

BARRY V. LYON LAWSUIT

CLAIM FORM
FOR FOOD ASSISTANCE PROGRAM (FAP) BENEFITS

Instructions:

Fill out this form to request Food Assistance benefits that may be owed to you for past months in which MDHHS denied or cut off your Food Assistance because of a “criminal justice disqualification.”

Please fill in all information. Please print clearly. (*Denotes a required field.)

- If information that has been pre-printed is not correct, please write in the corrected information.
- Be sure to SIGN THE FORM and keep a copy with the date that you mail it.
- Mail this form to: Michigan Department of Health and Human Services
Barry Lawsuit Processing Unit
PO Box 30784
Lansing MI 48909-9561

*First Name	*Middle Name	*Last Name
MDHHS Case Number (if known)	Date of Birth (Month, Day, Year)	Social Security Number XXX-XX-

Current Mailing Address

*Street Address or PO Box	*City	*County	*State	*Zip
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Residential Address (if different from above)

*Street Address	*City	*County	*State	*Zip
Home Phone Number	Cell Phone Number	Work Phone Number		
Phone number where MDHHS can leave a message	Whose phone number is this (name and relationship)			
Email Address	What is the primary language spoken in your home?			

This is a request for supplemental Food Assistance Program benefits due to me on or after January 1, 2013, which is submitted pursuant to BAM 406 p. 3, 7 CFR 273.17, and 7 USC 2020(b) and (e)(11) and 2023(b).

My signature means the information on this form is true.

*Signature	*Date
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Keep a copy of this form for your records.
Write the date you mail this form on your copy.

Michigan Department of Health and Human Services (MDHHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to an MDHHS office in your area.