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**

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
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, 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.

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)

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

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

/ / 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 32) 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. 10-22) Previous edition obsolete.

Household Members 2

SSN and US Citizen/National are optional for people who are not requesting assistance. See Info Booklet (Pg 32) for more details

Ethnicity/Race is optional and will not affect eligibility or benefits. See Info Booklet (Pg 36) 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

Do any children (under age 20) have a parent who is living outside the home?
☐ If yes, who? ____ ☐ No ← For Healthcare, only required for applicants

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 ever 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

Do you believe pursuing child support would be harmful for you or your child (examples include threats of abuse, history of abuse, incest, rape)?
☐ If yes, who? ____ ☐ No

If not a US citizen/national, does anyone have qualified immigration status? ☐ If yes, list below. ← See Info Booklet (Pg 36) 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, list below.** ☐ **No**

← In the last 90 days for FAP and SER

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

Income

5

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	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? ☐ 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**

← Including arrearages

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

7

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**

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

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

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

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

( ) -

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)

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

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 will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, gender identification or expression, sexual orientation, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

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