Form W-680B (page 1)
Rev. 6/22/00

Application/Job Profile

Human Resources Administration
Family Independence Administration

SHADED AREA FOR AGENCY USE.

CENTER NUMBER _____ DATE OF APPLICATION _____ UNIT WORKER _____

FUNCTION _____ Case Type: ☐ SN ☐ FA ☐ EAA ☐ EAF ☐ NPAFS ☐ MA only

Function Key
01-NEW APPLICATION
02-APPLICATION
03-APPLICATION WITHDRAWAL
04-APPLICATION MAINTENANCE
05-SPLIT APPLICATION
06-COMBINE APPLICATION

#

FOOD STAMP SUFFIX _____ (ENTER CORRECT CODE)

Statement of Mutual Expectations - The Human Resources Administration staff are committed to assisting you as you achieve self-reliance by providing employment and support services in a professional and respectful manner.

WORKER'S SIGNATURE DATE
X

If I am applying for cash assistance, I understand that cash assistance is temporary and that I am committed to the goal of self reliance. I am responsible for participating in activities to reach this goal and, if it is determined that I am employable, to look for and accept work.

APPLICANT'S SIGNATURE DATE
X

IF YOU HAVE ANY DISABILITIES, WHICH PREVENT YOU FROM COMPLETING THIS APPLICATION AND/OR WAITING TO BE INTERVIEWED, PLEASE NOTIFY THE RECEPTIONIST. THE AGENCY WILL MAKE EVERY EFFORT TO PROVIDE REASONABLE ACCOMMODATIONS TO ADDRESS YOUR NEEDS.

1

DO YOU WANT TO RECEIVE NOTICES IN: ☐ SPANISH AND ENGLISH ☐ ENGLISH ONLY

DO YOU NEED AN INTERPRETER? ☐ YES ☐ NO

WHAT IS YOUR PRIMARY LANGUAGE? (PLEASE CHECK) ☐ ENGLISH ☐ SPANISH ☐ OTHER (PLEASE SPECIFY) _____

FIRST NAME	M.I.	LAST NAME	DATE OF BIRTH	MARITAL STATUS:

HOUSE NUMBER	STREET ADDRESS	APT. NO.	CITY	STATE	ZIP CODE	AREA CODE/PHONE NUMBER

2

IN CARE OF NAME (IF YOU RECEIVE YOUR MAIL IN CARE OF ANOTHER PERSON):

ANOTHER PHONE WHERE YOU CAN BE REACHED:

MAILING ADDRESS (IF DIFFERENT FROM ABOVE ADDRESS-SUCH AS POST OFFICE BOX):

HOW LONG HAVE YOU LIVED AT YOUR PRESENT ADDRESS? YEARS _____ MONTHS _____
FORMER ADDRESS:

AGENCY HELPING APPLICANT APPLY	CONTACT PERSON	PHONE #

You may be eligible for expedited Food Stamps Service. If your household has little or no income or liquid resources, or if your rent and utility expenses are more than your income and liquid resources, you may be eligible to receive Food Stamps within a few days. Your worker will review your circumstances to see if you are eligible for these benefits. If your situation changes you can request an interview for expedited Food Stamps or an immediate needs grant any time during the application process.

3

IF YOU ARE APPLYING FOR FOOD STAMPS
You can file this application the same day you receive it. If eligible, benefits are provided back to the filing date of application. We must accept your application if at a minimum, it contains your name, address (if you have one) and signature, in this box. You can file your application before you have an interview. If you are applying for Cash Assistance, Food Stamps and Medical Assistance, usually you will only be required to have a single interview for the three programs.

APPLICANT'S/REPRESENTATIVE'S SIGNATURE DATE SIGNED
X

DO ANY OF THE FOLLOWING APPLY TO YOU?

- ☐ YOUR HOUSEHOLD'S TOTAL INCOME FOR THE MONTH IS LESS THAN $150 AND YOUR TOTAL LIQUID RESOURCES (i.e., cash on hand, checking or savings accounts) DO NOT EXCEED $100
- ☐ YOUR HOUSEHOLD'S TOTAL SHELTER EXPENSES, INCLUDING UTILITIES, ARE MORE THAN YOUR TOTAL INCOME AND LIQUID RESOURCES.
- ☐ YOU ARE A DESTITUTE MIGRANT OR SEASONAL FARM WORKER WITH NO MORE THAN $110 IN LIQUID RESOURCES.
- ☐ URGENT PERSONAL OR FAMILY PROBLEM
- ☐ NO PLACE TO STAY/ HOMELESS
- ☐ PENDING EVICTION
- ☐ CAN NO LONGER STAY WITH A RELATIVE OR FRIEND
- ☐ RECENTLY LOST INCOME
- ☐ OTHER (SPECIFY) _____
- ☐ SERIOUS MEDICAL PROBLEM
- ☐ VICTIM OF DOMESTIC VIOLENCE
- ☐ FIRE OR OTHER DISASTER
- ☐ FUEL OR UTILITY SHUTOFF
- ☐ NO FOOD OR MONEY TO BUY FOOD

4

CHECK WHICH PROGRAMS YOU ARE APPLYING FOR.
☐ PUBLIC ASSISTANCE ☐ MEDICAL ASSISTANCE ☐ MEDICARE BUY-IN
☐ FOOD STAMPS ☐ CASH ASSISTANCE AND MEDICAL ASSISTANCE

DO YOU NEED A REFERRAL(S) FOR ANY OF THE SERVICES LISTED BELOW? PLEASE CHECK ALL THAT APPLY.

- ☐ ASSISTANCE WITH CITIZEN APPLICATION
- ☐ HOME CARE
- ☐ OTHER: _____
- ☐ CHILD CARE
- ☐ CHILD SUPPORT
- ☐ PREVENTIVE/ PROTECTIVE OR FOSTER CARE SERVICES
- ☐ CASE MANAGEMENT SERVICES FOR PREGNANT/PARENTING TEEN IN HOUSEHOLD
- ☐ SSI/SSA
- ☐ PROTECTIVE SERVICES FOR ADULTS
- ☐ DOMESTIC VIOLENCE

FOR AGENCY USE ONLY

IMMEDIATE NEEDS?
Yes ☐ No ☐
If No, state reason: _____

EMERGENCY CASH ASSISTANCE?
Yes ☐ No ☐
If No, state reason: _____

EXPEDITED FOOD STAMPS?
Yes ☐ No ☐ - See Page 10
If No, state reason: _____

Human Resources Administration
Family Independence Administration

LIST EVERYBODY WHO LIVES WITH YOU, EVEN IF THEY ARE NOT APPLYING WITH YOU. LIST YOURSELF ON THE FIRST LINE. PLEASE PRINT.

LN	RI or SUF.	FIRST NAME	M.I. (MIDDLE INITIAL)	LAST NAME	IS THIS PERSON APPLYING?		DATE OF BIRTH Month	Day	Year	Sex M or F	Relationship To You	Social Security Numbers of Applying Household Members	Does this person (including your minor children) buy food and/or prepare meals with you? YES	NO
					Yes	No								
01				5							SELF			
02														
03														
04														
05														
06														
07														
08														

You do not have to fill out this section if you are
- applying only for Medical Assistance and you are pregnant
- an undocumented alien applying only for Medical Assistance benefits as a result of an emergency medical condition

LN	CHECK ONE FOR EACH PERSON		ALIEN NUMBER (IF KNOWN)
01	Citizen/ National	Alien	A
02	Citizen/ National	Alien	A
03	Citizen/ National	Alien	A
04	Citizen/ National	Alien	A
05	Citizen/ National	Alien	A
06	Citizen/ National	Alien	A
07	Citizen/ National	Alien	A
08	Citizen/ National	Alien	A

List maiden or other names by which you or anyone in your household has been known

LN	NO	ONC	FIRST NAME	M.I	LAST NAME
LN	NO	ONC	FIRST NAME 7	M.I	LAST NAME
LN	NO	ONC	FIRST NAME	M.I	LAST NAME
LN	NO	ONC	FIRST NAME	M.I	LAST NAME

DO NOT WRITE IN SHADED AREAS

IF THE HUSBAND OR WIFE OF ANYONE APPLYING LIVES SOMEPLACE ELSE, PLEASE INDICATE BELOW.

FIRST NAME	M.I.	LAST NAME 8	DATE OF BIRTH	SOCIAL SECURITY NO.
ADDRESS		CITY	COUNTY	STATE / ZIP CODE

LIST THE NAMES OF EVERYONE UNDER 21 IN THE HOUSEHOLD AND WRITE DOWN ANY INFORMATION YOU CURRENTLY HAVE ABOUT THAT PERSON'S ABSENT PARENT(S). IF YOU ARE UNDER 21, WRITE DOWN INFORMATION ABOUT YOUR ABSENT PARENT(S) ALSO.

Name of Person Under 21	Absent Parent's Name and Address	Absent Parent's Date of Birth Mo.	Day	Year	Social Security Number
	9				

ARE YOU UNDER 21? IF SO, COMPLETE THE SECTION ABOVE.
ARE YOU LIVING WITH AN ADULT OVER 18 YEARS OLD? ☐ YES ☐ NO
IF YES, WHO IS SHE/HE? _____
DO YOU LIVE WITH THE PERSON(S) IDENTIFIED IN SECTION 5? ☐ YES ☐ NO
ARE YOU A PREGNANT OR PARENTING TEEN? ☐ YES ☐ NO

Have you or anyone in your household ever been in Foster Care? No ☐ Yes ☐ 10
If Yes, enter the names _____

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SIGN AFTER YOU READ AND UNDERSTAND THE CERTIFICATION BELOW.
FOR QUESTIONS, SEE THE "HOW TO COMPLETE" INSTRUCTIONS. **You do not have to sign in the section below if you are:**
- applying **only** for Food Stamps or only for services.
- applying **only** for Medical Assistance and you are pregnant
- an undocumented alien applying **only** for Medical Assistance benefits as a result of an emergency medical condition

LN	SIGNATURES	DATE SIGNED MO Day Year
01	SIGN NAME X	
02	SIGN NAME X	
03	SIGN NAME X	
04	SIGN NAME X	
05	SIGN NAME X	
06	SIGN NAME X	
07	SIGN NAME X	
08	SIGN NAME X	

11

I WITNESSED THE MARK(S) MADE IN LINE(S):

_____, _____, _____, _____, _____, _____, _____, _____

SIGNATURE OF WITNESS DATE SIGNED

X

CERTIFICATION OF CITIZENSHIP/ALIEN STATUS

I CERTIFY, UNDER THE PENALTY OF PERJURY, BY SIGNING MY NAME ABOVE, THAT I, AND/OR THE PERSONS FOR WHOM I AM SIGNING, AM A UNITED STATES CITIZEN OR NATIONAL OF THE UNITED STATES OR AN ALIEN WITH SATISFACTORY IMMIGRATION STATUS. I UNDERSTAND THAT INFORMATION ABOUT ME WILL BE SUBMITTED TO THE IMMIGRATION AND NATURALIZATION SERVICE FOR VERIFICATION OF MY IMMIGRATION STATUS, IF APPLICABLE. I FURTHER UNDERSTAND THAT THE USE OR DISCLOSURE OF INFORMATION ABOUT ME IS RESTRICTED TO PERSONS AND ORGANIZATIONS DIRECTLY CONNECTED WITH THE VERIFICATION OF IMMIGRATION STATUS AND THE ADMINISTRATION OR ENFORCEMENT OF THE PROVISIONS OF TEMPORARY CASH ASSISTANCE AND MEDICAL ASSISTANCE PROGRAMS.

After you read this, sign above. If an applicant cannot sign, the applicant must make an "X' on the line, in front of a witness. The witness should sign in the witness space.

ENTER Y (YES) FOR EACH ETHNIC/RACE AFFILIATION THAT APPLIES TO YOU, ENTER N (N0) IF THEY DO NOT.

H	I	A	B	P	W

12

Ethnic/Race Affiliations Codes:

- H - Hispanic or Latino
- I - American Indian or Alaskan Native
- A - Asian
- B - Black or African American
- P - Pacific Islander or Other Native Hawaiian
- W - White

INDICATE PROGRAM(S) INDIVIDUAL IS APPLYING FOR ENTER Y OR N

LN	P	MA	FS	CLIENT IDENTIFICATION NUMBER	REL. CODE	SSN	SFUI	MS CODE	SI CODE	LA CODE	EM CODE	CI CODE	EL CODE
01													
02													
03													
04													
05													
06													
07													
08													

ANTICIPATED FUTURE ACTION

LN NO	CODE	DATE

SERVICE ELIGIBILITY PROCESS CODE

SFUI	CODE		SFUI	CODE
SFUI	CODE		SFUI	CODE

RELATED CASE NUMBERS

CASE TYPE	
CASE TYPE	
CASE TYPE	

DOCUMENTATION

Form W-680B (page 4)
Rev. 6/22/00

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INCOME	ANSWER ALL QUESTIONS LISTED BELOW.					
INDICATE IF YOU OR ANYONE WHO LIVES WITH YOU AND IS APPLYING RECEIVES MONEY FROM:	YES	NO	IF YES, GIVE AMOUNT/ VALUE	WHO	IF YES, GIVE AMOUNT/ VALUE	WHO
WAGES, SALARY, INCLUDING OVERTIME, COMMISSIONS, TRAINING PROGRAMS, TIPS			$		$	
SELF-EMPLOYMENT OR OFF-THE-BOOKS						
UNEMPLOYMENT INSURANCE BENEFITS						
SUPPLEMENTAL SECURITY INCOME (SSI) BENEFITS						
SOCIAL SECURITY DISABILITY BENEFITS						
SOCIAL SECURITY DEPENDENT BENEFITS						
SOCIAL SECURITY SURVIVOR'S BENEFITS						
SOCIAL SECURITY RETIREMENT BENEFITS						
RAILROAD RETIREMENT BENEFITS						
RETIREMENT BENEFITS (PENSIONS)						
DIVIDENDS/INTEREST FROM STOCKS, BONDS, SAVINGS, ETC.						
WORKER'S COMPENSATION						
NYS DISABILITY BENEFITS						
VETERAN'S PENSIONS/BENEFITS/AID AND ATTENDANCE						
GI DEPENDENCY ALLOTMENTS						
CASH ASSISTANCE GRANT						
EDUCATION GRANTS OR LOANS						
RENTAL INCOME (RECEIVED)						
BOARDERS/LODGERS INCOME (RECEIVED)						
CONTRIBUTIONS/GIFTS (RECEIVED)						
CHILD SUPPORT (RECEIVED)						
ALIMONY/SUPPORT (RECEIVED)						
PRIVATE DISABILITY INSURANCE - HEALTH/ACCIDENT INSURANCE POLICY INCOME						
NO FAULT INSURANCE BENEFITS						
UNION BENEFITS (INCLUDING STRIKE BENEFITS)						
LOANS (RECEIVED)						
OTHER INCOME (Please Specify)						

13

INCOME				DO NOT WRITE IN SHADED AREAS
LN NO	SOURCE CODE	AMOUNT	PERIOD	

IS ANYONE IN YOUR HOUSEHOLD AN ALIEN WHO WAS SPONSORED FOR ADMISSION INTO THE US WITHIN THE PAST THREE YEARS? ☐ YES ☐ NO

IF YES, WHO?_____

NAME OF SPONSOR/SPONSORING ORGANIZATION _____

	YES	NO	If yes, who?
DOES THE STEP-PARENT OF ANY CHILDREN WHO LIVE WITH YOU HAVE ANY RESOURCES OR RECEIVE INCOME OF ANY KIND?			

	YES	NO	BRANCH OR WHEN?
HAVE YOU EVER SERVED IN THE MILITARY? (Army, Navy, etc.)			
HAS YOUR SPOUSE EVER SERVED IN THE MILITARY? (Air Force, Marines,etc.)			
IS ANYONE IN THE HOUSEHOLD A DEPENDENT OF SOMEONE WHO SERVED IN THE MILITARY?			IF YES, WHO?

14

DO YOU HAVE A HIGH SCHOOL DIPLOMA OR GED? ☐ YES
IF NO, SPECIFY HIGHEST GRADE YOU COMPLETED

DO YOU SPEAK ENGLISH? ☐ YES ☐ NO
CAN YOU READ/WRITE ENGLISH? ☐ YES ☐ NO

HAVE YOU OR ANYONE 16 OR OVER EVER PARTICIPATED IN ANY EDUCATIONAL OR TRAINING PROGRAMS? ☐ YES ☐ NO IF YES, LIST BELOW

NAME	NAME OF PROGRAM	DATES OF PARTICIPATION

15

ADDITIONAL INFORMATION REQUIRED

	YES	NO	IF YES, WHO
HAVE YOU OR ANYONE WHO LIVES WITH YOU AND IS APPLYING, MOVED TO NEW YORK STATE WITHIN THE PAST TWELVE MONTHS? IF YES, WHEN:_____ FROM WHAT STATE:_____ HAS THIS PERSON EVER LIVED IN NEW YORK STATE BEFORE? ☐ YES ☐ NO IF YES,WHEN_____			
HAVE YOU OR ANYONE WHO LIVES WITH YOU, AND IS APPLYING, MOVED INTO THIS COUNTY FROM ANOTHER NEW YORK STATE COUNTY WITHIN THE PAST TWO MONTHS?			
HAVE YOU OR ANYONE WHO LIVES WITH YOU RECEIVED BENEFITS FOR WHICH THEY WERE NOT ENTITLED, AND WHICH HAVE NOT BEEN FULLY REPAID TO THIS OR ANOTHER AGENCY?			
HAVE YOU OR ANYONE WHO LIVES WITH YOU EVER BEEN FOUND GUILTY OF AND/OR BEEN DISQUALIFIED FOR PUBLIC ASSISTANCE AND/OR FOOD STAMP FRAUD/INTENTIONAL PROGRAM VIOLATION?			
DO YOU OR ANYONE WHO LIVES WITH YOU **NOW** RECEIVE ANY TYPE OF ASSISTANCE OR SERVICES OUTSIDE OF **NEW YORK CITY?**			**16**
DO YOU OR ANYONE WHO LIVES WITH YOU NOW RECEIVE ANY TYPE OF ASSISTANCE OR SERVICES OUTSIDE OF **NEW YORK STATE?**			
HAVE YOU OR ANYONE WHO LIVES WITH YOU **APPLIED FOR OR RECEIVED ANY TYPE OF ASSISTANCE OR SERVICES OUTSIDE OF NEW YORK CITY IN THE PAST SIX MONTHS?**			
HAVE YOU OR ANYONE WHO LIVES WITH YOU **APPLIED FOR** OR RECEIVED ANY TYPE OF ASSISTANCE OR SERVICES OUTSIDE OF **NEW YORK STATE** IN THE PAST SIX MONTHS?			

LN	TYPE OF ASSISTANCE	WHERE	DATE RECEIVED LAST ASSISTANCE

RESOURCES — ANSWER ALL QUESTIONS LISTED BELOW.

INDICATE IF YOU, OR ANYONE WHO LIVES WITH YOU AND IS APPLYING, HAS:	YES	NO	IF YES, GIVE AMOUNT/ VALUE	WHO	IF YES, GIVE AMOUNT/ VALUE	WHO
CASH ON HAND						
CHECKING ACCOUNT(S)						
SAVINGS ACCOUNT(S), CERTIFICATES OF DEPOSIT (CD's)						
CREDIT UNION ACCOUNT(S)						
OWN HOME OR COOPERATIVE OR CONDOMINUM APARTMENT						
SAFE DEPOSIT BOX						
SAVINGS BONDS						
STOCKS, BONDS, CERTIFICATES, MUTUAL FUNDS						
IS ELIGIBLE FOR AN INCOME TAX REFUND						
AN ANNUITY, IRA, KEOGH, 401-K						
OTHER DEFERRED COMPENSATION ACCOUNTS						
LIFE INSURANCE						
BURIAL TRUST/BURIAL FUND						
BURIAL SPACE						
AN "IN-TRUST" OR P.A.S.S. ACCOUNT(S)						
A TRUST BENEFICIARY						
A TRUST FUND, LAWSUIT SETTLEMENT, INHERITANCE OR INCOME FROM ANY OTHER SOURCES OR EXPECTED TO RECEIVE						
REAL ESTATE INCLUDING INCOME-PRODUCING AND NON-INCOME PRODUCING PROPERTY						
TITLE OR REGISTRATION TO A MOTOR VEHICLE(S) OR OTHER VEHICLE(S), SPECIFY: YEAR_____ MODEL/MAKE_____				**17**		
RESOURCES OTHER THAN THOSE LISTED ABOVE: TYPE: _____						
ANY RESOURCES OR RECEIVES INCOME OF ANY KIND FROM STEP-PARENT.						
ANYONE (INCLUDING YOUR SPOUSE EVEN IF NOT APPLYING OR LIVING WITH YOU) GIVEN AWAY ANY CASH, OR SOLD/ TRANSFERRED ANY REAL ESTATE, INCOME OR PERSONAL PROPERTY IN THE PAST 36 MONTHS OR CREATED A TRUST IN THE PAST 60 MONTHS? IF YES, WHEN?_____						

I HAVE ☐ I HAVE NOT ☐ SOLD/TRANSFERRED OR GIVEN AWAY ANY OF MY PROPERTY TO ANYONE TO GET PUBLIC ASSISTANCE, MEDICAL ASSISTANCE OR FOOD STAMPS. **18**

MEDICAL EXPENSES - INDICATE IF YOU OR ANYONE WHO LIVES WITH YOU AND IS APPLYING:	YES	NO	IF YES, IDENTIFY WHO OR GIVE AMOUNT($)
HAS MEDICARE (RED, WHITE AND BLUE CARD)			
HAS A HEALTH ATTENDANT			
IS A HANDICAPPED CHILD			
IS IN A HOSPITAL, NURSING HOME OR OTHER MEDICAL INSTITUTION			
IS PREGNANT			
IS BLIND, SICK OR DISABLED			
IS OR WAS DRUG OR ALCOHOL DEPENDENT			
RECEIVES TREATMENT FROM A DRUG ABUSE OR ALCOHOL TREATMENT PROGRAM			
HAS ANY MEDICAL BILLS OR MEDICALLY-RELATED EXPENSES			
HAS PAID OR UNPAID MEDICAL BILLS FOR THE THREE MONTHS PRECEDING THE MONTH OF THIS APPLICATION			
HAS NOT BEEN ABLE TO WORK FOR AT LEAST 12 MONTHS BECAUSE OF A DISABILITY OR ILLNESS			
HAS ANY GOVERNMENT AGENCY (PUBLIC PROGRAM) BESIDES MEDICAL ASSISTANCE OR MEDICARE PAID ANY OF YOUR MEDICAL BILLS			
HAS HEALTH OR HOSPITAL/ACCIDENT INSURANCE (INCLUDING INSURANCE FROM EMPLOYER)			
HAS DAILY ACTIVITY LIMITED BECAUSE OF A DISABILITY OR ILLNESS THAT HAS LASTED OR WILL LAST AT LEAST 12 MONTHS			
HAS BEEN IN A CAR ACCIDENT OR WORK-RELATED ACCIDENT IN THE PAST TWO YEARS			
SHELTER (HOUSING) EXPENSES - INDICATE FOR YOU (OR ANYONE WHO LIVES WITH YOU) AND IS APPLYING:	**YES**	**NO**	**IF YES, GIVE AMOUNT ($)**
HAVE A RENT, MORTGAGE OR OTHER SHELTER EXPENSE?			
DO YOU (OR ANYONE WHO LIVES WITH YOU) **HAVE THE FOLLOWING EXPENSES SEPARATE FROM YOUR RENT OR MORTGAGE:**			
HEAT			
ELECTRICITY			
GAS			
OTHER UTILITIES (WATER, ETC.)			
TELEPHONE			
AIR CONDITIONING			
UTILITY/TELEPHONE INSTALLATION FEES			
ARE YOU ABLE TO PREPARE MEALS AT HOME?			
LIVE IN AN DRUG/ALCOHOL REHAB OR DOMESTIC VIOLENCE SHELTER?			
LIVE IN PUBLIC HOUSING?			
LIVE IN SECTION 8 OR OTHER SUBSIDIZED HOUSING? IF YES, ARE YOU IN THE CERTIFICATE PROGRAM?			
DOES ANY PERSON, GROUP OR ORGANIZATION OUTSIDE THE HOUSEHOLD PAY ANY OF THE HOUSEHOLD EXPENSES?			
OTHER EXPENSES - INDICATE IF YOU OR ANYONE WHO LIVES WITH YOU AND IS APPLYING:	**YES**	**NO**	**IF YES, GIVE AMOUNT ($)**
PAYS TUITION AND FEES			
HAS CHILD OR DEPENDENT CARE EXPENSES			
PAYS CHILD SUPPORT			
PAYS ALIMONY			
BUYS OR PLANS TO BUY MEALS FROM A HOME-DELIVERY OR COMMUNAL DINING SERVICES			
HAS ADDITIONAL EXPENSES, SPECIFY: _____			

19

20

21

JOB EXPERIENCE/JOB POTENTIAL

IF YOU ARE CURRENTLY EMPLOYED, SPECIFY THE FOLLOWING:

HOURS YOU WORK PER WEEK? _____ WAGE PER WEEK? _____

TYPE OF JOB? _____

IF YOU HAVE AN EMPLOYMENT HISTORY BUT ARE NOT PRESENTLY WORKING, SPECIFY THE FOLLOWING ABOUT YOUR LAST JOB:

REASON(S) FOR LEAVING ? ☐ RESIGNED ☐ TERMINATED ☐ LAID OFF

DATE LAST EMPLOYED? _____ TYPE OF JOB? _____

HOW MANY JOBS HAVE YOU HAD IN THE LAST 5 YEARS?
☐ONE ☐2 ☐3-4 ☐5 OR MORE

WHO IS YOUR CURRENT OR LAST EMPLOYER?
NAME: ADDRESS: TELEPHONE:

22

WHAT JOB SKILLS DO YOU HAVE? CHECK ALL THAT APPLY:

☐ BEAUTY CULTURE ☐ CHILDCARE ☐ CLERICAL ☐ COMPUTER
☐ CONSTRUCTION ☐ DOMESTIC ☐ DRIVER'S LICENSE ☐ FOOD SERVICES
☐ HEALTH CARE ☐ HOUSEKEEPING ☐ MESSENGER ☐ SALES
☐ ACHOOL AID ☐ SECRETARIAL ☐ SECURITY
☐ OTHER (SPECIFY): _____

WHAT ARE YOUR SPECIFIC JOB INTERESTS?

IF YOU HAVE ANY MEDICAL CONDITION WHICH LIMITS YOUR ABILITY TO WORK, PLEASE SPECIFY BELOW:

IF YOU HOLD ANY SPECIAL LICENSES/CERTIFICATES (EXAMPLE: MECHANIC, FOOD HANDLER) OR SKILLS TRADE UNION MEMBERSHIP, PLEASE SPECIFY BELOW:

IF YOU ARE CURRENTLY PARTICIPATING IN VOLUNTEER WORK OR COMMUNITY SERVICE, PLEASE SPECIFY BELOW:

IF YOU OR ANYONE IN YOUR HOUSEHOLD IS PARTICIPATING IN A STRIKE, SPECIFY WHO:

IF YOU OR ANYONE IN YOUR HOUSEHOLD IS A MIGRANT OR SEASONAL FARM WORKER, SPECIFY WHO:

SPECIFY BELOW ANYONE IN YOUR HOUSEHOLD WHO IS 17 YEARS OF AGE OR OLDER AND WORKING:

	1.	2.
NAME OF EMPLOYED INDIVIDUAL:		
WAGE PER WEEK:		
TYPE OF JOB:		
EMPLOYER'S NAME:		
EMPLOYER'S ADDRESS AND TELEPHONE:	Address: Telephone: ( )	Address: Telephone: ( )

READ THE IMPORTANT INFORMATION BELOW

MEDICAID ELIGIBILITY DETERMINATION (YOU DO NOT NEED TO ANSWER THIS SECTION IF YOU ARE ONLY APPLYING FOR MEDICAL ASSISTANCE)

WHEN YOU APPLY FOR PUBLIC ASSISTANCE YOU MUST INDICATE IF YOU ARE ALSO APPLYING TO HAVE YOUR MEDICAID ELIGIBILITY DETERMINED. EVEN THOUGH YOUR APPLICATION FOR PUBLIC ASSISTANCE MAY BE DENIED, YOU MAY STILL BE ELIGIBLE FOR MEDICAID. IF YOUR APPLICATION FOR PUBLIC ASSISTANCE IS DENIED, A SEPARATE DECISION WILL BE MADE ON YOUR MEDICAID ELIGIBILITY. YOU MAY BE ASKED TO COME INTO A MEDICAID OFFICE FOR A MEDICAID CERTIFICATION AND BRING WITH YOU ANY OUTSTANDING MEDICAL BILLS WHICH YOU HAVE AND OTHER INFORMATION. IF YOU FAIL TO KEEP AN APPOINTMENT FOR MEDICAID CERTIFICATION OR FAIL TO BRING REQUESTED INFORMATION WITH YOU, YOUR MEDICAID APPLICATION MAY BE DENIED.
I UNDERSTAND THAT I HAVE THE RIGHT TO HAVE MY ELIGIBILITY FOR MEDICAID DETERMINED EVEN IF I AM FOUND INELIGIBLE FOR PUBLIC ASSISTANCE. IF YOU ARE FOUND INELIGIBLE FOR PUBLIC ASSISTANCE, WE WILL STILL EVALUATE YOUR MEDICAID APPLICATION, UNLESS YOU CHECK THE BOX AND SIGN BELOW.

☐ I DO NOT WANT TO RECEIVE MEDICAID IF MY PUBLIC ASSISTANCE APPLICATION IS DENIED.

APPLICANT'S SIGNATURE DATE SIGNED:

x

23

SUPPORT

Any person making application for those in receipt of Family Assistance (FA) and Safety Net Assistance (SNA) shall know that such application for or receipt of FA and SNA shall operate as an assignment to the State and the Social Services district concerned, of any rights to support from any other person, as such applicant or recipient may have in his own behalf of any other family member for whom the applicant or recipient is applying for or receiving assistance (Social Services Law 158 and 348).

SOCIAL SECURITY NUMBER (SSN)

A person making application for Temporary Cash Assistance (TA), for Medical Assistance (MA) or for Food Stamps (FS) shall disclose the SSN of any person for whom PA or MA or FS is requested, except when the individual is an alien seeking MA only for the treatment of an emergency medical condition. Such disclosure is mandatory for TA under the authority of Section 351.2 of Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (18NYCRR) and 42 USC 602(a) (25), 42 USC 98.71 (a) (12) for MA under the authority of Sections 351.2 and 360-1.2 of 18NYCRR and 42 USC 1320b-7, and for FS under the authority of Section 1327 of the Public Law 97-98 and 7 CFR 273.2. SSNs are used to provide proper identification of applicants for and recipients of TA, MA and FS and to verify income, eligibility and benefit amounts. We will also be using your SSN to match with the IRS unearned income data and with the New York State (NYS) Department of Labor for unemployment insurance information and with the NYS Department of Taxation and Finance for earned income data. For applicants for and recipients of TA and MA, we may provide the absent parent with SSN information for your children in order to enroll them as beneficiaries of health insurance coverage and, if necessary, to initiate intra/interstate child support enforcement services. For FS applicants and recipients, the SSN will be matched to Child Support Enforcement Records. Pregnant women who want only Medical Assistance are not required to supply SSNs.

24

PENALTIES - I understand that my application may be investigated, and I agree to cooperate in such an investigation. Federal and State laws provide for penalties of fine, imprisonment or both if you do not tell the truth when you apply for TA and/or MA benefits or at any time when you are questioned about eligibility, or cause someone else not to tell the truth regarding your application or your continuing eligibility. Penalties also apply if you conceal or fail to disclose facts regarding your initial and continuing eligibility for TA and/or MA or if you conceal or fail to disclose facts that would affect the right of someone for whom you have applied to obtain or continue to receive TA and/or MA benefit; and such benefits must be used for that other person and not yourself. Federal and State laws provide that any transfer of assets for less than fair market value made by an individual or an individual's spouse, within the 36 months (or 60 months in the case of trust related transfers) prior to the month in which the individual is both in receipt of nursing facility services and has submitted an application for Medical Assistance, may render the individual ineligible for nursing facility services or home and community-based wavered services for a period of time. This provision only applies to transfers made on or after August 11, 1993.

ASSIGNMENT OF INSURANCE AND OTHER BENEFITS

For TA and MA, I will file any claims for health or accident insurance benefits or any other resource to which I am entitled, and do hereby assign any such resources to the Social Services official to whom this application is made. In addition, I will assist in making any required assignment of benefits or resources to the Social Services official to whom this application is made.

DIRECT PAYMENT

I authorize the payment to me or members of my household for health or accident insurance benefits to be made directly to the appropriate Social Services official for medical and other health services furnished while we are eligible for MA.

MEDICARE

I authorize payments under "Medicare" (Part B of Title XVIII, Supplamentary Medical Insurance Program) to be made directly to physicians and medical suppliers on any future unpaid bills for medical and other health services furnished to me while I am eligible for MA.

25

RELEASE OF EDUCATIONAL RECORDS - I give permission to the State and Local Department of Social Services to:

- Obtain any information regarding the educational records of my child(ren), herein named necessary for claiming MA reimbursement for health-related educational services or for other reasons connected with my TA case.
- Provide the appropriate federal government agency access to this information for the sole purpose of audit.

I also authorize the NYC Board of Education to release to the NYC Human Resources Administration information pertaining to my children's school attendance for the sole purpose of complying with the Learnfare requirements.

CHANGES - I agree to inform the agency **promptly** of any change in my need, income, property, living or childcare arrangements, and address to the best of my knowledge or belief.

NON-DISCRIMINATION NOTICE

This application will be considered without regard to race, color, sex, disabilities, religious creed, national origin, sexual orientation or political beliefs.

FOOD STAMP AUTHORIZED REPRESENTATIVE - You can authorize someone who knows your household circumstances to apply for FS for you. If you do have them sign in the Signature section at the bottom of page 8. You can also authorize someone outside your household to get FS for you and to use them to buy food for you. If you like to authorize someone, print the person's name, address and phone number directly below your signature on page 8.

26

REQUIREMENT TO REPORT/VERIFY HOUSEHOLD EXPENSES

I understand that my household must report child care and utility expenses in order to get a FS deduction for these expenses. I further understand that my household must report and verify rent/mortgage payments, property taxes, insurance, medical expenses and child support paid to non-household members in order to get a FS deduction for these expenses.

I understand that failure to report/verify the expenses will be seen as a statement by my household that I/we do not want to receive a deduction for those unreported/unverified expenses. A deduction for these expenses may make you eligible for FS or may increase your FS benefit. I understand that I may report/verify these expenses at any time in the future. This deduction would then be applied to the calculation of FS benefits in the future months in accordance with the rules for change reporting.

27

CIVILITY RULES

Every person in an Income Support/Job Center is entitled to a safe, peaceful and secure business place. No one should feel unsafe. HRA staff are dedicated to helping you move on the Ladder of Success. Hostile, angry and threatening behavior interferes with HRA's goal of moving you towards financial independence. Behavior that interferes with the HRA's ability to get the information needed to determine your eligibility can result in a denial of assistance.

28

Human Resources Administration
Family Independence Administration

READ THE IMPORTANT INFORMATION BELOW, AND SIGN AT THE BOTTOM .

FOOD STAMP PENALTY WARNING

THE INFORMATION PROVIDED ON THIS FORM WILL BE SUBJECT TO VERIFICATION BY FEDERAL, STATE AND LOCAL OFFICIALS. IF ANY IS FOUND TO BE INACCURATE, YOU MAY BE DENIED FOOD STAMPS AND/OR BE SUBJECT TO CRIMINAL PROSECUTION FOR KNOWINGLY PROVIDING FALSE INFORMATION.

ANY MEMBER OF YOUR HOUSEHOLD WHO IS FOUND GUILTY IN A COURT OF LAW OF BUYING OR SELLING FIREARMS, AMMUNITION OR EXPLOSIVES IN EXCHANGE FOR FOOD STAMPS WILL NEVER BE ABLE TO GET FOOD STAMPS AGAIN. ANY MEMBER OF YOUR HOUSEHOLD WHO IS FOUND GUILTY IN A COURT OF LAW OF BUYING OF SELLING CONTROLLED SUBSTANCES (ILLEGAL DRUGS OR CERTAIN DRUGS FOR WHICH A DOCTOR'S PRESCRIPTION IS REQUIRED) IN EXCHANGE FOR FOOD STAMPS WILL NOT BE ABLE TO GET FOOD STAMPS FOR 12 MONTHS FOR THE FIRST OFFENSE AND PERMANENTLY FOR THE SECOND OFFENSE. ANY MEMBER OF YOUR HOUSEHOLD WHO INTENTIONALLY BREAKS ANY OF THE FOLLOWING RULES CAN BE BARRED FROM THE FOOD STAMP PROGRAM FOR 6 MONTHS AFTER THE FIRST VIOLATION, 12 MONTHS AFTER THE SECOND VIOLATION, AND PERMANENTLY AFTER THE THIRD VIOLATION. THE INDIVIDUAL CAN BE FINED UP TO $250,000, SENT TO JAIL FOR UP TO 20 YEARS, OR BOTH. A COURT CAN ALSO BAR AN INDIVIDUAL FOR AN ADDITIONAL 18 MONTHS FROM THE FOOD STAMP PROGRAM. THE INDIVIDUAL MAY ALSO BE SUBJECT TO FURTHER PROSECUTION UNDER OTHER APPLICABLE FEDERAL LAWS.

DO NOT GIVE FALSE INFORMATION, OR HIDE INFORMATION TO GET OR CONTINUE TO GET FOOD STAMPS.

DO NOT TRADE OR SELL FOOD STAMPS OR FOOD STAMP IDENTIFICATION/BENEFIT CARDS FOR YOUR HOUSEHOLD.

29

DO NOT ALTER FOOD STAMP IDENTIFICATION BENEFIT CARDS TO GET FOOD STAMPS YOU ARE NOT ENTITLED TO RECEIVE.

DO NOT USE FOOD STAMPS TO BUY INELIGIBLE ITEMS, SUCH AS ALCOHOLIC DRINKS AND TOBACCO.
DO NOT USE SOMEONE ELSE'S FOOD STAMPS OR FOOD STAMP IDENTIFICATION/BENEFIT CARDS FOR YOUR HOUSEHOLD.

IN SIGNING THIS APPLICATION, I CERTIFY, UNDER PENALTY OF PERJURY, THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

LIFELINE - I authorize the Department of Social Services to disclose the information provided in my application to Bell Atlantic for the sole purpose of assisting Bell Atlantic to verify my eligibility for Life Line telephone service.

CONSENT - I understand that by signing this application/certification form I agree to any investigation made by the Department of Social Services to verify or confirm the information I have given or any other investigation made by them in connection with my request for TA, MA or FS. If additional information is requested. I will provide it. I will also cooperate fully with the State and Federal personnel in a Temporary Cash Assistance and/or Food Stamp Quality Control Review.

CERTIFICATION OF CITIZENSHIP STATUS FOR FOOD STAMPS - I SWEAR AND AFFIRM, UNDER PENALTIES OF PERJURY, THAT ALL HOUSEHOLD MEMBERS INCLUDING MYSELF WHO ARE APPLYING FOR OR RECEIVING FS ARE UNITED STATES (U.S.) CITIZENS OR NATIONALS OR PERSONS WITH SATISFACTORY IMMIGRATION STATUS. I UNDERSTAND THAT INFORMATION ABOUT MY FOOD STAMP HOUSEHOLD WILL BE SUBMITTED TO THE IMMIGRATION AND NATURALIZATION SERVICE (INS) FOR VERIFICATION OF IMMIGRATION STATUS, IF APPLICABLE. I FURTHER UNDERSTAND THAT THE USE OR DISCLOSURE OF INFORMATION ABOUT ALL HOUSEHOLD MEMBERS INCLUDING MYSELF WHO ARE APPLYING FOR OR RECEIVING FS IS RESTRICTED TO PERSONS AND ORGANIZATIONS DIRECTLY CONNECTED WITH THE VERIFICATION OF IMMIGRATION STATUS AND ADMINISTRATION OR ENFORCEMENT OF PROVISIONS OF THE FOOD STAMP PROGRAM. I ALSO UNDERSTAND THAT INFORMATION RECEIVED FROM THE (INS) MAY AFFECT MY HOUSEHOLD'S ELIGIBILITY AND LEVEL OF BENEFITS.

30

AUTHORIZATION FOR REIMBURSEMENT OF PUBLIC ASSISTANCE BENEFITS FROM SSI RETROACTIVE PAYMENT

I authorize the Secretary of the United States Department of Health and Human Services, through the Social Security Administration (SSA), to send to the local social services district the amount due to me at the time of my first payment of (1) retroactive Supplemental Security Income (SSI) benefits that I may receive upon an application for SSI or (2) retroactive SSI benefits I may receive if I am terminated or suspended from receiving SSI benefits and am later reinstated.

I understand that the local social services district may take from my SSI payment the amount of Public Assistance (except assistance paid wholly or partly with federal funds) that was paid to me during the period beginning with my first day of eligibility for SSI or the first day to which SSI benefits were reinstated after a period of suspension or termination and ending with the month that SSI payments actually began (or the following month if the local social services district cannot stop delivery of my last public assistance payment during the month that SSI payments began).

After taking this money from my SSI check(s), the local social services district will pay me the balance, if there is any, no later than 10 working days from the date it receives my SSI payment. I also understand that if the district takes more money than I believe was paid to me as Public Assistance, I will be given an opportunity for a hearing.

I UNDERSTAND THAT:

- the SSA may treat the date that I submit this signed authorization to the local social services district as the date I first become eligible for SSI if I submit an application for initial SSI benefits within the next 60 days.

31

- this authorization will apply to any SSI application or appeal which is presently pending before the SSA with respect to me and to any SSI application I make or appeal I request with respect to the period ending one year after I sign this agreement.

This authorization will terminate one (1) year after it is received by the local social services district and will not have any effect upon future SSI applications, appeals or reviews if my case is completely decided, if the SSA makes an initial payment of SSI either on my application or after a period of suspension or termination or if the state and I mutually agree to terminate the authorization.

CERTIFICATION

In signing this application, I swear and affirm that the information I have given to the Department of Social Services as a basis for TA or care, MA or FS is correct. I also assign to the Department of Social Services any rights I have to pursue other third-party resources. I understand that I may be required, as a condition of eligibility for MA, to assign to the Department of Social Services the proceeds of the sale of my excess resources. I understand that upon receipt of MA, a lien may be filed and a recovery may be made against my real property under certain circumstances if I am in a medical institution and not expected to return home. I understand that MA paid on my behalf may be recovered from persons who had legal responsibility for my support at the time medical services were obtained.

32

APPLICANT/REPRESENTATIVE SIGNATURE- IF REPRESENTIVE PRINT NAME ADDRESS AND TELEPHONE NUMBER	DATE SIGNED
x _____ x _____ Name of Representative Please Print Address of Representative Tel.#	
HUSBAND/WIFE OR PROTECTIVE REPRESENTATIVE SIGNATURE x	**DATE SIGNED**

Human Resources Administration
Family Independence Administration

CENTER/OFFICE	APPLICATION DATE	UNIT	UNIT WORKER	DIST.	CASE TYPE	SERV. IND	CASE NUMBER	REGISTRY NUMBER	VERS
CASE NAME				DISTRICT	NO. REUSE INDICATOR	SUFFIX	FS SUFFIX	CATEGORY	LANG.	ETHNIC

EFFECTIVE DATE	DISPOSITION	EXTRA PAGES	SERVICES TRANSACTION TYPE	SEPARATE DET. CODE	REASON CODE	FORM / OF
	☐ DENIAL ☐☐☐ REASON CODE ☐ WITHDRAWAL	☐ SFED	☐ NEW OPENING ☐ REOPEN ☐ RECERTIFICATION	☐	☐☐☐	FORM _____ OF _____

ELIGIBILITY DETERMINED BY (WORKER)	DATE	ELIGIBILITY DETERMINED BY (SUPERVISOR)
SIGNATURE OF PERSON WHO OBTAINED ELIGIBILITY INFORMATION X	DATE	EMPLOYED BY: ☐ PROVIDER AGENCY SPECIFY _____ ☐ SOCIAL SERVICES DISTRICT

WITHDRAWAL

COMPLETE AND SIGN BELOW **ONLY** IF YOU WISH TO **WITHDRAW** YOUR APPLICATION/JOB PROFILE.

I WITHDRAW MY APPLICATION/JOB PROFILE FOR:

PUBLIC ASSISTANCE ☐
FOOD STAMPS ☐
MEDICAID ☐

33

I UNDERSTAND THAT I HAVE THE RIGHT TO PURSUE MY APPLICATION FOR FOOD STAMPS AND/OR MEDICAID EVEN IF I DO NOT PURSUE MY APPLICATION FOR TEMPORARY CASH ASSISTANCE. I ALSO UNDERSTAND THAT IF I WITHDRAW MY APPLICATION FOR CASH ASSISTANCE, MEDICAID AND/OR FOOD STAMPS I CAN REAPPLY AT ANY TIME.

IF I DO NOT WITHDRAW MY APPLICATION FOR FOOD STAMPS AND/OR MEDICAID, I HAVE THE RIGHT TO A REFERRAL FOR A NON-PUBLIC ASSISTANCE FOOD STAMP AND/OR MEDICAID DETERMINATION. THE FILING DATE FOR THESE BENEFITS IS THE DATE I COMPLETE AND SIGN THIS APPLICATION/JOB PROFILE.

APPLICANT'S SIGNATURE: _____ **DATE SIGNED:** _____

REFERRAL

I HAVE RECEIVED A REFERRAL FOR THE FOLLOWING: ☐ FOOD STAMPS ☐ MEDICAID

APPLICANT'S SIGNATURE: _____ **DATE SIGNED:** _____

EXPEDITED SERVICE WORKSHEET

(Complete this worksheet for all applicants)

Human Resources Administration
Family Independence Administration

Part One Check ☑ Yes or No

Has the household received Food Stamps this month?

☐ **Yes-Stop** Household ineligible for expedited service

☐ **No** Continue with Part Two

Note: if "yes" is checked, but household entered a domestic violence shelter during the month of application, continue with Part Two.

Part Two Check ☑ Yes or No

Has household received expedited food stamps in the past?

☐ **Yes** Answer Section A

☐ **No** Continue with Part Three

Section A

Has all previously pending verification been submitted since the last expedited issuance **OR**

Has the household been certified for ongoing benefits under normal processing standards since the last expedited issuance?

☐ **Yes** - Continue with Part Three

☐ **No-Stop** Household ineligible for expedited service

Part Three Check ☑ Yes or No

Does the household appear otherwise eligible for food stamps based on income/resources limitations (such as car, bank accounts, etc.), living arrangements and household composition.

☐ **Yes** Continue with Part Four

☐ **No-Stop** Household ineligible for expedited service

Part Four Check ☑ Yes or No

Does the household have $100 or less in cash, savings or other liquid resources, **and**
has the household received or does it expect to receive less than $150 gross income during the month of application?

☐ **Yes** Conduct an interview

☐ **No** Continue with Part Five

Is household's total gross income during month of application plus the household's resources less than their monthly rent/mortgage plus utility expenses?

☐ **YES** Conduct an interview

☐ **No-Stop** Household ineligible for expedited service unless qualified under Part Five

Description	Amount	Income: (Describe)	Amount
Rent/Mortgage:	$ _____	_____	$ _____
*Heat/AC:	$ _____	_____	$ _____
*Utilities:	$ _____	Resources:	
*Telephone:	$ _____	Cash on Hand	$ _____
		Bank Account(s)	$ _____
Other:	$ _____	Other _____	$ _____
Total Expenses	$ _____	Total Income+Resources:	$ _____

*** Use standard allowance if household incurs cost or received a HEAP benefit this year.**

Part Five-Migrant/Seasonal Farm Worker Household Only- Check ☑ Yes or No

Is this a migrant/seasonal farm worker's household with no more than $100 in liquid resources

☐ **Yes** (Answer questions below)

☐ **No-Stop** Household ineligible for expedited service

The only income for the month of application

(1) was terminated before application?

OR

(2) is new and no more than $25 gross income will be received within ten days after application .

☐ **If Yes to question 1or 2** conduct an interview

☐ **No** Ineligible

Agency disposition for expedited eligibility assessment

☐ Eligible ☐ Ineligible due to proration ☐ Ineligible (Other, indicate reason below)

_____

NYS Agency-Based Voter Registration Form

ESTE FORMULARIO ESTÁ DISPONIBLE EN ESPAÑOL

本表格有中文文本

Form W-680B (page 11)
Rev. 6/22/00

"If you are not registered to vote where you live now, would you like to apply to register here today?"

☐ YES (If you check yes, please complete VOTER REGISTRATION APPLICATION at bottom of page)

☐ NO because I choose not to register OR

☐ I am already registered at my current address OR

☐ I asked for and received a mail registration form

If you do not check any box, you will be considered to have decided not to register to vote at this time.

Signature ____ Date ____/____/____

(Please Print Name)

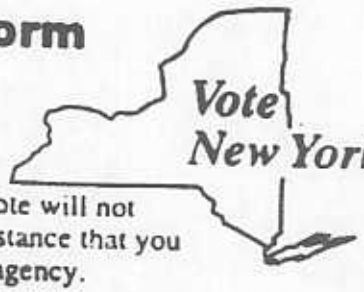
Qualifications for Registration

You Can Use This Form To:

- register to vote in New York State
- change your name and/or address, if there is a change since you last voted
- enroll in a political party or change your enrollment

To Register You Must:

- be a U.S. citizen
- be 18 years old by December 31 of the year in which you file this form (note: you must be 18 years old by the date of the general, primary, or other election in which you want to vote.)
- be a resident of the County, or of the City of New York at least 30 days before an election.
- not be in jail or on parole for a felony conviction
- not claim the right to vote elsewhere



IMPORTANT!

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with *New York State Board of Elections, 6 Empire State Plaza, Suite 201, Albany, New York 12223-1650.*
Tele: 1-800-469-6872, TTY 1-800-533-8683.

Your decision to register will remain confidential and will be used only for voter registration purposes. Anyone not choosing to register to vote and/or information regarding the office to which the application was submitted will remain confidential, to be used only for voter registration purposes.

VOTER REGISTRATION FORM

VOTER REGISTRATION APPLICATION

NVRA-00(1/00)

☐ Yes, I need an application for an Absentee Ballot **Please print or type in blue or black ink** ☐ Yes, I would like to be an Election Day Worker

1	Check boxes that apply ☐ new registration and enrollment ☐ address change ☐ party enrollment change ☐ name change	2	Are you a U.S. citizen? ☐ Yes ☐ No If you answered NO do not complete this form.
			For Board Use Only
3	Last Name / First Name / Middle Initial / Suffix		
4	Address Where You Live (do not give P.O. address) / Apt. No. / City/Town/Village / Zip Code / County		
5	Address Where You Get Your Mail (if different from above) / P.O. box, star rte., etc. / Post Office / Zip Code		
6	Date of Birth	7	Sex (circle) M F
8	Home Tel. Number (optional)		
9	The last year you voted / Your Address was (give house number, street, and city) / In county/state / Under the name (if different from your name now)		

10 Choose a Party — Check one box only

- ☐ REPUBLICAN PARTY
- ☐ DEMOCRATIC PARTY
- ☐ INDEPENDENCE PARTY
- ☐ CONSERVATIVE PARTY
- ☐ LIBERAL PARTY
- ☐ RIGHT TO LIFE PARTY
- ☐ GREEN PARTY
- ☐ WORKING FAMILIES PARTY
- ☐ I DO NOT WISH TO ENROLL IN A PARTY

Please note In order to vote in a primary election, you must be enrolled in a party

11 **AFFIDAVIT**. I swear or affirm that

- I am a citizen of the United States.
- I will have lived in the county, city, or village for at least 30 days before the election
- This is my signature or mark on the line below.
- The above information is true. I understand that if it is not true I can be convicted and fined up to $5,000 and/or jailed for up to four years

Signature or mark

X _____ Date

Please do not write in this space