Assistance Application

Submit this form by mail, fax, or bring it into a local MDHHS office

Find your nearest location at
www.michigan.gov/ContactMDHHS
or call 855-ASK-MICH

Apply online:
www.michigan.gov/mibridges

Welcome!

Fill out the Assistance Application
Answer questions about you and your household.

Fill out Program Details:

← Refer to the Information Booklet for details on each program

Healthcare Coverage

Food Assistance Program (FAP)

Cash Assistance
- Family Independence Program (FIP)
- Refugee Cash Assistance (RCA)
- State Disability Assistance (SDA)

Child Development + Care (CDC)

State Emergency Relief (SER)

Submit your application for one or more programs
It will be sent to your local MDHHS office for review and follow-up.
You may need to interview with a MDHHS Specialist.

Receive your results

What language do you prefer? Spoken Language | Written Language

If you do not speak English, have a hearing impairment, or have a disability, let us know how we can help you (an interpreter, sign language, TDD/TTY phone number we should call, assistance listening device, etc.) or bring your own support.

إذا كنت لا تتحدث اللغة الإنجليزية، تعاني من إعاقة سمعية، أو لديك إعاقة، أخبرنا كيف يمكننا مساعدتك (مترجم فوري، لغة الإشارة، رقم هاتف TDD/TTY يجب أن نتصل عليه، جهاز الاستماع للمساعدة، إلخ .....) أو أحضر أجهزة المساعدة الخاصة بك.

Si no habla inglés, tiene una discapacidad auditiva o tiene una discapacidad, hagános saber cómo podemos ayudarlo (un intérprete, un lenguaje de señas, un número de teléfono TDD / TTY al que debemos llamar, un dispositivo de asistencia auditiva, etc) o puede traer su propio apoyo.

If you are refused help, call **855-275-6424**.

Michigan Department of Health and Human Services

MDHHS-1171 (Rev. 3-20) Previous edition obsolete.

Case #:

ID #:

Applicant Registration

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If you are unable to finish the entire application today, you may complete this page and return it to MDHHS. MDHHS will still need to receive your completed application before any benefits can be approved

For Food Assistance (FAP), you are only required to fill in your name, address (unless homeless), and signature. For all other programs include date of birth

Legal Name (First, Middle, Last) ☐ Homeless

Household Street Address — the place where you currently live | Apt/Lot #

City | County | State | ZIP Code

Mailing Address — if different from above (Street, City, County, State, ZIP Code)

Date of Birth (/ /) | Social Security Number (- -)

← We need a Social Security number (SSN) for people who are requesting assistance and have a SSN or can get one. See Info Booklet (Pg 30) for more details

Cell Phone # ( ) - | Home Phone # ( ) - | Email @

Have you received assistance in Michigan in the past (or currently)? ☐ **Yes** ☐ **No**

What programs is your household applying for today?

☐ **Healthcare** ☐ **Food** ☐ **Cash** ☐ **Child Care** ☐ **State Emergency Relief**

Check any that apply: (You may qualify for 7 day processing of your food assistance) ← For FAP only

- ☐ My monthly income is less than $150 and I have $100 or less in cash/accounts right now.
- ☐ My household's combined monthly income and cash/accounts are less than my household's combined monthly rent/mortgage and utilities.
- ☐ I am a migrant or seasonal farmworker whose income has stopped and I have $100 or less in cash/accounts right now.

Sign Here

Under penalties of perjury, I state that I have reviewed this application, and to the best of my knowledge and belief, the answers I give within this application are true. If I am declaring an Authorized Representative, by signing below, I allow this person to sign my application and get official information about this application. For Healthcare only, I authorize my Authorized Representative to act for me on all future matters.

Signature of Applicant | Signature of Representative | Date

MDHHS-1171 (Rev. 3-20) Previous edition obsolete.

Household Members

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SSN and US Citizen/National are optional for people who are not requesting assistance. See Info Booklet (Pg 30) for more details

Ethnicity/Race is optional and will not affect eligibility or benefits. See Info Booklet (Pg 34) for more details

List everyone who lives in your home, including yourself and anyone who is not there all the time. If applying for healthcare coverage, list everyone who will be included on your federal tax return this year (note: you do not need to file taxes to receive assistance).

	Relationship to you	Full Legal Name	Sex	Date of Birth	Social Security #	US Citizen/ National	Married	In the Home?
1	self		M F	/ /	- -	Y N	Y N	Y N
2			M F	/ /	- -	Y N	Y N	Y N
3			M F	/ /	- -	Y N	Y N	Y N
4			M F	/ /	- -	Y N	Y N	Y N
5			M F	/ /	- -	Y N	Y N	Y N

For each person:

is requesting: HEALTHCARE FOOD CASH CHILD CARE STATE EMERGENCY RELIEF NONE

Ethnicity (optional): Hispanic/Latino | Not Hispanic/Latino

Race (optional): African American/Black | American Indian/Alaska Native | Asian | Native Hawaiian/Other Pacific Islander | White

Need more room to write? Go to notes on last page to answer these questions. ☐ **Yes, I've added more notes.**

Household Details

3

This page is not required for State Emergency Relief (SER)

Is anyone in your household pregnant now or were they in the last 3 months?
☐ If yes, who? Name(s) ☐ No ← Not required for FAP
Expected ____ End/Due Date / /

Does anyone in your household have a disability or a physical/emotional/mental health condition?
☐ If yes, who? ____ ☐ No ← For Healthcare, only required for applicants

Do any children (under age 20) have a parent who is living outside the home?
☐ If yes, who? ____ ☐ No

Is anyone in your household currently enrolled in college/vocational school?
☐ If yes, who? ____ ☐ No

Is anyone temporarily absent from the home (work, military, hospital, etc.)?
☐ If yes, who? ____ ☐ No

Has anyone in your household served in the military or armed services?
☐ If yes, who? ____ ☐ No ← Not required for eligibility

Is anyone in your household a foster child, foster parent, adopted child, or non-parent caregiver? (Circle all that apply)
☐ If yes, who? ____ ☐ No
Foster Child Foster Parent Adopted Child Non-parent Caregiver

Is anyone in your household currently a victim of domestic violence, victim of trafficking, migrant farmworker, seasonal farmworker, or refugee/asylee? (Circle all that apply)
☐ If yes, who? ____ ☐ No
Victim of Domestic Violence Victim of Trafficking
Migrant Farmworker Seasonal Farmworker Refugee/Asylee

If not a US citizen/national, does anyone have qualified immigration status? ☐ If yes, list below. ← See Info Booklet (Pg 34) for examples of qualified status. Non-applicants should skip this question

Who?	Document Type	Document Number	Date of US Entry
	Green card, etc.	#	/ /
		#	/ /
		#	/ /

Need more room to write? Go to notes on last page. ☐ Yes, I've added more notes.

Assets

4

This page is not required for Child Care (CDC)

Healthcare-only applicants should skip this page (unless disabled or in need of longterm care services)

Please include jointly owned accounts and/or assets

Money + Accounts

Does anyone in your household have money or accounts? ☐ **If yes, list below.** ☐ **No**

☐ **Checking** ☐ **Savings**

☐ **Other:** 401K Retirement Plans Life Insurance Stocks Mutual Funds IRAs CDs Burial Funds Lottery/Gambling Winnings Trusts/Annuities Payroll/Benefits Card Other

Who?	Type of Account	Name of Bank/Institution	Amount
			$
			$
			$

Vehicles

Does anyone in your household own vehicles? ☐ **If yes, list below.** ☐ **No**

☐ **Car** ☐ **Truck** ☐ **Motorcycle** ☐ **Boat** ☐ **Other**

Who?	Year, Make, + Model	Estimated Mileage

← Only list vehicles that are registered in a household member's name

Property

Does anyone in your household own property? ☐ **If yes, check below.** ☐ **No**

☐ **House(s)** ☐ **Buildings** ☐ **Rental Property** ☐ **Land/Lot** ☐ **Burial Plot** ☐ **Other**

Sales + Transfers

Has anyone sold, transferred, or given away assets in the last 5 years? ☐ **If yes, explain.** ☐ **No**

← In the last 90 days for FAP and SER

Income

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Change in Income

Has anyone in your household had a change in employment in the last 30 days? ☐ If yes, explain. ☐ No

☐ Laid off ☐ Quit ☐ Fired ☐ On strike ☐ Voluntarily reduced hours ☐ Refused work ☐ Other

Explain

Employment (Includes Temporary/Contract Jobs)

Is anyone in your household employed? ☐ If yes, list below. ☐ No

← Include anyone who worked in the last 30 days or expects to work next month

Who?	Employer Name	Avg Hrs/Wk	Wages/Tips (Before Tax)
			$ per Hr Wk 2Wks 2x/Mo Mo Yr
			$ per Hr Wk 2Wks 2x/Mo Mo Yr

Self-Employment (Includes Odd Jobs)

Is anyone in your household self-employed? ☐ If yes, list below. ☐ No

Who?	Type of Work	Income (Before Expenses)	Expenses
		$ Monthly	$ Monthly
		$	$

Additional

Does anyone in your household have additional income? ☐ If yes, list below. ☐ No

← For Healthcare, only include taxable income (unemployment, pensions, social security, alimony, etc.)

☐ Unemployment ☐ Disability (SSI) ☐ Alimony/Spousal Support ☐ Workers' Compensation

☐ Child Support ☐ Social Security (RSDI) ☐ Pension/Retirement

☐ Other: Rental Income Foster care Adoption Subsidy Loans/Gifts Interest/Dividends Tribal Income/Benefits Net Farming/Fishing Veterans Benefits/Military Allotments Refugee Resettlement Refugee Match Grant Short Term/Long Term Disability

Who?	Type of Income	Amount Received
		$ per Wk 2Wks 2x/Mo Mo Yr
		$ per Wk 2Wks 2x/Mo Mo Yr

Expenses

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This page is not required for Child Care (CDC)

Dependent Care

Does anyone in your household pay for dependent care expenses? ☐ If yes, list below. ☐ No

For all expenses, only include the amount you are responsible to pay

☐ Childcare (day care, after school programs, etc.) ☐ Care for a child or family member with a disability ← Not required for Healthcare

Who pays?	Who is it for?	Amount	How Often Paid
		$	
		$	

Medical

Does anyone in your household pay for medical expenses? ☐ If yes, list below. ☐ No

☐ Health Insurance ☐ Prescriptions ☐ In-Home Care ☐ Hospital Bills ☐ Other

☐ Co-Pays ☐ Dental ☐ Transportation for Care ☐ Guardian/Conservator Expenses

Who pays?	Type of Expense	Amount	How Often Paid
		$	
		$	

Court Ordered

Does anyone in your household pay for court ordered expenses? ☐ If yes, list below. ☐ No ← Not required for Healthcare

☐ Child Support ☐ Alimony/Spousal Support Paid Out

Who pays?	Who is it for?	Amount	How Often Paid
		$	
		$	

Student Loan Interest + Deductions

Does anyone pay for student loan interest or other tax deductible expenses? ☐ If yes, list below. ☐ No ← For Healthcare only

Who pays?	Type of Expense	Amount	How Often Paid
		$	

Final Details

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Fact Check

← Not required for Healthcare

Has anyone ever been disqualified from public assistance due to welfare fraud or an intentional program violation in any state, including Michigan?

☐ **If yes, who?** Name(s) ☐ **No**

Has anyone ever been convicted for receiving cash or food assistance from two or more states for the same period?

☐ **If yes, who?** ☐ **No**

Has anyone ever been convicted of a drug-related felony for conduct which occurred after August 22, 1996?

☐ **If yes, who?** ☐ **No**

Convicted more than once? Y | N

Voter Registration

Would you like help registering to vote at your current address?

← See Info Booklet (Pg 35) for more details

☐ **Yes, send me a voter registration application.**

☐ **No thanks, I am already registered/do not need a voter registration application.**

Authorized Representative

Do you want someone else to act for or represent you in this case? ☐ **If yes, list below.** ☐ **No**

← If you name an Authorized Representative, you will give permission for a trusted person to sign your application and get information from MDHHS. For Healthcare only, I authorize my Authorized Representative to act for me on all future matters. This information can also be collected later in the process

Name of your Authorized Representative (First, Middle, Last)

Address of Representative (Street, City, State, ZIP Code)

( ) -

Phone # of Representative

@

Email of Representative

If applying for food assistance, do you want someone else to have a Bridge Card and access your benefits to shop for you?

☐ **If yes, who?** Full Name ☐ **No**

(This should be someone you trust)

Your Signature

Sign the bottom of this page to complete your application

Anything Else?

Is there anything else you'd like for us to know about your situation? ☐ **If yes, write below.** ☐ **No**

Your Responsibilities

I have told the truth; I understand that I can be held criminally responsible for lying on this application.

I will have to provide papers that show that what I've told the department is true.

I will have to repay any benefits I should not have received, even if it is the department's error.

I will have to tell the department about any changes to the information I provided on my application.

I agree to cooperate with state or federal reviewers for an audit.

I agree to release my information for program needs.

I will use my benefits legally and will not sell, trade, or give away my benefits online or in person.

I understand that upon my death MDHHS has the legal right to seek recovery from some or all of my estate for services paid by Medicaid. All services paid by Medicaid are subject to estate recovery.

I have received, reviewed, and agree to the information provided in the Information Booklet.

← **By signing this application you are agreeing to these responsibilities**

Refer to your Information Booklet for a complete description of your rights and responsibilities

The Department's Responsibilities

If you think we, the department, made a mistake, you can ask for a hearing.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs, or disability.

Sign Here

Under penalties of perjury, I state that I have reviewed this application, and to the best of my knowledge and belief, the answers I give within this application are true, including household, citizenship and non-citizenship information, and I have listed all amounts and sources of income and property I receive/own. If I am declaring an Authorized Representative, by signing below, I allow this person to sign my application and get official information about this application. For Healthcare only, I authorize my Authorized Representative to act for me on all future matters. If I am signing as an Authorized Representative for Healthcare, I attest to my agreement to meet confidentiality and act in the best interest of the beneficiary.

Signature of Applicant	Signature of Representative	Date

When in-person interview completed:

Signature of Applicant	Signature of Department Witness	Date

Notes

Use this page to add any additional information/notes

Healthcare Coverage

Fill out the following details along with the Assistance Application if seeking Healthcare Assistance

Additional Group Details

Is anyone the primary caretaker for a child (under age of 19) in the home?
☐ If yes, who? Caretaker ☐ No

Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc), live in a medical facility or nursing home, or are you medically frail?
☐ If yes, who? Child ☐ No

Was anyone in foster care when they turned 18?
☐ If yes, who? ☐ No ← Only required for applicants

Is anyone applying for health insurance currently incarcerated (detained or jailed)?
☐ If yes, who? ☐ No

American Indian or Alaska Native

← AI/AN family members may not have to pay cost sharing and may get special monthly enrollment periods

Are you or is anyone in your family American Indian or Alaska Native?
☐ If yes, who? ☐ No

If yes, are they a member of a federally recognized tribe?
☐ If yes, Tribe ☐ No

Has anyone ever received a service or referral from the Indian Health Service, a tribal health program, or urban Indian health program?
☐ If yes, who? ☐ No

If no, is anyone eligible to get these services?
☐ If yes, who? ☐ No

Flint Water System

Did anyone in your home consume water from the Flint Water System and live, work, or receive childcare or education at an address that was served by the Flint Water System from April 2014 through present day?
☐ If yes, list below. ☐ No ← For individuals under age 21 or pregnant women. By checking "yes" you are requesting Healthcare

Names	Address Served by Flint Water (Street, City, Zip code)	Dates
		MO/YR - MO/YR
	☐ Home ☐ Work ☐ School ☐ Childcare Facility	
	☐ Home ☐ Work ☐ School ☐ Childcare Facility	

Your Name:

Individual ID #:

Healthcare Coverage

Fill out the following details along with the Assistance Application if seeking Healthcare Assistance

Tax Filers

Does anyone applying plan to file a federal tax return next year? ☐ **If yes, who?** ☐ **No**

← You do not need to file a tax return to receive Healthcare

Name of Primary Tax Filer

- Are they filing jointly with a spouse? ☐ **If yes, who?** Name of Spouse ☐ **No**
- Are they claiming dependents? ☐ **If yes, who?** Name of Dependent(s) ☐ **No**

- Are they filing jointly with a spouse? ☐ **If yes, who?** ☐ **No**
- Are they claiming dependents? ☐ **If yes, who?** ☐ **No**

Dependents

Will anyone applying be claimed as a dependent on someone else's tax return? ☐ **If yes, list below.** ☐ **No**

Dependent	Tax Filer	Relationship to Tax Filer
Name	Name	

Yearly Income

Does anyone's income change from month to month? ☐ **If yes, list below.** ☐ **No**

Who?	Total Estimated Income This Year	Total Estimated Income Next Year
Name		

← If you think it will be different

Your Name:

Individual ID #:

Healthcare Coverage

Fill out the following details along with the Assistance Application if seeking Healthcare Assistance

Health Coverage Info

Does anyone need help paying for medical bills from the past 3 months?

☐ If yes, who? Name(s) ☐ No

Which months? JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC

Did anyone have insurance through a job and lose it in the last 3 months? ☐ If yes, list below. ☐ No

Who lost coverage?	End Date	Reason Insurance Ended
Name	MM/YYYY	

Is anyone currently enrolled in health coverage (even if not applying)? ☐ If yes, list below. ☐ No

← Including Medicaid, CHIP/MIChild, Medicare, VA Healthcare Programs, Peace Corps, Employer Insurance, TRICARE (unless you have direct care or Line of Duty), and Other

Type + Name of Coverage	Person Covered	Policy #
	Name	

If Medicare, do you want help paying Medicare premiums? Y | N

If employer insurance: Is this COBRA coverage? Y | N

Is this a retiree health plan? Y | N

If other, is this a limited benefit plan (such as a school accident policy)? Y | N

To make it easier to determine your Healthcare eligibility in future years, do you agree to the use of IRS data for automatic renewals?

☐ Yes ☐ No

← This allows the Marketplace and the State of Michigan to use income data (including information from tax returns). See Info Booklet (Pg 8) for more details

If yes, for how many years? 5 4 3 2 1

Your Name:

Individual ID #:

Healthcare Coverage

If you need assistance, take a copy of this page to your employer and have them help you fill it out

Information on this page won't impact your application. It will be passed on to the federal government to determine your eligibility for APTC (Advanced Premium Tax Credits)

Health Coverage From Jobs

Complete this page if someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Is anyone in the household offered health insurance from a job? ☐ **If yes, list below.** ☐ **If no, skip this page.**
(This includes coverage from someone elses' job, such as a parent of a spouse)

Name _____ - - _____
Employee — Employee Social Security #

Name _____ _____ _____
Employer — Employer Identification # (EIN) — Address of Employer

Name _____ ( ) - _____ @ _____
Employer Contact — Phone # of Employer Contact — Email of Employer Contact
(This should be the person or department who manages employee benefits)

Can the employee get coverage now or sometime in the next 3 months? ☐ **If yes, when?** / / ☐ **No**

List everyone who is eligible for coverage from this job Name(s) _____

Does the employer offer a health plan that pays at least 60% of the total costs of benefits (the minimum value standard for health plans)? ☐ **Yes** ☐ **No**

- If yes, how much would the employee have to pay for the lowest cost plan that meets the minimum value standard?

$ _____ per Wk 2Wks 2x/Mo Mo Qr Yr

← Don't include family plans. If the employer offers wellness programs, enter the premium that the employee would pay if they got the maximum discount for a tobacco cessation program

Will the employer make any changes for the new plan year (if you know)? ☐ **If yes, list below.** ☐ **No**

- ☐ **Employer won't offer health coverage**
  - Date of change / /
- ☐ **The premium amount will change for the lowest cost plan that meets the minimum value standard**
  - Date of change / / Employee would pay this premium $ _____ per Wk 2Wks 2x/Mo Mo Qr Yr

Your Name:
Individual ID #:

Food Assistance Program (FAP)

Fill out the following details along with the Assistance Application if seeking Food Assistance

Household Details

Does anyone buy and make food separately from the rest of the household?	☐	If yes, who?		☐ No
Is anyone living in a facility or special living arrangement (now or within the past 3 months)?	☐	If yes, who?		☐ No
Is anyone in your household going to an alcohol or drug treatment program?	☐	If yes, who?		☐ No
Does anyone in your household receive tribal food distribution benefits?	☐	If yes, who?		☐ No
Has anyone received Food Assistance from another state in the last 30 days?	☐	If yes, who?		☐ No
		State		

Housing Expenses

Does anyone in your household pay for housing expenses? ☐ If yes, list below. ☐ No

← Only list the amount you pay, not Housing Choice Voucher (Section 8), HUD, MSHDA, etc.

☐ Rent ☐ Land Contract ☐ Homeowner's Insurance ☐ Other

☐ Mortgage ☐ Mobile Home Lot Rent ☐ Property Tax

Only list Insurance/Property Tax if not included in mortgage

Who pays?	Type of Expense	Amount	How Often Paid
		$	
		$	

Utilities

Does anyone in your household pay for utilities (not included in rent)? ☐ If yes, check below. ☐ No

☐ Heat ☐ Electricity ☐ Trash Pickup ☐ Cooking Fuel

← Heat types include gas, electric heating, propane, wood, etc.

☐ Air Conditioning ☐ Water/Sewer ☐ Phone

Electricity does not include heat or air conditioning

If utilities are included in your rent, does anyone in your household pay an extra fee for air conditioning?	Y N
Has anyone applying for FAP received more than $20 in State Emergency Relief (SER) energy payments or Michigan Energy Assistance Program (MEAP) payments in the last 12 months?	Y N
Has anyone applying for FAP received more than $20 in the Home Heating Credit (HHC) in the last 12 months?	Y N

Your Name:

Individual ID #:

Cash Assistance

Fill out the following details along with the Assistance Application if seeking Cash Assistance

Is anyone in the household…

Living in a facility or special living arrangement now or within the past 3 months?	☐	If yes, who?	Name(s)	☐ No
Going to an alcohol or drug treatment program?	☐	If yes, who?		☐ No
Attending special education classes?	☐	If yes, who?		☐ No
Receiving Michigan Rehabilitation Services?	☐	If yes, who?		☐ No
Receiving medical assistance based on disability or blindness?	☐	If yes, who?		☐ No
Currently applying (or planning to apply) for disability benefits with the Social Security Administration (SSA)?	☐	If yes, who?		☐ No
Have or expect to have medical coverage (including accident insurance, worker's compensation, health savings, health/hospital insurance or other)?	☐	If yes, who?		☐ No
In violation of probation or parole?	☐	If yes, who?		☐ No
Received Cash Assistance from another state since August 1996?	☐	If yes, who?		☐ No
		State		

For children in the household

Are there children under 6 years of age who are not up to date on their immunizations (shots)?	☐	If yes, who?		☐ No
Are any children (ages 6–18) in school now?	☐	If yes, list below.		☐ No

Name(s)

Your Name

Individual ID #:

Child Development + Care (CDC)

Fill out the following details along with the Assistance Application if seeking Child Care Assistance

Do you currently live in temporary or emergency housing? Y | N

You need child care so that you can participate in (check all that apply):

- ☐ **Work**
- ☐ **High School or GED Completion/College**
- ☐ **Training/Employment Preparation**
- ☐ **PATH program or other approved activity**
- ☐ **Activity required by MDHHS Child Protective Services**
- ☐ **Treatment for Health or Social Condition (explain):**

If you are in school, do you need study time? Y | N

How many hours of child care do you need every two weeks? #

Is either parent serving active duty in the US Military? ☐ **If yes, who?** ☐ **No**

Is either parent a member of the National Guard or Military Reserve Unit? ☐ **If yes, who?** ☐ **No**

Does the household have total assets that exceed one million dollars? Y | N

← This is an actual question; it is required on a federal level

Children (Age 18 and Under) in Household

Child Legal Name (First, Middle, Last)	Parent Legal Names (First, Middle, Last)	Living at Home with the Child?	Child up to date on Immunizations (Shots)?
	Mother	Y N	Y N
	Father	Y N	
		Y N	Y N
		Y N	
		Y N	Y N
		Y N	

Need more room to write? Go to notes on last page. ☐ **Yes, I've added more notes.**

Your Name
Individual ID #:

State Emergency Relief (SER)

Emergency Need

What services are you requesting? Check below and list the amount needed to resolve the emergency.

- ☐ Heat (see details below)
- ☐ Electricity (see details below)
- ☐ Water/Sewer $ _____
- ☐ Cooking Gas $ _____
- ☐ Eviction/Relocation $ _____
- ☐ Property Taxes $ _____
- ☐ Homeowner's Insurance $ _____
- ☐ Mortgage $ _____
- ☐ Home Repairs $ _____
- ☐ Furnace Repair $ _____
- ☐ Burial/Cremation $ _____
- ☐ Migrant Hospitalization $ _____
- ☐ Security Deposit $ _____
- ☐ Moving Expenses $ _____

Heat Request Details

How do you heat your home?

- ☐ Natural Gas
- ☐ Electricity
- ☐ Propane
- ☐ Coal
- ☐ Wood
- ☐ Fuel Oil
- ☐ Other:

Describe your current situation:

- ☐ My heat has been turned off/I have run out of my household's heating fuel source.
- ☐ I have received a past due or shut off notice/I am at risk of running out of my household's heating fuel source.

Date of shut off ___/___/___ Current balance (If prepaid account) $ _____ % remaining in tank _____ %

← To qualify, tank cannot be more than 25% full

Electricity Request Details

Describe your current situation:

- ☐ My electricity has been turned off
- ☐ I have received a past due or shut off notice

Date of shut off ___/___/___ Current balance (If prepaid account) $ _____

Your Name:

Individual ID #:

State Emergency Relief (SER)

Current Housing Expenses

Do you pay for any housing expenses? ☐ If yes, list below. ☐ No

	Name of Service Provider	Name on Bill/Account	Account #	Is This a Shared Meter?	Is There Theft or Illegal Use?
☐ Heat				Y N	Y N
☐ Electricity				Y N	Y N
☐ Water/Sewer				Y N	Y N
☐ Cooking Fuel				Y N	Y N
☐ Rent/Mortgage					
☐ Property Taxes					
☐ Home Insurance					

Household Information

Tell us about your expenses, income, and the people who have lived with you over the past 6 months.

	1 Month Ago	2 Months Ago	3 Months Ago	4 Months Ago	5 Months Ago	6 Months Ago
Month						
# of People in Home						
Total Monthly Income (Before Tax)	$	$	$	$	$	$
Rent/Mortgage	$	$	$	$	$	$
Heat	$	$	$	$	$	$
Electricity	$	$	$	$	$	$
Water/Sewer /Cooking Gas	$	$	$	$	$	$

Is anyone in the household fleeing from felony prosecution, an outstanding felony warrant or jail? ☐ If yes, who? _____ ☐ No

Is anyone in the household in violation of probation or parole? ☐ If yes, who? _____ ☐ No

Your Name:

Individual ID #:

State Emergency Relief (SER)

If this application is for burial services, it must be received by MDHHS no later than 10 business days after the burial, cremation, or donation takes place

Burial Service Request

If you are applying for burial services, please complete this page. Be sure to answer questions on the Assistance Application for the deceased, their spouse, and their parents (if deceased is a minor child).

Name of Deceased (First, Middle, Last) _____ Date of Death / / _____ Your Legal Relationship with the Deceased _____

Name of Funeral Home _____ Address of Funeral Home _____ Phone of Funeral Home ( ) -

Is this a cremation? Y | N

Place of Burial/Crematory _____ Date of Burial/Cremation / /

Is payment to the cemetery/crematory separate from the payment to the funeral home? Y | N

Did you sign a statement of goods and services with the funeral home? Y | N

Is there a memorial service? Y | N

Is the deceased a veteran? Y | N

Did the deceased own his or her home? ☐ **If yes, address?** _____ ☐ **No**

Is there a co-owner for this home? ☐ **If yes, who?** _____ ☐ **No**

Cost of burial/cremation $ _____

Is there a contribution from family/friends? ☐ **If yes, how much?** $ _____ ☐ **No**

Are there any death benefits that you have applied for or expect to receive? ☐ **If yes, list below.** ☐ **No**

- ☐ **Accident/Automobile Insurance**
- ☐ **Pre-paid Funeral Agreement**
- ☐ **Social Security Death Benefits**
- ☐ **Veteran's Death Benefits**
- ☐ **Labor Union Benefits**
- ☐ **A Community Assistance Fund/ Fraternal Organizations**
- ☐ **Life Insurance**
- ☐ **Other (list below)**

Type of Death Benefits _____ **Amount** $ _____