



The South Carolina Department of Social Services

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) APPLICATION SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) APPLICATION REFUGEE CASH ASSISTANCE (RCA) APPLICATION

Do you need help filling out this application due to disability? Do you need an interpreter? Do you need translated materials? If yes, please ask for help at your local DSS Office. To get the address or phone number of your local office, call toll free: 1-800-616-1309 or view online at www.dss.sc.gov.

Solicitudes en español están disponibles en su oficina local del DSS o usted puede llamar al 1-800-616-1309 para pedir que se le envíe una por correo.

Fraud

- **The information that you give DSS may be verified by federal, state or local officials to determine if the information is correct.**
- **If you give DSS information that is found to be incorrect for TANF or SNAP your case may be denied or closed.**
- **You may be subject to prosecution under federal and state laws for giving incorrect information.**

Social Security Numbers – Citizenship – Immigration Status

Temporary Assistance for Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP) Applicants:

- You must provide or apply for a Social Security Number (SSN) and citizenship/immigration status for **all** family members whom you want cash benefits or SNAP benefits. Immigration status may be subject to verification by United States Citizenship and Immigration Services (USCIS). The Social Security Number is not required to file an application for Refugee Cash Assistance (RCA) benefits. The refugee may provide a copy of the SS-5 until the card is received.
- Benefits will not be provided to individuals who do not provide, or show proof of application for, their Social Security Number and citizenship/immigration status.
- Social Security Numbers are not required for non-applicants or persons ineligible for SNAP or cash benefits, however the proof of income must be provided for **all** members of the SNAP and TANF benefit group.
- If we need information on a person for whom you did not provide information, a DSS worker will contact you to discuss the requirements.
- DSS does not share SSNs or citizenship/immigration status for non-applicants and individuals ineligible for benefits with the US Department of Homeland Security.
- DSS will use Social Security Numbers in the State Income and Eligibility Verification System and other computer matching and program reviews. This information may be verified through other sources when discrepancies are found and may also affect your household's eligibility and benefit level.

USDA-HHS NON-DISCRIMINATION STATEMENT

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

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

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

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

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

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

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

This institution is an equal opportunity provider.

You may also file a complaint of discrimination by contacting DSS. Write DSS Office of Civil Rights, P.O. Box 1520, Columbia, SC 29202-1520; or call (800) 331-7220 or (803) 898-8080 or TTY: (800) 311-7219

**Temporary Assistance for Needy Families (TANF), Refugee Cash Assistance (RCA) and
Supplemental Nutrition Assistance Program (SNAP)**

YOUR RIGHTS AND RESPONSIBILITIES

Confidentiality

The information that you give to DSS will be kept confidential.

Exceptions:

1. Information may be disclosed to other federal and state agencies for official examination and to law enforcement officials for the purpose of apprehending fleeing felons or probation/parole violators.
2. You agree that confidential information about you and/or your family may be released to other organizations if it is directly related to the operation of TANF, RCA and SNAP.

Social Security Numbers

In order to get benefits from the TANF, SNAP and other programs:

- You must provide or apply for a Social Security Number (SSN) for those persons who want to get TANF and/or SNAP. Although SSNs are not required for non-applicants or persons ineligible for TANF or SNAP, income information must be included for all Household (HH) / Benefit Group (BG) members.
- If DSS needs the SSN on a person for whom you did not provide information, a DSS worker will contact you to discuss the reasons for requesting the number and what will happen if you do not give DSS the number.
- SSNs will be used in computer matching programs and other reviews and you cannot receive SNAP benefits for any person an SSN is not provided for.
- If you do not have an SSN for an applicant, it will not delay your application, provided he/she applies for one immediately. DSS will help you apply for an SSN.
- DSS will not share or give SSNs of non-applicants or individuals ineligible for benefits with the U.S. Department of Homeland Security.

Citizenship and Immigration Status

- You must provide citizenship and immigration status information for those persons who want to get TANF, RCA and/or SNAP.
- DSS will not share the citizenship and immigration status of non-applicants or individuals ineligible for benefits with the U.S. Department of Homeland Security. However, information provided by applicant household members may be submitted to United States Citizenship and Immigration Services (USCIS) for verification of immigration status. The information received from USCIS may affect the household's eligibility and level of benefits.

Assignment of Child Support

- Any child support you receive or may receive for a TANF eligible child must be assigned to DSS.
- DSS may take action to collect child support from both maternal and paternal grandparents if the child's parent(s) are under age 18 and receive TANF.

Paternity Establishment

- In order to get benefits from the TANF Program, you must cooperate with the Child Support Services Division (CSSD) in establishing paternity and obtaining child support for your children.
- If you have a good reason to believe cooperation may cause harm to you or your child(ren) ask your case manager about establishing "good cause" for failure to cooperate.

Varied Benefits

- If you receive child support through CSSD, your SNAP benefits may change from month to month because of any changes in the child support you receive.

Work/Training Program Requirements

- To receive TANF or RCA benefits, you must participate in a work or training program, unless you are exempt from the work program requirement.
- To receive SNAP benefits, some household members must work, participate in an employment and training program and/or register for work. By signing your application, you will be considered to have registered all household members required to be registered.

Time Limits

- TANF benefits may be time limited.
- RCA is limited to 8 months from the date of arrival in the U.S.
- SNAP benefits may be limited to 3 months in a 36 month time period.
- The receipt of SNAP benefits has no effect on any other program's time limits.

Verification

- A DSS worker may need to contact other people or organizations (neighbors, banks, employers, etc.) in order to verify your income, work program/employment status, bank accounts, citizenship/immigration status, medical/shelter expenses, insurance/retirement benefits, medical history and any other fact that relates to your eligibility for TANF, RCA or SNAP benefits.
- For SNAP, failure to report or verify any deductible expenses will be seen as a statement that your household does not want to receive a deduction for the unreported expense.

Benefit Repayment

- You may be required to repay benefits you received from TANF (including child care and transportation), RCA and SNAP benefits that you should not have received even if you received them through no fault of your own.
- DSS may apply any benefits removed from your inactive EBT account to repay an outstanding SNAP claim(s).
- DSS seeks repayment of claims from any federal and/or state tax refunds that may be due you. The information that you give DSS, including SSNs, may be referred to federal/state agencies for claims collection action.

Fair Hearings

- If you do not agree with a decision made in your case, you may request a Fair Hearing, orally or in writing for SNAP, TANF and RCA, by contacting your county DSS office or SCDSS, Division of Individual and Provider Rights, P.O. Box 1520, Columbia, SC 29202-1520, 1-800-311-7220 for TANF and SNAP.
- **You may speak for yourself at the hearing. You may also bring a friend, relative, or lawyer to speak for you.**
- To request continuation of your TANF, RCA or SNAP benefits, while you wait for the hearing, the request must be made within 10 days from the date of the notice you receive reducing or stopping your benefits.
- If the hearing decision is not in your favor, the benefits will have to be repaid.
- The maximum time to request a hearing after you get a notice reducing or stopping your benefits is: 60 days for TANF and RCA and 90 days for SNAP benefits.

Application Filing Instructions

Your application is considered valid as long as it contains the name, address, and signature of a responsible household member or the household's authorized representative. Benefits are provided within 30 days from the date the application is received by the agency. If you are applying for SNAP benefits, your eligibility will be determined separately from any other programs and will not be denied solely because benefits from other programs have been denied. The Agency will process all SNAP applications in accordance with SNAP timeliness, notice, and fair hearing requirements, even if you are applying for other programs.

If you are a resident of an institution and jointly apply for SSI and food assistance prior to leaving the institution, the filing date of the application is your date of release from the institution. Processing time will begin from the date the application is received in the Department of Social Services.

- Please fill in all the blanks you can. If you need help or don't understand a question, a DSS worker can help you.
 - Make sure you **PRINT YOUR NAME, PRINT TODAY'S DATE, and SIGN THE APPLICATION.**
- Please tear off pages 1-6 and keep for yourself. Return pages 7-15 of this application to DSS. Once your application has been received by the agency, you will be given a phone number to call for an interview no later than 10 days from the date your application is received. You may request a face-to-face interview with a worker in the county where you live if you want. You may bring someone with you to the interview who can help you. If an interpreter is needed, DSS will provide one at no cost to you.
- Mail, fax, e-mail or take this application to the Department of Social Services (DSS).
- To get the address of your county DSS office, call toll free: 1-800-616-1309 or view online at **www.dss.sc.gov**.

SNAP Warnings and Penalties

- **DO NOT buy ineligible items such as alcoholic beverages or tobacco with SNAP benefits.**
- **DO NOT use your EBT card to pay for food charged to a credit account.**
- **Violators of the above rules may not be able to get SNAP benefits for a period of 1 year to permanently and may be fined up to \$250,000 or imprisoned up to 20 years or both. A court can also add an additional 18-month SNAP participation restriction for an individual.**
- **DO NOT buy or sell firearms, ammunition or explosives with SNAP benefits; if you do, you can never get SNAP benefits again.**
- **DO NOT buy or sell illegal drugs with SNAP benefits; DO NOT trade, sell or alter Electronic Benefit (EBT) cards; if you do, you cannot get SNAP benefits for 24 months for the 1st offense and permanently for the 2nd offense.**
- **DO NOT trade, sell or share EBT cards or SNAP benefits. If a court of law finds you guilty of selling benefits of \$500 or more, you will be permanently ineligible to participate in the program for the first offense.**
- **DO NOT receive SNAP benefits in more than one state for the same month. Any individual found to have made a fraudulent statement, or fraudulent representation of identity or residence in order to receive benefits shall be ineligible to receive SNAP benefits for 10 years.**
- **Any member of your Household who intentionally breaks the rules may not get SNAP for 12 months for the first offense, 24 months for the second offense and permanently for the third offense.**

Temporary Assistance for Needy Families Program (TANF)

The ePAY card should not be used in any electronic transaction:

- in any liquor store;
- casino, gambling casino or gaming establishment; or
- retail establishment which provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment.

Refugee Cash Assistance Program (RCA)

Refugee Cash Assistance is limited to eight (8) months from the date of arrival in the U.S. The RCA benefit amount is the same as the benefit amount for TANF. RCA is only available to adult refugees without minor dependent children. Your application for RCA will be completed at the local DSS office but the payment will be mailed to you from the office in Columbia, SC.

Supplemental Nutrition Assistance Program (SNAP)

An ABAWD is an able-bodied individual, 18 years of age or older but under 50, who has no household member(s) in the SNAP budget under the age of 18. An ABAWD can only receive three (3) months of SNAP benefits in a three (3) year time period unless also meeting the ABAWD work requirement or an exception to the work requirement.

ABAWD Work Requirement:

- Work at least 20 hours weekly, averaged as 80 hours monthly (in exchange for money, in-kind benefits, or with an established volunteer agency); or
- Participate in and comply with requirements of a work program at least 20 hours weekly, averaged as 80 hours monthly (such as SNAP E&T, WIOA, Project Hope, ect.); or
- Any combination of working and participating in a work program at least 20 hours weekly, averaged as 80 hours monthly.

Exceptions to ABAWD Work Requirement:

- Physically or mentally unable to work; or
- Pregnant; or
- Already meeting an exemption from the General Work Requirements (caretaker for someone, regular participant in a drug or alcohol program, student enrolled at least half-time, receiving unemployment benefits, or applied for but not yet receiving unemployment benefits).

An ABAWD who has already received three (3) months of benefits during this three (3) year time period may regain eligibility by providing proof of meeting the work requirement for 30 consecutive days, meeting an exception, or when the three (3) year time period starts over again.

Temporary Assistance for Needy Families Information and Referral Services

Households with income at or below 130% of the federal poverty level (FPL) are authorized to receive the South Carolina Temporary Assistance for Needy Families Information and Referral Services brochure. This brochure may be requested from the local office or by calling 1-800-616-1309 to request a brochure to be mailed to you.

Report Changes

- **You must report certain changes in your circumstances to DSS.**
- **Your failure to report changes is considered to be withholding of information and will permit DSS to recover any benefits paid to you in error.**
- **You may report in writing, by phone, electronically or by use of the Change Report Form to report changes between recertification/redeterminations.**

SNAP

For households who are required to recertify every six months, you must report when your total gross income exceeds 130 % of the federal poverty level or when an ABAWD in your SNAP household is no longer meeting the work requirement hours. These changes must be reported by the tenth day of the month after the month of the change. All other changes must be reported at recertification.

Temporary Assistance for Needy Families Program (TANF) and Refugee Cash Assistance Program (RCA)

Report these changes within **10 days**:

- Change in any income, hours of employment, rate of pay or new source of income, change in your address or residence, person(s) moving in or out of your home.

Report this change within **5 days**:

- Any household member temporarily living away from the household who has decided not to return to the household.

Application Checklist

The SNAP/TANF Eligibility Checklist is designed to provide examples of some of the information that may need to be verified in order to determine your eligibility for SNAP/TANF benefits. Please be aware that a DSS worker may request additional information during the interview. You may mail or drop off this information at any local DSS office.

IF APPLYING FOR SNAP ONLY

- Identification of person applying and of the authorized representative, if applicable. Examples include: driver's license, state ID card, work or school ID, ID for health benefits, assistance from another social services program, other acceptable forms of ID, or voter registration card.
- Income: Pay stubs for the last four (4) weeks of work, if you are currently working, or most current tax returns if self-employed (Please send entire tax return). Verification of the last four (4) weeks of child support payments, if you are receiving child support. Copies of award letters for unemployment, Social Security, Retirement, etc.
- Household expenses: Lease agreement, rent or mortgage payment receipts and utility bills (*optional*).
- Medical expenses for anyone disabled or aged 60 or older. Examples include: Medical bills, prescription co-pays, health insurance premium receipts, mileage to and from doctor appointments, etc.

IF APPLYING FOR TANF ONLY

- Birth Certificates for you and your children.
- Social Security Numbers for each family member for whom you are applying-children and adults.
- Identification of person applying and of the authorized representative, if applicable. Examples include: driver's license, state ID card, work or school ID, ID for health benefits, assistance from another social services program, other acceptable forms of ID, or voter registration card.
- Income: Pay stubs for the last four (4) weeks of work, if you are currently working, or most current tax returns if self-employed (Please send entire tax return). Copies of award letters for Unemployment, Social Security, VA, Retirement, etc.
- Bank account statements.

IF APPLYING FOR SNAP AND TANF

Please provide as many of the verification items listed in the two boxes above.

CHECK BOX FOR EACH PROGRAM YOU WANT TO APPLY FOR:

Temporary Assistance for Needy Families Supplemental Nutrition Assistance Refugee Cash Assistance

DSS USE ONLY: <input type="checkbox"/> New Application <input type="checkbox"/> Reapplication <input type="checkbox"/> Cure Sanction <input type="checkbox"/> TANF Redetermination		Date Filed: _____	
		Expedited Screener: _____	
CHIP Case No.:	Worker's Name:	Interview Date:	Expedited? <input type="checkbox"/> Yes <input type="checkbox"/> No

This information, including the Social Security Number (SSN) of each household member, is authorized under the Food and Nutrition Act of 2008. This information will also be used to monitor compliance with program regulations and for program management. 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 members.

PLEASE PRINT CLEARLY

Do you need an interpreter? If yes, what language do you use the most? _____

Do you need translated material? Yes No

Are you deaf or hard of hearing? If yes, and you need assistance when communicating with us, please check all that apply: TTY/Video Relay Sign Language Interpreter Other: _____

You may designate someone to help you with the application and the interview. This person should know your household's situation well enough to give any information needed to determine your eligibility. You are still responsible for the information that anyone acting as your authorized representative gives, including any information that may be incorrect.

Would you like for someone not in your household to complete this application or interview for you as your authorized representative? Yes No If yes, tell us who and sign below:

Name of Representative: _____ Telephone: _____

You may designate a second person or use the same person to assist you with utilizing benefits on your EBT card on your behalf.

Name of 2nd Representative: _____ Telephone: _____

Signature of Applicant/Client: _____

Signature of two witnesses, if signed by an "X": (1) _____ (2) _____

Expedited Service

You may get SNAP benefits within 7 calendar days if: your SNAP household has less than \$150 in monthly gross income and liquid resources such as cash, checking or savings accounts are less than or equal to \$100 or; your rent/mortgage and utilities are more than your household's combined monthly income and liquid resources or; a member of your household is a migrant or seasonal farm worker who is considered destitute.

Failure to answer the questions on this application may result in our inability to determine your eligibility for expedited service.

Section 1: Tell Us About Yourself

Last Name:		First Name:		MI:	Suffix:
Home Phone No.:	Cell Phone No.:	Another telephone number where you can be contacted:		Best time to call:	
WHERE DO YOU LIVE					
Street Address: (Include Apt./Lot No.)		City:	State:	Zip Code:	County:
IF YOU RECEIVE YOUR MAIL SOMEPLACE ELSE, PLEASE FILL IN SECTION BELOW					
Mailing Address: (If Different, Include Apt./Lot No.)		City:	State:	Zip Code:	County:

Please read and sign this statement/application.

I certify under penalty of perjury that the information I or my authorized representative has provided on this application, including information concerning citizenship and immigration status, is true to the best of my knowledge. I give permission for the Department of Social Services to make any necessary contacts to check my statements. I know that I could be penalized if I knowingly give false information. I certify I received the *Your Rights and Responsibilities* handout included in this application packet.

Signature of Applicant/Authorized Representative: _____ **Date:** _____

Signature of two witnesses, if signed by an "X": (1) _____ (2) _____

Section 2: Tell Us About Your Household Members

List everyone who lives with you. Answer all questions for each household member.

Verification of information about all household members may be required. You only have to provide the SSN or date of SS-5 and citizenship/immigration status for persons you are applying for. SSN and citizenship/immigration status is voluntary for non-applicants and ineligible persons in your household.

Name (First, Middle, Last) List names as they appear on the person's Social Security Card.	Relationship to Person on Line 1	Date of Birth	Age	Sex M/F	Hispanic or Latino	Race Code (Choose one or more)	Social Security Number or Date of SS-5	Blind or Disabled	US Citizen	In School	Working
1.	(Self)				Yes No			Yes No	Yes No	Yes No	Yes No
2.					Yes No			Yes No	Yes No	Yes No	Yes No
3.					Yes No			Yes No	Yes No	Yes No	Yes No
4.					Yes No			Yes No	Yes No	Yes No	Yes No
5.					Yes No			Yes No	Yes No	Yes No	Yes No
6.					Yes No			Yes No	Yes No	Yes No	Yes No
7.					Yes No			Yes No	Yes No	Yes No	Yes No

* Race: BL - Black or African American; WH - White; AS - Asian; AI - American Indian/Alaskan Native; NH - Native Hawaiian or Other Pacific Islander
The collection of ethnic and racial information from the applicant is voluntary and will not affect eligibility or the level of benefits the applicant may receive. The information is collected to assure that the program benefits are distributed without regard to race, color, or national origin.

Indicate any other people who live in the same house with you but you do not want included in your SNAP household because they do not purchase and prepare food with you or those noncitizens who do not wish the agency to contact USCIS to verify their immigration status. (Use another sheet of paper to add other people if there is not enough room for everyone here.)

Name	Age	Relationship to You	Does this person give you or anyone listed above any money?		Does this person pay any part of the household bill?	
			Yes/No	If Yes, Reason	Yes/No	If Yes, what bill(s)?
			Yes No		Yes No	
			Yes No		Yes No	
			Yes No		Yes No	

For Temporary Assistance for Needy Families only:
Is any teenager listed above (male or female) a parent? Yes No
If yes, who: _____

Is anyone listed above pregnant? Yes No
If yes, who: _____ Due date: _____

Is anyone listed above living in a special setting such as a shelter for battered women and children, homeless shelter, drug or alcohol treatment or rehabilitation facility (DAA), group home for blind or disabled individuals (GLA), or other institution? Yes No
If yes, who: _____ Type of Facility: _____
Facility Name: _____
Telephone Number: _____

Is anyone in your household a regular participant in a drug or alcohol program? Yes No (If yes, send proof)
If yes, who: _____

Are you or anyone who lives with you a fleeing felon or probation/parole violator? Yes No

If yes, who: _____

Have you or anyone who lives with you been found guilty of committing one of the following offenses after August 22, 1996:

• A drug-related felony? Yes No If yes, who: _____

• Receiving TANF (cash benefits) or SNAP benefits from two or more states at the same time? Yes No

If yes, who: _____

• Trading SNAP benefits for drugs? Yes No If yes, who: _____

• Buying or selling SNAP benefits over \$500? Yes No If yes, who: _____

• Trading SNAP benefits for guns, ammunitions, or explosives? Yes No

If yes, who: _____

Have you or anyone for whom you are applying received TANF or FI before? Yes No

If yes, in what state(s) were benefits received? _____

Do you have a South Carolina ePAY card? Yes No

Have you or your household received SNAP benefits (formerly food stamps) before? Yes No

If yes, in what state did you last receive benefits? _____ When? _____

Do you have a South Carolina EBT Card? Yes No

No Cost Health Insurance! – Optional, not required to received SNAP or TANF Benefits.

By checking the box below, if this SNAP and/or TANF application is approved, DSS will share needed information about your application with the South Carolina Department of Health and Human Services (DHHS) to enroll Medicaid eligible household members in the State's Medicaid program. DHHS will send you a letter notifying you about your household member's enrollment and provide you information about how to use the health care benefits your household members are eligible for.

Yes, I approve DSS sharing my information with DHHS for the purpose of enrolling members of my household in the State's Medicaid program. I understand that if anyone in my household gets Medicaid and their Medicaid bills are paid by a private health insurance or lawsuit settlement, Medicaid can get its money back from this source.

Section 3: For Temporary Assistance for Needy Families Only

Absent Parent Information: Provide the following information below for each child listed in Section 2 whose mother and/or father is not in the home. Additional information may be requested during your interview.

Absent Parent's Name, Last Known Address and Phone No.		Social Security No.	
<input type="checkbox"/> Mother <input type="checkbox"/> Father	_____		Date of Birth

Is this the child's legal Parent? <input type="checkbox"/> Yes <input type="checkbox"/> No	Employer's Name	Employer's Address	Employer's Phone No.
Child(ren)		Child(ren)	
Absent Parent's Name, Last Known Address and Phone No.		Social Security No.	
<input type="checkbox"/> Mother <input type="checkbox"/> Father	_____		Date of Birth

Is this the child's legal Parent? <input type="checkbox"/> Yes <input type="checkbox"/> No	Employer's Name	Employer's Address	Employer's Phone No.
Child(ren)		Child(ren)	
Absent Parent's Name, Last Known Address and Phone No.		Social Security No.	
<input type="checkbox"/> Mother <input type="checkbox"/> Father	_____		Date of Birth

Is this the child's legal Parent? <input type="checkbox"/> Yes <input type="checkbox"/> No	Employer's Name	Employer's Address	Employer's Phone No.
Child(ren)		Child(ren)	
Absent Parent's Name, Last Known Address and Phone No.		Social Security No.	
<input type="checkbox"/> Mother <input type="checkbox"/> Father	_____		Date of Birth

Is this the child's legal Parent? <input type="checkbox"/> Yes <input type="checkbox"/> No	Employer's Name	Employer's Address	Employer's Phone No.
Child(ren)		Child(ren)	
Absent Parent's Name, Last Known Address and Phone No.		Social Security No.	
<input type="checkbox"/> Mother <input type="checkbox"/> Father	_____		Date of Birth

Is this the child's legal Parent? <input type="checkbox"/> Yes <input type="checkbox"/> No	Employer's Name	Employer's Address	Employer's Phone No.
Child(ren)		Child(ren)	

I do hereby attest under penalty of perjury that the above information is true and correct to the best of my knowledge and belief and is given for the purpose of receiving services under Title IV-D of the Social Security Act. By signing this DSS Application for Public Assistance, I understand that these assertions are true and will be used in legal pleadings against the absent parent.

Section 4: Tell Us About Your Household Income

Are you or anyone in your household working? Yes No

If yes, who is working? _____

Enter **GROSS** pay, not take home pay below.

Note: If you do not receive payment in the form of money for your work, such as in-kind work or volunteering with an established volunteer organization, then have the person you work for complete this section.)

Name of Person Working:					Name of Person Working:								
Name and Address of Employer:					Name and Address of Employer:								
Telephone Number of Employer:			Fax Number of Employer:		Telephone Number of Employer:			Fax Number of Employer:					
Amount Each Pay Period Before Taxes: \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Monthly Hours Worked Each Week: _____					Amount Each Pay Period Before Taxes: \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Monthly Worked Each Week: _____								
	DATE PAY RECEIVED			GROSS PAY	TIPS	TOTAL HOURS		DATE PAY RECEIVED			GROSS PAY	TIPS	TOTAL HOURS
	MO	DAY	YEAR					MO	DAY	YEAR			
1.							1.						
2.							2.						
3.							3.						
4.							4.						
_____ Employer Signature Telephone No.						_____ Employer Signature Telephone No.							
Printed Name: _____						Printed Name: _____							

Is anyone in your household, aged 18-49, unable to work? Yes No

If yes, who: _____

Why is this person unable to work? _____

Do you or anyone in your household receive money from any other source(s)? Yes No

If yes, please complete section below.

Other Income	Amount	How Often Do You Get This Income?	Which Family Member Gets This Income?
Child Support	\$		
SSI	\$		
Social Security Benefits	\$		
Unemployment Benefits	\$		
Veterans Benefits	\$		
Retirement/Pensions	\$		
Other (Explain)	\$		

What is the **total** income you and your household have already received and expect to receive this month? \$ _____

Is anyone in your household a migrant or seasonal farm worker? Yes No (If yes, answer the following questions)

- Did all of your household income recently stop? Yes No

If yes, when did you receive your last pay? _____ What was the total amount? \$ _____

- Does anyone in your household expect to receive income from a new source this month? Yes No

If yes, how much? \$ _____ Do you expect to receive it within 10 days? Yes No

Section 5: Tell Us About Your Household Resources

How much does the household have in cash \$ _____, checking \$ _____, and/or savings account(s) \$ _____?

For TANF, please provide the most recent account statement.

Does anyone own any cars, trucks, other assets or land/buildings other than where you live? Yes No

If yes, for TANF, please provide proof.

Section 6: Tell Us About Your Household Expenses

Rent/Mortgage: \$ _____ Lot Space Rent: \$ _____ House Taxes: \$ _____ House Insurance: \$ _____

Condominium Fees: \$ _____

Do you pay to heat or cool your home? Yes No

If yes, how do you heat or cool your home? _____

Does your household receive LIHEAP (Low-Income Home Energy Assistance Program)? Yes No

If you answered NO to both of the questions above, what is the amount of your monthly utilities other than phone? _____

Do you pay someone to take care of your child(ren)? Yes No

Do you pay someone to take care of a dependent adult? Yes No

Does anyone in your household pay child support? Yes No

If yes, how much? \$ _____ How often? _____ Is it court ordered? Yes No

If anyone in your household is disabled or over 60, do they have out of pocket medical expenses over \$35 each month?

Yes No

Section 7: CONSENT FOR THE RELEASE OF INFORMATION (Optional)

The Department of Social Services (DSS) keeps the information you provide confidential, but in order for other government agencies to furnish services to you and/or members of your family it may be necessary for DSS to share some information contained in your files with other government agencies that have confidentiality standards like those of DSS. DSS may release information about you and/or your family with community agencies upon receipt of your written permission.

The answer to this optional question has no effect on your eligibility to participate in the SNAP and/or TANF programs. You may cancel this consent at any time by notifying DSS in writing. The cancellation will become effective no later than 60 days after it is received.

I grant DSS permission to release **my name, address, telephone number, TANF/SNAP recipient status and benefit issuance history** to community agencies that desire to assist me with services or in-kind assistance.

I do not want DSS to release my confidential information to any community agencies.

Client's Signature: _____ **Date:** _____

South Carolina Department of Social Services
VOTER PREFERENCE FORM

If you are not registered to vote where you live now, would you like to apply to register to vote?
(Please check one)

- Yes**, I would like to register to vote.
- I am registered, but **not** at my **current** address.
- No**, I am registered at my **current** address.
- No**, but I will use the Voter Registration Mail Application.
- No**. I do not wish to register to vote at this time.
- No**. I am not eligible to vote.
- No**. I am refusing to register.

IF YOU DO NOT CHECK A BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

Signature of Applicant/Declinee

Date

Important Notices

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 preference or other political preference, you may file a complaint with the following:
Executive Director at South Carolina Election Commission, 1122 Lady St. Suite 500, P.O. Box 5987
Columbia, SC 29205 or call 803-734-9060, fax to 803-734-9366, or email elections@elections.sc.gov. This address is for complaints only regarding your right to vote.

If you would like help in filling out the voter registration application, we will help you. The decision whether to seek or accept help is yours. For assistance in completing the voter registration application form outside our office, call 1-800-616-1309.

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 do register to vote, the location where your application was submitted will remain confidential. If you decline to register to vote, this fact will remain confidential. Applying to register or declining to register to vote will be used **only** for voter registration purposes.

RETURN FORMS TO DSS:

South Carolina Department of Social Services
Centralized Scan Center
P.O. Box 100203
Columbia, SC 29202-3203