Reset

South Carolina Department of Social Services
Food Stamp Program

SIMPLIFIED APPLICATION FOR THE ELDERLY

This application is used for persons applying for food stamps where:
- Everyone in the household is aged 60 or older; or
- All household members aged 60 or older purchase and prepare food separately from the other household members; and
- No member receives earnings from work.

You may file this application by completing at least your name, address and signing the form. If you need help completing this application, call toll-free 1-800-616-1309.

CHIP Case No.:	Date Filed:

PLEASE PRINT

1. Tell us who you are and where you live. We must be able to reach you by telephone.

Last Name:	First Name:	MI:	Phone Where We Can Reach You: ( )	
Street Address: (Include Apt./Lot No.)	City:	State:	Zip Code:	County: Select County ...
Mailing Address: (If Different, Include Apt./Lot No.)	City:	State:	Zip Code:	

2. Would you like for someone not in your household to complete this application for you or represent you as your authorized representative? ❑ Yes ❑ No If yes, tell us the information below:

   Name of Representative: _____

   Address: _____ Telephone: _____

3. Tell us who lives with you. List yourself (or the person shown in item 1 above) on the first line.

List Names as They Appear on the Person's Social Security Card (If the person has a card)	List Previous Married Name or Other Names Used	US Citizen	Age	Date of Birth	Social Security Number	Sex Male or Female	Relationship to Name on Line 1	Is anyone hispanic?	* Race Code (Choose one or more)	Marital Status	Last Grade Completed in School
1 Self		Yes No					Self	Yes No			
2		Yes No						Yes No			
3		Yes No						Yes No			
4		Yes No						Yes No			
5		Yes No						Yes No			

(FOR STATISTICAL PURPOSES ONLY) * Race: BL - Black or African American; WH - White; AS - Asian/Oriental; AI - American Indian/Alaskan Native; NH - Native Hawaiian or Other Pacific Islander

4. Is anyone in your household a fleeing felon or probation/parole violator? ❑ Yes ❑ No

   If yes, name: _____

5. Was anyone in your household convicted of a controlled substance abuse violation that occurred after Aug. 22, 1996?

   ❑ Yes ❑ No If yes, name: _____

6. Answer the following questions to see if you can get Food Stamps within seven days.
   a. Did anyone in your household get any money this month? ❑ Yes ❑ No

      If yes, how much? _____ When? _____
   b. Does anyone in your household expect to get any more money this month? ❑ Yes ❑ No

      If yes, how much? _____ When? _____
7. Tell us about the income your household receives. Types of income may include social security benefits, SSI, pensions, veteran's benefits, child support, cash contributions, unemployment, railroad retirement, dividends, interest and any other income.

Type of Income	Who Receives It?	Gross Monthly Income

8. Tell us about the assets your household has. Types of assets include vehicles, bank accounts, property, cash and any other assets.

Type of Asset	Asset Belongs To?	Value of Asset

9. Tell us about your shelter expenses:
   Does your household pay mortgage? ❑ Yes ❑ No If yes, list monthly amount: _____
   Does your household pay rent? ❑ Yes ❑ No If yes, list monthly amount: _____
   Does your household pay property taxes on your home? ❑ Yes ❑ No If yes, list yearly amount: _____
   Does your household pay homeowner's insurance? ❑ Yes ❑ No If yes, list yearly amount: _____
10. Tell us about your utility expenses:
    Does your household pay for heating or cooling costs? ❑ Yes ❑ No
    If your household does not pay for heating or cooling costs, do you pay for other utilities? ❑ Yes ❑ No
    If yes, list the utility costs you pay: _____
11. Does anyone in your household pay out-of-pocket medical expenses over $35 per month?
    (For example, prescriptions, doctor visits, hospital, health insurance, etc.) ❑ Yes ❑ No
    If yes, and to receive credit for these out-of-pocket medical expenses, you must list each type of medical expense and the monthly amount you are paying: _____ $ _____ _____ $ _____
    _____ $ _____ _____ $ _____ _____ $ _____
    _____ $ _____ _____ $ _____ _____ $ _____
    List any outstanding doctor or hospital bills that you owe and must pay out of your own pocket:
    _____ $ _____ _____ $ _____ _____ $ _____
    _____ $ _____ _____ $ _____ _____ $ _____
    You may attach an itemized listing of your prescriptions from your pharmacy.
12. Does anyone in your household pay legally obligated child support to someone living outside of your home?
    ❑ Yes ❑ No If yes, how much per month? _____
13. **Please read and sign this statement/application.**
    I certify that the information I or my authorized representative have provided above 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 from my caseworker.

    Signature of Applicant/Client: _____ **Date:** _____

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