



Do you want help filling out this application? Do you have questions? Call us at 1-855-797-4357 or Maine Relay 711 (TTY). We can help!

How do I apply?

Fill out this application by answering as many questions as you can. If you are applying for SNAP, we encourage you to fill out as much of the application as possible. We will accept your application if it is submitted with a name, address, and signature. The date we get this information will establish a start date for benefits and begin your application.

Apply faster online.

Visit www.mymaineconnection.gov to apply for benefits.

Who can complete the application?

The application should be filled out by you or an adult member for your household. If you would like to appoint an authorized representative to apply for benefits and act on behalf of the household, you may do so by filling out an Authorized Representative form found in Appendix B.

What other information may I need to provide?

We will attempt to verify the information you provide through electronic data matches. We will contact you to request additional verification if needed.

Do I need an interview?

SNAP and TANF both require an interview before we can determine if you are eligible for assistance. If you mail the application to us, we will schedule an interview for you.

Where do I return the application?

You can bring it in to a local DHHS office, mail, or fax it to us.

Mail: Office for Family Independence
State of Maine – DHHS
114 Corn Shop Lane
Farmington, ME 04938

Fax: 1-207-778-8429

How can I get help with this application?

- Phone: Call us at 1-855-797-4357 or Maine Relay 711 (TTY)
- In-Person: Visit your local Office for Family Independence (OFI).
Office locations:
<https://www.maine.gov/dhhs/about/contact/offices>

If you need help in your language (including an interpreter) or a disability accommodation, call 1-855-797-4357 or Maine Relay 711 (TTY). These services are free.

Program Information

Supplemental Nutrition Assistance Program (SNAP)

Helps low-income households buy food.

MaineCare (Medicaid) and CHIP (Children’s Health Insurance Program)

Provides free or low-cost health insurance to cover doctor’s visits, emergencies, prescription drugs, and more.

Temporary Assistance for Needy Families (TANF), Parents as Scholars (PaS), Alternative Aid (AA), or Emergency Assistance

Provides cash assistance or voucher payments for a limited number of months, to families with children in need of support.

Child Care (TANF Related)

Helps families that have received or are receiving TANF or PaS with childcare costs required to participate in work and/or education activities.

State Supplement

A MaineCare program that provides a small cash payment to people over age 65, who are blind, or people with a disability who get SSI or would be eligible for SSI.

Medicare Savings Program (Buy-in)

Helps pay Medicare premiums, and in some cases, deductibles, coinsurance, and copayments.

Limited Family Planning Services

Limited MaineCare benefit for reproductive and sexual health care.

Special Benefit Waiver

Provides a limited MaineCare benefit for individuals living with HIV or AIDS.

Please tear off and keep this page for you records.

Do I need to give a Social Security Number information when I apply?

All persons applying for assistance must provide a Social Security Number (SSN) if they have one (See 42 CFR §435.910; §457.340). A SSN is not required if the applicant is not eligible to receive a SSN, does not have a SSN and may only be issued a SSN for a valid non-work reason in accordance with 20 CFR §422.104, or refuses to obtain a SSN because of well-established religious objections. If you need help getting a SSN, we may be able to help. Call us at 1-855-797-4357. You can also visit www.ssa.gov or call the Social Security Administration at 1-800-772-1213 (TTY 1-800-325-0778).

Some lawfully present people may not have or be eligible for a SSN. They can still apply for assistance without a SSN. You don't need to provide immigration status or SSNs for household members who aren't seeking coverage but providing a SSN can speed up the application process. We'll keep all information you provide private and secure as required by law.

What proof may I need to send to complete my application?

To determine your eligibility, SSNs are used to conduct electronic data matches with state and federal agencies to verify information you provide, such as confirming your identity, citizenship, immigration status, income, or assets. If the information you provide does not match the information we get from these agencies, we may ask you to send us proof.

Proof of income is required for all programs. MaineCare will attempt to verify your income electronically before we ask you for proof. If you are applying for SNAP or TANF, you may need to send in proof of your income. Examples of income verification include pay stubs (most recent four weeks), employer statement verifying gross wages, federal tax return, business records for the last three months, or award letters.

Other proof may be needed depending on the programs you are applying for. Examples of items you may need to verify are listed within the application sections. We will contact you and ask for proof, if needed.

Department of Health and Human Services Non-Discrimination Policy

The Department of Health and Human Services (DHHS) does not discriminate on the basis of disability, race, color, sex, gender, sexual orientation, age, national origin, religious or political belief. Questions, concerns, complaints, or requests for additional information regarding the ADA and programs, services, or activities may be forwarded to the DHHS ADA/Civil Rights Coordinator, at 11 State House Station, Augusta, Maine 04333-0011; 207-287-3707 (V); Maine Relay 711 (TTY); or [ADA-CivilRights.DHHS@maine.gov](mailto:ADACivilRights.DHHS@maine.gov).

Civil rights complaints may also be filed with the U.S. Department of Health and Human Services, Office of Civil Rights, by phone at 1-800-368-1019 or 1-800-537-7697 (TDD); by mail to 200 Independence Avenue, SW, Room 509, HHS Building, Washington, D.C. 20201; or online through Office of Civil Rights (OCR) Complaint Portal at <https://ocrportal.hhs.gov/ocr/>.

Notification of Right to Request a Hearing

We will give you a written notice explaining your benefits. If we deny, change, or stop benefits, we will give you a written explanation of why. If you do not agree with the Department's eligibility decision, you have the right to appeal. You can ask for a hearing by contacting the Office for Family Independence over the phone, in writing, or in person at your local office.

Estate Recovery

Per federal law, if you are age 55 or older and receive MaineCare (Medicaid) to pay for nursing facility services, home and community-based waiver services, and any related hospital and prescription drug service, the State may make a claim on the assets of your estate (upon your death) to recover money that MaineCare (Medicaid) has paid for your care. No claim will be made if the only benefit you get is Medicare Savings Program (Buy-in).

For more information about the Estate Recovery Program, call 1-800-977-6740.

Good Cause

If you are an adult applying for TANF or MaineCare benefits, the law requires you to cooperate with establishing paternity and seeking support. You may be excused from these requirements if you prove it may be dangerous for you and/or your children. This is known as good cause.

Voter Registration

If you are not registered to vote where you live now and would like to apply to register to vote, you can download and print a Maine voter registration application at <https://www.maine.gov/sos/cec/elec/voter-info/voterguide.html>. Applying to register or declining to register to vote will not affect services or benefits from this agency.

What benefits do you want to apply for?

- SNAP (Food Assistance)
- TANF (Including AA and PaS)
- Child Care (TANF Related)
- MaineCare or CHIP (Health Insurance)
- Medicare Savings Program (Buy-in)
- Emergency Assistance

SIGN HERE – This application cannot be accepted without a signature

I understand that the information provided on this application may be verified by financial institutions, consumer reporting, and federal and state agencies. If information cannot be verified, I agree to provide documents to prove what I have stated on this application. If I have given incorrect information, my benefits may be denied.

If a MaineCare or TANF eligible child has a parent who lives outside of the home, I know I'll be asked to cooperate with the agency that collects support from an absent parent. If I think cooperating to collect medical or financial support will harm me or my children, I can tell the Office for Family Independence and I may not have to cooperate.

I understand that if anyone on this application is eligible for MaineCare (Medicaid or CHIP), I am giving the Medicaid agency the right to pursue and get money from any other health insurance, legal settlements, or other third parties. I am also giving the Medicaid agency rights to pursue and get medical support from a parent.

I am signing this application under penalty of perjury. That means, to the best of my knowledge, I gave true, correct, and complete answers to all the questions on this form, including information concerning citizenship and immigration status for all persons applying for benefits. I know that I must tell the Office for Family Independence if anything changes and is different than what I wrote on this application. I understand that a change in my information could affect my eligibility as well as eligibility for members of my household. I know that I may be subject to penalties under federal law if I intentionally provide false and/or untrue information.

X

Your signature or your representative's signature	Date Signed
If you are an authorized representative, you may sign here only if you and the applicant have completed and signed the authorized representative form (see Appointment of Authorized Representative form in Appendix B).	

MaineCare Applicants

Do any applicants need help with any medical bills incurred within the past three (3) months? Yes No
 If yes, who and which months?

If you are over the income limit for MaineCare, would you like to be quoted as six-month deductible? Yes No

If not eligible for full MaineCare coverage, does anyone want to be reviewed for the Limited Family Planning Services program? Yes No
 If yes, who?

If Family Planning Services are requested, we will only consider income of the requesting individual. We will need to evaluate the individual's household's income to see if they qualify for full MaineCare coverage.

Supplemental Nutrition Assistance Program (SNAP) Applicants

If the answer to any of these questions is yes, you may be able to get SNAP benefits right away.

1. Does your household have \$100 or less in available cash/bank accounts and expects to receive less than \$150 in income this month? Yes No
2. Is your monthly income and any other money available to you in cash or in bank accounts less than the amount of money you need to pay your rent/mortgage and utility bills this month? Yes No
3. Are you a migrant or seasonal farm worker? Yes No

STEP 1: Tell us about your household

We need to gather information about the people in your household to help us make sure everyone requesting benefits gets the best coverage they can. The amount of help or type of program you qualify for is based on the number of people in your household and your household income. Who you include in this application depends on the type of benefits requested.

MaineCare Applicants

Below is a list of who you should include on this application for household members seeking MaineCare coverage.

For adults who need coverage:

Include these people even if they aren't applying for health coverage for themselves.

- Any spouse
- Any child under age 21 they live with, including stepchildren
- Any other person on the same federal income tax return (including any children over age 21 who are claimed on a parent's tax return). You don't need to file taxes to get coverage.

For children under age 21 who need coverage:

Include these people even if they aren't applying for health coverage themselves.

- Any parent (or stepparent) they live with
- Any sibling they live with
- Any child they live with, including stepchildren
- Any spouse they live with
- Any other person on the same federal income tax return. You don't need to file taxes to get coverage.

SNAP Applicants

If you are applying for SNAP, be sure to also include anyone with whom you live with and purchase and prepare meals, their spouse, and their children under age 22.

TANF Applicants

TANF applicants need to include any spouse, children, or stepchildren who live with you, including the children's siblings and parents who also reside with you.

Answer the following sections for each person in your household. Start with yourself, then add other adults and children.

Providing race and ethnicity data about an applicant's household is optional; it will not affect your eligibility or the amount of benefits your household may receive. This information is collected to help us better understand and improve our programs and benefit delivery. If you are applying for SNAP or TANF and opt not to provide your race or ethnicity it will be collected by other means for reporting purposes.

Person 1 (Start with yourself) Are you applying for MaineCare? Yes No

A SSN is required for every person applying for coverage, if they have one. You do not have to give us the SSN for people in your home that are not applying for coverage but providing a SSN may help speed up the application process.

Name (first, middle initial, last):	Social Security Number:	Date of Birth:
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Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-binary	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married
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Home Address:

Check here if you do not have a home address. You will still need to give a mailing address.

Mailing Address (if different from home address):

Phone Number:	Phone Type: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	Preferred language:
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Go paperless! If you want electronic notices, you need to set up an account online at www.mymaineconnection.gov

Email Address:

Person 1 (Continued from Page 4)

Are you enrolled in school full-time? Yes No SNAP/TANF applicants: Please provide school information.

Name of School: _____ What grade/year? _____

Are you pregnant? Yes No If yes, estimated due date? _____ How many babies are expected? _____

Answer the questions below if you are applying for yourself.

Are you a U.S. citizen or U.S. national? Yes No

If yes, are you a naturalized or derived citizen? (This usually means you were born outside of the U.S.)

Yes, please provide an alien and certificate number. No

Alien Number: _____ Certificate Number: _____

If you aren't a U.S. citizen or U.S. national, do you have an immigration status?

Yes, please answer the questions below. See page 18 for a list of immigration statuses.

Immigration status: _____ Alien# or USCIS#: _____

Document type: _____ Card or Document Number: _____

Did you enter the United States before August 22, 1996? Yes No

Are you, or is your spouse or parent, a veteran or active-duty member of the military? Yes No

Ethnicity (*Optional*): Hispanic or Latino Non-Hispanic or Latino

Race (*Optional – check all that apply*): White Black/African American Native Hawaiian/Pacific Islander Asian

American Indian or Alaska Native Other _____

Person 2

Are they applying for MaineCare? Yes No

A SSN is required for every person applying for health care coverage, if they have one. You do not have to give us the SSN for people in your home that are not applying for coverage but providing a SSN may help speed up the application process.

Name (first, middle initial, last): _____ Social Security Number: _____ Date of Birth: _____

Gender: Male Female Non-binary Marital Status: Single Married

Are they enrolled in school full-time? Yes No SNAP/TANF applicants: Please provide school information.

Name of School: _____ What grade/year? _____

Are they pregnant? Yes No If yes, estimated due date? _____ How many babies are expected? _____

Answer the questions below if this person is applying for benefits.

Are they a U.S. citizen or U.S. national? Yes No

If yes, are they a naturalized or derived citizen? (This usually means you were born outside of the U.S.)

Yes, please provide an alien and certificate number. No

Alien Number: _____ Certificate Number: _____

If they aren't a U.S. citizen or U.S. national, do you have an immigration status?

Yes, please answer the questions below. See page 18 for a list of immigration statuses.

Immigration status: _____ Alien# or USCIS#: _____

Document type: _____ Card or Document Number: _____

Did they enter the United States before August 22, 1996? Yes No

Are they, or is their spouse or parent, a veteran or active-duty member of the military? Yes No

Ethnicity (*Optional*): Hispanic or Latino Non-Hispanic or Latino

Race (*Optional – check all that apply*): White Black/African American Native Hawaiian/Pacific Islander Asian

American Indian or Alaska Native Other _____

Person 3		Are they applying for MaineCare? <input type="checkbox"/> Yes <input type="checkbox"/> No	
A SSN is required for every person applying for health care coverage, if they have one. You do not have to give us the SSN for people in your home that are not applying for coverage but providing a SSN may help speed up the application process.			
Name (first, middle initial, last):		Social Security Number:	Date of Birth:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-binary		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	
Are they enrolled in school full-time? <input type="checkbox"/> Yes <input type="checkbox"/> No <u>SNAP/TANF applicants</u> : Please provide school information.			
Name of School:		What grade/year?	
Are they pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, estimated due date?	How many babies are expected?	
Answer the questions below if this person is applying for benefits.			
Are they a U.S. citizen or U.S. national? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, are they a naturalized or derived citizen? <input type="checkbox"/> Yes, please provide an alien and certificate number. <input type="checkbox"/> No			
Alien Number:		Certificate Number:	
If they aren't a U.S. citizen or U.S. national, do you have an immigration status?			
<input type="checkbox"/> Yes, please answer the questions below. See page 18 for a list of immigration statuses.			
Immigration status: _____		Alien# or USCIS#: _____	
Document type: _____		Card or Document Number: _____	
Did they enter the United States before August 22, 1996? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are they, or is their spouse or parent, a veteran or active-duty member of the military? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Ethnicity (<i>Optional</i>): <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino			
Race (<i>Optional – check all that apply</i>): <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Asian			
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Other _____			

Person 4		Are they applying for MaineCare? <input type="checkbox"/> Yes <input type="checkbox"/> No	
A SSN is required for every person applying for health care coverage, if they have one. You do not have to give us the SSN for people in your home that are not applying for coverage but providing a SSN may help speed up the application process.			
Name (first, middle initial, last):		Social Security Number:	Date of Birth:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-binary		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	
Are they enrolled in school full-time? <input type="checkbox"/> Yes <input type="checkbox"/> No <u>SNAP/TANF applicants</u> : Please provide school information.			
Name of School:		What grade/year?	
Are they pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, estimated due date?	How many babies are expected?	
Answer the questions below if this person is applying for benefits.			
Are they a U.S. citizen or U.S. national? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, are they a naturalized or derived citizen? <input type="checkbox"/> Yes, please provide an alien and certificate number. <input type="checkbox"/> No			
Alien Number:		Certificate Number:	
If they aren't a U.S. citizen or U.S. national, do you have an immigration status?			
<input type="checkbox"/> Yes, please answer the questions below. See page 18 for a list of immigration statuses.			
Immigration status: _____		Alien# or USCIS#: _____	
Document type: _____		Card or Document Number: _____	
Did they enter the United States before August 22, 1996? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are they, or is their spouse or parent, a veteran or active-duty member of the military? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Ethnicity (<i>Optional</i>): <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino			
Race (<i>Optional – check all that apply</i>): <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Asian			
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Other _____			

Person 5		Are they applying for MaineCare? <input type="checkbox"/> Yes <input type="checkbox"/> No	
A SSN is required for every person applying for health care coverage, if they have one. You do not have to give us the SSN for people in your home that are not applying for coverage but providing an SSN may help speed up the application process.			
Name (first, middle initial, last):		Social Security Number:	Date of Birth:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-binary		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	
Are they enrolled in school full-time? <input type="checkbox"/> Yes <input type="checkbox"/> No <u>SNAP/TANF applicants</u> : Please provide school information.			
Name of School:		What grade/year?	
Are they pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, estimated due date?	How many babies are expected?	
Answer the questions below if this person is applying for benefits.			
Are they a U.S. citizen or U.S. national? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, are they a naturalized or derived citizen? <input type="checkbox"/> Yes, please provide an alien and certificate number. <input type="checkbox"/> No			
Alien Number:		Certificate Number:	
If they aren't a U.S. citizen or U.S. national, do you have an immigration status? <input type="checkbox"/> Yes, please answer the questions below. See page 18 for a list of immigration statuses.			
Immigration status: _____		Alien# or USCIS#: _____	
Document type: _____		Card or Document Number: _____	
Did they enter the United States before August 22, 1996? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are they, or is their spouse or parent, a veteran or active-duty member of the military? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Ethnicity (<i>Optional</i>): <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino			
Race (<i>Optional – check all that apply</i>): <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Other _____			

Person 6		Are they applying for MaineCare? <input type="checkbox"/> Yes <input type="checkbox"/> No	
A SSN is required for every person applying for health care coverage, if they have one. You do not have to give us the SSN for people in your home that are not applying for coverage but providing an SSN may help speed up the application process.			
Name (first, middle initial, last):		Social Security Number:	Date of Birth:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-binary		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	
Are they enrolled in school full-time? <input type="checkbox"/> Yes <input type="checkbox"/> No <u>SNAP/TANF applicants</u> : Please provide school information.			
Name of School:		What grade/year?	
Are they pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, estimated due date?	How many babies are expected?	
Answer the questions below if this person is applying for benefits.			
Are they a U.S. citizen or U.S. national? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, are they a naturalized or derived citizen? <input type="checkbox"/> Yes, please provide an alien and certificate number. <input type="checkbox"/> No			
Alien Number:		Certificate Number:	
If they aren't a U.S. citizen or U.S. national, do you have an immigration status? <input type="checkbox"/> Yes, please answer the questions below. See page 18 for a list of immigration statuses.			
Immigration status: _____		Alien# or USCIS#: _____	
Document type: _____		Card or Document Number: _____	
Did they enter the United States before August 22, 1996? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are they, or is their spouse or parent, a veteran or active-duty member of the military? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Ethnicity (<i>Optional</i>): <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino			
Race (<i>Optional – check all that apply</i>): <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Other _____			

If there are more than six (6) people in your household, copy page 7 and include the completed copy with your application.

Household Relationships

If there are two or more people in your household, please describe how they are related to you. Examples may include:

- Spouse* *Child* *Parent* *Sibling* *Grandparent*
Grandchild *Aunt/Uncle* *Niece/Nephew* *Cousin* *Not related*
Step, half, adopted, and foster relationships should be included. You may also include other relationships not listed above.

Name of person	Relationship to you (Person 1)

Other questions about your household

Does any applicant have a special health care need, physical disability, or mental health condition that limits their ability to work, attend school, or take care of their daily needs (like bathing, dressing, daily chores, etc.)? Yes No

If yes, who?

MaineCare applicants who need to be reviewed for eligibility programs based on age (over 65) or disability may need to provide asset information in **Step 3**. This step is optional right now but answering now may speed up the application process.

Is any applicant in your household American Indian or Alaska Native?

Yes – Complete **Appendix A** and include with application. No

Is any applicant in foster care or state custody? Yes No If yes, who?

Were any applicants under the age of 26 previously enrolled in foster care at the age of 18? Yes No

If yes, who?

In what state were they in foster care?

Is any applicant currently in jail or prison? Yes No If yes, who?

Incarceration Date:

Anticipated release date (if known):

SNAP Benefit Questions

You do not need to answer these questions if you are only applying for MaineCare.

Have you ever had an Electronic Benefit Transfer (EBT) or P-EBT Card? Yes No If yes, do you still have it? Yes No

How many people, including yourself, live in your home and purchase and prepare meals with you?

If someone is age 18 to 56 years old, did they get SNAP in another State in the past three years? Yes No

If yes, who?

Which state(s)?

Are you or anyone you are applying for in violation of parole or probation or fleeing to avoid prosecution or confinement for a felony? Yes No

If yes, who?

Have you or anyone for whom you are applying ever been convicted of making false or misleading statements about your identity or address to get SNAP, Medicaid, or TANF in two or more states at the same time? Yes No

If yes, who?

Have you or 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? Yes No

If yes, are they in compliance with the terms of the sentence? Yes No

If no, who is not in compliance?

STEP 2: Income

The Department will check electronic data sources to see if it can verify your income. We will ask you to submit proof of income if we are not able to verify your income electronically. You may also send in proof (e.g., pay stubs, award letters, etc.) with this application if you choose.

Employment

If you are applying for SNAP or TANF, sending proof (pay stubs from the last 4 weeks or a letter from your employer) with this application may speed up the eligibility determination for these benefits. Examples of earned income:

	<i>Wages</i>	<i>Salary</i>	<i>Tips</i>	<i>Bonus</i>	<i>Commission</i>	<i>Severance Pay</i>
Employed Person	Employer			Average hours per week	How often paid	Wages/Salary (before taxes)
						\$
						\$
						\$
						\$

SNAP and TANF applicants: Has anyone in your household left a job in the last 60 days? Yes No

If yes, who?
Reason:
Date last paid:

SNAP and TANF applicants: Is anyone in your household on strike? Yes No If yes, who?

Self-Employment Income

Complete this section if anyone in your household is self-employed.

SNAP and TANF applicants: Self-employed applicants must send a copy of their most recent federal tax return, including all schedules. If they did not file a tax return, copies of business income and expense records must be sent.

MaineCare applicants: We will request tax returns or business income and expense records to verify income, or you may send these documents with your application to speed up the process.

Name of person who is self-employed:	Type of work:
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How much net income (profits once business expenses are paid) will they get from self-employment this month?	\$
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SNAP and TANF applicants: Please provide the business name and average hours per week worked.

Name of business:	Average hours per week worked:
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Has this business filed taxes? Yes No If yes, for what tax year did the business last file taxes?

Has the business had a significant change in income or expenses? Yes No

Other Income

Complete this section if anyone in your household has unearned income. Examples of unearned income:

<i>Social Security Benefits</i>	<i>Unemployment</i>	<i>Railroad Retirement</i>	<i>Rental Income</i>	<i>Veterans Benefits*</i>
<i>SSI*</i>	<i>Child Support/Alimony</i>	<i>Workers' Compensation*</i>	<i>Pensions</i>	<i>Interest/Dividends</i>

* These income types must be reported for SNAP and TANF. They do not need to be reported for MaineCare applicants who are not applying on the basis of age (over 65) or disability.

Person with income	Type/source of income	How much?	How often?
		\$	
		\$	
		\$	
		\$	
		\$	

Do you expect any change in income? Yes No explain:

SNAP and TANF applicants: Does anyone give any money or assistance to anyone in your household? Yes No

SNAP and TANF applicants: Has anyone recently received, or does anyone expect to receive in the future, any payments such as retroactive government benefits, compensation, pay raises, lawsuit settlements, inheritance, lottery winnings, etc.?

Yes No If yes, please explain:

STEP 3: Assets

SNAP and TANF applicants: Asset information is required.

MaineCare applicants: Asset information is only needed to review eligibility for programs based on age (over 65) or disability. While completing this section is optional upfront, providing this information now will help speed up the application process.

Applicants who are under age 65 and do not have a disability may skip to **Step 4**.

Please tell us about assets you or members of your household own or have interest in. Examples include:

Owner(s)	Type of Asset	Name of Bank or Institution	Current Value
			\$
			\$
			\$
			\$
			\$

Vehicles

If you or anyone in your household own, or jointly own any vehicles, list them below. Examples of vehicles:

Owner(s)	Vehicle Type	Year	Make/Model	Amount Owed
				\$
				\$
				\$
				\$

Property

If you or anyone in your household owns, or jointly owns property, list them below. Examples of property:

Owners(s)	Property Type	Full Address of Property	Amount Owed
			\$
			\$
			\$

STEP 4: Expenses and Deductions

Household Expenses Please answer these questions if you are applying for SNAP or TANF.

If you do not report an expense, you waive your right to have the expense used in the determination of benefits.

Some expenses, such as child support paid, medical expenses, or dependent care expenses require verification. Failure to report or verify such expenses will be seen as a statement that you do not want to receive a deduction for the unreported or unverified expense. If you have difficulties getting verifications, the Office for Family Independence can help.

Expense Type	How much?	How often paid?	Expense Type	How much?	How often paid?
Rent	\$		Lot Rent	\$	
Heat	\$		Mortgage	\$	
Air Conditioning	\$		Property Taxes	\$	
Other Electricity	\$		House Insurance	\$	
Telephone (basic)	\$		Cooking Fuel	\$	
Water and/or Sewer	\$		Trash Collection	\$	

Is your heating cost included in your rent? Yes No

Does your mortgage include taxes and house insurance? Yes No

Has General Assistance helped you with any shelter or utility expenses in the last 6 months? Yes No

Do you receive a rent subsidy? Yes No If yes, how much? \$ How often?

Does anyone outside your household pay all or part of the expenses listed above? Yes No

If yes, who? Explain what bills they pay:

Did your household get more than \$20.00 in HEAP (fuel assistance) benefit in the last 12 months? Yes No

If yes, what was the last date of receipt?

Does anyone pay child support? Yes No If yes, who? Is it court ordered? Yes No

Amount? \$ How often? For whom?

Does any applicant over 60 or disabled have over \$35 per month in out-of-pocket medical expenses? Yes No

If yes, who?

Child or Dependent Care Please answer these questions if you are applying for SNAP or TANF

Does anyone pay for childcare or the care of an adult with a disability? Yes No

If yes, who? Amount paid: \$ How often paid?

Person being paid: Type of provider:

Address: Phone number:

Deductions Please answer these questions if you are applying for MaineCare

Complete this section if anyone has expenses that could be deducted on a federal income tax return. Examples may include:

Student Loan Interest

Alimony paid (for divorces finalized before 1/1/2019)

Health Savings Accounts

401K Contributions

Health Insurance Premiums

Other Pre-tax Deductions

Who pays this expense?	Type/description	How often paid?	How much?
			\$
			\$
			\$

STEP 5: Tax Information Please answer these questions if you are applying for MaineCare

Do any of the people listed on the application plan to file a federal tax return NEXT YEAR? Yes No

If yes, list the tax filer and the spouse of the tax filer, if filing a joint return.

Name of tax filer	If filing jointly, name of spouse

Will any of the people listed on the application claim any dependents on their tax return? Yes No

If yes, list the tax filer and their dependents

Name of tax filer	Dependent(s):

Will any of the people listed on the application be claimed as a dependent on the tax return of someone who is not part of your household? Yes No

If yes, list the tax filer for whom the dependent will be claimed.

You do not need to complete this table if the dependent is already listed as a dependent on page 11.

Name of dependent	Name of tax filer	Relationship to tax filer

STEP 6: Health Insurance Please answer these questions if you are applying for MaineCare

Policy holder name: _____ Policy holder SSN or DOB: _____

Name of health insurance company: _____ Policy number: _____

Coverage start date: _____ Coverage end date: _____

Type of coverage: Employer Private Long Term Care Dental Vision Prescription Other

List all household members covered under this plan: _____

Has any child lost health insurance in the past 3 months? Yes No If yes, who? _____

If more people have health coverage, include the information requested above on a separate sheet with your application.

Medicare

Please list anyone who has Medicare or will become eligible for Medicare in the next 30 days. Please be sure to list the name exactly as it is shown on the Medicare Card.

Name	Medicare or Railroad Number	Part A Start Date	Part B Start Date

STEP 7: Other Program Specific Information

Financial and Medical Support

If a dependent child with a parent living outside of the home applies for and is eligible for MaineCare or TANF, cooperation with the Division of Support Enforcement and Recovery (DSER) to collect financial and medical support is required.

If you think seeking support would put you or your family at risk, check this box and you may not have to cooperate.

TANF Applicants who are only applying for MaineCare and SNAP may skip this section.

Please provide information about the parent living outside of the home.

Name of Child(ren)	Name of Other Parent	Other Parent's SSN	Other Parent's Date of Birth

Has anyone in the household received TANF benefits from another state? Yes – list them below. No

Person Name	State Providing Assistance	Date Assistance Started	Date Assistance Ended	Months on TANF in Other States

Maine law prevents TANF or PaS cash benefits from being paid directly to unmarried minor parents. Instead of cash payments, the Department will send portions of the TANF or PaS benefit directly to vendors to pay monthly expenses. The rest of the TANF or PaS benefit must be sent to an adult payee who agrees to manage the money and agrees to explain how it is used on the minor's behalf. If you are under the age of 18 who would you like to be your payee:

Name	Relationship to you	Address	Phone number

Emergency Assistance

If you are seeking help from Emergency Assistance, please complete this section. Verification of the emergency will be needed. If you have difficulties getting verifications, the Office for Family Independence can help. Examples include:

Proof of Disaster Eviction Notice Proof of Homeownership Quote for Repair/Equipment Utility Disconnect Notice

I am asking for assistance because of:

- Disaster (fire, flood, storm, etc.)
- Eviction (Provide landlord's name, address, and phone number)
- Repair or replacement of furnace, chimney, septic system, heating stoves, plumbing, or electrical
- Utility shutoff (electricity, gas, sewer, or water)
- Special Equipment due to disability (not covered by MaineCare)

Please explain why you need this help (in your own words as completely as possible). _____

Has any adult member in your household refused employment or training? Yes No

Appendix A: American Indian or Alaska Native Household Members

American Indians and Alaska Natives can get services from Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay MaineCare or CHIP (Maine’s Children’s Health Insurance Program – CHIP) copayments and premiums. Complete this section if you or a family member are American Indian or Alaska Native to make sure your family gets the most help possible.

Is anyone applying a citizen of a federally recognized tribe? Yes No If yes, list each member below.

Name of person(s)	Tribe Name

Are you or anyone in your household eligible to get services from the Indian Health Service, a tribal health program, or urban Indian health program? Yes No

If yes, who?

Have you or anyone in your household ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? Yes No

If yes, who?

Certain money received may not be counted for MaineCare or CHIP. List any income (amount and how often) reported on your application that includes money from these sources:

- Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
- Money from selling things that have cultural significance.

Name of person with income	How much?	How often?
	\$	
	\$	
	\$	
	\$	
	\$	

For TANF applicants: Does anyone in your household live on tribal land? Yes No

Appendix B: Appointment of an Authorized Representative - Office for Family Independence

You have the right to appoint an authorized representative to act on your behalf with the Department. If you want to name a person or organization as your authorized representative, use this form.

We are committed to the privacy of your health information. Please read this form carefully.

Individual's Name: _____

Date of Birth: _____ Social Security Number: _____

Individual's Address: _____

I (individual named above) hereby appoint the following individual/organization to act as Authorized Representative for me.

Authorized Representative's Name: _____

Address: _____

Telephone Number: _____ Email Address: _____

Existing legal authority (if any) for individual to act on my behalf (check all that apply):

- Guardianship Power of Attorney Advance Healthcare Directive
 Other (explain): _____

By making this appointment, I want my Authorized Representative to (check all that apply):

- Sign and submit an application on my behalf (including an electronic application)
 Sign and submit a recertification form on my behalf (including an electronic application)
 Receive copies of Notices of Decisions and all other written communications from the Department
 Obtain SNAP benefits on behalf of my household
 Represent me at fair hearings
 Other (please describe): _____
 Act on my behalf in all other matters with the Department of Health and Human Services

-
- My Authorized Representative's authority is limited to the task or tasks I have delegated, above.
 - This appointment is valid until:
 - I change this appointment in writing by notifying the Department that this Authorized Representative is no longer authorized to act on my behalf; or
 - My Authorized Representative informs the Department in writing that he/she is no longer acting as my Authorized Representative.
 - I understand that taking back this appointment does not apply to any documents signed by or sent to my Authorized Representative before I took back the appointment.
 - I understand that if I want my Authorized Representative to receive copies of the Notices of Decisions and all other written communications from the Department, the information shared will be for all programs in which I participate that are administered by the Department.

I am signing this form voluntarily, and I have the right to a signed copy of this form if I request one.

Signature of the Individual: _____ Date: _____

For the Authorized Representative

I (Individual Named as Authorized Representative) hereby agree to:

- Fulfill all above-designated responsibilities on behalf of the individual who appointed me as their Authorized Representative;
- Maintain the confidentiality of any information regarding the individual who appointed me as their Authorized Representative;
- Adhere to the regulations 42 C.F.R. § 431(F) and at 45 C.F.R §155.260(f) (relating to confidentiality of information), 42 C.F.R. §447.10 (relating to the prohibition against reassignment of provider claims as appropriate for a facility or an organization acting on the facility's behalf), as well as all other applicable state and federal laws concerning conflicts of interest and confidentiality of information.

Signature of the Authorized Representative: _____ Date: _____

SNAP Nondiscrimination Statement

Do Not Send Applications Here

In accordance with federal civil rights laws and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on 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 in any program or activity conducted or funded by USDA. Programs that receive federal financial assistance from the U.S. Department of Health and Human Services (HHS), such as Temporary Assistance for Needy Families (TANF), and programs HHS directly operates are also prohibited from discrimination under federal civil rights laws and HHS regulations.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotope, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or who 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.

CIVIL RIGHTS COMPLAINTS INVOLVING USDA PROGRAMS

USDA provides federal financial assistance for many food security and hunger reduction programs such as the Supplemental Nutrition Assistance Program (SNAP), the Food Distribution Program on Indian Reservations (FDPIR) and others. To file a program complaint of discrimination, complete the Program Discrimination Complaint Form, (AD-3027) found online at: <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, 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:** 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. **phone:** (833) 620-1071; or
4. **email:** FNSCIVILRIGHTSCOMPLAINTS@usda.gov.

For any other information regarding 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: SNAP hotline.

CIVIL RIGHTS COMPLAINTS INVOLVING HHS PROGRAMS

HHS provides federal financial assistance for many programs to enhance health and well-being, including TANF, Head Start, the Low Income Home Energy Assistance Program (LIHEAP), and others. If you believe that you have been discriminated against because of your race, color, national origin, disability, age, sex (including pregnancy, sexual orientation, and gender identity), or religion in programs or activities that HHS directly operates or to which HHS provides federal financial assistance, you may file a complaint with the Office for Civil Rights (OCR) for yourself or for someone else.

To file a complaint of discrimination for yourself or someone else regarding a program receiving federal financial assistance through HHS, complete the form on line through OCR's Complaint Portal at <https://ocrportal.hhs.gov/ocr/>. You may also contact OCR via mail at: Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201; fax: (202) 619-3818; or email: OCRmail@hhs.gov. For faster processing, we encourage you to use the OCR online portal to file complaints rather than filing via mail. Persons who need assistance with filing a civil rights complaint can email OCR at OCRMail@hhs.gov or call OCR toll-free at 1-800-368-1019, TDD 1-800-537-7697. For persons who are deaf, hard of hearing, or have speech difficulties, please dial 7-1-1 to access telecommunications relay services. We also provide alternative formats (such as Braille and large print), auxiliary aids and language assistance services free of charge for filing a complaint.

This institution is an equal opportunity provider.

Do Not Send Applications Here

Important Information for SNAP Applicants

SNAP Processing

The normal processing time for SNAP applications is 30 days. Certain households are entitled to expedited processing. Those households include those with less than \$150.00 in gross income, migrant or seasonal farmworkers households whose total liquid assets do not exceed \$100, and households whose monthly rent or mortgage and utility expenses are higher than the combined monthly gross income.

Information about SNAP Penalties

If you do the following...	You will lose your food benefits for...
<ul style="list-style-type: none"> • Hide information or make false statements • Use food benefits to buy alcohol or tobacco • Trade or sell benefits or EBT cards • Dump containers only for the cash redemption value • Resell food bought with food benefits for cash • Use Electronic Benefits Transfer (EBT) cards that belong to someone else 	<ul style="list-style-type: none"> • 12 months for the first offense • 24 months for the second offense • Permanently for the third offense
<ul style="list-style-type: none"> • Trade food benefits for controlled substance such as drugs 	<ul style="list-style-type: none"> • 24 months for the first offense • Permanently for the second offense
<ul style="list-style-type: none"> • Trade food benefits for firearms, ammunition, or explosives 	<ul style="list-style-type: none"> • Permanently
<ul style="list-style-type: none"> • Trade, buy, or sell food benefits of \$500 or more 	<ul style="list-style-type: none"> • Permanently
<ul style="list-style-type: none"> • Give false information about your identity and where you live so you can get extra food benefits 	<ul style="list-style-type: none"> • 10 years for each offense
<p>You can also be fined up to \$250,000 or put in prison for up to 20 years or both, for doing these things. You may also be charged under other federal laws.</p>	

If you knowingly do the following...	You may be...
<ul style="list-style-type: none"> • Use of EBT cards that are not yours • Transfer your EBT cards to other people • Acquire or possess EBT cards that are not yours 	<ul style="list-style-type: none"> • Guilty of a felony or misdemeanor • Fined • Put in prison • Ineligible for food benefits for a period of time

You may be required to cooperate with a Quality Control review to ensure you are receiving the correct benefit amount. Failure to cooperate may cause your benefits to end or be denied.

Privacy Act Statement

(i) The collection of this information including the Social Security number (SSN) of each household member, is authorized under the Food and Nutrition Act of 2008, as amended, 7 U.S.C. 2011-2036d. The information will be used to determine whether your household is eligible or continues to be eligible to participate in the SNAP 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.

(ii) 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 feeling to avoid the law.

(iii) If a 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 collection action.

(iv) Providing the requested information, including the SSN of each household member, is voluntary. However, failure to provide an SSN will result in the denial of SNAP benefits to each individual failing to provide an SSN. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible household members.

Important Information about MaineCare

Marketplace Health Coverage

If you are determined eligible for MaineCare and have Marketplace health coverage with financial help (premium tax credits) you should cancel it. If you don't cancel your financial help, you may have to pay it back. To cancel your financial help, visit CoverME.gov or call the Consumer Assistant Center at 1-866-636-0355.

If you are not eligible for MaineCare you might be able to get health coverage – and help paying for it – through the Health Insurance Marketplace. If you or any applicant included on this application are not eligible for MaineCare, we will send your information to the Marketplace to be reviewed for other insurance affordability programs.

Immigration Statuses and Document Types

For applicants who are not U.S. citizens: Information about current immigration status is needed to determine eligibility. We will attempt to verify declared immigration status through an electronic data match. It may help us process this application faster if you include a copy of immigration documents for all individuals who are applying.

See the list below for common document types. If your status or document isn't listed, you can write in another status or choose to leave questions blank. If needed, we will send you a letter to get more information.

If information regarding immigration status is not provided applicants may only be eligible for coverage of emergency services under MaineCare. Exception: *Children under 21 years of age and pregnant people who would be otherwise eligible for federal Medicaid benefits but are not eligible due to their immigration status may still qualify for MaineCare.*

Immigration Status	Document Types
<ul style="list-style-type: none"> • Refugee • Asylee • Granted Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT) • Cuban or Haitian entrant • Amerasian • Victim of trafficking and his or her spouse, child, sibling, or parent • Afghan or Iraqi special immigrant visa holder • Citizen of Compact of Free Association (Micronesia, the Marshall Islands, and Palau) • Lawful Permanent Resident (LPR/Green Card holder) • Battered non-citizens and spouse, child, or parent • Paroled into the U.S. for at least one year • Paroled into the U.S. for less than one year • Lawful temporary resident • Conditional entrant granted before 1980 • Citizen of a federally recognized Indian tribe or American Indian born in Canada • Non-immigrant status (worker visas, student visas, U-visa, T-visa, and other visas) • Temporary Protected Status (TPS) or applicant for TPS with employment authorization • Granted employment authorization • Family Unity beneficiaries • Deferred Enforced Departure (DED) • Deferred Action Status except for Deferred Action for Childhood Arrivals (DACA) • Pending application for Special Immigrant Juvenile status • Adjustment to LPR Status with an approved visa petition • Granted an administrative stay of removal • Applicant for asylum or for Withholding of Removal, under immigration laws or under the Convention against Torture (CAT) who has either been granted employment authorization, OR is under 14 and has had an application pending for at least 180 days • Resident of American Samoa • Other 	<ul style="list-style-type: none"> • Permanent Resident Card, "Green Card" (I-551) • Reentry Permit (I-327) • Refugee Travel Document (I-571) • Employment Authorization Document (I-766) • Machine Readable Immigrant Visa (with temporary I-551 language) • Temporary I-551 Stamp (on passport or I-94/I-94A) • Arrival/Departure Record (I-94/I-94A) • Arrival/Departure Record in foreign passport (I-94) • Foreign Passport • Certificate of Eligibility for Nonimmigrant Student Status (I-20) • Certificate of Eligibility for Exchange Visitor Status (DS-2019) • Notice of Action (I-797) • Document indicating citizenship in a federally recognized Indian tribe or American Indian born in Canada • Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR) • Document indicating withholding of removal • Office of Refugee Resettlement (ORR) eligibility letter (if under 18) • Resident of American Samoa card • Alien number (also called alien registration number or USCIS number) or I-94 number

Get help in a language other than English

ATTENTION: If you speak a language other than English language assistance services, free of charge, are available to you.

Français (French)	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-797-4357 (ATS: 711).
español (Spanish)	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-797-4357 (TTY: 711).
繁體中文 (Chinese)	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-797-4357 (TTY: 711)。
Afaan Oromoo (Cushite-Oromo)	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-797-4357 (TTY:711).
Tiếng Việt (Vietnamese)	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-797-4357 (TTY: 711).
العربية (Arabic)	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-797-4357 (رقم هاتف الصم والبكم 117).
ខ្មែរ (Cambodian)	ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃគឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 1-855-797-4357 (TTY: 711)។
Русский (Russian)	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-797-4357 (телетайп: 711).
Tagalog (Tagalog)	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-797-4357 (TTY: 711).
Deutsch (German)	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-797-4357 (TTY: 711).
ภาษาไทย (Thai)	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-797-4357 (TTY: 711).
Thuɔŋjaŋ (Nilotic – Dinka)	PIN KENE: Na ye jam në Thuɔŋjaŋ, ke kuony yenë koc waar thook atö kuka lëu yök abac ke cïn wënh cuatë piny. Yuɔpë 1-855-797-4357 (TTY: 711).
한국어 (Korean)	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-797-4357 (TTY: 711) 번으로 전화해 주십시오.
Polski (Polish)	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-797-4357 (TTY: 711).
日本語 (Japanese)	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-797-4357 (TTY: 711) まで、お電話にてご連絡ください。
Português (Portuguese)	ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-797-4357 (TTY: 711).
Kiswahili (Swahili)	KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-855-797-4357 (TTY: 711).
Ikirundi (Bantu – Kirundi)	ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-855-797-4357 (TTY: 711).
رسی (Farsi)	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. 1-855-797-4357 (TTY: 711) تماس بگیرید.
Ikiyarwanda (Kinyarwanda)	ICYITONDERWA: Nimba uvuga Ikiyarwanda, uzahabwa serivisi zo kugufasha mundimi. Hamagara 1-855-797-4357 (TTY: 711)
Lingala (Lingála)	KEBA, soki olobaka Lingala, yeba ete lisalisi ya mobongoli ya lonkota olobaka epesamaka ofele. Benga 1-855-797-4357 (ATS: 711).
دری (Dari)	1-855-797-4357 توجه: اگر به زبان دری صحبت می کنید، سهولت های زبانی بطور رایگان برای شما فراهم می شود. 1-855-797-4357 (TTY: 711) تماس بگیرید.

