



# 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](http://www.michigan.gov/ContactMDHHS)

Apply online: [www.michigan.gov/mibridges](http://www.michigan.gov/mibridges)

← Refer to the Information Booklet for details on each program

## Welcome!

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

### Fill out Program Details:



**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**  
You will need to interview with a MDHHS specialist, unless applying for healthcare coverage only.

## 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, hagáanos 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

Case #:

ID #:

MDHHS-1171 (Rev. 10-20)

# Applicant Registration

1

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

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.

I am a migrant or seasonal farmworker whose income has stopped 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.

## 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

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

← 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

# Household Members

# 2

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).

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

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
is requesting:		HEALTHCARE	FOOD	CASH	CHILD CARE	STATE EMERGENCY RELIEF	NONE
Ethnicity (optional):		Race (optional):					
Hispanic/Latino   Not Hispanic/Latino		African American/Black	American Indian/Alaska Native	Asian	Native Hawaiian/Other Pacific Islander	White	
2		M   F	/ /	- -	Y   N	Y   N	Y   N
is requesting:		HEALTHCARE	FOOD	CASH	CHILD CARE	STATE EMERGENCY RELIEF	NONE
Ethnicity (optional):		Race (optional):					
Hispanic/Latino   Not Hispanic/Latino		African American/Black	American Indian/Alaska Native	Asian	Native Hawaiian/Other Pacific Islander	White	
3		M   F	/ /	- -	Y   N	Y   N	Y   N
is requesting:		HEALTHCARE	FOOD	CASH	CHILD CARE	STATE EMERGENCY RELIEF	NONE
Ethnicity (optional):		Race (optional):					
Hispanic/Latino   Not Hispanic/Latino		African American/Black	American Indian/Alaska Native	Asian	Native Hawaiian/Other Pacific Islander	White	
4		M   F	/ /	- -	Y   N	Y   N	Y   N
is requesting:		HEALTHCARE	FOOD	CASH	CHILD CARE	STATE EMERGENCY RELIEF	NONE
Ethnicity (optional):		Race (optional):					
Hispanic/Latino   Not Hispanic/Latino		African American/Black	American Indian/Alaska Native	Asian	Native Hawaiian/Other Pacific Islander	White	
5		M   F	/ /	- -	Y   N	Y   N	Y   N
is requesting:		HEALTHCARE	FOOD	CASH	CHILD CARE	STATE EMERGENCY RELIEF	NONE
Ethnicity (optional):		Race (optional):					
Hispanic/Latino   Not Hispanic/Latino		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

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?   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.

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

← See Info Booklet (Pg 34) for examples of qualified status. Non-applicants should skip this question

Need more room to write? Go to notes on last page.

Yes, I've added more notes.

# Assets

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

## 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)

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

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

Who?	Employer Name	Avg Hrs/Wk	Wages/Tips (Before Tax)	How often paid?
			\$ 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

# 6

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

## 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?   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?   
 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?   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

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## 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.

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Signature of Applicant

Signature of Representative

Date

### When in-person interview completed:

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Signature of Applicant

Signature of Department Witness

Date

# Notes



Use this page to add any additional information/notes

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Notes section containing 15 horizontal light blue lines for writing.



# 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?   No

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?   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,   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
<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Childcare Facility	
<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Childcare Facility	

# 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

<input type="text" value="Name of Primary Tax Filer"/>			
Are they filing jointly with a spouse?	<input type="checkbox"/> If yes, who?	<input type="text" value="Name of Spouse"/>	<input type="checkbox"/> No
Are they claiming dependents?	<input type="checkbox"/> If yes, who?	<input type="text" value="Name of Dependent(s)"/>	<input type="checkbox"/> No
<input type="text"/>			
Are they filing jointly with a spouse?	<input type="checkbox"/> If yes, who?	<input type="text"/>	<input type="checkbox"/> No
Are they claiming dependents?	<input type="checkbox"/> If yes, who?	<input type="text"/>	<input type="checkbox"/> 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	
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

## 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		
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

← If you think it will be different

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

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

# Healthcare Coverage



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

## 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.

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)

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 else's 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
<small>(This should be the person or department who manages employee benefits)</small>		

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

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

# 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
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>

## Utilities

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

Heat  Electricity  Trash Pickup  Cooking Fuel  
 Air Conditioning  Water/Sewer  Phone

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

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

Michigan Department of Health and Human Services

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?   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

# 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)?
<input type="text"/>	Mother	Y   N	Y   N
	Father	Y   N	
<input type="text"/>	<input type="text"/>	Y   N	Y   N
	<input type="text"/>	Y   N	
<input type="text"/>	<input type="text"/>	Y   N	Y   N
	<input type="text"/>	Y   N	

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

# State Emergency Relief (SER)



## Emergency Need

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

<input type="checkbox"/> Heat (see details below)	<input type="checkbox"/> Property Taxes \$ _____	<input type="checkbox"/> Burial/Cremation \$ _____
<input type="checkbox"/> Electricity (see details below)	<input type="checkbox"/> Homeowner's Insurance \$ _____	<input type="checkbox"/> Migrant Hospitalization \$ _____
<input type="checkbox"/> Water/Sewer \$ _____	<input type="checkbox"/> Mortgage \$ _____	<input type="checkbox"/> Security Deposit \$ _____
<input type="checkbox"/> Cooking Gas \$ _____	<input type="checkbox"/> Home Repairs \$ _____	<input type="checkbox"/> Moving Expenses \$ _____
<input type="checkbox"/> Eviction/Relocation \$ _____	<input type="checkbox"/> Furnace Repair \$ _____	

## Heat Request Details

How do you heat your home?

<input type="checkbox"/> Natural Gas	<input type="checkbox"/> Propane	<input type="checkbox"/> Wood	<input type="checkbox"/> Other:
<input type="checkbox"/> Electricity	<input type="checkbox"/> Coal	<input type="checkbox"/> Fuel Oil	

Describe your current situation:

<input type="checkbox"/> My heat has been turned off/I have run out of my household's heating fuel source.			
<input type="checkbox"/> 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 <input type="text"/> / <input type="text"/> / <input type="text"/>	Current balance (If prepaid account) \$ <input type="text"/>	% remaining in tank <input type="text"/> %	← To qualify, tank cannot be more than 25% full

## Electricity Request Details

Describe your current situation:

<input type="checkbox"/> My electricity has been turned off	
<input type="checkbox"/> I have received a past due or shut off notice	
Date of shut off <input type="text"/> / <input type="text"/> / <input type="text"/>	Current balance (If prepaid account) \$ <input type="text"/>

# 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?	
<input type="checkbox"/> Heat				Y	N	Y	N
<input type="checkbox"/> Electricity				Y	N	Y	N
<input type="checkbox"/> Water/Sewer				Y	N	Y	N
<input type="checkbox"/> Cooking Fuel				Y	N	Y	N
<input type="checkbox"/> Rent/Mortgage							
<input type="checkbox"/> Property Taxes							
<input type="checkbox"/> 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

Michigan Department of Health and Human Services

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).

<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
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Name of Deceased (First, Middle, Last)      Date of Death      Your Legal Relationship with the Deceased

<input type="text"/>	<input type="text"/>	<input type="text"/> ( <input type="text"/> ) <input type="text"/> - <input type="text"/>
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Name of Funeral Home      Address of Funeral Home      Phone of Funeral Home

Is this a cremation?    Y   N	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
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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?	<input type="checkbox"/>	If yes, address?	<input type="text"/>	<input type="checkbox"/>	No
Is there a co-owner for this home?	<input type="checkbox"/>	If yes, who?	<input type="text"/>	<input type="checkbox"/>	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

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Accident/Automobile Insurance | <input type="checkbox"/> Pre-paid Funeral Agreement | <input type="checkbox"/> Social Security Death Benefits                          |
| <input type="checkbox"/> Veteran's Death Benefits      | <input type="checkbox"/> Labor Union Benefits       | <input type="checkbox"/> A Community Assistance Fund/<br>Fraternal Organizations |
| <input type="checkbox"/> Life Insurance                | <input type="checkbox"/> Other (list below)         |  |

Type of Death Benefits	Amount
<input type="text"/>	\$ <input type="text"/>