Assistance Application

Submit this form by mail, fax, or bring it into a local MDHHS office. If determined eligible, SNAP benefits will be issued from the date the application is filed.

Find your nearest location at **www.michigan.gov/ContactMDHHS.**

Apply online: 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

Supplemental Nutrition Assistance Program (SNAP)

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

Assistance Application

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.)

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.)

إذا كنت لا تتحدث اللغة الإنجليزية أو تعاني من ضعف في السمع، أو لديك إعاقة، فأخبرنا كيف يمكننا مساعدتك (مترجم فوري، لغة الإشارة، رقم هاتف TDD/TTY الذي يجب أن نتصل به، جهاز الاستماع للمساعدة، وما الى ذلك .....)

Applicant Registration

If you are unable to finish the entire application today, you may complete this page and return it to MDHHS to save your application date. MDHHS will still need to receive your completed application before any benefits can be approved. The date MDHHS receives your assistance application or filing form may affect the date your benefits start. If determined eligible, SNAP benefits will be issued from the date the application is filed.

For SNAP, 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 38) for more details.

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 @

Applicant Registration

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

What program(s) 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 SNAP 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 migratory or seasonal agricultural worker 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 (if you are declaring an authorized representative, complete the Authorized representative section on page 12). For Healthcare only, I authorize my Authorized Representative to act for me on all future matters.

Signature of Applicant	Signature of Representative	Date

Household Members 3

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 38) for more details.

Ethnicity/Race is optional and will not affect eligibility or benefits. See Info Booklet (Pg 44) for more details.

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Relationship to you	Full Legal Name	Sex	Date of Birth	Social Security #
self		M F	/ /	- -

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 | Middle Eastern/North African | Native Hawaiian/Other Pacific Islander | White

2

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

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 | Middle Eastern/North African | Native Hawaiian/Other Pacific Islander | White

Household Members 4

US Citizen/National Y | N **Married** Y | N **Sex** M | F **In the Home?** Y | N

3 _____ _____ / / - -

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 Middle Eastern/North African
Native Hawaiian/Other Pacific Islander White

US Citizen/National Y | N **Married** Y | N **Sex** M | F **In the Home?** Y | N

4 _____ _____ / / - -

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 Middle Eastern/North African
Native Hawaiian/Other Pacific Islander White

US Citizen/National Y | N **Married** Y | N **Sex** M | F **In the Home?** Y | N

5 _____ _____ / / - -

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 Middle Eastern/North African
Native Hawaiian/Other Pacific Islander White

US Citizen/National Y | N **Married** Y | N **In the Home?** Y | N

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 SER.

Is anyone in your household pregnant now or were they in the last 2 months? Not required for SNAP.

☐ **If yes, who?** Name(s) ☐ **No**

\# Expected ____ End/Due Date / /

Does anyone in your household have a disability or a physical/emotional/mental health condition? For Healthcare, only required for applicants.

☐ **If yes, who?** ____ ☐ **No**

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**

Is anyone in your household a Veteran or has anyone served in the military or armed forces? Not required for eligibility.

☐ **If yes, who?** ____ ☐ **No**

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

Household Details

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Is anyone in your household currently a victim of domestic violence or victim of trafficking?

☐ **If yes, who?** _____ ☐ **No**

Are you a migrant farmworker, refugee or asylee?
(Circle all that apply)

☐ **If yes, who?** _____ ☐ **No**

Migrant Farmworker Refugee or Asylee

Do you believe pursuing child support would be harmful for you or your child (examples include threats of abuse, history of abuse, incest, rape)?
Not required for CDC or SNAP.

☐ **If yes, who?** _____ ☐ **No**

If not a US citizen/national, does anyone have qualified immigration status?
See Info Booklet (Pg 45) for examples of qualified status.
Non-applicants should skip this question.

☐ **If yes, list below.**

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

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Money + Accounts

The asset section is not required for CDC.
Healthcare-only applicants should skip the asset section (unless disabled or in need of longterm care services).

Does anyone in your household have money or accounts? Include jointly owned accounts and/or assets.

☐ **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

Not required for CDC or SNAP.

Does anyone in your household own vehicles?

☐ **If yes, list below.** ☐ **No**

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

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

Who?	Year, Make, + Model	Estimated Mileage

Assets + Income

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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? In the last 90 days for SNAP and SER.

☐ If yes, list below. ☐ No

Person Sold/Given To	Type of Asset	Date	Amount
		/ /	$
		/ /	$

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

Income (continued)

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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	How often paid?	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? For Healthcare, only include taxable income (unemployment, pensions, social security, alimony, etc.).

☐ If yes, list below. ☐ No

☐ 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

The expense section is not required for CDC.

Dependent Care

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

Does anyone in your household pay for dependent care expenses?

☐ **If yes, list below.** ☐ **No**

☐ **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
		$	
		$	

Expenses + Final Details 11

Court Ordered

Does anyone in your household pay for court ordered expenses? Including arrearages. Not required for Healthcare.

☐ **If yes, list below.** ☐ **No**

☐ **Child Support** ☐ **Alimony/Spousal Support Paid Out**

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

Student Loan Interest + Deductions

For Healthcare only.

Does anyone pay for student loan interest or other tax deductible expenses?

☐ **If yes, list below.** ☐ **No**

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?** 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**

Final Details (continued) 12

Authorized Representative

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.

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

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? (This should be someone you trust) ☐ **If yes, who?** Full Name ☐ **No**

Voter Registration

If you are not registered to vote where you live now, would you like to apply to register to vote here today? ☐ **Yes** ☐ **No**

If you do not check any box you will be considered to have decided to not register to vote at this time, **but a paper voter registration application form will be mailed to you should you decide to register or update your registration.**

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided, or your eligibility. Your decision to register to vote or not will be kept confidential. If you would like help filling out the voter registration application, we will help you or you can call the Secretary of State toll-free at 888-SOS-MICH; 888-767-6424 for assistance. The decision to seek or accept help is yours. You may also fill out the application in private.

If you believe that someone has interfered with your right to register or to decline to register to vote, or your right to privacy in deciding whether to register; you may file a complaint with the:

Michigan Department of State: Richard H. Austin Building
430 W. Allegan, Lansing, MI 48918
toll-free at 888-SOS-MICH; 888-767-6424

Your Signature

Anything Else?

Sign the next page to complete your application.

Is there anything else you'd like for us to know about your situation?

☐ **If yes, write below.** ☐ **No**

Your Responsibilities

By signing this application you are agreeing to these responsibilities.
Refer to your Information Booklet for a complete description of your rights and 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 and any adult program group member(s) (18 yrs and older) will have to repay any benefits I/we 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.

Your Signature (continued)

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 on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

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.

Notes

Use this page to add any additional information/notes.

Notes

Use this page to add any additional information/notes.

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 Child ☐ **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 in Michigan when they turned 18?
☐ **If yes, who?** ☐ **No** ← Only required for applicants.

Was anyone in foster care in another state when they turned 18 on or after January 1, 2023?
☐ **If yes, who?** State ☐ **No**

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 September 30, 2025.
☐ **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 7) 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?
(This includes coverage from someone else's' job, such as a parent of a spouse)
☐ **If yes, list below.** ☐ **If no, skip this page.**

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 #:

Supplemental Nutrition Assistance Program (SNAP)

Household Details

Fill out the following details along with the Assistance Application if seeking SNAP.

Does anyone buy and make food separately from the rest of the household?	☐	If yes, who?		☐ No
Is anyone in your household a boarder?	☐	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
Is anyone a member of a tribe?	☐	If yes, who?		☐ No
Has anyone received SNAP from another state? When?	☐	If yes, who?		☐ No
		State		

Housing Expenses

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

Only list Insurance/Property Tax if not included in mortgage.

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

☐ Rent ☐ Rent with meals (room/board) ☐ Meals only (board) ☐ Land Contract

☐ Mortgage ☐ Mobile Home Lot Rent ☐ Property Tax ☐ Homeowner's Insurance ☐ Other

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

Your Name:
Individual ID #:

Supplemental Nutrition Assistance Program (SNAP)

Utilities

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

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

Electricity does not include heat or air conditioning.

☐ **Heat** ☐ **Electricity** ☐ **Trash Pickup** ☐ **Cooking Fuel**

☐ **Air Conditioning** ☐ **Water/Sewer** ☐ **Phone**

Does anyone who you do not share food with pay any portion of housing expenses or utilities? Y | N

Has anyone applying for SNAP 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

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 SNAP received more than $20 in the Home Heating Credit (HHC) in the last 12 months? Y | N

Cash Assistance

Is anyone in the household...

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

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?** **State**		☐ **No**

Your Name

Individual ID #:

Cash Assistance

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)

Child Development + Care (CDC)

Fill out the following details along with the Assistance Application if seeking CDC 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?

Are you working at the licensed child care center that your child attends? Y | N

If yes, MDHHS must confirm your child is not in your care while at work. Provide the owner/director's name and phone number:

Child Development + Care (CDC)

I understand that a DHS-4025 Provider Verification form must be submitted to assign and pay my CDC provider: Y | N

Note: If my child care provider is not licensed (ex: family or friend), they must be enrolled as a license exempt provider. The License Exempt Provider Application can be found at www.michigan.gov/childcare.

Is either parent serving on active duty, or as a reservist, or with the National Guard with the US military? ☐ **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)?
	Parent 1	Y | N	Y | N
	Parent 2	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.**

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** $ _____

For non-burial SER services, does the household have cash assets that exceed $15,000? Y | N

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** $