

**RESIDENCE VERIFICATION**

Do you plan to continue living in New Jersey? [ ] YES [ ] NO

If "NO", EXPLAIN: \_\_\_\_\_

11. You can authorize a person(s) outside of your household to apply for benefits for you, or to discuss your application for benefits, or to receive an EBT card and use your benefits for you. This can be a social worker, case manager, family member or friend. If you wish to designate an authorized person to do any or all of this for you, please complete the following questions:

11a. Do you want to give permission for someone to make application for your benefits?  YES  NO  
 If "YES", complete the following information:

Name of Authorized Representative	Date of Birth (Optional)	Address	SSN (Optional)	Telephone Number

11b. Do you want to give permission for someone to discuss your application with the county welfare agency?  YES  NO  
 If "YES", complete the following information:

Name of Authorized Representative	Date of Birth (Optional)	Address	SSN (Optional)	Telephone Number

11c. Do you want to give permission for someone to use your benefits to make purchases for you? If you are eligible for benefits, the individual you authorize will receive a Families First EBT card to make purchases for you.  YES  NO  
 If "YES", complete all of the following information:

Name of Authorized Representative	Date of Birth	Address	SSN	Telephone Number

**QUESTIONS 12 and 13 BELOW - FOR NJ SNAP APPLICANTS ONLY**

12. You have the right to file an application for NJ SNAP immediately by providing your name, address, signature and date signed. If you are determined eligible, your benefits will be paid from that date. (If you file an application and provide all the necessary information about your circumstances and are found eligible, you can get NJ SNAP within 30 days of the date the NJ SNAP office receives your application.)
13. If you have very little income and resources, you may be eligible for expedited benefits (to be received within 7 days. **YOUR ANSWERS TO THE FOLLOWING QUESTIONS WILL DETERMINE IF YOU QUALIFY FOR THIS SERVICE:**
- (a) Is your household's total gross monthly income less than \$150.00 and your household's total liquid resources (such as cash or checking/savings accounts) \$100.00 or less?  YES  NO
  - (b) Is your household's monthly rent or mortgage plus utilities more than your household's total monthly gross income plus total liquid resources?  YES  NO
  - (c) Is your household a migrant or seasonal farm-working household with little or no income?  YES  NO

14. \_\_\_\_\_  
 (SIGNATURE OF PERSON INITIATING APPLICATION) (DATE SIGNED)

**SECTION II**

15. **BASIC INFORMATION:** (List each person in the household for whom application is being made, including yourself.)  
 List adult applicants first, beginning with the female adult, then the oldest to the youngest child.  
For NJ SNAP purposes, people who live, purchase food and eat with you should be counted as household members.

**NOTE:** The submission of Social Security numbers (SSNs) for all household members is authorized under the Food Stamp Act of 1977, as amended, 7 U.S.C. 2011-2036; Public Law 104-193 requires the submission of SSNs for all individuals applying for WFNJ. Your SSN will be used to determine whether your household is eligible or continues to be eligible to participate in the NJ SNAP Program and/or WFNJ program. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management. 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 NJ SNAP 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 action. The providing of the requested information, including the SSN of each household member, is voluntary for NJ SNAP purposes. However, failure to provide this information will result in the denial of NJ SNAP benefits and/or WFNJ benefits to your household.



Name	Social Security Number	Birthdate _____	Relationship To Applicant	Sex (F) or (M)	Race/Ethnicity	Legal Alien & BCIS Status	Marital Status	Grade and School	
<b>Other Applicant</b>		Birthplace							PA
Last									NJ SNAP
First M.I.									
<b>For Office Use Only</b>									
<b>Other Applicant</b>									PA
Last									NJ SNAP
First M.I.									
<b>For Office Use Only</b>									
<b>Other Applicant</b>									PA
Last									NJ SNAP
First M.I.									
<b>For Office Use Only</b>									
<b>Other Applicant</b>									PA
Last									NJ SNAP
First M.I.									
<b>For Office Use Only</b>									

**16. List Names of Aliens/Non-Citizens in Your Household**

NAME	DATE OF ENTRY/ COUNTRY OF ORIGIN	REGISTRATION #	SPONSOR NAME/ RESETTLEMENT AGENCY	SPONSOR/ RESETTLEMENT AGENCY ADDRESS	DATE APPLIED FOR CITIZENSHIP	SPONSOR INCOME

**17. List Other Persons in the Home not Listed Above (Include Roomers/Boarders)**

NAME	RELATIONSHIP TO APPLICANT

**17a. List an Emergency Contact Person (GA Cases Only)** \_\_\_\_\_  
 Phone Number \_\_\_\_\_ Address \_\_\_\_\_

18. Expectant Mother's Name \_\_\_\_\_ Expected Date of Birth \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Doctor's Address \_\_\_\_\_

19. What is the main language spoken in your home? \_\_\_\_\_.

20. Do you or any member of the applicant household now receive, or have you received, TANF, GA, SNAP, or SSI in New Jersey or any other state or territory since April 1997?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Individual Receiving Assistance	Type of Assistance	When	Assistance Provider

21. Are you or any member of your household a fleeing felon or in violation of a condition of parole or probation imposed by a Federal or State court?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Individual Fleeing or in Violation	Fleeing From	

22. Have you or any member of your household been convicted of fraudulently receiving means tested benefits in two or more places at the same time?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Individual Convicted of Fraud	Where Fraud Occurred	When	What Benefits

23. Since August 22, 1996, have you or any member of your applicant household committed and been convicted of possession, use or distribution of a controlled substance, which is an indictable offense? <b>Applies to GA only</b>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Individual Committing Offense	Type of Offense	Where Did Offense Occur	

24. If you were convicted of an indictable offense for possession or use, have you enrolled in or completed a Department of Health and Senior Services licensed or approved residential drug treatment program?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Individual Receiving Treatment	Treatment Facility	Date of Treatment

24.a. If you have not enrolled in or completed a Department of Health and Senior Services licensed or approved residential drug treatment program, what is the reason?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_.

25. Has anyone in the household voluntarily quit a job?

In the last 90 days for WFNJ  YES  NO If YES, Who? \_\_\_\_\_  
 In the last 60 days for NJ SNAP  YES  NO If YES, Who? \_\_\_\_\_  
 If YES, Why? \_\_\_\_\_

26. Is anyone in your household on strike?  YES  NO If YES, Who? \_\_\_\_\_

27. What was the last date of employment? \_\_\_\_\_

27.a. What have you been doing since your last employment? \_\_\_\_\_  
 \_\_\_\_\_

28. For WFNJ purposes only, list all employment for each person applying for assistance in the last 3 years, starting with the most recent.

Name	Name of Employer	Address of Employer	Start Date	End Date

29. Does any member of the applicant household expect any change in circumstances in the near future, such as a change in income; household size; change in residence; shelter costs; or the purchase or sale of an automobile?  
 YES  NO If "YES", What changes: \_\_\_\_\_  
 \_\_\_\_\_

30. **EARNED INCOME:** Do you or anyone living with you get money from working, baby-sitting, your own business, odd jobs, selling, or other earned income?  YES  NO If "YES", provide the following information for each person:

LAST NAME FIRST NAME				
HOURS PER WEEK				
HOW OFTEN PAID				
EMPLOYER'S NAME AND ADDRESS OR "SELF" IF SELF-EMPLOYED				
PAY (BEFORE ANY PAID DEDUCTIONS) GROSS AMOUNTS AND DATES	DATE	AMOUNT	DATE	AMOUNT

**31. CHILD/ADULT CARE:** Did anyone included in your welfare or NJ SNAP household pay for child care or adult care because of a job, going to school, or looking for work?  **YES**  **NO** If **"YES"**, who was cared for? (List Below)

NAME OF CHILD/ADULT	CARE PROVIDED BY (PERSON)	DAYS PER WEEK	HOURLY RATE	TOTAL DAYS	ACTUAL AMOUNT PAID/ BY WHOM

**VERIFICATIONS**

**32. CHILD SUPPORT:** Are you legally obligated to pay or provide child support to a child outside of your household?  **YES**  **NO** If **"YES"**, complete the following information: (Include payments for child support arrearages, as long as you are legally obligated to pay them.)

TO WHOM	ADDRESS	AGE OF CHILD	MO. AMOUNT PAID/ PROVIDED	COURT ORDER NUMBER

**33. HEALTH INSURANCE:** Who is covered by health insurance? **IF NONE, CHECK ( ) HERE.**

LAST NAME, FIRST NAME	INSURANCE COMPANY	POLICY NUMBER	POLICY HOLDER

**34.** Does an absent spouse have medical or health insurance coverage for you?  **YES**  **NO** If **"YES"**, what insurance?

\_\_\_\_\_.

**35.** Does any absent parent have medical or health insurance coverage for any of the children for whom you are applying?  **YES**  **NO** If **"YES"**, what insurance, and for whom?

\_\_\_\_\_.

**36.** Have you or your household members applied for other Medicaid programs? If **"YES"**, which program?

\_\_\_\_\_. Date you applied \_\_\_\_\_.

**37. OTHER INCOME:** Do you or anyone included in your welfare or NJ SNAP household (including stepparents) receive or applied for any of the following: **YES \_\_\_ NO \_\_\_ IF YES, CHECK ALL THAT APPLY.**

Unemployment Insurance	Income from Property Rent	Workers' Compensation
Veterans' Benefits	Income from Roomer(s) and/or Boarders	Union/Pension Benefits
Social Security/Railroad Retirement	Income from Relative, Friend, Lodges or Unions	Child Support
Supplemental Security Income (SSI)	Income Tax Refund or Earned Income Credit	Allotment Check from a Serviceman
Disability Payments	Foster Care Payments	General Assistance
Subsidized Adoption	Trust Fund	Training Allowance
Interest/Dividends from Stocks, Bonds, Bank Accounts, etc.	Lump Sum Payments (from Retroactive Benefits, Money from Lawsuits, etc.)	Student Loans, Grants, Scholarships, or Stipends
Annuity Benefits (Include Life Insurance Dividends)	Lump Sum Earnings, Winnings, or Gifts	Supplemental Work Support
DCP&P Relative Care Permanency Support	DCP&P Legal Guardianship Subsidy Programs	Other Income, such as, alimony (Specify):

Give the following information for the items checked above:

Last Name, First Name	Source of Income	Dates Received	Total Amount

**VERIFICATIONS**

**38. RESOURCES: (Does apply to NJ SNAP households not eligible for expanded categorical eligibility)** Do you or anyone living with you have cash, checking, or savings accounts, stocks, bonds, C.D.'s, IRA's/Keogh, mutual funds, trust funds, U.S. Savings Bonds, Christmas/vacation or other club savings accounts, Credit Union membership, money or valuables in a safe deposit box, notes or contracts of value, ownership of mortgages or other resources? **[ ] YES [ ] NO**

Person Who Owns Resource	What is the Resource?	Where is the Resource?	How Much is the Resource Worth?

**VERIFICATIONS**

39. List all vehicles owned by persons in the applicant household. Include all types of transportation such as cars, vans, tractor trailers, pick-up trucks, trailers, motor homes, motorcycles, boats, etc. **IF NONE, CHECK ( ) HERE.**

Owner's Name	Model/Style	Year/Make	Use	Kelley Bluebook Value

40. Do you or does anyone living with you own any land or real estate other than the house you live in?  YES  NO  
 If "YES", explain: \_\_\_\_\_

41. Did anyone trade, give away, transfer or sell real or personal property (including stocks): For TANF and GA purposes within the past 12 months?					<input type="checkbox"/> YES <input type="checkbox"/> NO	
For NJ SNAP purposes within the past 3 months?					<input type="checkbox"/> YES <input type="checkbox"/> NO	
What was sold, given away, etc.?	By Whom?	To Whom?	Date of Gift or Sale?	Total Market Value	Amount Received	

42. Do you, or anyone included in your applicant household, have any pending claims such as lawsuits, divorce, settlements, inheritance, accident claims, sale of property, other claims, or does anyone owe you or them money?  YES  NO  
 If "YES", explain: \_\_\_\_\_

**DATE WFNJ-10D COMPLETED** \_\_\_\_\_ (Does not apply to NJ SNAP only clients)

43. Does anyone in the applicant household have: (Does not apply to NJ SNAP)

(a) Part or full ownership of valuable personal property such as jewelry, coin/stamp collections, furs, etc.?  
 YES  NO If "YES", Explain \_\_\_\_\_

(b) A burial plot or arrangement ?  YES  NO If "YES", VALUE \_\_\_\_\_

**NJ SNAP AND GA**

**SHELTER INFORMATION:** To be completed if household is applying for participation in the NJ SNAP Program and/or GA.

44. Does anyone outside of the household pay or assist with payments of any household expenses?  YES  NO  
 If "YES", complete below:

TYPE OF SHELTER EXPENSE	PAID TO WHOM	PAID BY	AMOUNT PAID	HOW OFTEN BILLED

45. SHELTER COSTS (List household expense for the following)				FOR OFFICE USE ONLY	
SHELTER EXPENSE	AMOUNT PAID	HOW OFTEN BILLED	MONTHLY COST	If using HCSUA	
Rent/Mortgage	\$		\$		
Property Taxes	\$		\$		
Insurance on Home	\$		\$		
<b>SHELTER SUBTOTAL</b>			\$		
Electricity	\$		\$	HCSUA	
Gas	\$		\$		
Oil	\$		\$		
Water	\$		\$		
Sewerage	\$		\$		
Garbage/Trash Removal	\$		\$		
Cost of Installation of Utilities	\$		\$		
Other (Coal, Wood, Kerosene)	\$		\$		
<b>UTILITIES SUBTOTAL</b>			\$		or
46A. Do you pay for utilities (separate from your rent) to heat or cool your house? [ ] YES [ ] NO			\$		or
46B. If your household is responsible for payment of utilities in addition to water, sewerage, and garbage removal, your household may qualify to choose to receive either the <b>standard or heating utility allowance</b> .					
			<b>MONTHLY TOTAL SHELTER DATE OPTION SELECTED</b>		

**47. EXCESS MEDICAL COSTS**

Is anyone in your household 60 years of age or older, and/or certified for Federal Supplemental Security Income (SSI), Social Security Disability or Veteran's payments? [ ] YES [ ] NO If "YES", complete the following. If "NO", continue on Page 12. Medical expenses may include amounts which have been billed, even if you have not actually paid the medical bill.

				FOR OFFICE USE ONLY	
Besides regularly occurring medical expenses, list those other medical services which you may have required.	Amount Paid	How Billed	Often	Monthly Total	VERIFY RECEIPT OF SSI  _____ FEDERAL SHARE    <b>SSA and SSI Listed on Page 6</b>
Medical and Dental Services	\$			\$	
Hospital or Nursing Care	\$			\$	
Drugs Prescribed by a Doctor	\$			\$	
Dentures, Hearing Aids and Eye Glasses	\$			\$	
Transportation Costs to Get Medical Care	\$			\$	
Services of an Attendant or Nurse	\$			\$	
Other (Explain)	\$			\$	
47A. List the names of household members who have these expenses:				<b>TOTAL</b>	

47B. Are any of the medical expenses you've listed above paid for, partially paid for or reimbursed by another source outside of your household such as medical insurance, Medicare, PAAD or another individual?  
[ ] YES [ ] NO If "YES", which expense(s) do they pay? How much do they pay?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FOR OFFICE USE ONLY**

WORK FIRST NEW JERSEY AND/OR NJ SNAP WORK REGISTRATION

NAMES (ALL OVER 16)	EXEMPT WFNJ CODE	MANDATORY WFNJ DATE	VOLUNTARY WFNJ DATE	REFERRAL DATE	NJSNAP WORK EXEMPT CODE	DATE OF REG.

**48. HOME ENERGY ASSISTANCE**

Your answer to the following question will be used to determine eligibility for Home Energy Assistance (HEA) and the amount of HEA benefits. Using the list below, indicate which item best describes your heating/living arrangement.

- My heat is paid for by others. **(A)**
- My heat is provided by a public housing authority or I received a rent subsidy, and my heat is included in my rent. **(C)**
- I pay only for a secondary source of heat (such as a wood stove, kerosene heater, electric space heater, etc.). **(E)**
- I share the cost of heat with others. **(F)**
- My heat is included in my rent, which is not subsidized. **(G)**
- I pay a separate charge to my landlord for heat. **(W)**

**HEA CODE:** \_\_\_\_\_

I pay my fuel supplier directly for the primary source of heat for my house or apartment. My source of heat is:

- fuel oil **(J)**
- kerosene **(M)**
- wood **(R)**
- electricity **(K)**
- natural gas **(N)**
- bottled gas **(L)**
- coal **(P)**
- I do not wish to receive HEA benefits. **(T)**

**IMPORTANT NOTICE**

THE INFORMATION PROVIDED ON THIS FORM WILL BE SUBJECT TO VERIFICATION BY FEDERAL, STATE AND/OR COUNTY OFFICIALS. IF ANY IS FOUND INCORRECT, YOU MAY BE DENIED NJ SNAP BENEFITS AND/OR SUBJECT TO CRIMINAL PROSECUTION FOR KNOWINGLY PROVIDING FALSE INFORMATION.

In order to comply with 45 CFR 206.10(a)(iii) and 7 CFR 273.2(b), we are notifying you that income and eligibility information for BCIS, State and local child support agencies, Social Security Wage and Benefit files, and State Wage and Unemployment files will be obtained using your Social Security Number(s) and will be used in the determination of your continuing eligibility. This may involve our contacting your employer, bank, or other party.

THE PENALTIES PROVIDED BELOW APPLY TO THE FOLLOWING:

ANY NJ SNAP RECIPIENT WHO INTENTIONALLY BREAKS ANY OF THE RULES LISTED ON THE APPLICATION; OR

ANY PERSON WHO APPLIES FOR OR RECEIVES NJ SNAP BENEFITS TO WHICH THEY ARE NOT ENTITLED BY HAVING INTENTIONALLY:

MADE A FALSE OR MISLEADING STATEMENT.

CONCEALED OR WITHHELD FACTS.

- COMMITTED ANY ACT WHICH CONSTITUTES A VIOLATION OF THE FOOD STAMP ACT, NJ SNAP PROGRAM REGULATIONS OR ANY STATE LAW RELATING TO THE USE, PRESENTATION, TRANSFER, ACQUISITION, RECEIPT OR POSSESSION OF NJ SNAP BENEFITS OR ACCESS DEVICES (SUCH AS FAMILIES FIRST EBT CARDS).

**PENALTIES**

THE PENALTIES FOR INTENTIONALLY VIOLATING SNAP RULES INCLUDE A DISQUALIFICATION FROM PARTICIPATING IN SNAP FOR THE FOLLOWING TIME PERIODS

- 12 MONTHS for a first offense;
- 24 MONTHS for a second offense, OR the first court conviction for trading SNAP benefits for a controlled substance;
- 10 YEARS for lying or misrepresenting information about the identity or residence of an individual to receive multiple SNAP benefits at the same time;
- PERMANENTLY for a third offense, OR a second court conviction for trading SNAP benefits for a controlled substance, OR a court conviction for selling/trading SNAP benefits of \$500 or more, OR a court conviction for trading SNAP benefits for firearms, ammunition or explosives.

\*AN ADDITIONAL 18 MONTHS SUSPENSION (CONSECUTIVE TO THIS PERIOD) MAY BE IMPOSED BY THE COURT FOR ANY PERSON CONVICTED OF FELONY OR MISDEMEANOR VIOLATION.

THE VIOLATOR MAY BE FINED UP TO \$250,000, IMPRISONED UP TO 20 YEARS, OR BOTH, AND SUBJECT TO PROSECUTION UNDER OTHER APPLICABLE FEDERAL LAWS.

IN ADDITION, THE REMAINING HOUSEHOLD MEMBERS WILL BE REQUIRED TO REPAY ANY NJ SNAP BENEFITS THE HOUSEHOLD RECEIVED TO WHICH IT WAS NOT ENTITLED.

P.L. 103-66 AND 104-193 ESTABLISHED PENALTIES FOR INDIVIDUALS WHO ARE FOUND GUILTY IN A FEDERAL, STATE, OR LOCAL COURT OF:

- 1) TRADING NJSNAP BENEFITS FOR FIREARMS, AMMUNITION, EXPLOSIVES, OR CONTROLLED SUBSTANCES; OR
- 2) USING, TRANSFERRING, ACQUIRING, OR POSSESSING NJ SNAP BENEFITS, THROUGH THE USE OF FAMILIES FIRST EBT CARDS, OR PRESENTING NJ SNAP BENEFITS FOR PAYMENT KNOWING SAME TO HAVE BEEN FRAUDULENTLY OBTAINED OR TRANSFERRED, IF THE VALUE IS \$500 OR MORE.

**PENALTY WARNING**

DON'T give false information, or hide information, in order to apply for or receive or continue to receive NJ SNAP benefits.

DON'T give or sell NJ SNAP benefits or access through the use of Families First EBT cards to anyone who is not authorized to use them for your household.

DON'T use any NJ SNAP benefits to buy ineligible items, such as alcoholic drinks and tobacco, or to pay for food that was purchased on credit.

DON'T use any NJ SNAP benefits your household was not entitled to receive.

DON'T cheat or take part in any dishonest act to get NJ SNAP benefits your household isn't entitled to receive.

DON'T transfer resources to a non-household member in order to apply for and receive NJ SNAP benefits.

I understand the questions on this application. My answers are correct and complete to the best of my knowledge and belief. I understand that I must be interviewed, and that I must cooperate with the NJ SNAP office. I understand the penalty warning. I understand that I may have to provide documents to prove what I've said. I agree to do this. If documents are not available, I agree to give the name of a person or organization the NJ SNAP office may contact to obtain the necessary proof. I understand that if I have not reported any earned income, then I must report any change in unearned income of more than \$50.00, or the receipt of earned income within 10 days of the date of my first paycheck. I understand that if I have no earned income, I must report all changes in household composition (including student status), changes in residence and the resulting change in shelter costs, changes in my legal obligation to pay or provide child support, a change in the amount of child support I provide if I have less than a 3-month record of paying it and the change is greater than \$50.00, a purchase of a vehicle or an increase in my household's resources (savings and checking account, cash on hand, stocks or lump sum payments, any cash deriving from the sale or trade of a vehicle) if they reach or exceed my maximum resource limit. I understand that if I reported earned income, or I am on a six-month reporting, I am only required to report a change in my monthly total income that exceeds 130 percent of the federal poverty level limit. I understand that I must report household lottery or gambling winnings greater than \$3,500 which may disqualify the household from SNAP. My worker will provide me with a notice of that limit. I also understand that I may request a fair hearing of the decision made on my application for NJ SNAP benefits. If I need more information concerning NJ SNAP benefits, I can contact the county NJ SNAP office.

I understand that I, or my representative, may request a fair hearing, either orally or in writing, if I disagree with any action taken on my case. My case may be presented at the hearing by any person I choose.

**NJ SNAP MANDATORY EMPLOYMENT AND TRAINING PARTICIPANTS**

Certain NJ SNAP household members, unless specifically exempted, are required to register for and participate in Employment and Training activities. Mandatory registrants who fail to comply with work requirements will be subject to the following penalties:

- 1) The 1<sup>st</sup> violation results in a minimum disqualification of 1 month;
- 2) The 2<sup>nd</sup> violation results in a minimum disqualification of 3 months;
- 3) The 3<sup>rd</sup>, and subsequent violations, result in a minimum disqualification of 6 months.

**U.S. CITIZENSHIP/LEGAL ALIEN STATUS  
(FOR WFNJ AND NJ SNAP PROGRAM PURPOSES)**

For each person who is not a U.S. citizen, you will need to show the county welfare agency office either documentation from the Bureau of Citizenship and Immigration Service (BCIS) or other documents the State agency determines are proof of your immigration status. Alien status may be subject to verification with the BCIS which will require submission of certain information from this application form to the BCIS. Information received from the BCIS may affect your household's eligibility and level of benefits. You must certify that each household member is a U.S. citizen or is living in the U.S. in lawful immigration status.

**BEFORE YOU SIGN, READ THE STATEMENTS BELOW. IF YOU DO NOT UNDERSTAND  
OR HAVE ANY QUESTIONS, PLEASE ASK.**

- ❖ I (we) agree that the statements that I (we) made on this form are true and complete to the best of my (our) knowledge. I (we) know that lying about my (our) situation, failing to give the necessary information or causing others to hold back information is against the law and may subject me (us) to prosecution.
- ❖ I (we) understand that any information I (we) give is subject to verification by the County Welfare Agency, and/or the Division of Family Development.
- ❖ I (we) hereby authorize the County Welfare Agency or the Division of Family Development to contact any individual or other source who may have knowledge about my (our) circumstances (to include IRS, State and local child support agencies, Social Security Wage and Benefit files, State Wage and Unemployment files, credit reporting services, as well as employers, banks or other parties) for the sole purpose of verifying the statements I (we) have made. I (we) understand that any income and eligibility information obtained will be used to determine my (our) continuing eligibility.
- ❖ I (we) understand that, in accordance with Work First New Jersey Act, Public Law 1997 c.13, c.14, c.37 and c.38, application for public assistance will include all future members of the budget unit required to be included, whether by birth, adoption, or by beginning to live with the budget unit after the date of the original application.
- ❖ I (we) know that any information I (we) give will be used in connection with my (our) application for public assistance, NJ SNAP benefits, home energy assistance benefits, Universal Service Fund benefits and other benefits for which I may be eligible.
- ❖ I (we) understand that if this application is accepted for the WFNJ category, that I (we) and all members of my (our) household are enrolled in the New Jersey One Stop Career Center and may be required to participate in education, training, vocational assessment and job placement activities.
- ❖ I (we) understand that all home energy assistance payments are subject to the availability of federal funds.
- ❖ I (we) understand that all home energy assistance payments made are to be used toward the purchase of heating/cooling energy.
- ❖ I (we) have received and had explained to me (us), if necessary, information concerning my rights and responsibilities. (See WFNJ Handbook.)
- ❖ I (we) agree to let the County Welfare Agency know immediately of any change in living conditions, family situation or money received (except for earned income that is subject to six-month reporting requirements) from any source, including lottery or gambling winnings, when applicable. (See WFNJ Handbook.)
- ❖ I (we) understand that I (we) or my (our) representative may request a fair hearing, either orally or in writing, if I (we) am (are) not satisfied with any action taken by the County Welfare Agency. My (our) case may be presented at the hearing by any person I (we) choose.
- ❖ I (we) understand that upon signing this application for WFNJ purposes only, I (we) assign to the County Welfare Agency any right to support, including any arrears that have accrued, from any other person for myself or any other family member for whom I (we) am(are) applying for or receiving aid.

\*This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotope, American Sign Language, etc.), 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. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](#), (AD-3027), found online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) mail: U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW  
Washington, D.C. 20250-9410
- (2) fax: (202) 690-7442; or
- (3) email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the [State Information/Hotline Numbers](#) (click the link for a listing of hotline numbers by State); found online at: [http://www.fns.usda.gov/snap/contact\\_info/hotlines.htm](http://www.fns.usda.gov/snap/contact_info/hotlines.htm).

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.



## **IMPORTANT NOTICE NJ SNAP INCOME DEDUCTION WAIVER**

**IF YOU FAIL TO REPORT OR VERIFY ANY OF THE FOLLOWING EXPENSES WHICH EITHER YOU OR ANOTHER HOUSEHOLD MEMBER IS PAYING, WE WILL TAKE THIS TO MEAN THAT YOU DO NOT WANT TO RECEIVE AN INCOME DEDUCTION FOR THOSE UNREPORTED EXPENSES.**

- A DEPENDENT CARE EXPENSE, IF YOU ARE PAYING FOR THE CARE OF A CHILD OR OTHER DEPENDENT SO THAT A HOUSEHOLD MEMBER CAN WORK, SEEK EMPLOYMENT, OR ATTEND TRAINING OR EDUCATION CLASSES IN ORDER TO PREPARE FOR EMPLOYMENT;
- AN UNREIMBURSED MEDICAL OR DENTAL EXPENSE, INCLUDING PRESCRIBED MEDICATION, HEALTH OR HOSPITALIZATION INSURANCE, EYE GLASSES, OR ATTENDANT CARE;
- A CHILD SUPPORT PAYMENT WHICH A HOUSEHOLD MEMBER IS MAKING UNDER A LEGAL OBLIGATION, INCLUDING PAYMENTS ON ARREARS; OR
- A SHELTER EXPENSE, SUCH AS RENT, UTILITIES (INCLUDING INSTALLATION CHARGES), PROPERTY TAXES, HOMEOWNER'S INSURANCE, AND CHARGES FOR REPAIR OF YOUR HOME DUE TO A NATURAL DISASTER.

EVEN IF YOU DO NOT TELL US (OR VERIFY) THAT YOU ARE INCURRING ONE OF THESE EXPENSES WHEN YOU APPLY FOR NJ SNAP, YOU MAY STILL RECEIVE AN INCOME DEDUCTION LATER IF YOU TELL US (OR VERIFY) THAT YOU ARE PAYING ONE OF THESE EXPENSES. THE DEDUCTION WILL NOT BE RETROACTIVE FOR THOSE MONTHS THAT YOU DID NOT TELL US THAT YOU WERE PAYING THE EXPENSES.

**HEAD OF HOUSEHOLD SIGNATURE**

\_\_\_\_\_

**TODAY'S DATE**

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